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Choice in Planning and Experiencing Childbirth

Physicians should play a critical role in expanding access to reproductive health choices for women, including the choice to give birth under the care of a midwife.

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"Choice" is a central concept in the struggle for reproductive freedom around the world. Yet one of the most damaging consequences of our bruising abortion debates is the gutting of choice itself. In US political discourse, "choice" has come to be identified almost exclusively with the right to choose an abortion, and "reproductive rights" has been conflated with this narrow, legalistic notion of choice.

But for many women, reproduction includes both the prevention of unwanted pregnancy *and* the process of carrying a pregnancy, progressing through labor, and giving birth to a child. Wherever a woman finds herself on that spectrum, her experience of reproductive choice is not just a yes-or-no decision protected in law; rather, the experience of reproductive freedom is profoundly influenced by her interactions with the health system. Thus access to health care must be a core element of choice. Moreover, access ultimately means more than getting in the door. In a system that respects, upholds, and values reproductive freedom, access implies entrée to health care practices that acknowledge the complexity of the reproductive experience for women—its social, psychological, and political dimensions—and that honor the different choices women make throughout that experience.

US law is a particularly blunt instrument for the advancement of these ideas about reproductive freedom. Here, in both law and political discourse, rights are conceptualized almost exclusively as entitlements of the individual, and analysis centers on violations of those individual rights. The question of what social and institutional conditions are necessary for the individual to exercise and fully enjoy her rights is usually deemed a public policy or even a private issue, beyond the scope of rights analysis. Thus US law guarantees a right to choose between terminating and continuing a pregnancy, but stops short of ensuring the conditions that would enable women actually to exercise the choices they make. At one end of the reproductive spectrum, the classic statement of this distinction is the Supreme Court opinion in *Harris v McRae*, holding that although all women have an equal right to choose abortion, Medicaid is not constitutionally required to pay for it, even if that effectively closes off the option for poor women [1]. At the other end, in the conditions surrounding childbirth, women's choices have also been constricted by laws, practices, and the powerful social and intellectual constructions that underpin them, as we demonstrate below.

Can human rights be used to break open these constraining forces and foster new understanding of reproductive freedom and choice? Following the model of US civil rights law, traditional approaches to international human rights law have focused heavily on civil and political rights—issues such as torture, prisoner abuse, discrimination—with an emphasis on identification of violations and punishment of violators. But human rights also includes another branch of international law, social

and economic rights (such as the rights to health and to health care), which brings the challenge of "enabling conditions" out of the private or the policy sphere, and into the domain of rights analysis [2]. These social and economic rights are not recognized as enforceable rights in US law. But the principles that underlie them (and civil and political rights as well) are increasingly used in global health work, not just to mark the boundaries of behavior, but also to shape the way problems are analyzed, solutions are crafted, and professional responsibility is approached.

This evolving use of the principles of human rights to shape all aspects of professional practice is termed a "rights-based approach" [3,4]. We believe it can be a valuable way to analyze the role and obligations of physicians in promoting reproductive freedom for women in this country as well as in countries where maternal mortality is high and death in childbirth is a real danger for every woman.

What should physicians do to promote this fullest sense of choice and reproductive freedom? We recognize that the health system has become a massively complex edifice with myriad competing interests, often perverse incentive structures, and proliferating restrictions on the physician's own freedom to set the terms of his or her practice. **Still, physicians as individuals and members of a professional community remain powerful arbiters of ideas about health care and the ways in which those ideas translate into public policies and ultimately into health care choices available for women. The influence that the medical profession has had over the conditions under which women give birth in a range of different settings globally serves to illustrate our point.**

Accounting for Risk

Pregnancy and childbirth are, of course, normal and natural parts of life, experienced by most women without physical complications. But in every setting, no matter how technologically advanced, pregnancy and childbirth also pose risks. A routine delivery can quickly and unexpectedly turn into a life-threatening situation. Where access to emergency obstetric care is nearly universal, few women die from obstetric complications. However, in many countries, especially in South Asia and sub-Saharan Africa, health systems are in a state of collapse. Unmet need for emergency obstetric care often climbs to over 90 percent and, in such settings, maternal mortality is shockingly high [5]. A comparison of lifetime risk makes the point starkly: In Africa, a woman has a 1 in 16 chance of dying in pregnancy or childbirth, while in North America her lifetime risk is only 1 in 3500 [6].

These data describe only 1 aspect of reproductive risk. In every society, reproduction has many kinds of social, economic, cultural, and emotional significance for both individuals and the society [7]. These meanings influence the way that childbirth and its risks are actually experienced by women, **how they are managed by the health system, and, ultimately, how they are regulated by the legal system.** It is useful, therefore, to distinguish among 3 levels of risk [7]. At the *population level*, risk is quantified through epidemiological data correlating risk factors and outcomes across a society as a whole. At the *clinical level*, epidemiological data and the characteristics of the individual patient inform the assessment of risk that a clinician uses in counseling and treating a specific person. Finally, at the *individual, subjective level,* a woman processes, understands, and acts on statistical information she is given, taking into account the entire, multi-dimensional context of her life—a concept that has been called *lived risk* [8].

When the clinical model of risk eclipses all other models and controls childbirth policies across the whole health system, women's choices shrink. For example, Western medicine's notions of safety and risk have been used to justify "scope-of-practice" rules that unduly restrict the role of midwives, with

negative impact not only on the efficiency and functioning of the health system [9], but also on the rights of pregnant and laboring women.

