Elizabeth Bogdan-Lovis and Raymond G. de Vries, "Ethics and the Architecture of Choice for Home and Hospital Birth," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 192-7.

Special Issue on Place of Birth

Guest Edited by Elizabeth Bogdan-Lovis, Charlotte de Vries, and Raymond G. de Vries

Ethics and the Architecture of Choice for Home and Hospital Birth

Elizabeth Bogdan-Lovis and Raymond G. de Vries

ABSTRACT

In this issue of *The Journal of Clinical Ethics*, we offer a variety of perspectives on the moral and medical responsibilities of professionals with regard to a woman's choice of where she will birth her baby. The articles in this special issue focus on place of birth, but they have larger resonance for clinicians whose decisions about providing the best possible care require them to sort through evidence, consider their own possible biases and the limitations of their training, and balance the wishes of their patients with the demands of colleagues, hospitals, and insurers. The articles published in this special issue of *The Journal of Clinical Ethics* will help those who wrestle with such dilemmas in everyday clinical decision making.

In 1989, Marc Keirse and colleagues wrote *A Guide to Effective Care in Pregnancy and Childbirth,* which paved the way for development of the Cochrane Collaboration/Cochrane Library of Systematic Reviews. In 1995, Keirse captured the dilemmas associated with clinical decision making regarding place of birth when he wrote, "It is a woman's prerogative and her fundamental human right to determine her reproductive behavior, and this includes how and where to give birth. The issue is to accommodate the autonomy of pregnant women in as safe a manner as possible for both mother and baby."[1] In order to illustrate the difficult clinical and ethical issues that arise when balancing "a woman's prerogative" with "safety for mother and baby," we open our introduction with the case of Linda Sterkte.

CASE

Linda Sterkte, 32, decided to give birth at home under the care of a certified nurse-midwife (CNM). Her previous physician-managed hospital birth was difficult: labor was induced, she had a vacuum delivery, and a midline episiotomy caused a tear that extended into her anal sphincter. This second pregnancy has been uneventful. She estimated to be at 41 weeks' gestation, and during her most recent exam her baby was of average gestational weight, around eight pounds. Her midwife has a formal backup arrangement with clinicians at the local hospital, and their collaborative protocol stipulates that at 41 weeks care is to be transferred from the midwife to the physician team, making home birth impossible.

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Despite the length of gestation, Ms. Sterkte still wishes to give birth at home. She asks the CNM to advocate on her behalf, to request that an exception be made to the established protocol, to give Ms. Sterkte an additional week, during which she would still be able to give birth at home.

Currently, in the U.S., there are perhaps three ways this story might proceed. (1) Because the midwife does not feel that she can obtain an exception to the backup protocol arrangement, she tells Ms. Sterkte that her care will be transferred to the backup physicians, and Ms. Sterkte reluctantly agrees. Or, (2) the midwife orders a biophysical profile using ultrasound to assess fetal movement, tone, breathing, amniotic fluid volume, and heart rate. The evaluation comes back normal, suggesting that the fetus is doing well. With this reassuring assessment, the CNM approaches the backup physicians to appeal for an exception. Or, (3) Ms. Sterkte refuses to be transferred to the care of the physicians at the hospital.

Each of these outcomes is rife with questions of ethics and professional responsibility, and exemplify the tensions inherent in the organizational arrangements that now structure the relationship between pregnant women and the medical professionals responsible for their care.

The first scenario highlights the situation of midwives in the United States. CNMs are autonomous professionals in their own right, but they are required to have an established collaborative agreement with a physician to insure availability for consultation and/or referral if a transfer to the hospital should become necessary. These arrangements can be delicate. To function effectively—that is, to facilitate continuity of care and seamless transport when necessary—arrangements need to be predicated on a habit of communication and professional trust. When midwives contest the opinions and routines of their supporting physicians, they may risk losing the collaborative agreement they need to meet the standards for safe practice.

The second outcome directs our attention to the fact that there are differences of opinions and *fact* about the risks of pregnancy and birth. Current best evidence indicates that, in and of itself, there is nothing particularly dangerous about 41 weeks of gestation.[2] Ms. Sterkte's biophysical profile suggests her baby is doing well; it simply is not ready to be born. The demands of the backup protocol, in light of the existence of evidence challenging its medical foundation and the contrary wishes of Ms. Sterkte, place the CNM, her physician colleagues, and Ms. Sterkte in an ethically and socially difficult situation.

The third outcome is perhaps the most challenging, as it pushes caregivers to find a way to respect Ms. Sterkte's wishes while upholding their professional commitment to provide competent care. This ordinary question of professional responsibility is complicated by the fact that Ms. Sterkte is pregnant and is making a choice for her unborn child as well.

