MIDWIFERY, INFORMED CHOICE, AND REPRODUCTIVE AUTONOMY:
A RELATIONAL APPROACH

by

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ABSTRACT

This thesis examines correlations between the midwifery philosophy of care and feminist reconfigurations of autonomy and choice. Based on content analysis, two sets of divergent models are compared: the medical model of informed consent and mainstream frameworks of autonomy, and the midwifery model of informed choice and feminist relational approaches.

This investigation begins by examining the classic Principle of Respect for Patient Autonomy and the process of informed consent as proposed by Beauchamp and Childress. A critical survey of this framework brings to light shortcomings of bioethical theories that maintain a narrow ideology of autonomy and a limited perception of human characteristics.

In response to mainstream bioethicists' theories of autonomy, many feminists have offered a relational approach recognizing the individual as situated within a broader social matrix. Distinguishing the unique elements of a relational model, Susan Sherwin's framework contrasts that of Beauchamp and Childress. Relational methods emphasize the manner in which external forces may enhance or restrict one's sense of self-trust and their capacity for autonomous decision-making. Autonomy is thus a process, developed and augmented through the acquisition of a series of skills.

The midwifery model of care and the process of informed choice demonstrate an applied form of relational autonomy. Midwives aim to extend a women's sense of self-trust and empower her through the decision-making process. Shifting beyond the consent paradigm of the medical model, autonomy is respected in a fuller sense.

Examining cases of women who are abused during pregnancy highlights the importance of developing an expanded vision of autonomy and the responsibilities this entails on the part of health care professionals. It is my contention that the midwifery model of care offers an exemplary standard of practice, demonstrating the merits of integrating a relational approach to autonomy within bioethical theory and the health care context at large.

DEDICATION

For my mother and all my relations

ACKNOWLEDGEMENTS

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Introduction

Over the course of the 20th century, and into the 21st century, health care has

developed into a highly specialized and exclusive field. With governing bodies in the

core disciplines of medicine and nursing, amongst other professions, such as midwifery,

scientific advances in diagnosis and treatment, technological devices, and a distinct

language of its own, Western medicine lays claim to a great deal of social and political

power and prestige. The last several decades, however, have witnessed a diverse and

increasing range of critiques of the medical system. One set of these critiques has been

embodied in the long and colourful history of the women's health movement. From

Margaret Sanger in the early 1900s and her crusade to legalize birth control in the

United States, to the 1960s, and continuing, Boston Women's Health Book Collective

and their classic *Our Bodies, Ourselves*,[1] many women have engaged in the struggle to

speak out and have their voices heard. Gender and racial discrimination, the increasing

medicalization of women's bodies, and the valorisation of scientific knowledge all

continue to be strong points of contention. Feminists at both the grassroots and

academic levels have spoken out against power differentials experienced within the

medical field. Today, as in the past, it is often the glaring lack of relevant and necessary

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[1] First published in 1970, *Our Bodies,Ourselves* has since sold more than four million copies, and has been translated into almost 20 different languages. A book for teens about sex and relationships has also been published, along with another focusing on aging issues.

information, and alienating interactions with the medical system that fuel many women to persist in their calls for change.

The medical institution itself has not been the only target of feminist criticism. Much of mainstream bioethical theory and its proposed moral guidelines for professional conduct and judgment have also been subjected to critical assessments. The most frequently raised critiques include: "(1) lack of concern for women's interests; (2) neglect of 'women's issues'; (3) denial of women's moral agency; (4) depreciation of 'feminine' values; and (5) devaluation of women's moral experiences" (Jaggar cited in Tong 1997, 52). In response, we are currently witnessing a burgeoning of feminist approaches to health care ethics as an integral component of the women's health movement.

