**Harming one to benefit another: The paradox of autonomy and consent in maternity care.**

Abstract

This paper critically analyses ‘the paradox of autonomy and consent in maternity care.’ It argues that maternity care has certain features that increase the need for explicit attention to, and respect for, both autonomy and rigorous informed consent processes. And, moreover, that the resulting need is considerably greater in than in almost all other parts of medicine. These features are:

1. Maternity care involves particularly socially sensitive body-parts that are regularly implicated in consent-centred procedures—as well as unconsented interventions – in ordinary, non-medical life; and
2. Much of maternity care (especially intervening in childbirth) is medically unique, in that it harms one patient (the mother) not primarily for the promotion of her own health, but to the benefit of another (the baby). The apt comparison, within medicine, is therefore with non-therapeutic research and organ transplantation—both of which have elevated consent requirements characterised by very rigorous consent processes.

At the same time—and this delivers the titular paradox—the importance of autonomy and consent in maternity care is at particular risk of being denied or overlooked. Jointly this makes a very strong case for change: attention to and respect for autonomy and consent should be (1) core values; (2) key points of practical attention in the years going forward; and (3) central quality indicators in maternity care.

Abuse in childbirth, ranging from disrespect to obstetric violence and human rights violations, has become a global ‘hot’ topic in the last decade.[[1]](#footnote-1) In response, the WHO issued a 2018 report outlining recommendations on ‘respectful maternity care during labour and childbirth’, explicitly citing a ‘humans rights approach’.[[2]](#footnote-2) This report endorses the ‘respectful maternity charter’ issued by the White Ribbon Alliance, which details seven articles of the ‘universal rights of childbearing women’.[[3]](#footnote-3) The importance of respecting women’s consent and autonomy, though not necessarily under that word, appears to feature prominently in these developments: ‘non-consented clinical care’ is one of the seven major categories of disrespect and abuse identified by Bowser and Hill in their landscape report underpinning the White Ribbon Alliance charter;[[4]](#footnote-4) the most egregious examples of obstetric violence often involve women being harmed and/or assaulted in labour, when clinical interventions are administered not just in the absence of consent, but despite explicit refusal;[[5]](#footnote-5) and the UN special rapporteur on violence placed special emphasis on the importance of consent for tackling mistreatment during childbirth[[6]](#footnote-6)

This focus on consent and autonomy (among other issues) presents a striking new development in women’s activism on childbirth. After all, respect for autonomy and informed consent are by now well-described, deeply embedded and relatively uncontested core values in the literature on bioethics – as well as legally embedded in many local jurisdictions *and* international human rights law. Why, then should they require explicit additional articulation in women’s rights in childbirth charters? And why do they appear to be frequently, and according to some, routinely, violated in the maternity context? This paper aims to partially explain these phenomena by critically analysing what I refer to here as ‘the paradox of autonomy and consent in maternity care.’ I argue that certain features of maternity care *increase* the need for explicit attention to, and respect for, both autonomy and rigorous informed consent processes. And, moreover, that the resulting need is considerably *greater* in than in almost all other parts of medicine. At the same time – and this delivers the paradox – the paper identifies *that,* and some possible reasons *why* the importance of autonomy and consent in this setting may be at particular risk of being frequently denied or overlooked. Jointly this makes a very strong case for change: attention to and respect for autonomy and consent should be (1) core values; (2) key points of practical attention in the years going forward; and (3) central quality indicators in maternity care.

**1. Vaginas are not knees: Messing with bodies and the risk of violation**

Why are respect for consent and autonomy such widely endorsed values and requirements in medical ethics and law? In brief, a first principled reason is that medical diagnosis and treatment requires touching and invading the body with hands, lines, tubes, needles and knives. Absent consent (and other requirements, such as the professional context and training of the doctor and envisaged benefit to the patient) this constitutes a direct assault on fundamental rights to private life, life and dignity, and against inhuman and degrading treatment – as well as legal rights against assault and battery.[[7]](#footnote-7) Morally valid – that is, informed and voluntary – consent is therefore a central ethical and legal requirement for medicine. [[8]](#footnote-8) It is also legally and morally *transformative*: it changes the nature of an act from (potentially) torture or assault, into a procedure that is agreed, autonomously chosen, and congruous with ones values.[[9]](#footnote-9)

These requirements are particularly pronounced and demanding in maternity care, because here medical professionals routinely need to interact with parts of the body whose invasion raises particularly sensitive issues. It is one thing to have a doctor manipulate your knee, look in your ears or cut your tonsils without consent during a medical encounter; this is a (grave) infringement of the body and the person. But in maternity care the care-provider has to look at, manipulate, invade and in some cases cut – amongst others – body parts that have broader social significance, which makes for an additional layer of complexity and risk. This sensitivity and social significance is evidenced – for example – by the ways in which even routine examination of these body parts, with consent, is experienced by women.[[10]](#footnote-10)

One way in which these body-parts – the vulva and vagina – are unique is that the importance and morally transformative nature of consent is a more general social feature of our engagement with these body-parts, such that their infringement can, or is more likely to take on, broader meaning by echoing other infringements. For unlike noses or knees, questions about consent – when it comes to vaginas – are not normally restricted to the medical encounter alone. Indeed, and unlike almost all other body-parts, for most women, that is not even the primary setting in which such questions arise, or in which violations are encountered (more on which, below).

Prosaically, then having someone stick their finger in your ear, nose or even mouth, without consent, is just different, and has a very different and social meaning, from having someone stick a non-consensual finger in your vagina. This holds *even* if it is done with the best of intentions; and *even* if it is done in a medical context.[[11]](#footnote-11) Although both are violations, we cannot escape the fact that non-consensual touching of the vulva and/or vagina has a wider social meaning, tied explicitly to deliberate and routine violation, sexual objectification, and dehumanisation.[[12]](#footnote-12) All of this makes the importance of respecting autonomy and consent by and large *more* important in maternity care than in branches of medicine that mess with less sensitive and socially meaningful body-parts.

