Risk, Safety, and Choice in Childbirth

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ABSTRACT

In this column, the author explores current understandings of risk and safety in pregnancy and childbirth. An emphasis on risk management places the provider and hospital in control of women's decisions related to pregnancy and birth and may make pregnancy and birth less safe for mothers and babies. Accepting that no life is risk free, women can let go of fear and make choices that take into account real, not imagined, or exaggerated risk and, in doing so, increase safety for themselves and their babies. The focus of maternity care becomes enhancing safety through evidence-based practice rather than managing risk.

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"Better safe than sorry" seems to drive women's childbearing choices. Choices related to care provider, place of birth, prenatal testing, what foods to avoid, eliminating all caffeine, alcohol, and over-the-counter medications, how much and what kind of exercise, and whether and when one can safely travel, just to name a few, make pregnancy a full-time, stressful job. Women go through pregnancy worried for their babies and themselves. Rothman (2001) notes that Dutch midwives describe prenatal testing as "spoiling the pregnancy." Every risk, however small, is discussed and, too often, exaggerated. Obstetricians have convinced women that managing risk is the key to safety in pregnancy and childbirth. But, is it?

PERSPECTIVES ON RISK

Merriam-Webster's Collegiate Dictionary (2008) defines *risk* as a possibility, a chance. Slovic (1987) notes that society is safer now than at any time in history, but there is increasing concern with risk and a societal desire to have a risk-free life, which is an impossibility. Slovic's research focuses on perceptions of risk from an individual and societal perspective, asking the question "What is acceptable risk?" And the answer to that question changes depending on whose risk we are talking about and the particular circumstances.

DeVries (1992) describes that the common strategy of professional groups gaining control is to create risk or exaggerate risk. One way groups gain power is by reducing risk and uncertainty. Where there is limited risk, it can be "created" by redefining ordinary life events as risky and emphasizing whatever risk exists. The medical model of birth encourages women to see birth as inherently risky for mother and baby (DeVries, 1992; Rooks, 1997), taking advantage of women's normal fears for themselves and their babies. The obstetrician is then in the powerful position of reducing the risk and uncertainty. During pregnancy, women are advised and cautioned about every conceivable, however small, risk; but interestingly, when it comes time for the birth,

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there is little, if any, discussion about the risks of routine interventions, such as continuous electronic fetal monitoring, elective induction, and epidurals.

The consequences of creating, exaggerating, and managing risk in pregnancy and childbirth include a 33% cesarean rate, an ever increasing induction rate, and neonatal intensive care units filled to capacity. It has led to pregnancies fraught with worry, an ever increasing fear of labor and birth, and a reluctance of women to make choices that reflect putting risk in perspective and deciding for themselves what "acceptable" risk is. Women are especially reluctant to make decisions that go up against the system or against "medical advice" (Cartwright & Thomas, 2001).

What is acceptable risk for the mother and her baby may indeed not be acceptable risk for the obstetrician or hospital. Although women are led to believe that maternity care is designed to manage (reducing risk and uncertainty) the risks for mother and baby, in fact, the risks for the obstetrician and the hospital drive practice in ways that most women are unaware of. The overuse of technology and testing, inductions, and cesarean surgeries are just a few examples of practices that decrease the risk of litigation for physicians. Interestingly, there is increasing evidence that the risk of litigation, like risk, is also exaggerated (Cartwright & Thomas, 2001). While during pregnancy the obstetrician in addition to routinely using technology (e.g., frequent ultrasounds) and increasing numbers of prenatal tests, it is once labor starts that there is a shift from managing maternal and fetal risk to managing obstetrician and hospital risk. The result is intervention intensive labor and birth.

The more we focus on risk, the more fear we create and the less able women are to trust their bodies, the beautifully designed process of pregnancy and birth, and their ability to give birth. The less women trust themselves, the more vulnerable they become and the less able they are to make sensible decisions for themselves and their babies. It is not a surprise that women resort to "better safe than sorry" as a guide to decision making. But does managing risk, the woman's or the obstetrician's, make things safer?

Managing small (or exaggerated) risk can actually increase risk. A classic example of this is that the routine use of electronic fetal monitoring increases the risk of a cesarean but is no safer for the baby than intermittent auscultation of the fetal heart rate (Alfirevic, Devane, & Gyte, 2006).

