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Medical authority and expectations of conformity: crystallising a key barrier to person-centred care during labour and childbirth

Abstract

Those giving birth within modern maternity systems are recognised as facing a number of barriers to person-centred care. In this paper, I argue that in order to best facilitate the conditions for positive change, work needs to be done to provide a more granular articulation of the specific barriers. I then offer a nuanced and contextually-aware articulation of one key component of the overall failure to ensure person-centred care: medical authority and the expectation of conformity. Articulating these barriers with increased specificity is valuable, as it creates a stronger foundation from which to challenge existing problems which serve to constrain the autonomy of birthing individuals. The analysis offered in this paper also underscores the need for change at an institutional, rather than individual, level.

Introduction

"In order to tackle the problem...we need to know what the problem is. We need to know what we're talking about" [1, p3].

It is widely recognised that those who are labouring and birthing often find themselves and their bodies subjected to medical control, diminishing their ability to make meaningful choices about where, how, and in what circumstances to birth.

In this article, I contribute to the existing scholarship on this issue by offering a specific and contextually-aware articulation of one of the core barriers which acts to inhibit access to person-centred care during labour and childbirth. I argue that the exercise of medical authority during childbirth operates to produce an expectation of conformity with medical norms or recommendations, which also converges with broad cultural expectations placed upon pregnant women to be 'good' and 'self-sacrificial' mothers [2, p139; 3].

This, I argue, represents a key source of control over the birthing body, and by extension the choices of the birthing person. I argue that by teasing out the specific role played by medical authority in this more granular fashion, we can create a stronger and more productive foundation from which to explore and address the way that it operates to impose control and undermine access to (legally protected and ethically salient) choice. [1]

Choice in childbirth

> *"A competent woman who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be the death or serious handicap of the child she bears, or her own death"* [4, at 30].

The black letter of the law is unequivocal in its position that the competent pregnant person has the final and legally binding say on whether to accept or refuse medical intervention during pregnancy and birth. However, there is a significant gap between law and reality in this regard – and a substantial body of literature illustrating the difficulties that pregnant and birthing people have in exercising this right in practice [5-8].

Supporting autonomy and respecting choice in childbirth is important not only because of its legal grounding, but also because it has an important role to play in protecting the well-being of the birthing person – and their family [9, 10].[2] Research has indicated that people's recollections of "their birth experience are related more to feelings and exertion of choice and control than to specific details of the birth experience" [11, p158]. Loss of autonomy during birth has been linked to lower "self-worth, trust, self-esteem, and confidence"[12, p2], and it increases the likelihood of the birth being experienced as "traumatic" [12, 13], as well as increasing the risk that the woman or birthing person will experience post-birth PTSD [14, 15].

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[1] This paper has been developed on the basis of work from my doctoral thesis: **[ref removed for anonymity].**
[2] This is also highlighted in the Ockenden Review in which it was noted that: "the review team has heard recollections from women relating to feelings of loss of control and power, (2016), excessive and painful vaginal examinations (2003), not being listened to (2002; 2004; 2015; and 2016) which resulted in psychological trauma for themselves and on occasion their birth partners": Ockenden D. *Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services and the Shrewsbury and Telford Hospital NHS Trust.* The Stationary Office, HC 1219, 2022.

It has been recognised those giving birth with the modern healthcare system are often face barriers to accessing meaningful choice during childbirth [3, 5, 6, 16]. These challenges not only contribute towards creating a gap between law and practice, but also act as an impediment to respectful care which serves the rights and wellbeing of the birthing person.

Therefore, in order to improve the quality and experience of birthing care it is necessary to tease out the exact nature of these barriers. Promoting access to person-centred care requires that we parse exactly what forces are operating to create a birth environment which decentres the birthing person, their needs and their choices. In this paper, I narrow in on a specific issue which is both facilitated and compounded by the overall medicalisation of childbirth; the expectation of conformity which arises from the convergence of medical authority with socio-cultural expectations of how a pregnant person *should* act [2].

The coercive nature of medical authority is contingent upon, and perpetuate by, the hierarchal and patriarchal healthcare institution within which it operates [17]. Women (and others receiving birthing care) are expected to have a "natural or biological impulse towards maternal self-sacrifice" [2, p139], such that they will willingly act in accordance with medical norms or recommendations in the interests of their foetus, regardless of the personal sacrifice involved [3].

This then intersects with pervasive suspicions regarding the (ir)rationality of labouring women [18], such that a person who makes decisions about childbirth which do not align with medical norms or recommendations may face doubt about their capacity to reason and make their own decision: if any rational women would do whatever a doctor says is best for the foetus, so the (problematic!) reasoning goes, then the capacity of one who seeks to make a divergent decision ought to be treated with some suspicion. Thus, the impact of this convergence is particularly significant in the context of maternity and birthing services.