It also means that small missteps can have huge consequences. Accidentally touching ears, toes or knees without proper, *morally transformative* consent in a medical setting is wrong, but may not be experienced as a profound violation, with devastating emotional consequences for the receiver. In maternity care, by contrast, this is a serious risk: “*It felt like rape, I can still feel the hand (inside me)”**[[13]](#footnote-13); “I felt raped and violated by this perfect stranger*.”[[14]](#footnote-14)

There is therefore substantial need to err on the side of caution in maternity care, and always carefully request explicit consent. This need is amplified by the statistical likelihood of a history of sexual abuse or assault amongst the maternity care population. Globally, 35% of women have been physically and/or sexually abused/raped.[[15]](#footnote-15) One in ten girls worldwide have been sexually assaulted or raped.[[16]](#footnote-16) The expectation of such a potential history should therefore be the norm in maternity care, rather than presuming otherwise unless a patient makes the effort to declare it. Whilst doing little to harm or even affect those without such a history, such an approach would greatly benefit those with such a history: it would save potentially already vulnerable/traumatised patients the need to label, discuss and disclose such personal and potentially very painful matters to their health care providers.[[17]](#footnote-17) Nor should they need to: if maternity care made a point of explicitly requesting and respecting consent and autonomy always, then a woman’s potential history of abuse is simply not something health care providers need to know in order to provide the level of care and respect for autonomy/consent that invasions in a vulnerable women’s private sphere and intimate body parts require.

All of this gives a first reason to makes the importance of explicitly respecting autonomy, and of gaining free, informed consent, of *particular* concern in the context of maternity care, compared with areas of medicine intervening with socially less complicated body parts.[[18]](#footnote-18)

**2. Harming one to benefit the other: The altruistic nature of maternity care**

My main focus on this paper is on a second reason for thinking that maternity care gives rise to a greater need for attention to, and more demanding requirements on, respecting informed consent and autonomy than nearly all other branches of medicine.[[19]](#footnote-19) This is related to another main and long-established tenet underpinning the moral permissibility of medical treatment: consent alone is not enough. Any (iatrogenic) risks imposed or damage done to a patient, such as risks of side-effects or surgical damage, must be justified by benefitting that patient to a considerably larger degree.[[20]](#footnote-20) Here, maternity care is truly unique because it is one of the very few areas of medicine that routinely harms the one *not* in the expectation of benefitting them, but in the expectation of benefitting another. This is not a point about statistics; in much of medicine, multiple people are screened or treated – and hence suffer the associated risk of harms such as side effects, false positives and iatrogenic harm – in the knowledge that only one or some will benefit as a result. But outside obstetrics, the beneficiary is at least amongst the people incurring the (risk of) harm. In obstetrics, by contrast, invasive treatments and tests that constitute or bear risks of physical and emotional harm – such as induction, caesarean section, forceps, , etc. – are nearly all administered to one group (mothers) for the envisaged primary benefit of another group entirely (their babies).[[21]](#footnote-21)

That is not to deny that mothers can greatly benefit from having their baby saved, and (for many) to such a degree that they are willing to incur significant risks. We will return to that. Nevertheless, many interventions and harms in obstetrics are routinely done *not* for the intended primary promotion of (statistical) beneficial health outcomes of the persons incurring that harm, but for the intended primary promotion of the health benefit of another.

There are only two other areas of medicine where persons are routinely subjected to harmful intervention for the direct (statistical) benefit of others. The first is transplantation medicine: organ donation, bone marrow donation, blood donation, etc. The second is medical research. Both domains are characterised by a considerable *increase* in focus on autonomy and accompanying greater stringency of requirements for consent – and for good reason.

In human subjects research, for example, the research has to be deemed ‘ethical’ by a review board, and the subject has to go through a much more stringent, review-board approved consent protocol than in ordinary medicine. This is explicitly justified in terms of the research setting *lacking* what is a normal expectation in medicine: that the health care provider is primarily acting for the benefit of their individual patient. For in the research setting the health care providers is deemed to have a conflict of interest: acting not primarily in the interest of the ‘patient’ (rather: research subject) – but (also) for other goods, such as their research career; knowledge; or health benefits to future patients or the community.[[22]](#footnote-22)

In live organ and tissue donation, too – which is surely the prime example of harming one to save another – there are *very* strict requirements on consent and oversight as well as a considerable ethical literature questioning the practice. These vary with the harm inflicted: it is a lot easier to donate your blood than your kidney. Indeed it is not easy to altruistically donate a kidney at all. And – of interest in this context – some advocate that it should be especially difficult to donate to family members. For there is some concern, there, that out of care for the ill family member, the consent may not be genuinely voluntary, and hence morally invalid.[[23]](#footnote-23)

The comparison with maternity care here is striking. Obstetricians frequently do very serious iatrogenic harm – a caesarean section, for example, is major abdominal surgery – as well as a host of more minor but still serious interventions that impose short- and/or long-term harms or risks of harm on healthy women – such as an episiotomy or a forceps delivery[[24]](#footnote-24) – to confer an expected, but often statistically still small benefit to another person entirely: their baby.[[25]](#footnote-25) In the research or transplant settings this would raise serious ethical questions. At the very least such an intervention would be subject to far stricter requirements for informed consent and potentially require independent ethical oversight, as well as very careful attention to genuine, autonomy-respecting decision-making. In the maternity setting, however, the altruistic sacrifice is deemed normative; its ethical legitimacy assumed; and consent procedures are often minimal or absent.[[26]](#footnote-26)

**4. Mitigating Factors: reasonable presumptions and the relation between altruism and autonomy.**

Of course, it might be argued that the childbirth context comes with considerable mitigating factors: the relationship between the person bearing the risk of harm and the envisaged beneficiary is normally that between parent and child. And few would deny that the vast majority of parents, autonomously, greatly desire to benefit their children – nor that mothers in particular are often the first to greatly suffer emotionally, financially and otherwise, if their babies are still-born, disabled or otherwise harmed.[[27]](#footnote-27) One might therefore attempt to justify current paradigms in maternity care by arguing (1) that the maternity population genuinely *wants* to run certain risks for the benefit of their babies, and (2) that the envisaged benefit to the baby is *also*, indirectly, a benefit to that population. This second claim especially, representing the presumption of *indirect or secondary benefit,* is simply non-existent in research ethics, absent the rarest of circumstances, and is not automatic in transplantation medicine unless there is a family- or other personal connection.

