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‘She can’t come here!’ Ethics and the case of birth centre admission policy in the UK

INTRODUCTION

The practice of childbirth in the UK, as elsewhere across the world, is (and has been for more than fifty years) woven into mainstream biomedicine. As such, accepted frameworks for mothers’ decision-making predominately rely upon evaluations derived from fixed and normative principles or standards of judgement. The tendency to cling to familiar models of consequentialism, whereby confidence in determinable calculations of harms and benefits is privileged, means that decisions about birthing tend to be articulated in limited ways that can confine maternal autonomy.

The aim of this paper is to be attentive to the UK maternity policy mantra of *women-centred care* with emphasis on autonomy. This understanding of women-centred care will be used as an opportunity to ethically scrutinise birth choice in relation to place of birth. Using ethnographic data lifted from an investigation into the interpretative work midwives do when making sense of risk, this paper contests the grounds upon which *birth centres*[i] are managed, in particular their over-reliance on abstract calculations of risk – far removed from the material, lived experience of the pregnant woman wishing to access these birth centre services.

The paper will fall into four distinct sections. A policy context section will provide a backdrop for both the discussion raised in this paper and the study from which this paper draws. This section will be followed by a description of the research. In the third section, a research participant – a midwife called Martha (for the purposes of this paper) – will be introduced. Martha’s talk about a mother’s care will be used to interrogate routine UK birth centre admission policy and practice. The paper will conclude with a brief discussion and conclusion section.

[i] A birth centre is a midwifery-run facility where women can give birth with the support of qualified midwives. Should complications arise, mothers are advised to transfer to the nearest obstetric unit where care can be provided by the multidisciplinary team, including midwives, obstetricians, anaesthetists and paediatricians.

POLICY CONTEXT

The inherited biomedical wisdom that hospital birth and safe birth inevitably overlap was officially 'unsettled' back in the early 1990s in the UK. With the publication of what has commonly been referred to as the Winterton Report,[1] resistance to the assumption that safety for mother and baby is inevitably improved through the hospitalisation of childbirth moved from fringe social activism to mainstream, governmentally endorsed debate. In 1992, the House of Commons Maternity Care Select Committee concluded that: 'the policy of encouraging all women to give birth in hospital cannot be justified on grounds of safety'.[2] Recent epidemiology evidence corroborating this conclusion was published in 2010 following the first ever national survey set up to measure birth outcome in relation to intended place of birth.[3] Suffice to say, opinion on where birth should take place continues to be high on policy, professional and research agendas.

With the publication of the subsequent *Changing Childbirth* policy document in 1993, women-centred care became a fundamental principle upon which all National Health Service (NHS) maternity services should be delivered.[4] The 2007 *Maternity Matters* policy document galvanises the choice priority into a 'national choice guarantee'. Within this national choice guarantee, women have a right, among other things, to choose where they give birth to their babies. The policy states that:

> Women and their partners will be able to choose between three different options. These are: a homebirth; birth in a local facility, including a hospital, under the care of a midwife; birth in a hospital supported by a local maternity care team including midwives, anaesthetists and consultant obstetricians.[5]

The above-mentioned policy documents represent a snapshot of the relevant policy publications. However, even in isolation, they provide a flavour of the drivers shaping contemporary maternity care, whereby out of hospital birth and women-centred care have gained unprecedented prominence. The National Institute of Health and Clinical Excellence (NICE) 2007 intrapartum care guidelines echo this emphasis on choice of birth by stating that:

Women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. Women should be informed:

- That giving birth is generally very safe for both the woman and her baby.
- That the available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife-led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth.
- That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.
- Of locally available services, the likelihood of being transferred into the obstetric unit and the time this may take.
- That if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.
- That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.[6]

Having provided this, albeit brief, account of the policy context to which this paper speaks, the discussion will now move on to introduce the empirical element of this paper: firstly, through an introduction of the research design from which the paper draws; and secondly, through the presentation of some ethnographic interview data taken from a conversation with a midwifery research participant, pseudonym Martha.

THE STUDY

The data used to inform this paper comes out of an ethnographic research design, whereby 'naturalised' talk[ii] and practice of midwives working in both the

[ii] The concept of 'naturalised' talk and practice refers to data collected via participant and non-participant observation. These data are therefore distinct from interview data in that the conversations and social

NHS and the independent sector based in the south of England was observed and recorded. The investigation took place between 2008 and 2010, during which time the researcher (a practising midwife) worked alongside and talked to thirty-three midwives responsible for the delivery of intrapartum care in various clinical settings; among these a free standing birth centre (FSBC). The central premise of this work was to investigate how midwives made sense of, and talked about, risk, and how this meaning making impacted upon how birth could be legitimately performed.