Medical authority and expectations of conformity

In this paper I seek to crystalise the way that, within a medicalised birthing system, medical authority operate to create and compound expectations of conformity in a manner which can

undermines the autonomy of women and birthing people in relation to all kinds of birthing choices.

It is initially intuitive to assume that the problems experienced as a result the coercive manner in which medical authority manifests in a medicalised birthing environment stem straightforwardly from preference for medical or technological intervention in *all* situations – starting from the physical location of birth within the hospital environment and carrying on through induction and monitoring during labour to mode of delivery itself. Of course, the difficulty faced when attempting to refuse unwanted medical access to the body is *one important aspect* of concern. People can face pressure to consent, or at least to acquiesce, to a wide range of medical interventions during the process of labour and childbirth. It is well documented that some labouring women and birthing people face challenges when they attempt to decline (or delay) induction [16, 19, 20] or vaginal examination [6], to opt for care outside of guidelines [21, p51] or to resist being physically located in a medical environment (such as a hospital) [7].

However, this only gets us part of the way when it comes to understanding the challenges faced by those giving birth. This can be illustrated most clearly by examining the challenges that can be faced by those who seek to opt for caesarean birth absent accepted 'clinical indication'.[3] Were the barriers to choice in a medicalised birthing system to relate solely to an absolute preference for medical intervention, one would assume that such requests would be respected – or even encouraged. In reality, however, those who seek to opt for a caesarean birth by request face a significant uphill struggle in order to access this [22, 23].

This was also illustrated starkly by the stories which have come to light in recent years regarding the experiences that some labouring women and birthing people have when seeking to access epidurals for pain relief. An inquiry by the Department of Health and Social Care, published in 2020 [24], found that some labouring women and birthing people had been denied access to epidurals in contravention of NICE guidelines [25]. While resource issues played a role in restricting people's access to an epidural, this was not the sole contributing factor. There has been acknowledgement that some healthcare professionals imposed "artificial constraints" on when a request for an epidural could be complied with –

[3] I have argued that, in relation to pregnancy, the restrictive nature of clinical indications does not present a fair or sufficient picture of the reasons why a person may benefit from a particular treatment. See: **[ref removed for anonymity].**

unnecessarily shrinking the "viable epidural period to a 4 cm window which [could]...easily be missed" [26]. The consequence of this was that access to epidurals was, in some instances, "greatly" and unnecessarily reduced [26].

Both of these scenarios provide examples of situations in which women and birthing people seek to make a choice which represents the most technically 'medicalised' course of action in a particular scenario, yet face barriers to these choices and pressure to take a different course of actions [27, p32].

This points us towards the need for a nuanced articulation of the issues at play in the medicalised birth space. Regardless of the type of choice being made (or, being denied) the barriers faced share a common root; expressions of *medical authority* and the expectation of conformity therewith. I therefore argue that more explicit attention needs to be paid to the existence and operation of the coercive assumption that whatever course of action is suggested by healthcare professionals (which often means whatever course of action is deemed the 'norm' in that scenario) is the *only* legitimate one during labour and childbirth. Increased attentiveness to this will, I suggest, help to more effectively illuminate the source of control over the choices available to the birthing person: the coercive force of medicine as an institution which imposes normative expectations upon, and exercises control over, the pregnant and labouring body.

The consequence of this coercive expectation is that those who attempt to withhold consent from the suggested course of action, or aspects thereof, are often framed as being 'deviant', difficult or irrational [28, p7]. Where choices which diverge from medical recommendations are framed in this way, these choices may be framed as lacking legitimacy. This creates a space within which medical authority can operate coercively in an attempt to 'rationalise' decision-making, and bring this into conformity with medical norms / recommendations. This can be done, for example, through the manner in which healthcare professionals communicate with the birthing person.

For example, one vector through which this operates is through the framing and communication of risk. Where risk is communicated in a decontextualised manner, framed in unduly stark terms or focussed solely on physiological clinical concerns [29], this can undermine people's actual ability to make free and informed decisions about their birth;

particularly where these decisions sit outside of the clinical norms upon which the presentation of risk is centred. In this way, informational sharing practices give expression to expectations of conformity.

Medical authority, expected conformity and birth choices in the courtroom

The impact of this expectation of conformity with medical recommendations is not limited to the practical midwifery and obstetric spaces, we can also see its manifestation in the courtroom. Where questions are raised about whether a pregnant person has the capacity to make a particular decision about childbirth, this matter is referred to court. In such cases, the judge (potentially) has two jobs. Firstly, to determine whether the person has the capacity to make that decision, and then – if capacity is found to be lacking – to make a determination about what course of action is in *that person's* best interests [30]. While this clearly does not hand back decisional autonomy or power to the pregnant individual, *in theory* this process should serve both to recentre *their* interests and to relocate the decision making outside the influence of medical authority.