The notion of choice is a crucial subject in feminist moral discourse and is perhaps most salient to issues surrounding women's reproductive capacity: the right to choose if and when to conceive, the right to choose whether to carry a pregnancy to term, the right to choose where to give birth. While feminists have long argued for a woman's right to choose, there is a growing amount of discussion concerning the notion of choice and how and if it actually exists. With an escalating array of new reproductive technologies, women are now offered a diverse range of choices with regards to their reproductive lives. Or are they? Many have argued that this is not necessarily the case. Choice is constructed and re-constructed. Choice can be coerced. Choice can be misinformed, and arguably patients are rarely fully informed. Modern life is increasingly infused with the presence of technology, so much so that it is often taken for granted as the superior mode of interaction with our surroundings. In terms of obstetrical care, it is often assumed that expectant and birthing women necessarily want the newest, most innovative technology for the health and safety of their child. The manner in which choices are presented to pregnant and birthing women often reflects this "technocratic"

ideology (Davis-Floyd 1992). This same ideology serves to reconstruct the meaning of health and illness, and of bodies and subjectivities, the very way we see and experience ourselves. The physician and patient emerge in their designated roles, situated within a relationship mediated by scientific knowledge and medical discourse.

The current midwifery movement was initiated in response to this technocratic, medicalized model of birth. Many women, faced with discrepancies between what they expected and hoped for in childbirth, and what they actually encountered, question the unnecessary interventions and often alienating practices of birth rituals in North America. This mounting dissatisfaction, coupled with the determination and effort of many women, has led to the resurgence of midwifery in Canada. Midwives are witnessing a pronounced increase in employment of their services, as well as official recognition of their status through legislation and funding in a number of provinces and territories across the country (see Table 1, p.60). Through midwifery's emphasis on birth as a natural process, its recognition of the complexities of the individual woman's life, and in its attendance to issues of diversity among women, a much different form of practice and understanding materializes. Respecting both the physical and psycho-social needs of the woman, and valuing her position as the primary decision-maker, the midwife-client relationship is born.

In her journey to motherhood, a pregnant woman is situated in the midst of many relationships: with the fetus, her doctor, midwife, partner, parents, friends, and society as a whole. These relationships influence and inform her sense of self, and her experience as an expectant mother. Some relations may hold a positive influence while others may undermine her confidence in approaching pregnancy and childbirth, thus influencing the decisions she makes for her plan of parturient care. While not all women have a well-developed plan of care or actively participate in decisions regarding their care, this too

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may reflect how they situate themselves in their broader context. As members of a wider community, women are informed by cultural beliefs and values, media images, health policy and legislation, and financial constraints and cutbacks. Their socio-political positioning within that community is likewise an important influential factor. Despite this, it is often assumed that a woman's choice is ultimately made in isolation. Women's decisions are not made in seclusion, however, and these social, technological, and familial influences must be acknowledged and carefully considered. Caregivers must pay special attention to the manner in which information is presented and how patients' final conclusions are drawn.

One particularly fruitful approach to this issue introduces a feminist reconfiguration of the notion of autonomy in the decision-making process. *Relational approaches to autonomy* recognize individuals as situated within the vast array of relations that constitute and inform their lives. Rather than denying the influence of these relations, this approach examines the potential that relationships have for enhancing independence and the capacity for autonomous decision-making. This is not to claim that all relationships necessarily improve one's sense of autonomy. Oppressive forces restrict the development of self-trust and thereby undermine one's ability to choose freely. Young defines these oppressive forces as follows:

> Briefly, a group is oppressed when one or more of the conditions occurs to all or a large portion of its members: (1) The benefits of their work or energy go to others without those others reciprocally benefiting them (exploitation); (2) they are excluded from participation in major social activities, which in our society means primarily a workplace (marginalization); (3) they live and work under the authority of others and have little work autonomy and authority over others themselves (powerlessness); (4) as a group they are stereotyped at the same time that their experience and situation is invisible in the society in general, and they have little opportunity and little audience for the expression of their experience and perspective on social events (cultural imperialism); (5) group members suffer random violence and harassment motivated by group hatred or fear (Young 1990, 123).