I will argue that claims (1) and (2), even if true, cannot undermine the reasons given for *increased* respect for autonomy and informed consent in maternity care. But, prior to that, note three caveats about their applicability, content and inferential reach.

First, whilst both claims seem reasonable on the face of it, they do not apply universally. There may be birthing women who may not place quite as much weight (if any) on benefitting the baby at their own risk – for example, those engaging in altruistic or contract (also know as ‘surrogate’) pregnancies; those planning to give up a child for adoption; or those whose children will be removed from them at birth against their will. Equally, there will be some – the same examples apply – for whom a claim about indirect or secondary harm is false: harms to their baby simply do not translate much (if at all) into harm to themselves. The point is worth emphasising because, rather than there being signs that, for this reason, we expect less altruism or show greater consideration for autonomy and consent in some of these circumstances – as would warranted, if not imperative – the opposite appears to be the case.[[28]](#footnote-28)

Second: even if many parents may desire to benefit their children and be willing to incur some risk and/or cost to make this happen, this tells us little about what risks they deem acceptable in pursuit of this goal, or *how much* cost they are willing – or feel able – to absorb. The difference between a reasonable claim about willing maternal sacrifice on the one hand, and a (harmful) gender stereotype on the other, is that the former has clear limits, recognizes individual variation,[[29]](#footnote-29) and in principle treats mothers and fathers equally. The latter, by contrast, is near-limitless, and applies to women only (or at least: disproportionally).[[30]](#footnote-30) Obviously only reasonable versions of the above claims should feature in our reasoning; those rooted in problematic gender stereotypes should not.

Third, a reasonable claim about *indirect or secondary benefit* does not by itself automatically lower stringent ethical requirements for voluntary informed consent; recall that in transplantation medicine, an emotional/family connection (which also warrants a presumption of indirect/secondary harm) is sometimes considered as calling i*nto question* the moral legitimacy or voluntariness of consent, or of genuinely autonomous/rational decision-making. This is therefore, and correctly, considered a reason for *raising* our expectations of rigorous informed consent procedures and ensuring careful autonomous decision-making – not a reason for foregoing such care or something that justifies the imposition the (risk of) harm to benefit another without morally and legally transformative consent.

All this said, even applicable and reasonable versions of (1) and (2) cannot undermine the stated requirements for *increased* respect for autonomy and informed consent in maternity care. For any reasonable presumption about maternity care – that mothers *want* to run risks for the benefit of their baby, and that the mother-baby relationship is such that an envisaged benefit to the baby is *also*, indirectly, a benefit to her – is not independent from the mother’s autonomy. These presumptions hold true only because, and only insofar as, women, as autonomous agents, take on the value of altruistic maternal sacrifice (to at least some extent), as well as the value of love and care to the degree that another’s pain is one’s own (again at least to some extent). Thus, even if it were universally true that women are willing to incur significant (though not limitless) harm for their babies, *and* that they have a self-interest in doing so, then this willingness, it’s magnitude *and* her direct relation to a child are grounded in, and expressions of, her autonomy. They are not separate – let alone contradictory – facts.

Equally, suppose a bereaved father[[31]](#footnote-31) greatlydesire to participate in medical research into their late child’s condition, and will indirectly emotionally benefit from any benefits from that research. These facts do not *contrast* with, let alone, *undermine* the need for the research scientists to carefully monitor the validity of their consent and respect for autonomy: to respect the father’s wish and include him in research *is* to respect his autonomy – (although here, too, there may well be concerns about the emotional clouding of the father’s decision making). Equally, respecting the genuine heart-felt desires and emotional bonds of mothers – where they in fact exist – (including heeding concerns about whether these may cloud her judgment) is part of the complicated question of how best, in practice, to enact respect for autonomy and consent in maternity care – not something that contrasts with it. And a consideration that is particularly relevant in questioning whether respecting such desires and bonds is congruous with respecting the mother’s autonomy is the significant social pressure on mothers to think, act and desire in accordance with a predominant ideology of motherhood underpinned by expectations of near-limitless maternal self-sacrifice in response to the perceived needs or desires of children.[[32]](#footnote-32)

**5. And yet…… disrespect and abuse in childbirth**

In summary: ethical analysis provides at least two independent grounds for demanding *more stringent requirements* on informed consent and respect for autonomous decision-making in obstetrics, compared to the rest of medicine. First, obstetrics messes with particularly socially complicated body-parts, which leave no room for carelessness in respecting autonomy and checking for *genuine* consent. Second, most maternity care has a deeply altruistic character, more comparable with organ donation and non-therapeutic medical research than ordinary medicine.[[33]](#footnote-33) Yet it seems that, if anything, consent and autonomy are *less* well respected in maternity care than elsewhere in medicine – and even frequently under threat.

At one extreme, court cases about medical treatment on competent people without their consent have, where they have taken place, disproportionally focused on pregnant women. Indeed the forced caesarean – that is, forced or court-ordered major abdominal surgery in the interest of a *different* person, and *despite* refusal – frequently rears its ugly head.[[34]](#footnote-34) It is one of the few – perhaps the only – example of forced surgery on a competent patient *in the interest of a third party* explicitly defended in the literature.[[35]](#footnote-35) This, however, seems only the tip of the iceberg. An expanding literature on obstetric violence lists many more examples of non-consensual bodily infringements – such as vaginal examinations and episiotomies – that may be less extreme than forced caesareans, but also far more frequent.[[36]](#footnote-36) Media campaigns and charities, whose very existence is testament to the apparent failure to respect even *ordinary* legal rights in maternity care in otherwise well-regulated, well-funded countries make similar reports.[[37]](#footnote-37) A social media analysis of such a campaign sharing self-reported negative and traumatic experiences in the Netherlands on social media finds main themes to be ‘a lack of informed consent,’ ‘not being taken seriously by caregivers,’ and ‘not being listened to’. This led to women feeling dehumanized, objectified and losing control over their own birth.[[38]](#footnote-38) All of these are complaints clearly bound up with disrespecting autonomy and consent. Finally, research on traumatic birth experiences not only finds trauma to be a prevalent phenomenon, but also that this is bound up with autonomy: it is most often attributed to a lack and/or loss of control during labour and birth[[39]](#footnote-39). No comparable reports, activism, discussion or campaign seems to emerge form other areas of medicine It seems fair to say – and the above is only a selection of the available literature – that autonomy and consent *are* at particular risk of, and in fact, being disrespected in maternity compare to medicine in general. That itself delivers a paradox, given my arguments that they should be respected and attended to *more.*

