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At the Bedside

When a Mother Wants to Deliver with a Midwife at Home

Edmund G. Howe

ABSTRACT

In this special issue of *The Journal of Clinical Ethics,* different views on both the ethical desirability of women delivering in hospitals or at home with midwives are discussed. What careproviders, including midwives, should recommend to mothers in regard to the place of giving birth is considered. Emotional concerns likely to be of importance to mothers, fathers, midwives, and doctors are also presented. Finally, possible optimal approaches at the levels of both policy and the bedside are suggested.

This special issue of *The Journal of Clinical Ethics* (*JCE*) involves the question of whether pregnant women should deliver with a midwife at home and how careproviders should advise them when they make this choice.[1] These questions are pressing. More than 99 percent of mothers in the U.S., for example, now deliver in hospitals, and, of these, more than 90 percent undergo "interventions" while in the hospital, but there is some evidence that 50 percent of the women don't want these interventions![2] Challenges to the present system are, therefore, increasing. Elizabeth Bogdan-Lovis, Charlotte de Vries, and Raymond de Vries are the guest editors of this special issue of *JCE*. In their article, "Ethics and the Architecture of Choice for Home and Hospital Birth," for example, they write that when they first proposed this topic to *JCE* in 2011, they couldn't have predicted the present "currency" of the issue.[3] Bogdan-Lovis and de Vries believe the core change needed is for clinicians to find a way to "respect a woman's wishes while upholding their professional commitment to provide competent care."

Frank A. Chervenak, Laurence B. McCullough, Amos Grünebaum, Birgit Arabin, Malcolm I. Levene, and Robert L. Brent, in "Planned Home Birth in the United States and Professionalism: A Critical Assessment," state that mothers should deliver only in hospitals, if they can, since there—and only there—will newborns who need immediate emergency care receive it.[4] Further, these authors believe that careproviders should strongly recommend delivery only in hospitals to their patients, and, if they don't, they should not regard themselves as professionals. These careproviders include midwives, some of whom deliver infants at home.

"In-hospital birthing" is the model that is currently most highly recommended for delivery in the U.S. The authors in this issue of *JCE* present differing perspectives on the comparative pros and cons of delivery at home—an alternative that challenges the standard model's presumptive place as the "standard" or preferable choice for women.

Bogdan-Lovis, de Vries, and de Vries did not invite Chervenak and colleagues to write their piece for this issue, *JCE* did, as we sought to present both "sides," and the best possible balance. Who, then,

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is right, and why? I will not answer these questions here, but instead highlight some particularly deep feelings that those who participate in delivering children are likely to have. Whether they are consciously aware of their feelings or not, these feelings may affect them throughout their lives.

I will begin by reviewing conflicting views on how to resolve some of these questions, and I will describe some additional factors that decision makers may want to consider. Then, I will discuss the strong emotions that mothers, fathers, midwives, and doctors may have. To close, I will discuss some possible goals that policy makers and careproviders may pursue.

A core issue is the extent to which the infants' interests alone should determine the relative "status" of delivery in the hospital versus at home, although, as the articles in this issue of *JCE* make clear, it is greatly open to debate what an infant's best interests are, and even whether they can be validly determined and compared. A primary position is that the autonomy of the mother, as well as her own interests, warrant moral weight. Bogdan-Lovis, de Vries, and de Vries and the authors they invited to contribute to this special issue all support, in one way or another, the possibility that home births may rightly serve broader interests than those of just the infant. They propose that respecting a mother's autonomy and interests to a greater extent may contribute to mothers and physicians having a more collaborative, trusting relationship than mothers may experience now.

The core question that this controversy raises is highly paradigmatic of moral enigmas that occur in other medical contexts. Thus, while these considerations are of the utmost importance in this context, they are also far reaching, and involve three widely present, critical moral questions. First, when "evidence" in assessing outcomes may not be definitive or conclusive, and when competing treatment options may be clinically supportable, when, and how can, and should individual patient choices be buttressed, respected, and enabled? Second, how should this analysis and answer be altered—if at all—when the interest of an additional party also is at stake (in this case, the infant, who cannot speak)? Third, when should patients make choices that are at odds with "best" medical practices?

Taking all of these considerations together, then, this special *JCE* issue, in addition to pursuing the "in-the-hospital-versus-at-home" question, identifies the three open questions above, and suggests ongoing and future challenges for research and clinical practices.[5]

DIFFERENT VIEWS

There are different views on how the presently available empirical data regarding infants born at home versus the hospital should be best interpreted. There also are different views on the extent, if any, to which a mother's autonomy and interests should "count" in making decisions about childbirth. I will review these next.

The Interests of Infants

When needed, emergency care is quickly available to infants who are born in a hospital. The need for such care may arise even when a pregnancy has been low risk. Examples are cord prolapse, postpartum hemorrhage, and shoulder dystocia.[6] Whether infants born at home or at the hospital face more risks, overall, is a question, nonetheless, that is still open. Howard Brody and Carol Sakala point out in "Revisiting 'The Maximin Strategy in Modern Obstetrics,' " for instance, that infants may be harmed when born in a hospital.[7] For example, they may be born by cesarean section (CS), which may cause childhood type 1 diabetes, asthma, and obesity, possibly because CS may impair an infant's immunological function. When, on the other hand, a woman delivers at home, an infant is more likely to have a "physiologic" or natural birth, which can create, Brody and Sakala report, a "beneficial cascade." An infant born in a hospital is more likely to be premature, to weigh less at birth, and to require ventilatory assistance. How the net risks compare for an infant born in a hospital and an infant born at home isn't settled. Some experts say more studies are needed. Others say that studies won't show which infant group faces greater risks. There may be, they say, too much selection bias. Women who want a home birth may, for instance, have better nutrition and stronger emotional support; birth certificates may not distinguish between high-risk, unplanned, and unassisted home births and planned home births; and it may be impossible to determine whether the transfer of an infant to the hospital occurred before or during labor.[8] The risks to infants must, in any case, be calculated over years; for example, an initial CS may make CS for a subsequent delivery necessary. Thus, even if the first CS is beneficial, subsequent CSs may cause the net effect of all to be harmful.