Ethical approval

Written consent and sequential verbal consent[7] was gained from all those involved in the study (service providers and service users), and all transcripts and field notes were 'cleaned', with identifying features removed, prior to analysis. Ethical approval was sought through both local research and development at the NHS hospitals involved, along with national NHS ethical clearance (08/H1101/72). Project protocol was reviewed and approved, prior to the commencement of data collection, by the Trusts' Head of Risk, Assurance and Legal Services and Head of Midwifery.

THE DATA: MARTHA AND JOSEPHINE

The conversation from which what follows has been taken occurred between the researcher and an NHS midwifery participant working in an FSBC: a birthing setting run exclusively by NHS midwives which is located some distance away from the nearest obstetric-led centre[iii]. The discussion centres on the care of a first-time mother, pseudonym Josephine, who, having investigated her birthing options, had requested to have her baby in her local FSBC. Josephine was a well-educated, healthy mother, who, having read a broad selection of both lay and professional literature, favoured the FSBC as her preferred choice of place of

interactions recorded arise out of spontaneous and contextualised social circumstances that may be devoid of any active researcher contribution.

[iii] A unit staffed by a multi-disciplinary team, which includes midwives, obstetricians, anaesthetists and paediatricians.

birth. Despite being healthy, Josephine (along with approximately thirty per cent of the general population[8]) was colonised for Group B streptococcus (GBS)[iv] .

Risk and the case of GBS

Being identified as GBS positive, Josephine and her baby fall into the 'slippery' category of 'not yet ill'.[9] That is, Josephine's pregnancy could not be thought of as being 'normal' (or, in the language of maternity care, 'low-risk') by the midwives responsible for her care. As with all disease potential, GBS is talked about in terms of risk probabilities. In Josephine's case, the chances of her baby becoming symptomatic of disease depended upon many confounding factors. These include the age and size of the baby as well as any signs or symptoms of disease in the mother, in particular, raised maternal temperature.[10] In Josephine's case however, the pregnancy had already reached full term (beyond thirty-seven weeks' gestation) and the baby was considered to be 'a good size' (not presenting with any indicators to suggest intra-uterine growth restriction). Moreover, Josephine was known to be in good health. Although it is impossible to exclude these confounding conditions to estimate an infection rate probability due to the limitations in the epidemiological evidence, the literature suggests that a 1:100 risk of disease in a baby born to a mother with GBS within twenty-four hours of the birth may be assumed.[11] Given the clinical circumstances of this particular case however, this risk is likely to be considerably lower. Furthermore, such risk probabilities become even more complex when the current recommended treatment is also considered with its notoriously uncertain success rates.[12]

An important point to remember in this scenario is that Josephine and her baby were both well; even healthy. Josephine (and by association her baby) had a condition that **might**, based upon epidemiological probability calculations, make them unwell in the future. Furthermore, the degree of potential sickness can be fatal to newborns in some rare cases. In this clinical context, Josephine is thought of in terms of a potential future where disease or abnormality could arise; a disaster waiting to happen. This gloomy imagined future operates to blur the

[iv] *Streptococcus agalactiae* – a gram-positive bacteria that forms part of the normal fauna and flora of the mucus membranes found in the gut and genital tract; henceforth GBS.

boundary between health and ill health and, importantly for the purposes of this discussion, it operates to confine rights to choice. Such blurring produces an ambiguous state of being healthy, yet having a potential disease; being at risk.

As is typical of risk, the management of GBS is suspended within a complex web of multiplicity and active meaning making, whereby concurrent discourses compete for supremacy. What is important for this paper is to establish that Josephine was well versed in the debate. She had made the informed decision to refuse the recommended treatment – intra-venous, intrapartum antibiotics – and had chosen to have her baby in the local FSBC.

In the section above, GBS in pregnancy has been introduced in terms of risk calculation. As is the case with all such population-based probabilities, how such figures impact upon individual care inevitably involves a process of translation.[13] Despite, or perhaps because of, the fact that this condition is understood in terms of determinable calculations of harms and benefits, such calculations do not help to allay fears about future uncertainty. Indeed, such calculations arguably operate to heighten anxieties about uncertainty by drawing attention to the graphic horrors of unwanted futures through a process of risk amplification.[14] In the next section of the paper, data will be presented to illustrate this process of translation. Taking extracts from a conversation with an FSBC midwife, the bioethics around contemporary FSBC practices in relation to who is and who is not *allowed* access, will be scrutinised.