A second question is: what explains this paradox? We can certainly gesture towards a complicated story involving gender here, that again I do not have space or time to do justice – but others have. Being pregnant and giving birth are sexed phenomena deeply gendered ‘woman’.[[40]](#footnote-40) Gendered social expectations demand that women are particularly submissive, passive, non-assertive and at the service of others – and they invite (potentially violent) punishment if they do not comply.[[41]](#footnote-41) Their bodies are perceived as available, potentially primarily as objects, for the use of others, who may transgress these bodily boundaries at will, or at least face relatively low penalties for such transgressions.[[42]](#footnote-42) Finally, they are considered less ‘rational’ than men. All of these expectations may be amplified in childbirth, when woman are deemed to be *especially* lacking in rationality,[[43]](#footnote-43) and when they enter the state of motherhood in which (gendered) norms and expectations of maternal sacrifice are near-limitless and highly dichotomous: there are only perfect mothers, and dreadful ones.[[44]](#footnote-44) It is unsurprising, then, that many scholars have analysed various aspects of childbirth in explicitly feminist terms[[45]](#footnote-45), and that scholars have even characterised obstetric violence as a subset of gender-violence.[[46]](#footnote-46)

Overlooking the autonomy of pregnant women/pregnant humans as a class is clearly problematic, and the available literature (of which only a selection is cited above) gives good reason to think that there is a role for gender aspect here. This would certainly explain the paradox, but it also fails to justify it; if anything it gives *further* reason for being *particularly* careful and attentive that autonomy and consent are respected. For it strongly suggest we are illegitimately – because for sexist reasons – inclined to disrespect it in maternity care.

**6. Objections: What about the baby?**

In this section, I consider some objections to my claim that there are elevated requirements to respect autonomy and consent in maternity care.

First and foremost, some might ask ‘What about the baby?’ however, nobody denies that the baby’s health and interetss matter – least of all the mother. As was discussed at length in section 4, it is a reasonable (though not universally true) presumption in maternity care that many women, autonomously, care *deeply* about the health and well-being of their baby – to the extent of their widespread consenting to significant (but not limitless) altruistic sacrifice. At no point in this essay is the well-being and interest of the baby therefore absent. Indeed, supporting adequate, respectful autonomous decision-making on behalf of the mother must surely *always* include information about the baby, as that is information is likely to weight heavily in her decision-process.

The concern expressed, therefore, must be a different one. Perhaps: doesn’t the health and well-being of the baby – or rather, we may presume, the risk to health and wellbeing of the baby posed by a *callous, stupid, imprudent or unwise* mother[[47]](#footnote-47) – weigh against the increased importance of respecting autonomy and consent argued for in this essay? I maintain that the fact of the baby having interests *per se* cannot undermine this importance. As discussed above, medical ethics in general does not operate in such a way that the health benefits to a third party of my medical treatment undermine my rights to accept or refuse treatment. On the contrary: the idea that a treatment is primarily in another’s benefit normally undercuts one of the main ethical pillars that justifies iatrogenic harm (that it is presumably done in *my* interest). This straightforwardly *raises* the requirements on ensuring proper, voluntary informed consent and respect for autonomy. One cannot make maternity care the glaring exception here, especially in light of the above discussion of gender.

If an argument is to be made on behalf of the baby, it will require significant extra steps that go well beyond the future baby’s interest in the mother’s undergoing the treatment – after all, in organ donation and non-therapeutic research, third parties also have significant interests. It needs to be shown, first, that the mother has some *special obligation* to the baby, to undergo significant (risk of) harm to remove a risk of harm to the baby. Second, it needs to be shown that the medical profession is legitimately in the position to promote or even *enforce* this obligation, through measures that insufficiently respect autonomy or consent. Third and finally, it needs to be shown that both the extent of these supposed special obligations *and* the justification for medicine’s legitimately being in a position to promote or enforce them, outweigh not just *ordinary* requirements to respect autonomy and informed consent in medical encounters, but *also* the independent reasons noted in this essay for why these requirements should be more stringent in maternity care.

At present the literature on obstetric ethics very frequently mentions the interests of the baby;[[48]](#footnote-48) only occasionally argues *that* mothers have some special obligations to suffer harm for the sake of their child[[49]](#footnote-49) (although questions about the extent of those obligations are generally left unanswered[[50]](#footnote-50)) and generally fails to tackle the question whether medicine is legitimately in the business of enforcing this obligation (if it exists) altogether.[[51]](#footnote-51) Nobody considers that these arguments, if they can be made at all, should be evaluated in the light of a prima facie *increased* need to respect autonomy/consent in maternity care.That is the challenge posed by this paper.

**Conclusions**

I have argued that certain features of maternity care *increase* the need for explicit attention to, and respect for, autonomy and rigorous informed consent processes in maternity care, and that the resulting need is considerably *greater* in than in almost all other parts of medicine. These features of childbirth are:

1. Maternity care involves attention to, and treatment of, particularly sensitive body-parts that are frequently implicated in consent-centred procedures, as well as—too often—subject to unconsented intervention, in ordinary, non-medical life; and
2. Much of maternity care (especially childbirth interventions) is medically unique, in that it harms one patient (the mother) not primarily for the promotion of her health, but to benefit another (the baby). The only apt comparators, in medicine are non-therapeutic research and organ transplantation.