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A feminist reconfiguration of the notion of autonomy involves more than re-conceptualising the ways we think about autonomy and the notion of choice. "Feminist methodology directs us to evaluate practices within the broader scheme of oppressive social structures" (Sherwin 1992, 118). It calls on us to recognize power dynamics at play in the healthcare system and how these often reflect and reinforce similar dynamics in the broader social context.[2] It is a means of introducing and analyzing the *politics* of women's health. The failure of traditional bioethicists to explicitly address issues of power relations is a criticism often cited by feminist scholars. When autonomy is perceived in an individualistic and atomistic manner, oppressive structures are often overshadowed and therefore overlooked in the decision-making process. Only if a person is situated within their broader social context, and this positioning is carefully evaluated, can the physician-patient or caregiver-client relationship begin to facilitate informed choice. It is essential that the client or patient is recognized as socially situated, and that caregivers are aware of their own social positioning, and biases and ideologies they bring to the relationship. These preconceptions or prejudices can directly affect the caregiver's approach to care and case management. Both patient and caregiver must be recognized as individuals situated within a broader matrix of social relations.

In line with emphasising the individuality of each caregiver, it is important to note that what is presented here is an analysis of *models* of autonomy and choice. The

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[2] For Susan Sherwin, this involves adopting a different terminology to that used in traditional ethics. She proposes the use of "health care ethics" as a means of linguistically distinguishing her project from that of mainstream medical/bioethics, (Sherwin 1992, 3 n1). The term "medical ethics" directs attention towards the actions of physicians, while "bioethics" focuses on the biological and physical aspects of medicine. "Health care ethics" aims to highlight the importance of integrating a deeper understanding of the wider context at play. Following this line of reasoning, I will adopt the term "health care ethics" as a means of distinguishing feminist elements from those of traditional bio-medical ethics.

intention is not to present either the midwifery or medical communities as monolithic cultures. Rather, I offer a perspective of the continuum of "choice". Highlighting the benefits of the midwifery model of care may serve as a guiding light in how the shift from "autonomous choice as individualistic" to "autonomous choice as relational" may be facilitated. Only then will the complexities of women's lives and decision-making processes be recognized to a fuller extent, ultimately leading to a sensitive and holistic form of maternal care.

Outline of Chapters

In the following chapters, I will demonstrate how the concept of relational autonomy can and should be integrated into mainstream bioethics and health care practice. As relational approaches call for situating individuals, institutions, and knowledge within the broader social matrix, I also aim to position the theories I examine within their historical and contemporary contexts. Chapter Two, *The Principle of Respect for Autonomy: From Paternalism to Informed Consent*, begins with a brief examination of the rise of medical authority and the evolution of bioethics as an established discipline. I then introduce the mainstream principle of respect for autonomy as conceived by Beauchamp and Childress. Their collaborative work, "Principles of Biomedical Ethics," stands as one of the canonical texts on principle-based ethics (Beauchamp and Childress 2001). This classical approach is generally based on four principles: 1) Respect for Autonomy, 2) Nonmaleficence, 3) Beneficence and 4) Justice (Beauchamp and Childress 2001). For the purposes of this thesis project, I will focus almost exclusively on the principle of Respect for Autonomy, offering a theoretical framework to which relational approaches may be compared. Beauchamp and Childress argue that this standard notion of autonomy does not entirely clash with relational approaches, as personal relationships are not necessarily incongruent with the

maintenance of one's autonomy. While this may offer a positive rejoinder on superficial levels, a deeper critique exposes Beauchamp and Childress' failure to fully recognize systemic forces operating in the individual's broader societal context.

In analysing the notion of autonomy proposed by Beauchamp and Childress, I will set out how they define the concept, present their Principle of Respect for Autonomy, and outline conditions they deem necessary in the informed consent process. My reading of Beauchamp and Childress will further incorporate the analyses of both proponents and detractors of their work. In offering a feminist critique of their work, a foundation will be established for explicating relational approaches to autonomy and illustrating the merits of integrating such an approach in the process of facilitating choice in health care settings.