The case raises a number of questions:

- What are the responsibilities of the CNM to her client, to the baby, to her backup physicians, to health and malpractice insurers, and to self?
- What are Ms. Sterkte's responsibilities—to her baby, her family, and her careproviders?
- What are the responsibilities of the backup physicians to the CNM, to the baby, to Ms. Sterkte, to health and malpractice insurers, to the hospital, and to self?
- Whose best interests will trump others' best interests, and under what circumstances?
- How much latitude is there for a patient to comply with or, alternatively, to refuse to abide by, an established protocol (in this case, when the demand for transfer of care at 41 weeks is based on equivocal best evidence)?
- What are the responsibilities of a clinician when a patient chooses to ignore professional advice?
- In light of the reassuring biophysical assessment of the baby, how should the midwife and the backup physician manage care for Ms. Sterkte and her infant?
- What is the role of trust in these overlapping relationships?

These questions revolve around place of birth, but they have larger meanings for clinicians whose decisions about providing the best possible care require them to sort through evidence, consider their own possible biases and the limitations of their training, and balance the wishes of patients with the demands of colleagues, hospitals, and insurers. There are no easy answers to these questions. In this issue of *JCE*, we offer a variety of perspectives on the moral and medical responsibility of professionals with regard to a woman's choice of where she will birth her baby. It is our hope that the informed opinions of our authors will help those who wrestle with these dilemmas in everyday clinical decision making.

When in 2011 we first discussed a special issue on "place of birth" with *JCE,* we could not have predicted just how much currency this topic would have in 2013. In the past two years there have been an unprecedented number of position papers, committee opinions, and pages in the professional journals of medicine, midwifery, and obstetrics dedicated to

place of birth. In 2011 and in 2013, a group of maternity careproviders, epidemiologists, and health policy makers came together in "home birth summits" in Washington, D.C., with the goal of addressing "their shared responsibility for care across birth settings in the United States."[3] In March 2013, the Institute of Medicine (IOM) found the issue compelling enough to organize a two-day meeting, Research Issues in the Assessment of Birth Settings.[4]

We began this project with an interest in the ethical issues that attend routine maternity care, an interest inspired by two developments: an escalating rate of intervention in healthy pregnancies and births, and a small but growing number of women choosing home birth.[5] Our focus on place of birth offers an ideal starting point for the examination of the ethics of the "usual and ordinary" care given to healthy pregnant women. Although few women in the U.S. choose to birth at home, their choice represents a significant challenge to the ordinary routines of care in childbirth. Forgoing the sophisticated technologies used in the obstetric management of labor and birth, these women call into question the clinical value, and the costs, of the way we currently organize maternity care.[6] Given their small numbers, you might expect these women to be dismissed as outliers or members of some "fringe group," but their challenge to the *status quo* is taken seriously. In turning their backs on a typical hospital birth, the American women who choose to birth at home call attention to a potentially embarrassing fact. According to the U.S. Centers for Disease Control and Prevention (CDC), the higher rates of interventions used in childbirth in the U.S. (for example, induction, epidurals, cesarean section) are not associated with better outcomes, measured in terms of rates of infant and maternal morbidity and mortality.[7]

This special issue of *JCE* will be useful to clinicians who are called on to offer advice about place of birth and to clinical ethicists who are interested in the problems that arise when evidence, practice, and patients' wishes conflict. Given the nature of the questions surrounding choice of birth place, we asked authors from a variety of disciplines—including midwifery, obstetrics, nursing, various social sciences, law, and philosophy—to join us in the search for answers. The authors include women who have given birth at home and in the hospital. We also include a number of "personal perspectives" that give us a glimpse of how choice of birth place is experienced by clinicians and clients.

Reflecting the diverse orientations of our authors, the articles and personal perspectives collected here offer wide-ranging and conflicting perceptions about what constitutes a "good birth"—measured both morally and medically. These divergent perspectives result in dissimilar approaches to the management of pregnancy and birth. It is important to remember that each approach represents a well-intentioned attempt to balance the best interests of mother and baby, avoid risk, and respect autonomy. To the extent that these approaches are incompatible, ethical tensions emerge. For example, some argue that it is ethically irresponsible to monitor all laboring women continuously with an electronic fetal monitor (EFM)—they point to evidence that EFM has limited clinical value and increases the number of unnecessary cesarean sections—while others find it morally suspect to *not* use continuous EFM, a technology that can anticipate problems in labor and birth.