At the same time the paper identifies *that,* and possible reasons *why* the importance of autonomy and consent may be at particular risk of being, and in fact are, frequently denied or overlooked in maternity care. As these possible explanations are largely rooted in problematic sexism and/or gender stereotypes, they cannot justify foregoing consent or disrespecting autonomy. On the contrary: this adds a *third* reason for elevated attention to and respect for autonomy and consent in maternity care.

Concern for the interests of the baby cannot undermine or override this elevated need for autonomy and consent – though again such a concern may well be a contributing factor in explaining widespread disrespect for autonomy and consent. If so, it is a further reason thato bolsters the recommendations in this paper.

Jointly this makes a very strong case for change: attention to and respect for autonomy and consent should be (1) core values; (2) key points of practical attention in the years going forward; and (3) central quality indicators in maternity. That does not mean that any of this is, in practice, easy.[[52]](#footnote-52) Nor does it tell us how this respect should be enacted. I certainly don’t advocate an implementation where women in labour are (further) battered by reams of information; required to engage in complicated risk calculations; or made to read and sign written consent forms full of small print. As elsewhere in medicine, there are important questions about how to compassionately and sensitively build trust; scaffold autonomy; and enact shared decision-making so as to arrive at genuine, morally transformative consent without overburdening, isolating or alienating patients that may be scared, vulnerable, in pain or simply (temporarily or permanently) limited in their capacity to absorb information.[[53]](#footnote-53)

The crucial point, however, is that once autonomy and consent are recognized as the central values that they are and should be, as well as the *particularly elevated* need to respect and attend to them in maternity care, in light of both the general arguments above *and* the documented disproportionate risk of failing to meet this need, then that places an obligation and burden on Health Care Practitioners *and* the systems and institutions in which they work, to ensure these requirements are met. That is, (1) to facilitate and engage in *genuine* patient-centered clinical decisions-making and recommendations, congruous with autonomous patient values; and (2) to obtain – rather than presume – genuinely voluntary and active consent. These obligations will be *particularly pronounced* when caring for people that are, or at times when they are, most vulnerable and least able to assert or defend their values or rights. And the relevant contrasts with ordinary medicine exposed in this paper, especially the explicit comparison with transplantation medicine and non-therapeutic research ethics, may help inform such individual and institutional re-design. Finally, explicitly bearing these contrasts and comparisons in mind may also provide some practical assistance in resisting the psychological and institutional pull (for reasons identified) of relapsing into insufficient respect for autonomy and consent – or even into respect and procedures that are normal in medical settings, but insufficient for the unique context of maternity care.