The Interests of Mothers

Other experts hold that the interests of the mothers should count, if not prevail. For instance, Howard Minkoff and Jeffrey Ecker suggest, in "A Reconsid-

eration of Home Births in the United States," that even if the relative risks to infants born at home are as much as three times as great as for infants born in a hospital, the absolute risk involved is as small as one in one thousand.[9] They assert that since this is such a low absolute risk, mothers' interests warrant moral weight.

Mothers who give birth in a hospital face physical risks, as Mary Regan and Katie McElroy state in "Women's Perceptions of Childbirth Risk and Place of Birth."[10] In hospital births, invasive interventions such as epidural anesthesia, intravenous infusion, oxytocin, and intrauterine pressure catheters are over utilized, and each of the interventions has its own risks and morbidities. Each intervention may also, these authors relate, contribute to the "escalating incidence of surgical birth." This poses the risks to infants just considered above.

In addition to the risks posed by these interventions, the needs and wants of a woman concerning childbirth must be considered. A mother's "right" to choose how she will deliver her baby is greatly important, since it involves her own body. Even more important may be the meaning that women feel in giving birth. The birth event may have unique and extraordinary meaning because it is the beginning of a woman's relationship with her child. Experiencing greater comfort at this time may be quintessential, and may be no small part of why many women want a midwife to attend them, and/or to deliver at home. Judith A. Lothian, in "Being Safe: Making the Decision to Have a Planned Home Birth in the U.S.," gives an example illustrating how midwives may help mothers achieve greater meaning and comfort during their pregnancy.[11] Lothian quotes a mother, speaking of her midwife: "She listens. I can call her anytime. . . . I never worry that I am bothering her." Another mother relates how this may happen during labor: "Instead of requiring me to ask permission of others (to take a drink, take a walk . . .), my permission was asked (to check the baby's heart tones, to listen to her lungs . . .) . . . .We made decisions based on how my daughter and I were doing, not out of fear of what could possibly happen."[12] Another woman succinctly captures and conveys what a midwife offered to her: "Sophia told me to 'open like a flower' . . . ," she recalls.[13]

Some women may, on the other hand, experience childbirth as traumatic. Regan and colleagues state, in this regard, "Studies report that women feel violated by their birthing experience and some even suffer from post-traumatic stress syndrome." Since some women may have this response, careproviders should design, and consider taking, initiatives to prepare women for what may occur, so it is not so new and traumatic, and routinely look for post-traumatic stress syndrome later. If, in anticipating childbirth, while giving birth, or after delivery, a woman shows signs of exceptional stress, careproviders may recommend counseling. This is important to not only the woman but to her infant, because if a woman is post-traumatically stressed, the child most likely will be, too. I think here of a woman who was traumatized to this extent by giving birth. While ostensibly "asleep" due to general anesthesia, she reported that she was actually under-anesthetized, such that she felt and remembered her pain. Subsequently she would lash out at her children, which she had not done before, and her children then lashed out at each other and at their friends. It is not so surprising, then, in light of these relative pros and cons, that Lothian reports that some mothers choose home birth "specifically" to increase their and their baby's safety.

In light of these most important concerns, both when mothers don't give birth in hospitals and when they do, it is of little surprise that profound differences presently exist in regard to how this decision should be made. There are, for example, conflicting views in regard to what the empirical evidence indicates, and even whether empirical evidence should or should not suffice in decision making at both the policy and patient care level. When it comes to decision making and sorting through applicable information, De Melo-Martin and Intemann found, "more data in itself is unlikely to change the value assumptions that each side relies on to interpret the data . . . attention to the value judgments that underlie such research is also essential."[14]

For those who place greatest or exclusive weight on the outcomes of infants in making this decision (whether to give birth only in a hospital or not), the interpretation of the data now available, and even perhaps of future data, no matter how validly obtained, is not clear cut. Even when researchers do not have biases, the ways in which they interpret the data are often open to debate. Similarly, clinicians' interpretations of the same data may differ profoundly. Thus, throughout medicine, there are often best-clinical practices, representing the most current state of the art, arrived at on the basis of experts' consenses, even though, individually, the experts may disagree.

In contexts in which people have strong views, these problems are likely to be exponentially increased because, as Kahneman and others have shown us so clearly,[15] our emotions may limit not only how we interpret data, but even, in some contexts, what we are able to see—literally! The blind-

ness that we may have regarding data that we don't expect to see, or with which we disagree, is literal, not simply metaphoric. (Spoiler alert: readers who want to experience this blindness for themselves should watch this video before they read on: *http://www.theinvisiblegorilla.com/gorilla_experiment.html*.) Such blindness is exemplified by a research project in which study participants viewed a short film of people passing a basketball back and forth. During the film, a person in a gorilla suit walks through their basketball game. After viewing the film, participants were asked what they saw. About half of the participants did not notice the gorilla.[16]

Emotional Autonomy

But is it enough to value mothers' feelings? Or should we assign these feelings greater than usual moral weight? Sjöblom, Idvall, and Rådestad assert that most mothers "see quantitative risks as important," but mothers may place moral weight also on "other sources of knowledge" such as "instinct, intuition, and embodied knowledge that is not intellectual."[17] We could accord exceptional moral weight to mothers' feelings. Such greater weight might not prevail to the extent that it alone determines an outcome, but it may at least serve as a "tie breaker." This may be particularly important in considering place of birth, since views are as divided as they are.

Why might it make sense to accord greater weight to mothers' preferences? One consideration is that mothers often say they would give their life for their child—and many would if they could. (Of course fathers feel this way too.) One example of this, looking to earlier practices, is that of mothers who wanted to have fetal surgery when their fetus had a spinal defect. Surgeons would say no, because they viewed the risk to the mother, relative to the gains for her fetus, to be too great. With newer technologies, such surgery has become less risky for the mother, and so surgery is now routinely performed, as it is beneficial for the fetus: a spinal opening will get worse if it is left alone, since the spinal cord will remain susceptible, to a greater extent, to further damage during gestation.[18]

We already give exceptional moral weight to parents' views when we allow them to choose for their child, under certain circumstances. For example, when a child is so severely ill that there is no good ethical reason to maintain the child's life, the decision on how to proceed is most often given to the parents. We also accord greater than usual moral weight to the feelings of a patient's loved ones. A patient may be kept on a ventilator, for example, even after brain death, so that loved ones coming from far away can see the patient in this state. The feelings of many individuals may be flooded at times of birth and death. At these times, the feelings can become who the individuals are. These feelings may or may not be the most rational. Consider these examples involving birth and death that I heard from a pathologist colleague of mine.

