YES YOU CAN SAY NO!

Previously Published in THE NATURAL PARENT MAGAZINE –Autumn 2014

As usual in my articles for the Natural Parent magazine I'm assuming dear reader that you are a 'willing woman' with a yearning for normal physiological birth, right? Well, given that the stats point to normal physiological birth being under threat, looking more closely at the issue of informed consent and informed refusal becomes urgent.
In this article I want to draw out a few themes that shed light on this issue.

Patient autonomy and health literacy
Understanding the range of possible birth choices on offer is one thing, negotiating them is another. Patient autonomy and health literacy is something that the willing woman needs to be across. What I'm talking about here is the concept of a birthing woman having the right to be informed about and say 'yes' or 'no' to medical procedures and interventions suggested to her.

What health literacy and medical decision making should look like in practice is 'patient autonomy' on the part of the patient—in our case the birthing woman—who will make her choices in light of the evidence provided and based on her values and research, her baby's and her own health, her sense of responsibility and her capacity. Now her choice might either be giving 'informed consent'—that is, saying 'yes' to what's suggested; or it may be 'informed refusal'—saying 'no' to what's suggested. In either case there will be an expectation that her autonomous choice will be accepted without coercion or refusal of support and goodwill. On the part of the medical caregiver, in theory they should practice
in a way that honours patient autonomy and, in our case, provides the birthing woman with 'women-centred care' by sharing evidence-based information. They will quantify risk specific to the particular woman and her baby, and practice within the code of ethics of their profession.

That is what it should look like. But what it more often looks like in practice is a passive patient being informed of what is happening. Or, in many cases, not even being informed. The dynamic at play in these situations is what can be described as the 'trance of acquiescence'. In medical settings many of us have low levels of health literacy and may not realize that we even have a choice. We seem to automatically give up our autonomy and slip into this 'trance', accepting whatever is suggested without discernment about whether we want it, whether we need it, or what agendas might be behind whatever is being suggested. This passive trance of acquiescence is actually the psychological equivalent of a fear-based 'freeze' state.
Because of this, interactions between medical caregivers and their patients are often transacted within this dynamic—a compliant trance of acquiescence on the part of the fearful patient, and, a corresponding 'assumption of acquiescence' on the part of the medical caregivers. In many birthing situations this is what passes as 'informed consent'.
Added to this 'trance' and 'assumed acquiescence' dynamic, many of us are 'conflict avoidant'. We want to keep a 'good vibe' over and above speaking up for our needs in a tricky situation. Also, a tendency towards conflict avoidance is heightened in the birthing woman who is flooded with oxytocin—the loving, 'tend and befriend' hormone. She just wants to be sweet to everybody. So in the face of any tough negotiations about procedures and interventions she is more likely to fold if the environment gets tricky. Not only that, if the situation becomes conflicted this will impact the whole hormonal balance anyway—shooting up an adrenalin

response which effects oxytocin levels. You might win the point but the optimal hormonal flow for normal physiological birth will be compromised.

Willing women need to be awakened from this acculturated 'trance of acquiescence' and get savvy about the practices and procedures they will routinely be offered, in order to give 'informed consent' or—and given that routine protocols are designed for worst-case scenarios, more likely—to use 'informed refusal' to protect themselves from any unwanted interventions. So the willing woman needs to be aware of informed consent, but also of her right to informed refusal.

Philosophical match

These issues of patient autonomy and appropriate care bring us to the importance of ensuring you find a carer who is a good 'philosophical match' with you. Certainly the willing woman wants to claim her autonomy and will ideally find a match with caregivers who are woman centred in their practice. Woman-centred practitioners also want to work with women who are fully aware of the personal responsibility required of them when giving informed consent or refusal. This compatibility in terms of understanding patient autonomy would contribute to a philosophical match.

You can see that it would become problematic if a willing woman, aware of her need and right to exercise patient autonomy, is attended by a caregiver who is expecting acquiescence on her part. A power play generally gets going that does nothing for the birth hormones. Just as problematic would be the scenario of a woman caught up in the trance of acquiescence who wants to be told what to do, but is attended by a caregiver looking for her to take responsibility and make her own choices based on the evidence. So much is dependent on ensuring that you have a philosophical match with your caregivers. This is where continuity of care with a known caregiver comes in—trust comes out of an established relationship and a shared philosophy.