The historical relationship between feminist theory and notions of autonomy has witnessed many changes. Today, just as several notions of autonomy exist in mainstream bioethics, so do many feminist reconfigurations of autonomy. Chapter Three, *Relational Autonomy: A Feminist Theoretical Approach,* introduces various formulations of this contemporary concept. To assert that there is one unified feminist critique of standard autonomy and a single approach to relational autonomy would certainly obscure the inherent complexities of the project. I refer to two main collections of essays: *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Mackenzie and Stoljar 2000) and *The Politics of Women's Health: Exploring Agency and Autonomy* (Sherwin et al. 1998). The focus will be on the work of Susan Sherwin (1998), in which the term *relational* incorporates and moves beyond the individual's personal relationships to include the political breadth of one's social positioning, (Sherwin 1998, 19). Relational approaches require acknowledging oppressive systemic forces that may serve to impede or even empower one's access to

certain choices and the autonomous decisions regarding them. Only once those oppressive forces are dissipated can true autonomous decisions exist. Sherwin does not deny the merits of the Principle of Respect for Autonomy as espoused by Beauchamp and Childress. She is, however, concerned with the implications of its application when the notion of autonomy continues to be defined as self-reliant and self-sufficient. Mainstream notions of autonomy are narrow in scope and the standard conditions of autonomous decision-making fail to account for social conditions that influence and constrain such decisions.

Susan Dodds moves further in her formulation of relational autonomy and claims that respect for autonomy also involves developing and enhancing the individual's autonomy skills (Dodds 2000, 226). While Sherwin recognizes the importance of the development of autonomy competency, Dodds states the case more explicitly. Health crises and interactions with the medical system often precipitate a change in self-perception, thereby altering one's sense of autonomy and self-direction (Dodds 2000, 230). If respect for autonomy remains solely focused on the "front end" of healthcare, in terms of facilitating informed choice, it fails to promote support in terms of reintegrating a sense of autonomy in the potentially fragmented or altered individual. This need could involve extreme, life-threatening circumstances and also those facing a distinct life change. In terms of pre- and post-natal care, this is particularly salient as pregnancy and motherhood bring with them profound alterations in a woman's daily life and the roles that she assumes. The fostering of an individual's autonomy skills is thus an essential component of respect for the patient. Diana Meyers' work will be presented as it describes in detail the elements of autonomy competency and the process by which a sense of self-governance is developed (1989, 2000).

To render this theoretical project more concrete, I offer the example of the midwifery model of care as a means of illustrating the merits of applying relational autonomy in the health care context. In Chapter Four, *Relational Autonomy Applied: Informed Choice and the Midwifery Model of Care*, I provide a historical overview of midwifery in Canada, followed by an examination of intersections between midwifery practice and relational approaches to autonomy. Given its holistic approach to care and its emphasis on empowering the woman to trust herself and her body's capacity for bearing children, midwifery and the process of informed choice involves more than imparting evidence-based, scientific data on various testing and procedural options. Engaging with clients on a personal and time-intensive level, midwives strive to minimize the power differential between themselves and the client.[3] This atmosphere serves to foster a mutual rapport allowing clients to develop trust in their midwife and within themselves. This is not to imply that the midwife-client relationship is free of all power dynamics. The midwife, in her professional role of disseminating risk assessments and general information, necessarily maintains a position of authority. As with all health care providers, midwives must also remain aware of the dynamics at play in their relationships with clients. Given the nature of the midwifery model as a whole, however, I believe that the potential for the abuse of this power is reduced and intend to show how it continues to offer an exemplary form of parturient care that maximizes women's reproductive autonomy.