A mother delivered a stillborn baby who was greatly disfigured. He was so disfigured, in fact, that the staff chose not to let this mother see him. She grieved, badly, for a year. Then she learned that a picture of her baby had been taken and existed in the pathologist's report. She requested a copy of the picture. When she saw it, her grief went away.

An adult woman died when her camp stove exploded. Her face was literally "blown off." The staff didn't let her father see her like this. He, like the mother of the stillborn baby, grieved badly, until he learned, like the baby's mother, that there was a photo of his child in the pathology report. The father requested a copy of the photo. When he saw it, his grief, too, was relieved.

Feelings work like this, and the feelings of these two parents were extreme. Yet if only the "usual moral weight" given to parents' feelings had been extended to them, both would have continued to deeply grieve. In unusual cases like this, it may be better for careproviders (and others) to give the feelings of patients' loved ones exceptional weight. Giving loved ones what we might call "emotional autonomy" is in sharp contrast to the conventional practice of denying an individual's autonomy when her or his emotions are so strong that they impair the individual's capacity for adequate cognitive autonomy. Even if we granted a person emotional autonomy, how might we decide whether to assign a greater moral weight to that person's feelings?

An example of a criteria that might be used is to assess the person's proclivity for denial. An example from my own life involves a denial of dying. A person very dear to me was dying, and he knew death was near. He said, "I sometimes can't remember what I just said. This bothers me." His memory, not his dying, seemed to be primarily on his mind. My denial, however, was far greater: when he then asked to shake my hand, I did, perfunctorily. It did not occur to me that the reason he wanted to shake my hand was to say "Good-bye." How much we deny may reflect how much we feel. I should add that this person, very dear to me, may not have wanted me to shake his hand while showing full awareness that it could be the last time. He may have not wanted me to look with this sadness into his eyes.

EMOTIONS THAT PEOPLE MAY FEEL

In our discussions about childbirth, it is principally the mothers' feelings that are at stake, but the wellbeing of their newborn is at stake, too. Who will speak for the newborn? It may be that all of the people involved in childbirth do: the mother, the father, the careproviders. The differences in their views may not reflect their differing values regarding children, but rather reflect different notions of what is best for children.

Parents

Both parents may feel very strong emotions. This may, however, cause more rather than fewer problems.

Mothers

Mothers' feelings for their child may be unparalleled in their intensity. Mothers may also have other feelings that are of concern, and these feelings may leave the women more vulnerable to doing what others, seen as being in authority, want. Especially if stressed, mothers may, in the short run, overvalue what a perceived authority wants.

Impaired capacity to assert themselves. Often women aren't treated equally in our society. Many studies report that persons who have less status may be more vulnerable to not fully expressing what they need.[19] This effect may underlie some of the pain and trauma that some women report experiencing so often in hospitals, and, indeed, whether their doctors are men or women. In this context, our society's warped views may be internalized. Lothian offers a poignant, piercing example: one mother says, "I consider myself independent, a tough lady, but in those [doctors'] offices I, like I lose all my power. I want to cry instead of standing up and saying I don't want you to do that to me."[20]

The desire for immediate relief from fear. In all contexts, some people may be willing and able to give up immediate smaller gains for greater future gains. This difference is commonly referred to as the capacity to "defer gratification."[21] When the emotion felt is fear, however, some people bear it less well than others, and some individuals may want relief that is immediate.[22] Mothers may feel exceptionally fearful when they are delivering a child for the first time or when they have had a negative experience previously. They may, for these or other reasons, be more vulnerable to wanting the greater control and comfort they can have delivering at home with a midwife, although they might, if feeling less stressed, choose to deliver in a hospital. It is unclear whether babies will do better at home or in a hospital. Still, if mothers know that they felt fearful and chose to deliver at home with a midwife out of a need for emotional relief, this knowledge may leave them more likely to blame themselves if something goes wrong at home that might have been prevented in a hospital.

All careproviders, accordingly, should obviously seek to help mothers not have undue fear, to the degree that this is possible. As importantly, but perhaps less obviously, midwives who recognize this may take exceptional measures to help insure that mothers who deliver at home won't feel such guilt and regret. Midwives can inform a woman that even though she may feel fearful and has made choices to try to alleviate her fear, there are other sound reasons to choose to deliver at home. Thus, if the woman later happens to be among the rare group whose child does poorly, it is important that she be able to recall that her choice to deliver at home made sense for reasons other than trying to deal with fear.

More generally, if a woman delivers at home and has "bad results," she will be vulnerable to being second-guessed by other people who may think that she was not able to delay her own increased comfort or relief from fear for nine months, for the sake of her child. Even if others don't second-guess the mother, she may second-guess herself, for these and other reasons. Careproviders—in this context most likely midwives—might be able to prevent some of this pain by alerting women ahead of time about the risk second-guessing.

Midwives also could make it clear that a decision to have a child at home may be "scientifically" justifiable, or even preferable, based on the evidence presented in some of the articles in this issue of *JCE.* For example, as particularly Brody and Sakala's piece documents, there are serious risks in choosing either the hospital or the home setting.[23] Midwives also could quote Minkoff and Ecker, who write, "The goal in such conversation is to educate, not to make women feel guilty about what some may perceive to be a riskier choice. Regret is possible regardless of choice: a woman who has an uncomplicated low-risk hospital birth may, in retrospect, wish she had chosen a home delivery, while another who had a complication at home may wish she had opted for hospital birth."[24]

Grief and guilt. The risk most feared is, of course, that a baby might die or undergo severe harm due to delivery at home. Fortunately, these are fears that most mothers who choose to deliver at home won't experience. The most devastating emotion, in addition to regret, is guilt, although, as the articles in

this special issue point out, having feelings of guilt would not be based on reality.[25] Grief from an infant's death may be profound,[26] but may be still greater when accompanied by guilt. People have an almost irresistible urge to blame themselves when a calamity occurs, so long as there is any plausible way, that they could have prevented it. I think of examples from my own practice. For example, a mother called her teen-aged daughter but hung up after just a few rings. She did not know, when she hung up, that her daughter would take her own life soon after the phone stopped ringing. "If I had just hung on for another ring!" the mother cried. In another example, a man would visit his mother in the hospital after she'd had a stroke. One night, shortly after he left for the night, she died. "I should have stayed!" he cried. "If only I'd stayed another half-hour, I could have been with her."