1. See for example Williams, C. R., Jerez, C., Klein, K., Correa, M., Belizán J. M., & Cormick, G. (2018). Obstetric Violence: A Latin American Legal Response to Mistreatment during Childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology.* *125*(10), 1208–11.; Sadler, M., Santos, M. J., Ruiz-Berdún, D., Leiva Rojas, G., Skoko, E., Gillen, P. & Clausen, J. A. (2016). Moving beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence. *Reproductive Health Matters.* *24*(47), 47–55.; Pérez D’Gregorio, R. (2010). Obstetric Violence: A New Legal Term Introduced in Venezuela. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics.* *111*(3), 201–2. [↑](#footnote-ref-1)
2. World Health Organisation (2018). *WHO Recommendation on Respectful Maternity Care*. Retrieved from: <https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/who-recommendation-respectful-maternity-care-during-labour-and-childbirth> [↑](#footnote-ref-2)
3. White Ribbon Alliance. (2011). Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns. Retrieved from: https://www.whiteribbonalliance.org/respectful-maternity-care-charter/ [↑](#footnote-ref-3)
4. Bowser, D. & Hill, K. (2010). Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis, *USAID-TRAction Project* (Harvard School of Public Health). [↑](#footnote-ref-4)
5. See for example: Hodges S. (2009). Abuse in hospital-based birth settings?. *The Journal of perinatal education*, *18*(4), 8–11.; Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P…. Gülmezoglu, E. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine* *12*(6); Beck, C.T. (2018). A Secondary Analysis of Mistreatment of Women During Childbirth in Health Care Facilities. *Journal of Obstetric, Gynecologic & Neonatal Nursing.* *47*(1), 94–104. [↑](#footnote-ref-5)
6. Simonovic, D. (2019). *A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence: Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences.* New York: UN., for example section III.B.14. [↑](#footnote-ref-6)
7. E.g. Council of Europe. (1950). European Convention for the Protection of Human Rights and Fundamental Freedoms, as Amended by Protocols Nos. 11 and 14. *ETS 5 §*. Articles 2, 3, and 8. [↑](#footnote-ref-7)
8. Beauchamp, T. & Childress, J. (2009). *Principles of biomedical ethics*. New York: Oxford University Press.; Berg, J. W., Appelbaum, P. S., Lidz, C. W., Parker, L. S. (2001). *Informed Consent: Legal Theory and Clinical Practice.* New York: Oxford University Press.; Manson, N. C., O’Neill, O. (2007). *Rethinking Informed Consent.* Cambridge: Cambridge University Press. [↑](#footnote-ref-8)
9. Miller, F. & Wertheimer, A. (2009). *The Ethics of Consent: Theory and Practice*. Oxford: Oxford University Press. [↑](#footnote-ref-9)
10. E.g. Rifkin, J. I., Shapiro, H., Regensteiner, J. G., Stotler, J. K. and Schmidt, B. (2002). Why Do Some Women Refuse to Allow Male Residents to Perform Pelvic Exams? *Academic Medicine: Journal of the Association of American Medical Colleges.* *77*(10), 1034–38. [↑](#footnote-ref-10)
11. See, for example, the outrage expressed over revelations of widespread use of unconsented pelvic exams on anesthetized women for medical teaching purposes. See for example Bruce, L. (2020). A Pot Ignored Boils On: Sustained Calls for Explicit Consent of Intimate Medical Exams. *HEC Forum.* *32*(2), 125–45.; Friesen, P. (2018). Educational Pelvic Exams on Anesthetized Women: Why Consent Matters. *Bioethics.* *32*(5), 298–307. [↑](#footnote-ref-11)
12. See for example Shabot, S. C. (2020). Why “Normal” Feels so Bad: Violence and Vaginal Examinations during Labour – a (Feminist) Phenomenology. *Feminist Theory*; Frye, M., and C. Shafer, 1977, “Rape and Respect”, in *Feminism and Philosophy*, M. Vetterling-Braggin, F. Elliston and J. English (eds.), Savage, MD: Rowman and Littlefield, pp. 333–346; Cahill, A., 2001, *Rethinking Rape*, Ithaca NY: Cornell University Press..For a contemporary perspective: see discussions of Donald Trump’s infamous ‘grab them by the pussy’ line, for example Stenberg, S. J., & Hogg, C. (2020). Women’s March on Washington Organizers. *Persuasive Acts*: *Women’s Rhetorics in the Twenty-First Century*. (pp. 175–83). Pittsburgh, PA: University of Pittsburgh Press. [↑](#footnote-ref-12)
13. Van der Pijl, M. S. G., Hollander, M. H., Van der Linden, T., Verweij, R., Holten, L., Kingma, E., De Jonge, Ank & Verhoeven, C. J. M. (2020). Left Powerless: A Qualitative Social Media Content Analysis of the Dutch #breakthesilence Campaign on Negative and Traumatic Experiences of Labour and Birth. In F. Fischer. *PLOS ONE.* *15*(5) e0233114. [↑](#footnote-ref-13)
14. Beck, C. T. *op cit.* note 5, p. 101. [↑](#footnote-ref-14)
15. World Health Organisation, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, and South African Medical Research Council. (2013). *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Geneva: World Health Organisation, 2. [↑](#footnote-ref-15)
16. United Nations Children’s Fund. (2014). *Hidden in Plain Sight – a Statistical Analysis of Violence* *against Children*. New York: UNICEF, 167. [↑](#footnote-ref-16)
17. Grateful to [*anonymised*] for the point about disclosure. [↑](#footnote-ref-17)
18. The focus in this section on socially/sexually meaningful body-parts does not purport to be an exhaustive account of all the possible sensitivities with respect to autonomy and consent specific to maternity care. I just lists one that is rather obvious; there are likely many others including, e.g. the (active) physiology of labour which is not independent from psychology and works better undisturbed – and hence may be extra sensitive to uninvited/unconsented intrusion (Buckley, S. (2013). Undisturbed Birth: mother nature’s blueprint for safety, ease and ecstasy. In: Buckley, S. *Gentle Birth, Gentle Mothering.* Random House pp 95-127.); the risk of epistemic injustice in particular with respect to first-person-knowledge (Cohen-Shabot, S. (2019) ‘Amiga’s, Sisters, we’re being gaslighted. In: Pickles, C. & Herring, J. *Childbirth, Vulnerability and the Law.* Routledge. <https://doi.org/10.4324/9780429443718>); and gendered sensitivities and vulnerabilities surrounding pain, speed, unpredictability, capacity and rationality during labour (Villarmea, S., & Kelly, B., (2020). Barriers to Establishing Shared Decision-making in Childbirth: Unveiling Epistemic Stereotypes about Women in Labour. *JECP.* *26*(2), 515–19; Brione, R. (2015). To What Extent Does or Should a Woman’s Autonomy Overrule the Interests of Her Baby? A Study of Autonomy-Related Issues in the Context of Caesarean Section. *The New Bioethics.* *21*(1), 71–86.). I thank an anonymous reviewer for pressing me on this. [↑](#footnote-ref-18)
19. I discuss further reasons in *[anonymised]*. [↑](#footnote-ref-19)
20. Beauchamp, T., & Childress, J., *op. cit. n*ote 8. [↑](#footnote-ref-20)
21. This is not true of all maternity care; much of it – such as antenatal screening for pre-ecclampsia - aims directly at promoting maternal health. The same applies to obstetric interventions such as stopping or reducing the risk of post-partum haemorrhage. But much more often, interventions on the mother are primarily aimed at rescuing the life or improving the health of babies, particularly during birth. (And, sometimes, for example in placenta praevia, the two concerns coexist.) The analysis in this section only applies to maternity care partially or wholly motivated by the second kind of concern, as the first is just ‘ordinary’ medicine. Note, by contrast, that the issue discussed in the previous section (as well as other potential sources of particular sensitivities cited there) applies throughout maternity care, regardless of whether an intervention is primarily for the sake of the mother, the baby, or both. I also set aside the problem of *unnecessary* or *too much too soon (TMTS)* care, such as interventions done to the (statistical) benefit of neither mother nor baby, or interventions whose putative benefits don’t outweigh the risks or downsides (see e.g. Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé … Althabe, F. (2016). Beyond Too Little, Too Late and Too Much, Too Soon: A Pathway towards Evidence-Based, Respectful Maternity Care Worldwide. *The Lancet.* *388*(10056), 2176–92).

