Regulating risk and the boundaries of state conduct: a relational perspective on homebirth in Australia


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An OPC on Minkoff and Marshall’s “Fetal Risks, Relative Risks and Relatives Risks”

The concept of motivated reasoning and conflicting moral domains behind the state’s conduct towards pregnant women, as described by Minkoff and Marshall (2015), can also be observed in the apparent attitudes towards homebirth in Australia. In this commentary, we briefly outline the status of homebirth in Australia and provide some examples of motivated reasoning in the Australian context. Despite this, some commentators have refrained from risk-based judgments to instead emphasize the importance of communication with, and making ‘reasonable accommodation’ for, pregnant women; even in high-risk situations. We consider that a relational approach might work better than Minkoff and Marshall’s conclusion that pregnant women are best situated to decide on risk. Indeed, their paper hints to a relational approach at several points, but this is not explicitly taken up. We also claim that a relational approach provides a way to give rise to a principled compromise of conflicts in this contested space.
Homebirth in Australia
While less than 1% of women in Australia plan a homebirth (Commonwealth of Australia 2009), access is becoming increasingly difficult. Where homebirth is available, women can access it via two pathways. The first is through a publicly funded program, although entry is often restricted to those living in a particular (often urban) catchment. It is also only usually available to women assessed as ‘low risk’. Second, women can engage the services of a private, independent midwife. However, pending changes to midwife registration processes will mandate professional indemnity insurance. This may make it more difficult for independent midwives to practice homebirth, as there are currently no Australian insurers willing to provide cover that includes homebirth.

Motivated reasoning in Australia
The type of motivated reasoning outlined by Minkoff and Marshall has also been observed in the Australian context. For example, the language of risk has been used to support claims that the state should not facilitate homebirth as an option for pregnant women (Pesce 2010). Unlike the United States, Australia has not yet seen a court-ordered caesarean section, but scenarios with similar features have occurred. In 2005, the Royal Brisbane and Women’s Hospital reported a woman to the Department of Child Safety when she refused a repeat caesarean. She later attended another hospital where she gave birth vaginally (Australian Associated Press 2005).

Alternate reasoning to risk-based judgments is prevalent too, however. In June 2015, Western Australian Coroner Linton released separate decisions in relation to the deaths of three babies born at home (Coroner’s Court of Western Australia 2015). All of the mothers were assessed as ‘high risk’. The Coroner did not condemn homebirth, but instead emphasized the importance of communication between women and care givers to keep women engaged with mainstream medical care. She also endorsed a concept of ‘reasonable accommodation’ by the state of birth choices, even for high risk women.

Respectful communication to promote engagement
Coroner Linton’s approach, which emphasizes communication between women and care givers, still allows care givers considerable authority in assessing risk. While she ultimately found that each baby would have had a better chance of survival if born in a hospital, Coroner Linton also respected that high risk women may choose a homebirth due to their personal concerns about giving birth in hospitals. The issue was therefore how to ensure that such women remained engaged with their care team. Coroner Linton determined that the key was to have respectful communication between the women and their care givers. This approach may therefore depart from Minkoff and Marshall’s conclusion that decisionally capable pregnant women, rather than third parties, are best suited to decide on risk. It implies that decisions are made collaboratively.

Insisting that a pregnant woman bear the full burden (and consequences) of a decision on risk may also potentially cause problems. A pregnant woman may be vulnerable, particularly if she has little personal support or has concurrent medical conditions. Any vulnerable person, who may also be fatigued or under emotional stress, may struggle and feel unprepared to make such a decision. As Goering (2009) discusses, this kind of vulnerability can also be seen in new parents of children in the neonatal intensive care unit. This vulnerability does not mean that medical paternalism is justified, with all potentially stressful decisions taken away. However, parents’ autonomy may be enhanced by care givers who foster a trusting relationship and offer support to help them develop self-trust. Similarly, a supportive and trusting relationship between pregnant women and third parties such as care givers can give the women the self-trust that is necessary to make a decision on risk.
A role for relational autonomy

We suggest that Coroner Linton’s respectful communication approach exemplifies a relational approach to autonomy. Supporters of relational autonomy theories seek to analyze the relational, social and political dimensions of autonomy, emphasizing the importance of social support that can enhance an individual’s capacity for autonomy (MacKenzie 2015). The benefit of a relational approach means that whilst a pregnant woman has moral authority over her birth choices, she does not give up her autonomy if she chooses not to make these choices on her own. The drawback of a relational approach is that it takes time and resources to build a supportive and trusting relationship between pregnant women and care givers. Not all care givers will have the personal skills to develop these types of relationships. Nonetheless, this should still be the ideal, with appropriate training to reach that ideal (Goering 2009).

That is, whether or not there are conflicting moral domains, the state can still be supportive of pregnant women who make decisions outside of the mainstream (such as homebirth). It will take time and resources, but the state can potentially increase women’s autonomy and still advise them of the risks of certain birth choices. This is achieved by fostering a trusting and supportive relationship and allowing women to make their ‘best’ choice. A choice should not be made simply on prescriptive guidelines based solely on medical indications; nor should it be solely directed to ‘consumers’, whereby women are given a list of options with their respective risks and left to ‘place their order’. With a relational approach, the state ought to consider the types of policies and practices that will best promote and support women’s full inclusion in a safe and positive birth process (Kukla et al. 2009).

An approach incorporating principled compromise?

In addition to respectful communication and recognizing the relational nature of decisions on risk, homebirth would also benefit from a clinical and governance system termed principled compromise. Rather than focusing on conflicts and attempting to enforce one moral domain upon another, principled compromise promotes good relationships and respectful dialogue when conflict arises. A principled compromise is a way to resolve conflicts between equally valid values or domains, and requires the parties to negotiate. (A premise for our claim here is that homebirth is an equally valid choice). The concept of principled compromise has been developed in the context of end-of-life decision making (Huxtable 2013), but we claim that it will also be a helpful concept in birth choice; especially given the conflicts such choices tend to give rise to. For example, Minkoff and Marshall refer to the conflicts between the domains of autonomy, community and sanctity in state conduct over birth choices.

We agree with Minkoff and Marshall that when a pregnant woman chooses a homebirth, there is not necessarily a conflict between autonomy and community, as she is speaking to the collective interests of her family unit. However, the conflict with the domain of sanctity is still problematic, and results in some care givers prioritizing the fetus and mandating that pregnant women assume (sometimes significant) personal and bodily risks in order to benefit the fetus. A principled compromise is a form of resolution which would recognize a plurality of values, and would not involve forceful coercion of either the pregnant woman or her care givers. Rather, the compromise should allow them to co-exist and preserve the relationship between them.

However, a principled compromise requires both the pregnant woman and her care giver to be willing to negotiate a resolution, and both must be respectful of the other’s views. Many models of maternity care arguably do not facilitate the fostering of such respectful relationships, for example there may be limited services in remote areas (Kukla et al. 2009). Nevertheless, we posit that a relational approach to women’s autonomy in birth choices, with a focus on communication and developing supportive
relationships within maternity care, will create an environment where principled compromise is more likely to occur when conflicts arise.

Relational, supportive engagement with birth choices
The concepts of motivated reasoning and conflicting moral domains behind the state’s conduct towards pregnant women are also reflected in the apparent attitudes towards homebirth in Australia. However, a relational approach to maternity care has the potential to encourage pregnant women to make autonomous decisions with the support of her care givers and family. A supportive environment is also conducive to the resolution of any conflicts by a principled compromise, rather than forceful coercion.

REFERENCES
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