Fathers

Fathers can be immensely beneficial to women while they are giving birth.[27] While some assert that biological fathers should have a say in numerous aspects of what happens to their fetus and baby, I shall not focus on that here.[28] Fathers who are present during childbirth may, though, cause some women stress.[29] A father may, for instance, insist that his partner deliver in the hospital when the woman wants to deliver at home. Most notably, some midwives have established training centers that enable them, with the mothers' permission, to invite fathers in and then put them at ease to the greatest extent possible.[30]

This, of course, adds some questions. For example, should fathers share what they feel during delivery? Because it is the mothers, not the fathers, who are doing the delivering![31] There are, however, sometimes very substantial gains when mothers have the baby's father with them during delivery. It may enhance fathers' bonding with their child, and this greater bonding may be particularly crucial should the two partners later separate.[32] If the mother and father disagree on whether the mother should deliver at home, and the child dies or has severe special needs, it may prove fatal to their future relationship. The parents may not be able to overcome the disagreement and/or the loss, and this may harm their child. Such a rift may occur even when both partners believe that there should be no blame. Either partner may find that the mere presence of the other evokes constant memories and associations of the birth and the child that are just too painful to bear. Our capacity to transcend such feelings may be limited.

Careproviders

Parents are not alone in being vulnerable to experiencing profound grief. Careproviders may feel unbearable pain as well. Feelings may affect midwives and doctors differently, for reasons I shall outline below. The differences may affect what midwives and doctors do, and may bear, as well, on what mothers choose.

Midwives

Midwives may experience as much or more agony as any careprovider when an infant is born dead or with severe special needs. Their agony may be greater if they generally tend to feel increased empathy for others.[33] They may have one advantage, though, if they know they will assist a mother to deliver at home: they will know in advance that there are limits to what they can do if a complication occurs. Midwives know and accept, for example, that advanced technology won't be available at home. They can thus anticipate these risks emotionally as well as cognitively. This may help them prepare for the possible pain, much as adult children may be able to emotionally and cognitively prepare for the death of a parent as they age. Our minds may prepare us in this way, outside our control, even though we might not want to prepare if we could choose. For example, as this happens, we may feel more distant from our aging loved ones. Midwives also may know—and know well—what they have to offer, and they may have already come to terms, cognitively, with the gains from home birth relative to the risks. Doctors, in contrast, may have emotional difficulty in not doing all that is possible.

But midwives have an additional source of chronic stress, and, one might say, emotional pain that doctors lack. As one midwife tersely notes, "we stand insignificant and socially marginalized in a culture that has passed us by in favor of technologically managed birth."[34] This pain may be exemplified by the following uncommon, but specific, example. As a registered midwife in New South Wales was delivering a baby, an emergency occurred and she used a "vacuum cup" to extract the baby, thereby saving the baby's life. The midwife had been trained to do this, although she was not credentialed to do this. She had, indeed, done it 30 times previously. But her professional Standards Committee then reprimanded her, and placed new "conditions" on her registration. The dean of an Australian nursing school, also a law professor, had this advice for midwives, in response: "make sure you understand the purpose of any continuing professional education program you participate in. . . . "[35]

Doctors

Doctors may be as vulnerable to feelings of fear as midwives are. Their fear may affect them in a different way, however, because they are credentialed to use technological interventions. As a result, they may feel afraid to not use interventions if their use could prevent harm to the babies they deliver. If they choose to do less than they could, and harm ensues, they may feel guilty throughout the rest of their lives. Doing all they can in this way may extend to their believing that they should, as strongly as they can, recommend to mothers that they not deliver at home, as Chervenak and colleagues do.[36]

This is not to say that making such a "strong recommendation" is justifiable or preferable. That is, all of the articles presented in this issue of *JCE,* taken together, might be construed as suggesting that the current state of the art is what, in research, would be called *clinical equipoise.* Clinical equipoise is a concept that is most often used in research contexts, and refers to situations in which clinicians are divided in regard to which one of two or more treatments is best for patients. If there is no agreement among physicians on which treatment is best, participants in research can enter studies in which they may, usually, on a random basis, receive any of the treatments offered in the study. Use of the phrase "clinical equipoise" indicates that clinicians do not know, at this time, which of two or more treatments is best. In the situation at hand, if doctors do not believe that there is clinical equipoise, they may be more fearful of not strongly recommending a birth in the hospital.

Doctors' emotional reality may not align with this. They may feel highly reluctant to accept what they see as more-risky outcomes. Like mothers, they have a wide range of choices, and the accompanying greater feelings of fear that come with them. There also may be psychological factors that affect and possibly limit doctors' capacity to objectively assess competing realities. Here I will focus on two.

Doctors' aversion to loss. First, doctors may be unduly loss averse. They may, as is the case for many among us, so strongly fear a loss that they will do all that they can to prevent it, even when the cost is giving up far greater, and highly disproportionate, gains.[37] Examples may be insisting on and strongly recommending that all mothers deliver in the hospital.

Doctors' vulnerability to being overly influenced by data and images. Second, doctors may be unduly influenced by data and images. This may compound their risk of making biased judgments due to being loss averse. An instance in which this affected practice most notoriously occurred not long ago, when orthopedic surgeons inferred from images of protruding spinal discs that the discs were the likely cause of patients' back pain. Thus, surgeons operated and "corrected" the discs until studies indicated that the surgical patients didn't do better than other patients.[38] An over-reliance on data and images, in addition to being loss averse, may be reasons that doctors choose to do CSs as often as they do, notwithstanding the objections voiced by mothers, such as those reported in articles in this issue of JCE. Yet, as in all questions regarding physicians' choices with their patients, doctors' concern for their patients may play the far greatest contributory role. Most, if not all, after all, chose to become doctors to help people.