    TMTS care and over-medicalisation play an important role in discussions of maternity care in general, and obstetric violence in particular. I set them aside nonetheless, because if the benefits of treatment (if any) don’t outweigh the harms, then offering the treatment cannot be ethically justified in the first place. The recommendations in this paper therefore apply *regardless* of the extent of problems of obstetric violence/over-treatment; the first two reasons in the argument are grounded in other, necessary, features of maternity care. (The third reason, however, is *not* independent from the existence of such problems). I thank two reviewers for pushing me on this. [↑](#footnote-ref-21)
22. This applies in medical research in general – and even more so in non-therapeutic medical research – which would be the apt comparison for obstetrics. See for example Emanual, E. J., Wendler, D. & Grady, C. (2000). What makes clinical research ethical? *JAMA. 283*, 2701-11.Emanuel, E. J., Grady, C., Crouch, R. A., Lie, R. K., Miller, F. G. & Wendler, D. (2008). *The Oxford Textbook of Clinical Research Ethics.* New York: Oxford University Press. [↑](#footnote-ref-22)
23. See for example: Forsberg, A., Nilsson, M., Krantz, M., & Olausson, M. (2004). The essence of living parental liver donation–donors’ lived experiences of donation to their children. *Pediatric transplantation*, *8*(4). 372-380.; Crouch, R. A., & Elliott, C. (1999). Moral agency and the family: The case of living related organ transplantation. *Cambridge Quarterly of Healthcare Ethics*. *8*(3). 275-287.; Burnell, P., Hulton, S. A., & Draper, H. (2015). Coercion and choice in parent–child live kidney donation.*JME.* *41*(4). 304-309. [↑](#footnote-ref-23)
24. E.g. Abraham, S., Child, A., Ferry, J., Vizzard, J. and Mira, M. (1990) ‘Recovery after childbirth’, *Obstetrical & Gynecological Survey*, 45(10), p. 688. doi: 10.1097/00006254-199010000-00008; Dietz, H.P. (2015) ‘Forceps: Towards obsolescence or revival?’, *Acta Obstetricia et Gynecologica Scandinavica*, 94(4), pp. 347–351. doi: 10.1111/aogs.12592; Royal College of Obstetricians and Gynaecologists (2015b) *The management of third-and fourth-degree perineal tears*. Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-29.pdf (Accessed: 13 July 2016). [↑](#footnote-ref-24)
25. All of these interventions are also, at least sometimes, done unnecessarily, but this is not the focus of the present analysis; see note 21. [↑](#footnote-ref-25)
26. US survey data show only 41% of women who had episiotomy in childbirth reported playing any role in the decision to undergo the procedure (Declercq, E. R., Sakala, C., Corry, M. P., Applebaum, S., Herrlich, A. (2013). *Listening to Mothers III: Pregnancy and Birth.* New York: Childbirth Connection, 36; a UK survey by Birthrights and Mumsnet found that 24% of mothers said that their decisions and opinions about their care were not respected, whilst 30% of mothers said that their decisions and opinions were not sought at all (Birthrights. (2020). *A Quarter of Mothers Say Their Decisions Were Not Respected When Giving Birth.* Retrieved from <https://www.birthrights.org.uk/2020/09/03/a-quarter-of-mothers-say-their-decisions-were-not-respected-when-giving-birth/>). [↑](#footnote-ref-26)
27. There is a tricky mixture here of reasonable presumption, and gender stereotype. It *is* reasonable to think that parents generally desire to benefit their children, and are willing to incur risks/costs to make that happen. Indeed, a substantial philosophical literature on parental obligations think they are *obliged* to bear some such risks/costs. It is also reasonable to think that parents often suffer as a result of their child suffering and that – merely as a result of the greater statistical likelihood of mothers (compared to fathers) becoming the only or primary parent – mothers are (statistically) more likely to suffer, and likely to suffer more. But the latter association is at least in part a result of gendered social stereotypes and expectations, which are also at work in the application of these presumptions to maternity care. We should be careful not to reinforce these; I return to this later (see Note 30). I am grateful to an anonymous reviewer for pressing me on this. [↑](#footnote-ref-27)
28. For example: a number of UK judgments sanctioning forced caesarean sections explicitly cite the idea that healthy baby will be in the best interest of the mother, even though in these cases the baby was forcibly removed from the mother directly after birth – see for example re: AA, [2013] EWHC 4378 (COP), [2013] EWCOP 4378; NHS Trust v JP, No. [2019] EWCOP 23 (High Court 18 June 2019). For an overview of disrespect and abuse in childbirth in the context of contract pregnancies see e.g. Baron, T. (2019). Nobody Puts Baby in the Container: The Foetal Container Model at Work in Medicine and Commercial Surrogacy. *Journal of Applied Philosophy.* *36*(3), 498. [↑](#footnote-ref-28)
29. Thus, for example, a professional athlete and an office worker may attach different importance to – and hence be willing to take different risks in labour for – their pelvic floor strength. See Obstetrics and Gynecology Risk Research Group, Kukla, R., Kuppermann, M., Little, M., Lyerly, A. D., Mitchell, L. M., Armstrong, E. M., Harris, L. (2009). Finding autonomy in birth. *Bioethics. 23*(1), 1-8. [↑](#footnote-ref-29)
30. For the predominance of an ideology of motherhood underpinned by near-limitless expectations of maternal self-sacrifice in response to the perceived needs or desires of children, see e.g.: Kukla, R. (2005), *Mass Hysteria: Medicine, Culture, and Mothers’ Bodies.* New York: Rowman & Littlefield Publishers, Inc.; Woollard, F. (2016). Motherhood and Mistakes about Defeasible Duties to Benefit. Philosophy and Phenomenological Research. 97(1), 126-149. Mullin, A. (2005). *Reconceiving pregnancy and childcare.* Cambridge: Cambridge University Press.; Lupton, D. (2012). ‘Precious cargo’: foetal subjects, risk and reproductive citizenship. *Critical Public Health. 22*(3), 329-340. [↑](#footnote-ref-30)
31. It is important to explicitly compare to a father here, because such comparisons, assuming similar choices/risks/burdens in similar circumstances, are a useful tool to test claims about willing parental sacrifice, parental duty, or acceptable parental risk, for both reasonableness and potential gender-bias (see Kingma, E., & Porter, L. (2020). Parental Obligation and Compelled Caesarean Section: Careful Analogies and Reliable Reasoning about Individual Cases. *Journal of Medical Ethics*. *22*.). [↑](#footnote-ref-31)