When talking about Josephine's birth choices, Martha explained:

> 'Originally, she (Josephine) wanted to come here (the FSBC) and I said: "No. We are not doing that." You know we have to be clear about where we, you know, you have to make it clear; you have to make it easy for every member of staff to know where **to draw the line**. And I am afraid, needing IV antibiotics, she doesn't fit the protocol. She is a woman with a risk factor!'

What Martha is referring to is the admission criteria for the birth centres. A combination of concordant drivers lies behind Martha's position on Josephine's care:

- Firstly, a legitimate concern to protect herself and her staff from the possibility of the prospect of a risk management investigation following a poor outcome is being articulated.
- Secondly, Martha's position reflects both national and local standards and guidelines. For example, in 2009, the Royal College of Midwives (RCM) published standards specifically applicable to the provision of maternity care, staffing and environment of midwifery birth centres in England. In these standards it is recommended that **all** birth centres should have:

> Agreed acceptance criteria that describe those women considered suitable for midwifery-led care specific to the setting of birth centre.[15]

Similarly, NICE 2007 intrapartum care guidelines state that:

> A midwife-led unit (sometimes called a birth centre) was defined as a place that offers care to women with a *predefined uncomplicated pregnancy* and where midwives are the lead professionals for intrapartum care… (and)
>
> That if she (a woman) has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.[16]

What we have is a process of 'risking-out'. Women have a choice of where to give birth, provided their bodies (measured through a battery of biomedical surveillance tests) fit within predetermined risk parameters set through the guideline recommendations. Only then are women granted full autonomy over their birthing bodies. If, for example, a mother is considered to be too old, too fat, too young, too thin or in this case too colonised, then her choices around her place of birth are confined. A further extract from Martha's conversation provides a sense of how midwives practise this risking-out.

Martha explained:

> 'So I talked her (Josephine) through the issues and said: "You know the baby could die, but read through the guidelines. Talk it through with your husband".'

Although Martha knows that newborn fatality due to maternal colonisation GBS infection of the newborn baby is unlikely (highest estimate approximately 0.4:100 risk, which is comparable to background perinatal mortality in the UK 0.4:100 term pregnancies,[17]) this imagined future shapes her practice. The severity of the possible undesirable future operates to obscure its likelihood in Martha's talk.

Martha went on to explain her advice in medical-legal terms. She said:

> 'In coming to the birth centre, she (Josephine) is accessing something that is not designed for her. The birth centre model of care is designed for low risk women, whereas she has a risk factor, so it makes her unsuitable and, in the same way that you go to your doctor with a sore throat, you, as the patient, cannot demand the treatment that you think you, you think you might want... If she stays at home, she is not recommended to stay at home, still the same advice, but we can't stop her staying at home. She is declining our care.'

According to Martha, Josephine is not welcome because FSBC care is a 'treatment' she has no right to demand. Martha's explanation is framed by a bioethical argument, whereby service user autonomy is conceptualised in terms of rights established predominately through the medico-judicial system. According to UK tort law (precedent set by case law),

> doctors are under no legal or ethical obligation to agree to a patient's request for treatment if they consider the treatment is not in the patient's best interests.[18]

This suggests that Martha is correct in her assessment of the situation: not only does Martha successfully appeal to current guidelines and standards, thereby passing the Bolam test[v], she also demonstrates an awareness of precedent law, whereby patients do not have positive rights to demand treatment.

What is less certain however, is whether this midwifery talk is consistent with a woman-centred approach to care. It is at this point that a bioethical perspective becomes helpful in that it demands the scrutiny of interests: whose interests are being served by this talk: Josephine's or Martha's? Using this simple ethical question, two 'areas of tension' arise out of this data that deserve further consideration:

[v] The test set down through common law precedent to assess appropriate standards of reasonable care based upon accepted current expert practice.

1. The rather obvious concern of whether FSBC care should be imagined in terms of medical treatment.
2. A perhaps more contentious question leading directly on from this, asking if FSBC support during birth is something other than a form of medical treatment. If it is instead a way of caring (dare I say nurturing?), then is it possible to turn to other areas of care (as opposed to treatment) for inspiration for a more woman-centred approach?

The remainder of this paper will attend to the following two questions in an effort to interrogate the ethics behind current midwifery talk and practice around birth admission criteria in the UK.