Midwifery's tenet of informed choice will be the primary focus of Chapter Four. The process of informed choice in the midwife-client relationship centralizes the woman

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[3] The term "client" is generally used in reference to a woman receiving the care of a midwife. While this term is sometimes contested, it is preferable to referring to the woman as a "patient" given its traditional association with illness and pathology. Likewise, positioning the woman as a client rather than a patient aims to diminish the paternalistic hierarchy of power and knowledge. For further discussion see MacDonald 2001, 260-261.

as the primary decision-maker and actively encourages the woman to assume responsibility for her health through the development of autonomy skills. It is explicit in its promotion of shared decision-making. Some overlap exists with the medical model of informed consent; however, the process of informed choice contains distinct elements making it unique to midwifery (Valerio 2001, 71). Focusing on the power dynamics within each of these approaches highlights the divergent philosophies adopted by the medical and midwifery models respectively (Valerio 2001, 72). This approach also emphasises the relevance of Sherwin's analysis of oppression and autonomy on both theoretical and practical levels.

A further element to be explored is the intersections between self-trust and autonomy. A sense of confidence and trust in one's capacity to make informed decisions in accordance with one's true values and beliefs is an essential component of autonomy (McLeod and Sherwin 2000). Often, those faced with oppression are confronted by a diminished sense of self-governance, perhaps best illustrated through the example of pregnant women in abusive relationships. Abuse often diminishes a woman's sense of power to claim and control her life as her own (McLeod and Sherwin 2000, 272). This will likely influence how she interacts with her healthcare providers and how she confronts decisions regarding her care. Although deemed to be of great importance, screening for violence during pregnancy is sadly lacking among many family physicians (Saxell 2000, 90). Abuse during pregnancy highlights the importance of recognizing the greater social context of the woman's life beyond her relationship with her health care provider. It also reinforces the need to broaden respect for autonomy beyond the process of informed choice and to actively engage in the development of the individual's autonomy skills. While initially it may appear that this example is overly concerned with the individual's personal relationships, the issue of domestic violence is

at its roots a deeply political issue and will be treated as such. While there exists some debate surrounding routine screening for violence and, to date, there is no conclusive evidence revealing midwives' ability to detect abuse, the holistic approach of midwifery, facilitating deeper levels of trust within the care-giving relationship, allows for greater opportunity for disclosure on the part of the client.

The midwifery model of care has the potential to inform other clinical practices in the movement towards women-centred care. Using midwifery as an example, we see how the implementation of a relational approach to autonomy can and should be integrated into the broader reaches of the medical field. Each of us face different constraints and issues in our lives. Attempts to conveniently standardize care overlook this. When political, familial and technological relations are taken into consideration, the one-dimensional patient of a caregiver evolves into the multi-dimensional individual in a complex social environment.

CHAPTER TWO

THE PRINCIPLE OF RESPECT FOR AUTONOMY: FROM PATERNALISM TO INFORMED CONSENT

> Throughout the land, arising from the throngs of converts to bioethics awareness, there can be heard a mantra '...beneficence...autonomy...justice...'
>
> (Clouser and Gert 1990, 219).

Dating back to the days of Hippocrates, moral theory has played a central role in medicine. Bioethics continues today in its "attempt to apply general ethical theories to specific forms of conduct and moral judgment in the medical realm" (Tong 1997, 54). Applying principles such as beneficence, justice, and respect for patient autonomy has been a standard approach to resolving ethical quandaries presented in modern medical care. This has not always been the case. The historical enterprise of medical ethics as a unique discipline is an integral facet of, and is ensconced within, the professional development of medicine itself. At the heart of moral issues in health care today are the tensions often created between physician authority and control, and the patient's right to choose. Yet it was not until the later part of the twentieth century that these power differentials became of great concern.