32. See Kukla, R., *op. cit.* note 30; Mullin, A., *op. cit.* note 30; Lynch, K. D. (2005). Advertising Motherhood: Image, Ideology, and Consumption. *Berkeley Journal of Sociology.* *49*, 32–57. [↑](#footnote-ref-32)
33. There is a third ground, as I argue elsewhere in detail [*anonymised* note 19; see also Kukla, R. et al. op. cit. note 29]: maternity care – again fairly uniquely – speaks to a much wide range of personal, cultural and spiritual values compared to medicine in general, and engages particularly complex inter- and intra-personal trade-offs between very different kinds and magnitudes of risks and uncertainties. All of this further increases the need for engaging in particularly careful & detailed personalized (or values-based) decision-making, which places increased demands on engaging autonomy. [↑](#footnote-ref-33)
34. See Redden, M. (2017, 5 October). New York Hospital’s Secret Policy Led to Woman Being Given C-section Against Her Will. *The Guardian*. Retrieved from <https://www.theguardian.com/us-news/2017/oct/05/new-york-staten-island-university-hospital-c-section-ethics-medicine?CMP=share_btn_link>. [↑](#footnote-ref-34)
35. Savulescu, J. (2007). Future People, Involuntary Medical Treatment in Pregnancy, and the Duty of Easy Rescue. *Utilitas.* *19*(1), 1–20.; Deshpande, N. A. & Oxford, C. M. (2012). Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery. *Reviews in Obstetrics and Gynecology.* *5(* 3–4), 144–50. [↑](#footnote-ref-35)
36. See for example Pickles, C. & Herring, J. (2019).[*Childbirth, Vulnerability and Law*](https://www.dur.ac.uk/law/staff/display/?mode=pdetail&id=18543&sid=18543&pdetail=126081)*.* Routledge.; Borges, M. T. R. (2018). A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence. *Duke Law Journal.* 67, 827–62; Simonovic, D. *op. cit.* note 6*;* Vacaflor, C. H. (2016). Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina. *Reproductive Health Matters. 24*(47), 65.;Ramos, R*.* Grupo de Información en Reproducción Elegida (GIRE)[Group for Information on Reproductive Choice]. (2013). *Omisión e Indiferencia: Derechos Reproductivos en México* [Omission and Indifference: Reproductive Rights in Mexico], Mexico: GIRE, A.C., 126; Sadler, M. et al. *op. cit.* note 1]. [↑](#footnote-ref-36)
37. E.g. [https://www.birthrights.org.uk](https://www.birthrights.org.uk/); [https://humanrightsinchildbirth.org](https://humanrightsinchildbirth.org/); <https://improvingbirth.org>; [www.geboortebeweging.nl](http://www.geboortebeweging.nl). [↑](#footnote-ref-37)
38. Van der Pijl, M. S. G. et al. *op. cit.* note 13. [↑](#footnote-ref-38)
39. Hollander, M. H., Van Hastenberg, E., Van Dillen, J., Van Pampus, M. G., De Miranda, E., Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women’s perceptions and views. *Archives of Women’s Mental Health*. *20*, 515–523. [↑](#footnote-ref-39)
40. Even if not all people who are pregnant/give birth are women. (see e.g. MacDonald,T. (2016) *Where is the Mother? Stories from a Transgender Dad.* Winnipeg: Trans Canada Press.) We should also remember that not all people who give birth have similar experiences; the gendered phenomena treated here as unified are in fact *intersectional*: they can take on very different forms depending on the rest of one’s social identity/location/situation (see for example the recent literature on high maternal mortality amongst black American women, e.g. Greenwood, B. N., Hardeman, R. R., Huang, L. & Sojourner, A. (2020). Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborns. *Proceedings of the National Academy of Sciences of the United States of America.* *117*(35), 21194–200<https://doi.org/10.1073/pnas.1913405117>; Leonard, S. A., Main, E. K., Scott, K. A., Profit, J. & Carmichael, S. L. (2019). Racial and Ethnic Disparities in Severe Maternal Morbidity Prevalence and Trends. *Annals of Epidemiology.* *33*, 30–36.) I thank an anonymous reviewer for pressing me to clarify this and [anonymised] for help with the clarification. [↑](#footnote-ref-40)
41. Manne, K. (2017). *Down Girl: The Logic of Misogyny*. Oxford: Oxford University Press. [↑](#footnote-ref-41)
42. Langton, R. (2009). *Sexual Solipsism: Philosophical Essays on Pornography and Objectification.* Oxford: Oxford University Press. [↑](#footnote-ref-42)
43. Villarmea & Kelly, *op. cit.* note 18. [↑](#footnote-ref-43)
44. Kukla, R. *op. cit.* note 30. [↑](#footnote-ref-44)
45. e.g. Bordo, S., (1993). *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley and Los Angeles, C. A.: University of California Press.; Purdy, L. M. (1990). Are Pregnant Women Fetal Containers?. *Bioethics, 4*(4). [↑](#footnote-ref-45)
46. Borges, *Op cit. note 36;* Chadwick, R. (2017). Ambiguous Subjects: Obstetric Violence, Assemblage and South African Birth Narratives. *Feminism & Psychology.* *27*(4), 489–509. [↑](#footnote-ref-46)
47. There is an odd tension here: If women generally *want* to sacrifice for their baby, there is no widespread need to ‘defend’ the baby by disrespecting women’s autonomy. On the other hand, if there *is* a widespread need to ‘defend’ the baby against its mother, then no presumption of widespread indirect benefit or maternal willingness for sacrifice could serve ethically to justify ‘harming one to save the other’ in the first place – let alone reduce or bypass the need for consent. So one can’t have it both ways.Finally, if it is just a matter of women making poor or uninformed choices, then that is not an issue that can undermine the need for respecting autonomy either; providing information and supporting prudent decision-making congruent with one’s personal values *is* an aspect of respecting autonomy and ensuring an adequate consent process; the baby’s interests make no difference there. [↑](#footnote-ref-47)
48. E.g. Deshpande & Oxford, *op. cit.* note 35. [↑](#footnote-ref-48)
49. See e.g. Savulescu, J. *op. cit.* note 41*;* Malek, J. (2016). Parental obligation regarding fetal risk. *American Journal of Bioethics*. *16*(2), 27-28*.*  [↑](#footnote-ref-49)
50. See Porter & Kingma, *op. cit.* note 31. [↑](#footnote-ref-50)
51. Ibid [↑](#footnote-ref-51)
52. Brione, R. *op. cit.* note 18. [↑](#footnote-ref-52)
53. e.g. Manson, N. C., & O’Neill, O. (2007). *Rethinking Informed Consent in Bioethics*. Cambridge: Cambridge University Press.; Brione, R. *op. cit.* note 18. [↑](#footnote-ref-53)