Some persons believe and assert that, instead, doctors make decisions, especially in obstetrics, mostly to protect themselves from legal suit. Surely, to some degree, this is true.[39] In my psychiatric practice, I certainly do. When treating patients, as I come near the margins of the standard of care guidelines, my fear increases, not because I think that what I am doing in not best for a patient, but because of my fear of negative repercussions, such as a suit. An example is whenever I do something that is literally in a "black box warning" in the Physicians' Desk Reference (PDR). A warning placed in a black box in the PDR indicates that a particular practice is especially risky. This occurs, for instance, when I prescribe an anti-psychotic drug for an elderly patient, especially when the patient has dementia. When a patient has dementia, he or she may become so aggressive that a caregiver can't care for the patient at home. It may be that only these medications enable patients to remain calm enough to continue to live at home and, thus, continue to have the quality of life that they cherish. Yet antipsychotic drugs increase the risk that patients will have a serious side-effect such as a stroke, or even die. For this reason there is a "black box warning." If these drugs are prescribed, doctors should proceed much more carefully, which they view as being at their own peril.[40] To assume that physicians act as they do primarily for this reason is, I believe, generally wrong and short-sighted. For example, in the above situation, I will worry more when I prescribe these drugs, although there is no legal risk. Many people, including patients, presume that doctors leave their feelings for their patients at the hospital or clinic when they come home—that they can "compartmentalize" their feelings. Can they?

A study of oncologists found that grief was "pervasive in their lives." The "most striking finding"

was, in fact, "how poorly" compartmentalization works.[41] This failure of doctors to "contain" their most loving emotions may be greater when the patient is a child.

For example, Danielle Ofri, MD, describes the experiences of "Eva," a pediatrician.[42] When Eva was a resident, a baby was born with Potter syndrome, and the parents, who knew about the outcome before the birth, asked not to see the infant. (Babies with Potter syndrome almost always die within minutes of being born.[43]) Eva was asked to remove the baby from the room. She wrapped the baby in a blanket and took her to a "cramped room," alone, where she "was consumed with" immense sadness for the baby girl. Eva rocked her back and forth. "I love you, baby," she whispered, "I love you." The baby died. Eva "stuffed the whole thing way down" in her "consciousness," and continued to do so throughout her residency. At the end of her residency, a four-year-old boy was brought in, unconscious, and even though this was a tragic case, Eva didn't feel "even a twinge" of emotion. Her "armor had solidified." But later, watching a lighthearted Hollywood movie, even though it was a comedy, when a child lay in deep water and was sinking, Eva uncontrollably sobbed. "It was exactly like the post-traumatic stress experienced by war veterans." For years afterward, her nerves continued to clench whenever her beeper went off.[44]

This doctor's post-traumatic stress reaction was like that of some mothers who have a bad experience in a hospital, as some articles in this issue of JCE describe.[45]

POSSIBLE SOLUTIONS

In light of these different contentions, and particularly the deep feelings that some individuals have, what might we best do, at the policy level and at the bedside? Surely it is possible to avoid some of the tragedy and sadness described here. Mothers and babies have bad effects from CS. Babies have problems that are not treatable outside hospitals. Mothers feel traumatized. Mothers and fathers feel guilt. Midwives feel and are marginalized. Doctors feel grief and alone, and, sometimes, hostility, as well.

Policy

Mothers may want to be delivered by midwives at home. Doctors may want to be able to do all they can. Might better processes possibly allow all to do and feel better? Might, for example, contexts be established so that mothers and fathers, midwives, and physicians could meet all together, as equals, to forge somewhat better end results? This, in fact, has been done. In Nebraska, a medical practice has been established in which careproviders, at all "ranks," get together to seek, as a group, optimal results. They all share all of their thoughts, regardless of their different "status." All of those present are expected, first, to share each and every concern, and to be nonjudgmental. Moreover, and, indeed, most impressive to me, they are expected, when speaking, *to look each other in the eye*. They have found that this dynamic works.[46] Working together like this, midwives could give mothers and, indeed, doctors maximal support, and doctors could supervise and intervene, to a greater extent, when and as needed. Doctors might, with midwives' help and influence, choose to respond in some different ways.[47] Mothers, and fathers, might make different choices as well.

Infants experience a variety of problems during birth, throughout the world.[48] In some places, doctors and midwives, once viewed as "outsiders," have succeeded in working together harmoniously and effectively. Midwives have come to function, and indeed feel as, equals, too.[49]

Careproviders' Responses "at the Mothers' Bedside"

What, then, should careproviders recommend now? They could all recommend strongly, as Chervenak and colleagues urge, that all mothers deliver in the hospital. Alternatively, careproviders could simply share the current view of the American Congress of Obstetrics and Gynecology (ACOG), that while delivering at home, in their view, isn't preferable, it is still reasonable and, thus, acceptable. The basis for strongly recommending against home birth or the basis for the ACOG's approach may or may not be true, as the articles in this issue of *JCE* might challenge. But it is generally the standard of care for careproviders to share the truth, as they see it, with their patients—and it is often most effective. An example is when patients smoke. When careproviders tell patients, unequivocally, how smoking may harm them, it may help patients to find a way to not smoke. But in one study, careproviders were able to counsel a much greater percentage of patients who smoked, by approaching the patients before they were discharged from a hospital—a captive audience, as it were.[50]

In every clinical context, however, careproviders might do well to consider the connotative effect of what they say, as well as what is "the truth." This is because expressing some truths in some contexts may have the opposite effect than the speaker intended. For example, this might happen if carepro-

viders recommend to mothers—weakly or strongly—that they shouldn't deliver at home. Such negative responses often occur.[51] Such a negative response may be more likely when the careprovider's advice is emotionally driven.[52] That has been found to be the case in other contexts.[53]