Question 1: Is it ethically justified to conceptualise FSBC care as a medical treatment, clinically suitable for some birthing mothers but not others? To start to 'unpick' this question, a brief look at the nature of *midwifery care* will follow. The RCM suggests that:

> Midwives are expert professionals skilled in supporting and maximising normal birth… The role of the midwife is integral to models of care, which promote normality.[19]

Similarly, according to a recent Cochrane Data Base Review on midwifery care:

> The philosophy of midwife-led care is normality… There is an emphasis on the natural ability of women to experience birth with minimum intervention.[20]

The ontological link between midwifery care and medical treatment is 'conspicuous in its absence' in these two statements. Indeed, the implication is that midwifery care might be seen to operate to confine medical treatment by facilitating normal birth and minimising intervention.

The International Confederation of Midwives, another key stakeholder in midwifery care, states that the key concepts that define the unique role of a midwife are:

- respect for human dignity and for women as persons with full human rights;
- advocacy for women so that their voices are heard; and

- a focus on health promotion and disease prevention that views pregnancy as a normal life event.[21]

In other words, the overlap between women-centred care and midwifery care in this definition is robust. By contrast, the overlap between midwifery care and medical treatment is at best tenuous. By looking at this question of whether midwifery care should be conceptualised as a form of medical treatment, the tensions underpinning this piece of ethnographic data begin to emerge, exposing ethical dimensions of this routine midwifery talk. Furthermore, it moves the discussion on to the second question.

Question 2: If the ontological positioning of FSBC care is such that it should not be conceptualised as a form of medical treatment but, rather, is more suitably captured by the notion of women-centred care, what other areas of care can be used for guiding best practice in FSBC? Following Martha's lead, I would like to turn again to a medico-legal framework, proposing that ethical principles borrowed from end of life medical care capture an essence of patient-centred care that is so painfully absent in Martha's talk. To explore this idea, I want to present a hypothetical case:

Rebecca is a 45-year-old woman diagnosed with cancer. She is offered surgery and chemotherapy at her local hospital for her condition. Rebecca chooses to refuse this treatment even though this choice could, based upon a statistical calculation of probability, prematurely end her life. Her condition deteriorates and, despite having refused treatment in a hospital setting, Rebecca now seeks out the nursing care provided by a free standing hospice care environment. Rebecca understands that this environment is not equipped to offer any of the potential lifesaving therapy usually given in her clinical situation. Nevertheless, this is still her choice. The possibility of denying Rebecca this care, even though it falls out of the clinical recommendations appropriate for the management of her condition, is, of course, unthinkable.

Returning to Josephine's care, she too has refused the routine care offered for the management of her condition, even though this choice could theoretically put her unborn baby in danger of illness and even death. This is Josephine's right. The

1998 decision from the Court of Appeal in S versus St George's Healthcare holds that:

> an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends upon it.[22]

According to English legal precedent, Josephine has a negative right: the right to decline treatment. Furthermore, Josephine, like Rebecca, is aware that, by exercising her negative right, she cannot access medical treatment for her clinical condition. Nonetheless, the FSBC is still her choice of birthplace.

Despite the apparent parallels in these two scenarios, there is one conspicuous difference: not only is the possibility of denying Josephine midwifery care in a FSBC contemplated, it is actively endorsed through policy as well as through routine midwifery talk and practice.

DISCUSSION

The case on which the above argument rests describes what might be considered to be a relatively small risk in probability terms. It is important to note that it is not the aim to suggest that there should be a risk probability figure beyond which the denial of access to midwifery care within FSBCs in the UK is morally justified. Indeed, the bioethical premise presented here stands fast regardless of the statistical probability underpinning the perceived risk. Some risks carry a higher probability burden than others (although grappling with the evidence base that underpin models of consequentialism is never straightforward) but these burden calculations are not relevant to the fact that in the UK pregnant women have the right to refuse treatment regardless of the probability of an untoward outcome. While it would seem reasonable to assume that Josephine would have been unlikely to request midwifery care at an FSBC had the statistical probability of harm to her baby been significantly greater, the bioethical objection to refusing her care should create the same moral and professional concerns.