Evolution of Medical Authority

Shifts in physician authority have coincided with historical developments in practice, knowledge, and patient relations. It has been argued that medicine has

undergone three distinct phases – bedside medicine, hospital medicine, and laboratory medicine - each correlated with transitions in scientific knowledge (Jewson cited in Doyal 1981, 30). From the middle ages and into the late eighteenth century, "bedside medicine" was practiced in Western Europe. Medical care was a luxury that only the privileged could afford and physicians were often of a lower social status than that of their patrons (McCullough 1999, 5). As the physician had to gain his patron's trust and confidence if he wished to continue his employment, this prompted a patient-centred form of care (Doyal 1981, 30). Enhancing this emphasis on the patient was the notion that illness was not merely a physical ailment, but an ailment of the mind and body. How patients disclosed their conditions to the physician was central to diagnosis (Doyal 1981, 30). Moreover, "concepts of health, disease, and treatment offered by any one physician met fierce competition from other physicians, surgeons, apothecaries, and female midwives …" (McCullough 1999, 4). In this market, the patron held a great deal of power.

The onset of Industrialization, in the early 19th century, hastened the growth of urban centres, fuelling a great deal of illness amongst the working poor. The establishment of the infirmary was instigated to house and care for the sick, thus witnessing the dawn of "hospital medicine" (Doyal 1981, 31). This precipitated a critical shift in the nature of medical knowledge, and subsequently the physician-patient relationship. As noted by Foucault:

> The medical gaze was also organized in a new way. First, it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention. Moreover, it was a gaze that was not bound by the narrow grid of structure (form, arrangement, number, size), but that could and should grasp colours, variations, tiny anomalies, always receptive to the deviant. Finally, it was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating (Foucault 1973, 89).

Working with a greater population base, the patient was no longer considered an individual as such, but a 'case'. A classificatory form of medical pathology emerged. No longer was illness considered a disturbance of the system but was believed to potentially reside in localised areas of the body (Doyal 1981, 32). Illich contends:

> If 'sickness' and 'health' were to lay claim to public resources, then these concepts had to be made operational. Ailments had to be turned into objective diseases. Species had to be clinically defined and verified so that officials could fit them into wards, records, budgets and museums (Illich cited in Doyal 1981, 31).

Three essential factors thus contributed to the elevation of physicians' status. First, the population they were dealing with was now generally of a lower class. Second, as symptoms and the disease itself became the focus of medical attention, the patient was no longer afforded a central role. Finally, advances in medical knowledge, and "the birth of the clinic" (Foucault 1973), initiated the establishment of medicine as a professional and authoritative body.

By the mid-nineteenth century, advancements towards a germ theory of disease coupled with an emerging mechanistic view of the world led to the initiation of "laboratory medicine." Medicine had moved beyond the simple observation of physical symptoms. It was increasingly aimed towards direct intervention through the use of experimental methods and performance of live operations (Doyal 1981, 33). Medicine as a natural science was developing. Advances in histology and physiology likewise endowed the profession with further epistemic and diagnostic esteem. The physician-patient relationship "… reinforced the tendency to view the patient as an object to be manipulated – a trend which has reached its apotheosis in post-war scientific medicine" (Doyal 1981, 34).

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Evolution of Biomedical Ethics

Traditionally, within professionalized, allopathic medicine, the "doctor knows best" ideology prevailed. This ideology and practice, known as paternalism, dominated the physician-patient relationship and the decision-making process. Based on the principles of nonmaleficence (Do No Harm) and beneficence, physicians' decisions, derived from their expert knowledge and skills, reflected patients' best interests. Given the technical and scientific expertise of the physician, it was assumed *a priori* that the professional's opinions were the sole, or at least dominant, determining factor in planning and executing a patient's plan of care (Sherwin 1992, 138). The extent to which this paradigm was adopted is reflected in the American Medical Association's 1847 Code of Medical Ethics, which stated that "the *obedience* of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness to influence his attention to them" (cited in Meyer 1992, 543, italics added). Although medical expertise is still very powerful and many cede their power to such experts, this directive towards strict compliance with a doctor's orders appears morally antithetical to contemporary practice where a patient's right to choose is emphasised.