Mothers' negative responses to careproviders telling them what they should do may, surprisingly, be exacerbated by what the women are experiencing biochemically. De Dreu, in "Oxytocin Modulates Cooperation Within and Competition Between Groups: An Integrative Review and Research Agenda," reports that the hormone oxytocin, which is present in greater amounts during pregnancy, may not only increase bonding; it may increase a tendency to react defensively when we find another to be threatening.[54] In this context, some women may respond in a way that is, without question, bad for their baby: they may refrain from visiting a maternal health center altogether.[55] Also, careproviders who tell women what to do might evoke "greater guilt" in women who deliver at home and have a "bad result." Further, careproviders who tell women what to do might have this effect on all women who choose to deliver at home. The women might echo what a careprovider has said to them: "This is not something I should do," even while they go ahead and do it. Thus, this approach could greatly impair the beauty women are otherwise hoping to feel in giving birth. In their article, Minkoff and Ecker ask whether careproviders should discuss with mothers their "moral duty of beneficence" to their infant. Doing this may increase the mothers' awareness of their duty, but, at the same time, may add to any guilt they might feel.

A different approach, using the principles of "motivational interviewing," has been successful in reducing the rate at which a fetus could be harmed by its mother's use of alcohol: women of childbearing age substantially reduced their consumption of alcohol and substantially increased their use of effective contraception.[56] This may be most instructive—this approach is wholly different from and mutually exclusive with telling patients what to do. In this approach, careproviders encourage patients to explore their ambivalence regarding a particular course of action by asking open-ended questions, listening, and reflecting what they have heard, and then inviting patients to consider with them what they consider to be the relative pros and cons. In this process, there is no "expert," although the careproviders, of course, give patients all of the information they request. Through such discussions, mothers may be able to see something they didn't see before, and they might, in response, by themselves, change their mind.

How might a careproviders use this approach when a woman is trying to decide whether to deliver in a hospital or at home? A careprovider might say, if the policy of the ACOG remains as it is, "The present consensus among some leading medical experts is that it is okay for mothers to deliver at home, and the experts also express a preference based on the risks. There are different risks either way. Would you like to discuss what you see as the relative pros and cons for you?" A careprovider can go one step further, and add, for a woman who wants to deliver at home, that because the risk is immediate, rather than long term, if the baby has a bad result, the woman may be more vulnerable to feeling guilt.

Pregnant women should understand that leading experts, at this time, see delivering at home as reasonable. Thus, if they feel guilt at any time, they should know that this guilt is not based in reality.[57] Indeed, if a bad result were to occur, women should regard this, both now and afterwards, as a risk and decision that they share with their careprovider and these foremost experts. This converts the mothers' decision to a shared choice. As Sherwin Nuland, a noted surgeon and author has said, it is most important for careproviders to convey to their patients that "they're both enmeshed in a journey they're taking together."[58]

CONCLUSION

In regard to questions involving where and how mothers will deliver their baby, mothers, fathers, midwives, and doctors all have especially deep feelings. This makes sense. Babies' and mothers' well-being is at stake. Here I have summarized different views and these persons' strong, different feelings. I have also proposed that, from the standpoint of policy, midwives and physicians may be able to work together to a much greater extent than they do now. Clinically, it is mothers who will and must, in the end, make these decisions. To the degree that they have "bad feelings" during that process, their decision making is likely to be impaired.[59] It is most critical, especially for this reason, for all careproviders to find ways to support mothers as richly as they can. Midwives may be now setting the paradigmatic example.[60]

NOTES

1. "Mothers" will be used subsequently to refer to

these women throughout this discussion. "[F]or purposes of ease, and without prejudice we will refer to [pregnant women] from herein as 'the mother.' " H. Draper and J. Ives, "Men's Involvement in Antenatal Care and Labour: Rethinking a Medical Model, *Midwifery* 29 (2013): 723-9, 724.

2. D. Boucher et al., "Staying Home to Give Birth: Why Women in the United States Choose Home Birth," *Journal of Midwifery & Women's Health* 54, no. 2 (March/April 2009): 119-26, 125.

3. E. Bogdan-Lovis and R.G. de Vries, "Ethics and the Architecture of Choice for Home and Hospital Birth," in this issue of *JCE.*

4. Frank A. Chervenak, Laurence B. McCullough, Amos Grünebaum, Birgit Arabin, Malcolm I. Levene, and Robert L. Brent, "Planned Home Birth in the United States and Professionalism: A Critical Assessment," in this issue of *JCE.*

5. I wish to thank and acknowledge Norman Quist for thoughts and wording in the above introduction, and, particularly, for his insights regarding this delivery issue's much wider implications.

6. I. de Melo-Martin and K. Intemann, "Interpreting Evidence: Why Values Can Matter as Much as Science," *Perspectives in Biology and Medicine* 55, no. 1 (2012): 59-70, 5.

7. H. Brody and C. Sakala, "Revisiting 'The Maximin Strategy in Modern Obstetrics,' " in this issue of *JCE.*

8. See note 6 above.

9. H. Minkoff and J. Ecker, "A Reconsideration of Home Births in the United States," in this issue of *JCE.*

10. M.J. Regan and K. McElroy, "Women's Perceptions of Childbirth Risk and Place of Birth," in this issue of *JCE.*

11. J.A. Lothian, "Being Safe: Making the Decision to Have a Planned Home Birth in the United States," in this issue of *JCE.*

12. Emphases added. L. Shive, "A Midwife's Gift: Olivia's Birth Story," *Midwifery Today—International Midwife* 88 (Winter 2008): 12-3, 13.

13. J. Strutt-Izzard, "A Bermuda Birth Story," *Midwifery Today—International Midwife* 93 (Spring 2010): 55-69, 69.

14. de Melo-Martin and Intemann, see note 6 above, p. 7.

15. D. Kahneman, *Thinking Fast and Slow* (New York: Farrar, Straus and Giroux, 2011); D. Kahneman and A. Tverski, "Prospect Theory: An Analysis of Decision Under Risk," *Econometrica* 47 (1079): 263-92, *http://www.princeton.edu/~kahneman/docs/Publications/prospect_theory.pdf,* accessed 19 August 2013.