By adopting an end of life care analogy for the analysis of midwifery decision-making (in particular, the decision to refuse entry to, and withdraw midwifery intrapartum care within, a midwifery-led unit), it has been possible to highlight an ethical ambiguity that has been overlooked in the literature, in FSBC guidelines and in midwifery practice in the UK. The data presented in this paper shows midwives borrowing heavily from an ethical-legal framework of clinical interventions and the absence of the patient's positive right to demand such an intervention. Moreover, this borrowing is such that other professional concerns relating to respect for women's autonomy are usurped. Within this context, midwifery practice is not about caring so much as about treating and gaining compliance with the prescribed treatment. This is a serious indictment, given the concerns raised by the recent Mid Staffordshire NMS Foundation Trust Public Inquiry chaired by Robert Francis**.**

The ethical interrogation of current FSBC admissions practices and midwives' policing of them presented in this paper makes it possible to imagine an inclusive midwifery model of care, whereby woman-centred care can be honoured. This interrogation allows for a level of attentiveness to mothers' autonomy that moves beyond a reliance on abstract principles of risk calculation and medical treatment, providing an opportunity to expose the absence of fairness, honesty and respect in current FSBC practice. While it is not the intention to attempt to 'pin down' midwifery care to a few definitive best practice points, by making use of some facets of bioethics it has been possible to confront some of the politically unsettling dimensions of midwifery talk and practice in FSBCs that are otherwise routinely accepted and taken for granted.

CONCLUSION

The corrective potential of this critique offers an opportunity to reinvigorate midwifery commitment to rationality and mutual interconnectedness, relocating risk within a professional ontology that aims to encompass rather than circumvent the intrinsic uncertainties of birth. Through such reworking (which is able to privilege women-centred care), birth need not be seen as something

that has to be fixed or controlled but as something that deserves reverence and should be preciously defended in every clinical setting.

1. House of Commons. Second Report: Maternity Services (Winterton Report). London: HMSO 1992.
2. House of Commons. Second Report: Maternity Services. (Winterton Report). London: HMSO 1992:Pxii.
3. Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011;**343**:d7400.
4. Department of Health. Changing Childbirth. London: HMSO 1993.
5. Department of Health. Maternity Matters: choice, access and continuity of care in a safe service. London: HMSO 2007:P5.
6. National Institute of Health and Clinical Excellence (NICE). Intrapartum care: care of healthy women and their babies during childbirth. Manchester: NICE 2007:7 & 8.
7. Parker M. Ethnography/ethics. *Social Science & Medicine* 2007;**65**(11):2248–2259.
8. Olin Lauritzen S, Sachs L. Normality, risk and the future: implicit communication of threat in health surveillance. *Sociology of Health and Illness* 2001;**23**(4):497–516.
9. Barcaite E, Bartusevicius A, Tameliene R, et al. Prevalence of maternal group B streptococcal colonisation in European countries. *Acta Obstet Gynecol Scand*. 2008;**87**(3):260–71.
10. Royal College of Obstetricians and Gynaecologists. The Prevention of Early-onset Neonatal Group B Streptococcal Disease. Green Top Guideline no. 36, 2nd ed. 2012.
11. Colbourn T, Gilbert R. An overview of the natural history of early onset group B streptococcal disease in the UK. *Early Hum Dev* 2007;**83**:149–56.

12. Ohlsson A, Shah V. Intrapartum antibiotics for known maternal Group B streptococcal colonization. Cochrane Database of Systematic Reviews 2013;1.
13. Heyman B, Shaw M, Alaszewski A, et al. Risk, Safety and Clinical Practice: Health Care through the Lens of Risk. Oxford: Oxford University 2010.
14. Pidgeon N, Kasperson R, Slovic P. The Social Amplification of Risk. Cambridge: Cambridge University Press 2003.
15. Royal College of Midwives (RCM). Standards for Birth Centres in England: a Standards Document. London: RCM 2009:6.
16. National Institute of Health and Clinical Excellence (NICE). Intrapartum care: care of healthy women and their babies during childbirth. Manchester: NICE 2007:54 & 8.
17. Office of National Statistics. Infant and Perinatal Mortality in England and Wales by Social and Biological Factors, 2011. London: HMSO Press 2012.
18. GMC Consent Guidance: Legal Annex – Common Law. Available at: http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_common_law.asp [accessed 14 Jun 2013].
19. Royal College of Midwives (RCM). Position statement no. 4: Normal Birth. London: RCM 2004:1.
20. Hatem M, Sandall J, Devane D, et al Midwife-led continuity versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2013, Issue 8.
21. International Confederation of Midwives. International Definition of the Midwife. Available at: http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/ [accessed: 14 Jun 2013].
22. Court of Appeal in S versus St George's Healthcare 1998:FCR 685.