Paternalism continued to hold sway until the mid-twentieth century when "acceptance [of paternalism] ended ... for reasons including the increased complexity of medical treatment, the growing development of medical ethics as a specialty and the increase of litigation over the right to choose or reject medical treatment" (Brooks and Sullivan 2002, 197). Following the Nuremburg trials, the issue of consent attracted greater attention, yet "the term *informed consent* did not appear until a decade after these trials (held in the late 1940s), and it did not receive detailed attention until the 1970s" (Beauchamp and Childress 2001, 77, italics in original). Initially, the facilitation of

the informed consent process obligated physicians to properly inform patients and research subjects. With increased emphasis on patient autonomy, informed consent has since evolved to include "the quality of a patient's or subject's *understanding* and *consent*" (Beauchamp and Childress 2001, 77, italics in original). The medical institution continues to face a marked erosion in patient trust as a result of the bureaucratization and standardization of care, and the increased distancing between physicians and those they care for (Beauchamp and Childress 2001, 35). The rise of malpractice suits and public criticism of the health care system are indicative of this.

Increasing accessibility, via widely available resources, to the once esoteric and somewhat mystified realm of medical knowledge, propels the shift towards a framework of informed consent. No longer do physicians stand as the sole gatekeepers to health care information or practice decisions. This is not to imply that paternalism has vanished from medical practice. Its presence may be eclipsed by the cries of the "converts to bioethical awareness" but paternalistic undertones leaven their call for respecting patients' autonomy and right to informed consent.

Contemporary bioethics is likewise situated within the historical and evolutionary matrix of advancing medical knowledge and destabilized physician-patient relations. While there is no single methodology in the effort to resolve the complex issues presented within the medical field, principle-based ethics, or *principlism*, presents a classical approach adopted by many. This framework, most strongly advanced in the work of Beauchamp and Childress, rests on four main principles:

(1) Respect for Autonomy,

(2) Nonmaleficence,

(3) Beneficence, and

(4) Justice (quoted verbatim from Beauchamp and Childress 2001, 12).

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The four principles, formulated by Beauchamp and Childress can be summarized as follows:

Respect for Patient Autonomy

This principle holds that "personal autonomy is, at a minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice" (ibid., 58). Respecting a competent individual's autonomy may include the following rules:

> (1) Tell the truth.
>
> (2) Respect the privacy of others.
>
> (3) Protect confidential information.
>
> (4) Obtain consent for interventions with patients.
>
> (5) When asked, help others make important decisions (quoted verbatim from Beauchamp and Childress 2001, 65).

Nonmaleficence

This principle, *Primum non nocere*, calls for "Above all [or first] do no harm" (Beauchamp and Childress 2001,113). It is an obligation to not inflict harm or injury on another. The principle of nonmaleficence is often not distinguished from the principle of beneficence (see below). Nonmaleficence involves refraining from particular actions, while beneficence obligates individuals to perform certain actions (ibid., 115). The distinction between the two categories can be illustrated by the respective rules derived from each of the principles. Examples of rules based on the principle of nonmaleficence include:

(1) Do not kill.

(2) Do not cause pain or suffering.

(3) Do not incapacitate (quoted verbatim from Beauchamp and

Childress 2001, 117).

Beneficence

Generally, this principle "establishes an obligation to help others further their important and legitimate interests" (ibid., 166). Typical examples of rules derived from the principle of beneficence include:

(1) Protect and defend the rights of others.

(2) Prevent harm from occurring to others.

(3) Remove conditions that will cause harm to others (quoted from

Beauchamp and Childress 2001, 167).

The principle of beneficence is a partial or imperfect obligation. We are not obliged to follow its derivative rules at all times and in all places, nor towards all people. Our beneficence is often directed more towards those with whom we have relationships. In contrast, the principle of nonmaleficence is a perfect obligation in that we are obligated to refrain from inflicting harm on anyone (Beauchamp and Childress 2001, 168).