As social scientists, we also have a keen interest in the underlying social structures that generate these varied perspectives on pregnancy and birth and the way these perspectives are translated into action. We find it noteworthy that while perspectives about the advisability of home and hospital birth vary, all of the participants in the discussion share a belief in the value of evidence as a guide to medical decision making. In this era of evidence-based medicine, evidence—data—have become *the* tool to organize clinical practice and to support ethical argument. The authors in this issue of *JCE* have differing opinions about what "counts" as evidence, which evidence is to be believed and which discounted, and how to interpret and use the evidence that they judge to be the most compelling. They also differ on the extent to which evidence should or shouldn't be balanced with other values.

More than in other areas of clinical practice, these articles suggest that discussions about place of birth are marked by "dueling data," heated disputes over the source, analysis, interpretation, publication, and dissemination of evidence. These disputes are grounded in fundamental disagreements about the nature of a "good birth." A disinterested observer of the research literature on birth place safety could easily conclude that researchers start with a conclusion and then search for data to support that conclusion. Almost without exception, supporters of home birth find it to be a safe, if not preferable, way to bring a child into the world, and supporters of hospital birth find that the hospital setting is the safest place for birth.

Researchers who favor hospital birth begin with the notion that birth is inherently unpredictable and risky, requiring *all* women, even those who are healthy, to be attended in a hospital or a well-

equipped birth center (located near a hospital).[8] If risks cannot be predicted, women must be monitored by technologies that can continuously confirm that the pregnancy and birth remain within the narrowly defined range of "normal" markers and mileposts. When those markers are exceeded, pharmacological and surgical interventions must be at hand.

Increasing reliance on electronic methods of monitoring and medical interventions may progress to the point that maternity careproviders may not be able to provide care to women who are unwilling to submit to the medical definition of "normal." These women may have a different view of birth, one that begins not with risk, but with a view of pregnancy and childbirth as natural physiological processes. They trust in the ability of their body to bear and birth children and fear the consequences of routine medical interventions that may not be necessary.

As these articles indicate, the "science" of birth place safety can give comfort to widely divergent views on birth. Since it is possible to interpret the currently available evidence differently, parties who hold differing views may come to feel additional distrust toward each other because their "facts" differ. Those who begin on the side of "all births are risky" produce and invoke research reporting that, compared to hospital birth, home birth is associated with poorer outcomes for babies. Those who start by trusting the ability of a woman's body to give birth generate and use scientific studies reporting home birth to be as safe statistically for mother and baby as hospital birth, while having the advantage of using fewer interventions that may cause long-range iatrogenic problems. These different bodies of evidence are then used to make moral arguments about women's choices.[9]

The effect of these different orientations and different bodies of evidence on clinical practice can be seen in how each of the parties thinks about the normal and safe length of gestation, as exemplified in the above case of Ms. Sterkte. Those working within the medical paradigm begin by identifying the normal range of gestation: between 39 and 41 weeks. By the logic of averages, a normal pregnancy should last 40 weeks, a marker that then is seen as the *normative* length of gestation, the uppermost limit of what is safe. For those who are alert to risk, pregnancy is then technologically arranged to ensure that babies are born as near as possible to the 40-week mark. There are a variety of strategies and drugs to stimulate labor, and those methods often are implemented either before or, more often, at the 40-week mark.[10] If risk to the baby increases as pregnancy exceeds 41 weeks, then it is imprudent to even approach that limit. The initiation of a technological solution to a *possible* problem more or less guarantees that a baby will be born within the next 12 to 24 hours, because when one technology is introduced, additional interventions often follow, based on the same clinical assumption: this will be best for the baby. This escalating effect is known as a "cascade of intervention," an approach to managing labor and birth that is partially responsible for the high rate of surgical births in the U.S.[11] When birth is seen to be fraught with danger, each step in the cascade is seen as justified to minimize risk and becomes a guarantee of a "safe" birth that more than compensates for the interventions used that may not have been necessary.

At the other end of the spectrum are those who see birth as an integral part of normal life, a rite of passage into motherhood/parenthood. In this perspective, the entire range of a usual gestation, from 39 to 41 weeks, is considered normal (that is, nonpathological) until proven otherwise.[12] Providers who begin with this understanding come to the delivery with knowledge, expertise, and methods for managing births that differ significantly from those who begin with the notion that birth is unpredictable and risky. In this second paradigm, the rare and unexpected poor outcome is seen as inevitable, a chance occurrence associated with the decision to avoid the plethora of unnecessary procedures that befall healthy mothers who birth in the hospital.