In the United States, the troubled relationship between physicians (especially obstetricians) and midwives goes back more than a century, with the struggle to capture social and legal authority over childbirth and to dominate the market for childbirth services. Economic aspects of this struggle have been well documented [10]. But, in the medical and public health literature, the debate has been dominated by questions of risk and safety.

The current paradigm of childbirth in America pits 2 contrasting models against one another. **The medical model, based on notions of clinical level risk, approaches every birth as potentially pathological and intervenes medically to cut the risk of anything going wrong**. The medical profession's involvement in routine pregnancy and labor began with the well-intentioned goal of reducing the pain and risk involved in bearing children and has progressed to the point that, for women who want it, childbirth can be made virtually pain free and even predictably timed.

The midwifery model, by contrast, approaches childbirth as a normal, natural event, although it does not deny the occasional need for emergency medical intervention. Midwifery care often represents a more holistic, female-centered, and less medicalized way of giving birth. Midwives approach every birth as a potentially powerful experience for the woman, facilitating her ability to maintain control over the process. Women seeking this kind of care see the medicalization of childbirth as a disempowering cycle in which one medical intervention leads to another, leads to another, eventually ending in, at best, a harried, frightening experience and, at worst, an unwanted and possibly avoidable caesarian section.

From a human rights perspective, this uniquely American battle—however honestly and fervently it is waged—misses the point. By pitting the 2 models against each other, it fails to give meaningful weight to either population level risks or lived risks—and the values of access and choice that flow from each.

First, we should put the safety issue to rest. **The United States stands virtually alone among industrialized nations in its lack of support for midwife-attended births.** For example, midwives attend 90 percent of normal births in Germany and virtually all normal births in Denmark and France. In Austria, the law actually requires all births to be attended by a midwife [11]. In contrast, in 2002 (the last year for which data is available), midwives attended only 7.6 percent of births in the United States [12]. Although European countries rely heavily on midwives for routine births, and support them to practice with varying degrees of autonomy, they also ensure that women have universal access to emergency obstetric care in high quality health facilities in the event they experience complications. **As a result, these countries have low maternal mortality, low perinatal mortality, and low rates of medical interventions, such as episiotomies and caesarian sections—indeed, on all counts lower than the United States [11].** Clearly, it is possible to organize the health system around a model of care that values the strengths of both midwives and doctors to achieve the best results for women without any trade-off in safety.

In some high-mortality countries, midwives are the backbone of the maternal health care system. But in many others, **the medical profession has enormous influence over health policy, and the interests and clinical perspectives of physicians have determined scope-of-practice regulations that severely restrict the procedures that skilled, professional midwives** (as distinct from

traditional birth attendants) are permitted to perform [13]. In these settings, when safety debates framed as “midwives versus physicians” are allowed to obscure issues of access to basic life-saving care, the consequences are nothing short of tragic. Every year, half a million women worldwide die in pregnancy and childbirth. The single most important reason for these deaths is the lack of emergency obstetric care that women can access when life-threatening complications strike. The desperate shortage of trained, professional providers (midwives, nurses, and doctors), especially in rural areas, is both a fundamental part of the problem and an indispensable part of the solution [14]. **A human rights approach that takes population level risk as seriously as clinical risk, that emphasizes equitable access to life-saving care, and analyzes the situation from a structural, public health perspective will yield policies that strongly support an expanded role for non-medical providers, including midwives** [15]. But such policies have little chance unless and until the medical profession changes its stance on scope-of-practice regulations and supports the training and deployment of midwives as safe and effective providers of emergency obstetric care.

Physicians' Role in Promoting Reproductive Rights by Expanding Choice

Of course, it takes more than the good will of physicians to make midwifery care a viable option for women. Political choices that determine the structure and functioning of the health system are key. **In New York City, for example, the percentage of births attended by midwives is actually decreasing as access constricts [16]. Malpractice insurance premiums, skyrocketing for all providers of maternal care, have become completely untenable for midwives, rising as much as 1000 percent in the last year [17]. In September 2003, New York's Elizabeth Seton Birth Center, the first freestanding birth center in the country, was unable to afford insurance and forced to close its doors. Hospital-based midwifery care has fared little better. Medicaid, for example, only reimburses midwives 65 percent of the physician fee schedule [17]. As a result, hospitals around the country, including Columbia Presbyterian in New York City, are shutting down their midwifery services, citing economic considerations.**

Other barriers relate more directly to the physician-midwife relationship. Some states require that midwives partner with physicians in providing care to patients. While these laws prohibit midwives from practicing without the partnership of a doctor, they do not require doctors to work with midwives. Midwives often face serious difficulty in finding doctors who are willing to practice with them on terms of respect and trust in a truly collaborative, nonhierarchical relationship.

At a social level, the barriers are more profound: In the United States, unlike in Europe and many other countries, the choice of medicine versus midwifery is laden with value judgments, which the medical profession has done little to dispel. The woman who, based on her own lived risk, chooses a midwife to attend her pregnancy and delivery is often denigrated and marginalized, pushed out of, rather than embraced by, the health system.

A New Vision

A new vision of care in pregnancy and childbirth is urgently needed. The World Health Organization—joined by the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO)—**has now made professional midwifery skills a central plank in its strategic platform for reducing maternal mortality in developing countries** [18]. In the United States, a 1998 report of an expert commission on health professions called for dramatic change in the American system as well, stating: **“[T]he midwifery model of care is an**

essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women" [9]. A resolution passed by The American Public Health Association takes a similar position [19].

The US medical community—perhaps locked in too narrow a vision of reproductive risk—has lagged far behind. Physicians, obstetricians in particular, have a critical role to play in expanding access by recognizing and supporting the range of reproductive health choices that women make, including the choice to give birth under the care of a midwife.

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