Human Rights in Childbirth

According to Dr Andrew Kotaska in an article, *Informed consent and refusal in obstetrics: A practical ethical guide',* [Birth Journal - wileyonlinelibrary.com/journal/birth] *the historical adage: 'the doctor knows best' is no longer valid. Historically, when there were disagreements in the doctor-patient relationship, the locus of control resided with the doctor. This is no longer the case. Patient autonomy carries more ethical weight than caregiver beneficence.*

Kotaska goes on to explain, (*T)he Universal Declaration of Human Rights guarantees everyone, including pregnant women, security of person. This includes the right to decline any medical procedure that violates her bodily integrity, even if that refusal increases her or her fetus' risk of death. This right is enshrined in medicine and law as a patient's right to give or refuse consent.*

Some suggest a woman has an ethical duty to her fetus that limits her autonomy and imply that physicians have a moral obligation and authority to enforce this duty if a woman neglects it. This stance is paternalistic, condescending, and without ethical or legal basis.

Coercion, he further explains, *is compelling by force of authority. In the clinician-patient relationship, it can take several forms; magnifying risk estimates to dissuade a patient from an option; exaggerating benefits or withholding risks of a recommended treatment; demeaning a woman for putting her fetus at risk; asserting a woman's decision makes her a 'bad parent' and*

threatening to involve child protection services; threatening to withdraw care if a woman refuses medical advice.

Rebecca Schiller in *Why Human Rights in Childbirth Matter* [Printer & Martin. 2016 UK] further expands on the relevance of human rights to maternity care. *The fundamental human rights values of dignity, privacy, equality and autonomy are often relevant to the way a woman is treated during pregnancy and childbirth. Failure to provide adequate maternity care, lack of respect for women's dignity, invasions of privacy, procedures carried out without consent, failure to provide adequate pain relief without medical contraindication, giving pain relief where it is not requested, unnecessary or unexplained medical interventions, and lack of respect for women's choices about where and how a birth takes place, may all violate human rights and can lead to women feeling degraded and dehumanized.*

Obstetric Violence

When contemplating this yes or no issue, we might also put into the mix the ddefinition of obstetric violence, presented by UK Obstetrician Dr Amali Lokugamage @ RCOG World Congress 2014.

Obstetric violence is the act of disregarding the authority and autonomy that women have over their own sexuality, their bodies, their babies and in their birth experiences.
It is also the act of disregarding the spontaneity, the positions, the rhythm and the times the labour requires in order to progress normally when there is no need for intervention.
It is also the act of disregarding the emotional needs of mother and baby throughout the whole (childbearing) process.

Now, given that, sadly, this definition of obstetric violence is what so often passes for standard care in birth you can see how important it is to be on the case about informed consent and informed refusal.

Evidence-Based care

But there's some good news coming out of recent research.
It supports trusting birth rather than continuing to over medicalize it, and even though there is always a time lag before research translates into changes in practice and protocols, nonetheless its very encouraging. *Safe prevention of the primary caesarean delivery,* a consensus statement from the American College of Obstetricians & Gynecologists and the Society for Maternal-Fetal Medicine [www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery] recommends taking a more hands off approach—waiting longer on babies to initiate labour because induction increases the risk of caesarean; suspected 'big' babies not an indication for caesarean; slow but progressing labour in first stage is not an indication for caesarean; extended timing protocols for second stage of labour (up to 3 hours for first baby); changes to the interpretation of fetal heart rate patterns; encourage continuous labour support as it is one of the most effective ways to decrease the caesarean rate—mmm, seems the research is finally shining a light on trusting birth and women's birthing capacity.

Conclusion

Putting together an awareness of human rights in childbirth; naming obstetric violence; referring to evidence-informed care, brings us to the conclusion that yes, you can say no. And

really if you are a 'willing woman' with a yearning for normal physiological birth, then there are many instances in which you must say no, if you are to honour your birthing capacity.