This issue of *JCE* also unpacks the special complexities of shared decision making that attend decisions about place of birth. Within the new model of patient-centered care, widely accepted now in many other contexts, shared decision making is held up as an ideal, even though current assessments suggest that multiple barriers exist to its full implementation.[13] Disagreements over the selection and interpretation of the available evidence, the evaluation of risk, the presentation of relevant information, the rights and responsibilities of mother and baby, and the rights and responsibilities of the careprovider may confound the desire for open communication and mutual respect. These disagreements are fueled by the democratization of evidence made possible by the ability of women to obtain information on the internet, independent of their careprovider. Open and honest communication about the place of birth is further complicated when a woman's choice of place of birth is depicted as a contest between the baby's best interests and mother's (selfish) desires. Shared decision making—here and elsewhere—requires a level of trust and respect that will

allow conversations to move beyond the characterization of patients as poorly informed and foolishly self-interested.

Another dynamic—"birth exceptionalism"—may complicate clear thinking about the benefits and burdens associated with place of birth. A birth exceptionalist has a tendency to see her experience as existing outside of regular patterns of behavior in maternity care. Viewed in isolation from larger social patterns, every woman's birth experience is seen as idiosyncratic, obscuring and obviating structural patterns of cause and effect. A woman might say, "I know that childbirth can be natural, but, in my case, medical intervention was necessary." The medical intervention may refer to a range of "necessary" interventions, that include labor induction of delivery (in the U.S., 41 percent) and cesarean surgery (in the U.S., 32.8 percent).[14] Mothers describe a precipitating crisis: "The cord was wrapped around my baby's neck." "My labor was too long." "My labor stalled." "My baby was too big." Because there is a crisis, medical intervention is justified. But the frequency of such claims of exceptionalism—often conveyed in the language of an heroic intervention that "saved the baby"—may cause us to question the frequency of these "heroic" stories among U.S. birth narratives. Perhaps instead, this may be the predictable process of a maternity care system that views all births as catastrophes waiting to happen. Framing these interventions as heroic may perpetuate such a catastrophic view, and complete the circle, erroneously justifying the conclusion that childbirth is unpredictable. Childbirth includes an element of risk, of potential pathology—in spite of the best care in the hospital or at home, babies sometimes die, and sometimes mothers do, too. Opponents of birth outside of the hospital setting are inclined to emphasize the poor outcomes in births outside of the hospital. The specter of newborn mortality and morbidity carries a particular moral weightiness, with a vividness that exceeds most other experiences of mortality and morbidity.[15] We humans express more regret over errors of omission than errors of commission. Thus, injuries from an unnecessary cesarean section will be lamented less than injuries that result from a decision to reject a medical intervention.[16] But for healthy, well-nourished women living in a safe environment, most of the time, the experience of childbirth is "uneventful," that is, ultimately, it results in both a healthy mother and a healthy baby. Proponents of birth options outside the hospital setting emphasize those outcomes.

Returning to Ms. Sterkte—might there be a fourth and more preferable outcome? We hope that reading this special issue will encourage readers to think of new ways to approach the difficult decisions that careproviders must make together with patients. In the process of collecting and editing these articles, we have seen our authors become less defensive about their points of view, more open to considering the informed opinions of others, and more willing to reflect on the sources of once stridently held beliefs. Remaining stubborn, seeking only to find evidence that confirms our own opinion about the morality and medical benefit of a woman's desire for a home or hospital birth, will not bring us closer to better, more just maternity care. Ms. Sterkte is best served when her caregivers listen to her, explain their own fears and desires, and together—patient, midwife, and physician—develop a plan that respects the interests of all parties.

MASKING OF THE CASE

The case of Ms. Sterkte is a composite of several actual cases from our experience and reports in the media, and the persons involved in the actual cases cannot be identified from the information provided.

ACKNOWLEDGMENT

As much a colleague as a managing editor, Leslie LeBlanc was both intimately involved in all production aspects for this special issue, and a highly interactive intellectual sounding board for our perspectives on direction and substance. From initial conception of this special issue, her keen insights into the related macro- and micro-level political tensions that led to all manner of ethical complexities enriched this volume. Beyond that intellectual contribution, her editorial persistence, patience, and skill effectively nurtured the volume to completion. With immeasurable gratitude, we thank her for this.

NOTES

1. This quotation is from M.J.N.C. Keirse, "Planned Homebirth in Australia," *Medical Journal of Australia* 198, no. 11(2013): 574-575. Keirse (Department of Obstetrics and Gynecology, Flinders University, Adelaide, Australia) is one of the original contributors to the inaugural, systematic review initiative that paved the way for subsequent development of the Cochrane Collaboration/ Cochrane Library of Systematic Reviews, M. Enkin et al., *A Guide to Effective Care in Pregnancy and Childbirth* (New York: Oxford University Press, 1989).

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