PERSPECTIVES ON SAFETY

Safety is defined as a condition of being out of harm's way, protected, careful, cautious, not dangerous (*Merriam-Webster's Collegiate Dictionary*, 2008). Safety for individual mothers and babies is more than medical safety. Is birth inherently dangerous? Can it ever be risk free or danger free? No.

Sandall (2011) notes that in the current maternity care system, women are the "risk creators" (genes, disease, lifestyle) that obstetricians need to manage. The safety focus of the Institute of Medicine's (2001) safety initiative is, by contrast, to make the system safer. It is the risk in the system that needs to be managed. Sandall suggests a broader definition of safety that moves beyond risk reduction focused on the women to evidence-based care.

There is a wealth of research that provides evidence for best practice in pregnancy and childbirth; however, in the United States, evidence-based practice is not the norm (Sakala & Corry, 2008). Lamaze International's six Healthy Birth Practices (Lothian, 2009) provide a summary of best practices that is an important resource for women and their families. The Cochrane Library is an excellent source of systematic reviews and guidelines for evidence-based practice. The research findings are clear. It is dangerous to interfere in the normal, physiologic process of birth without a clear medical indication.

Perhaps the biggest threat to safety is technocratic, fragmented, depersonalized care. Edwards (2011) describes the kind of safety provided by small-scale midwifery practices. It is the kind of care that "engages women's hopes, aspirations, concerns and fears and in doing so builds trust, so women can focus on well being and avoiding harm" (p. 21).

MAKING CHOICES THAT REFLECT REAL RISK AND ENHANCE SAFETY

Where does all of this leave women? Sandall (2011) suggests moving beyond the typical "Tell us what you like and we will do what we think is best" to encouraging women to make autonomous decisions about what is best for themselves and their babies.

What stands in the way of this happening? There is a moral dimension to not following rules and protocols, and this puts enormous pressure on women to conform and not rock the boat. There is a moral imperative to follow established ways of doing things and to buy into the societal view that

managing risk improves outcomes. If a woman chooses something different, for instance home birth, refusing to be induced or opting out of prenatal testing, the powerful obstetrician counters with "You are endangering your baby." It is a rare woman who has the confidence to refuse to comply.

Informed decision making requires knowledge and support, and childbirth education can provide both. Childbirth education can help women put risk in perspective and develop a deeper understanding of the relationship between evidence-based care and safety.

CHILDBIRTH EDUCATION

It is important that women in childbirth classes understand that a risk-free life does not exist. It is also essential to remind women that they construct and manage risk every day. We can help women sort out the ways in which they do this in their everyday lives. It is risky to fly in a plane or drive a car. Which is most risky? The car, but most of us drive every day. What is the real risk of having an occasional glass of wine in pregnancy? The examples are endless. We need to be careful not to jump on the medical train that puts the onus on the woman to reduce risk: don't eat unpasteurized cheese, avoid all alcohol and caffeine, take prenatal vitamins, get a flu shot.

It is important that we spend time discussing the differences between risk and safety and making it clear that the current maternity care system increases risk and makes birth less safe for mothers and babies. Women need to know the care practices that make birth safer for mothers and babies and the practices that do not.

Childbirth educators need to take a strong stand in support of changing the system to increase safety for mothers and babies. Women need to know there is an inherent, simple wisdom in nature's plan for birth. Is there potential danger? Yes. But we can minimize the danger with knowledge, with confidence, with being able to avoid unnecessary medical interventions, by being healthy in general, by letting labor start on its own, by working with contractions rather than immediately having an epidural, and by opting out of elective induction and cesarean unless there is a clear medical indication. In the current maternity care system, choosing "better safe than sorry" is risky. It is a reasonable guide only if women know that the care they are receiving is evidence based.

Safety is not about frantically trying to minimize small or exaggerated risks during pregnancy and then giving birth in hospitals that protect obstetricians' interests while increasing risk for mothers and babies. Navigating the maze of risk and safety in maternity care is daunting. Childbirth educators can make a difference by ensuring that women are confident in their own ability to give birth and knowledgeable about safe, evidence-based care.

The Lamaze Six Healthy Birth Practice papers can be accessed at http://www.lamaze.org

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