16. D.J. Simons and C.F. Chabris, "Gorillas in Our Mist: Sustained Inattentional Blindness for Dynamic Events," *Perception* 28 (1999): 1059-74.

17. I. Sjöblom, E. Idvall, and I. Rådestad, "A Provoking Choice—Swedish Women's Experiences of Reactions to their Plans to Give Birth at Home," *Women and Birth* 25 (2012): e1-18, 15.

18. M. Meuli and U. Moehrlen, "Fetal Surgery for Myelomeningocele: A Critical Appraisal," *European Journal of Pediatric Surgery* 23, no. 2 (April 2013): 103-9.

19. Individuals' decision making can be influenced and diminished by concerns about being stereotyped as by devaluation because of their gender: "Studies of targets of stereotype threat, as they try to suppress thoughts of negative stereotypes, experience a depletion of self-control resources. . . . It is evident that stereotype threat . . . plays a more significant role in decision making than previously believed." P.B. Carr and C.M. Steele, "Stereotype Threat Affects Financial Decision Making," *Psychological Science* 21, no. 10 (Oct 2010): 1411-16, 1414.

20. Lothian, see note 11 above.

21. People generally prefer to receive rewarding outcomes sooner than later. For neuroimaging findings now supporting this, see B. Kim, Y.S. Sung, and S.M. McClure, "The Neural Basis of Cultural Differences in Delay Discounting," *Philosophical Transactions of the Royal Society of London, Series B, Biological Sciences* 367, no. 1589 (5 March 2012): 660-6.

22. S.A. Bynum et al., "Unwillingness to Participate in Colorectal Cancer Screening: Examining Fears, Attitudes, and Medical Mistrust in an Ethnically Diverse Sample of Adults 50 Years and Older," American Journal of Health Promotion 26, no. 5 (May-June 2012): 295-300. See, also, generally, "Fear is a Factor in Health Decisions," *Washington Post*, 11 June 2013, E3.

23. Brody and Sakala, see note 7 above.

24. Minkoff and Ecker, see note 9 above.

25. For neuro-imaging findings now supporting this, see A. Nicolle et al., "Amygdala Involvement in Self-Blame Regret," *Social Neuroscience* 6, no. 2 (2011): 178-89.

26. An example here is a mother whose face is widely known. She is the model for what some say is most famous of all Victorian paintings, John Everett Millais's "Ophelia." This painting portrays Ophelia in Shakespeare's "Hamlet" after she has drowned. She lies dead, face up, in a brook. Sadly, in real life, the model for this painting later gave birth to a stillborn child and took her life. A.C. Faxon, *Dante Gabriel Rosseti* (New York: Abbeville Press, 1989), 144.

27. Some evidence shows that mothers who receive active support during labor are likely to have shorter labor and need less pain relief. E.D Hodnett et al., "Continuous Support for Women During Childbirth," *Cochrane Database of Systematic Reviews* 3 (18 July 2007): CD003766; (update in 2011: 2 CD003766).

28. H. Draper and J. Ives, "Men's Involvement in Antenatal Care and Labour: Rethinking a Medical Model," *Midwifery* 29 (2013): 723-9.

29. In one study, when careproviders sought to draw fathers in, some mothers then felt excluded. Ibid., 724.

30. The Royal College of Midwives has offered guidance to midwives which included addressing fathers by name and encouraging them to express their thoughts and feelings. Ibid., 723.

31. "Protecting a vulnerable woman may be difficult to achieve if her husband is always present." Ibid., 725.

32. "Significant difficulties arise when the putative father is not the woman's partner. . . . It is, however, precisely these men toward whom policies designed to ensure future active fathering toward early involvement need

to be directed." Ibid., 724.

Fathers, once involved, may acquire feelings of commitment on a biological level. See, e.g., K.G. Lambert et al., "Modeling Paternal Attentiveness: Distressed Pups Evoke Differential Neurobiological and Behavioral Responses in Paternal and Nonpaternal Mice," *Neuroscience* 234 (27 March 2013): 1-12.

Kittay says, however, "We want to understand why the sense of commitment that attaches to motherhood seems not to be as deep . . . for the men who abandon their families and their obligations as a provider." E.F. Kittay, *Love's Labor: Essays on Women, Equality, and Dependency* (New York: Routledge, 1999), 26.

33. This is as true of all people who have, we might imagine, more "empathy neurons." This gift, for them and others, may come "with a price." They may be more vulnerable to experiencing emotional pain.

34. C.M. Bean, "Rights and Relationships," *Midwifery Today—International Midwife* 101 (Spring 2012): 39.

35. Emphasis added. L. Starr, "Policy, Scope and 'the Agony of the Moment,' " *Australian Nursing Journal* 19, no. 8 (March 2012): 29.

36. Chervenak et al., see note 4 above.

37. "It has been suggested that enhanced sensitivity to losses is driven by negative emotions, such as fear." S.M. Tom et al., "The Neural Basis of Loss Aversion in Decision-Making Under Risk," *Science* 315, no. 5811 (26 January 2007): 515-8, 515.

38. E.J. Carragee, "Intradiscal Treatment of Back Pain," *Spine Journal* 11, no. 2 (February 2011): 97-9. More generally, in regard to how such an over-reliance on visual images may occur, see M.E. Roser et al., "Right Hemisphere Dominance in Visual Statistical Learning," *Journal of Cognitive Neuroscience* 23, no. 5 (May 2011): 1088-99.

39. Nearly half of primary care doctors surveyed say they give their patients too much medical care, and 80 percent say that their need to practice defensive medicine has interfered with their patient care, and 30 percent of healthcare may be unnecessary. "When to say 'Whoa!' to Your Doctor: Common Tests and Treatments You Probably Don't Need," *Consumer Reports* 77, no. 6 (June 2012): 12-3.

40. V.C. Desai, P.C. Heaton, and C.M. Kelton, "Impact of the Food and Drug Administration's Antipsychotic Black Box Warning on Psychotropic Drug Prescribing in Elderly Patients with Dementia in Outpatient and Office-Based Settings," *Alzheimer's & Dementia* 8, no. 5 (September 2012): 453-7. These risks, although small, are increased in the elderly and greater still when these patients have dementia.