However, I argue that by examining the case law in this area we can see that this is not the case in practice. Rather, the influence of medical authority and expected compliance permeate judicial reasoning and decision-making in the childbirth context. It is important to recognise and address this in the judicial system as well as the healthcare system as both institutions have the power to shape and constrain the choices that are (actually) available to birthing people. Generally, pregnant people who end up in court are those who are already most vulnerable to having their choices constrained and their voiced de-centred. Therefore, it is important to understand the way the medical authority operates in both settings if we are to effectively break down the barrier this poses.

Previously, cases about birth choices have focussed on issues related to mode of delivery – and have seen pregnant women attempting to decline consent to proposed caesarean sections [8, 31, 32]. More recently a number of cases have been heard by the Court of Protection which have dealt instead with location of delivery – namely whether enforced transfer to hospital for or during labour should be permitted [33, 34]. One recent case dealt with the right to decline certain interventions during birth, should these be required (in this instance, the use of blood products) [35]. All of these cases reached the Court because questions were

raised about whether the pregnant individual had, or would at time of birth have, the (legal) capacity to decline consent to the course of action being recommended by their healthcare team. In each instance the Court had to determine whether capacity was lacking (or was likely to be lacking during the birth) and, if so, what course of action was in the best interests of the pregnant individual.

At the heart of these cases sits a deference towards the course of action recommended by healthcare professionals and a seeming suspicion about the capacity of those who seek to deviate from these recommendations. In this way, the court acts to legitimise the power of medical authority to undercut the autonomy of birthing people and to shore up expectations of compliance therewith.

A common thread which runs through many of the reported cases is that capacity appears to be called into question at the point at which the pregnant person begins to voice opposition to medical recommendation. In many of the cases the pregnant person at the centre has a pre-existing mental health condition which is known from the start, but which does not seem to prompt concern regarding capacity where the person initially agrees with their healthcare team; or based on a concern that they will stop complying. This can be illustrated by the recent case involving the attempted refusal of all interventions involving blood products by a "deeply religious" pregnant woman [35]. Despite having previously accepted that the woman had the capacity to consent to a number of other obstetric interventions, the Trust in this case sought a declaration of incapacity when she sought to decline these particular interventions.[4] During the case the Official Solicitor observed that P's treating clinicians considered her capacitous "in all the areas in which she is willing to take that [medical] advice" and that her capacity was only considered lacking "where she is not willing to follow medical advice" [35].

A similar concern can be identified in *GH*, a case involving a pregnant woman who had agoraphobia and wished to remain at home during labour and have a homebirth. An application was made to the Court of Protection on the basis that she lacked the capacity to decline to birth in a hospital setting. For the present purposes, the significant aspect of this

[4] It is significant to note here that the court has a strong history of supporting people's right to decline blood products for religious reasons in non-pregnancy cases, even where the consequence of this is death. See: *Nottinghamshire Healthcare NHS Trust v RC* [2014] EWCOP 1317.

was that questions about her capacity – or lack thereof - did not arise until the point at which GH's decision differed from that of the medical professionals. As noted in the judgement, "at the time she gave that agreement there were no concerns regarding GH's capacity to make decisions concerning her admission to hospital should this be clinically indicated during the course of her labour" [34].

We lack the information needed to offer a factual critique of the legitimacy of this capacity decision. However, "it is not clear whether and how her agoraphobia had changed in between these two points" [36]. Regardless of whether such a change *had* taken place in reality, the fact that any explanation of this was omitted from the judgement may be seen to be concerning in itself; indicating, perhaps, an implicit assumption that those decisions which depart from medical advice are inherently irrational and that irrationality itself may be seen as an indicator of incapacity.

Therefore, those whose capacity is called into question as a consequence (in part at least) of failing to conform to medical authority or medical recommendations face a double jeopardy - as the same forces which bring them into the courtroom are likely to act against them once they are there. Rather than offering an important counter-weight to the operation of medical authority within the birth space, the courts instead have a tendency to reify and re-enact this in their decision making.

Conclusion

Understanding the forces at play within the modern birthing system in more granular detail allows us to more precisely articulate coercive nature of medicine as an institution, and the harms which arise when this operates to impose normative expectations upon, and exercise control over, the birthing body. In doing so, we create a stronger foundation from which to address the ways in access to person-centred, respectful birthing care can be undermined within a medicalised birthing system.

Given the complexity and polarisation which surrounds debates about childbirth there is substantial value in bringing increased specificity and granularity to our analysis, in order to

further facilitate detailed exploration of the barriers to person-centred maternity care – and the steps we can take to fix them.

Importantly, recognising that it is the system which is the source of the problem correctly locates the locus of responsibility for change; moving beyond the individualised need to equip birthing people to fight for access to fundamental rights, and instead demanding that systemic changes occur (across both medical and judicial institutions) so that their rights are respected, and their choices centred as a matter of course.[5]

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