41. D. Ofri, *What Doctors Feel* (Boston, Mass.: Beacon Press, 2013), 107, citing L. Granek et al., "Nature and Impact of Grief Over Patient Loss on Oncologists' Personal and Professional Lives," *Archives of Internal Medicine* 172, no. 12 (25 June 2012): 964-6.

42. Ofri, ibid.

43. A baby with Potter's sequence just recently has survived, at least up until now, with dialysis and saline (salt water) infusions, although she has no kidneys. "She is every bit a miracle," one of her parents says. R. Roxane and A. Argetsinger, "Abigail Rose: Every Bit a Miracle," *Washington Post,* 30 July 2013, C2.

44. D. Ofri, see note 42 above, pp. 98-106. The author of this book offers pieces she writes for people wanting to subscribe, through *author@danielleofri.com.*

45. The post-traumatic stress that these mothers may experience calls for interventions designed to help prevent this early on, prior to delivery. Preventive interventions, now called "prehabilitation interventions," have been already introduced for women with breast cancer, once it is diagnosed. J.K. Silver and J. Baima, "Cancer Prehabilitation: an Opportunity to Decrease Treatment-Related Morbidity, Increase Cancer Treatment Options, and Improve Physical and Psychological Health Outcomes," *American Journal of Medicine & Rehabilitation* 92, no. 8 (August 2013): 715-27. These interventions may be helpful to doctors, as well.

46. This approach, known as Crew Resource Management (CRM), involves communication tools adopted in the aviation industry more than 25 years ago. It "provides an opportunity for each member of the team to speak up so that everyone feels responsible." Nebraska Medical Center, "From Cockpit to Operating Room," Nebraska (Fall/Winter 2006), *www.nebraskamed.com/article/95/from-cockpit-to-operating-room,* accessed 2 August 2013. "Throughout the procedure, team members verbalize concerns by making eye contact with the person with whom they're speaking." C. Lytle, "Operating Rooms Take Cue from the Cockpit," *University of Nebraska Medical Center News,* 22 February 2006, *http: //app1.unmc.edu/publicaffairs/todaysite/sitefiles/today_full.cfm?match,* accessed 2 August 2013.

47. J. D'Arcy, "Midwives vs Hospitals: There is a Middle Ground," *Washington Post,* blogs on parenting, 13 May 2011, accessed 2 August 2013.

48. Neonatal mortality accounts for 43 percent of children under five. A.C. Moran et al., "Measuring Coverage in MNCH Indicators for Global Tracking of Newborn Care," *PLoS Medicine* 10, no. 5: e1001415. Doi: 10.1371/journal.pmed.1001415 .p,

49. C.M. Josif et al., " 'No More Strangers': Investigating the Experiences of Women, Midwives and Others During the Establishment of a New Model of Maternity Care for Remote Dwelling Aboriginal Women in Northern Australia," *Midwifery* (12 May 2013), *http: //dx.doi.org/10.1016/j.midw.2013.03.012,* accessed 2 August 2013. "The divide between MGP [midwifery group practice] midwives and medical staff . . . in the early days of the model had been . . . well documented . . . as a risk to maternity services. . . . After 12 months divisions between hospital staff and MGP midwives and resistance to the model had diminished. In fact during the final round of interviews, relationships were described by all participants as more cooperative with much greater insight and appreciation of each other's roles. Emphases added; p. 6.

50. "[T]he most important take-home message was the set-up . . . the investigators made their initial counseling call while patients were still in the hospital while they were inpatients, a captive audience, if you like." M.A. Otto, "Begin Tobacco Counseling Efforts Before Discharge,"

Clinical Psychiatry News 41, no. 6 (June 2013): 22.

51. See note 2 above.

52. See note 17 above, p. e15.

53. Patients may, though, respond when careproviders are more emotional in what they say by being more compliant. Instruction leaflets in one study presented a hierarchy of "doctors at the top, midwives in the middle, and pregnant women at the bottom." This worked against women's having a more informed choice, as the document intended. It resulted instead in "informed compliance." H. Stapelton, M. Kirkham, and G. Thomas, "Qualitative Study of Evidence Based Leaflets in Maternity Care," *British Medical Journal* 324, no. 7338 (March 2002): 639.

54. C.K.W. De Dreu, "Oxytocin Modulates Cooperation Within and Competition Between Groups: An Integrative Review and Research Agenda," *Hormones and Behavior* 61, no. 3 (March 2012): 419-28.

55. See note 17 above, p. e14.

56. M.N. Velaquez et al., "A Dual-Focus Motivational Intervention to Reduce the Risk of Alcohol-Exposed Pregnancy," *Cognitive and Behavioral Practice* 17, no. 2 (May 2010): 203-12. These careproviders "roll with" their patients' resistance. If patients seem reluctant to hear information, for example, the careproviders suggest that they can do this at another time. Careproviders ask, though, which option for changing the patients prefer, reducing their alcohol use or using contraception. This approach may, in my view, be problematic in that patients may "hear this" as coercive; they may then be less willing to change, as a result. See, also, K.S. Ingersoll et al., "Pregnancy Motivational Interventions to Reduce Alcohol-Exposed Pregnancy Risk," *Journal of Substance Abuse Treatment* 44 (2013): 407-16.

57. This could, of course, reduce their guilt as intended, or possibly increase it, resulting in home delivery being a risk that they don't want to take on.

58. J. Wolfe, "Physician Sees Widening Gap Separating Doctor and Patient," *Psychiatric News* 47, no. 8 (20 April 2012): 27.

59. "Focused entirely on the bad feelings generated by the problem at hand, we lose our capacity to . . . [consider] . . . other ways of thinking and responding." S. Andreas, "Breaking the Spell," *Psychotherapy Networker* (May/June 2013): 42-9, 44.

60. For example: "Asking too many closed questions during a booking can dehumanize the interaction, making it feel almost like an interrogation." K. Murray, S. Hamilton, and D. Martin, "Delivering Effective Communication," *Practising Midwife* 9, no. 4 (April 2006) 24-6, 25. The gains from open questioning, in contrast to closed questioning are described when discussing motivational interviewing (also at note 56) in the text.