Issues surrounding paternalism often arise on the basis of the principle of beneficence. Some contend that the principle of autonomy is at odds with the principle of beneficence in the restrictions placed on medical professionals' promotion of their patients' best interests. This may be the case, for example, when a physician

recommends that a patient undergo a certain treatment and the patient denies consent

to the proposed plan of care. In contrast, others assert that incorporating respect for a

patient's autonomy is an inherent component of beneficent practice (Beauchamp and

Childress 2001, 176). Thus, by respecting an individual's autonomous decisions, the

medical professional promotes the patient's well-being and best interests. There are

others, however, who argue that the principle of physician beneficence is a philosophical

non sequitur, for only in rare circumstances can a medical professional determine the

overall best interests of the patient. Only the patient is able to determine such interests

(Veatch 2000, 703).

Justice

The principle of justice entails the fair distribution of benefits and burdens, risks

and costs among members of a given society. The issue of distributive justice within the

health care system focuses on such issues as the allocation of scarce resources,

universal access to health care, and the distribution of transplant organs. Many contend

that the principle of autonomy may conflict with the principle of justice. Some argue that

self-governance is constrained by the concerns of society at large, while others contend

that "communities need more than autonomy" (Murray 1994, 32). In the health care

context this may play out in the following manner (Beauchamp and Childress 2001, 16).

A woman is visiting her doctor and requests a referral for a mammography. Her

insurance provider will not cover the testing unless the purpose of the examination is to

rule out cancer. Her physician, however, does not feel that she is at risk. A dilemma is

created. Should the physician simply fill out the necessary forms stating the purpose is

to screen for breast cancer, thus adhering to the principle of respect for patient

autonomy or, acting in accordance with the principle of justice, explain to the woman that given the scarcity of resources and the overburdened health care system, that should she wish to undergo the procedure she will be personally responsible for any costs incurred?

These four *principles* stand as general moral directives, and as such they are less restrictive than operative or procedural *rules*.   No single principle necessarily or automatically supersedes the moral relevance of another. The principles do not stand as a unified theory but rather offer general guidance in the identification and resolution of moral issues (Beauchamp and Childress 2001, 15). Beauchamp and Childress argue that each of these principles is *prima facie* in nature, meaning each "must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation" (ibid., 14). The specifics of each situation must therefore be taken into consideration preceding the application of any one principle. This process of specification may also be governed by professional ethical guidelines that aid in the resolution of conflicting principles. Steadfast specifications, however, will necessarily evolve as new cases and circumstances arise.

The Principle of Respect for Autonomy

Despite claims of the *prima facie* nature of each of the four clusters, it appears that "the principle of autonomy has become so elevated so that it is now, surely, the first among equals" (Dodds 2000, 216). On television and radio talk-shows, and bound within the covers of numerous medical and philosophy journals, the notions of patient autonomy and informed consent continue to attract heated debate. Theories of

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autonomy are as diverse and abundant as the number of individuals who have undertaken an analysis of its fundamentals. What precisely is autonomy? What does it mean to respect another's autonomous decisions and what constitutes an autonomous decision?

Originally derived from a combination of the Greek terms *autos,* meaning "self", and *nomos,* meaning "governance and rule", autonomy denoted the self-governance of city-states (Beauchamp and Childress 2001, 57). It has since evolved to cover a diverse range of meanings and usages. Beauchamp and Childress define autonomy as governance of the self that is not restricted by undue restraints or impediments that may influence independent choice (ibid., 58). Two qualifying conditions are implicit in this definition: (1) liberty, or freedom from external pressures, and (2) agency, or decisional competency. Decisional competency entails the individual's understanding of the issues and risks at hand, and their intentional action in forming a conclusion regarding the choices. Levels of understanding and external influence may vary and thus Beauchamp and Childress argue that actions are "autonomous by degrees", and "rarely, if ever, fully autonomous" (Beauchamp and Childress 2001, 59).

In health care, the principle of respect for autonomy obligates the medical professional to respect the competent and intentional decision-making of the patient. In some instances, this entails engaging with the individual in enhancing their capacity for understanding and developing their autonomy skills (ibid., 63). Invoking the principle of respect for autonomy aims to minimize the dependent nature of the patient in the health care context. This is not to imply that patients are then abandoned to themselves in reaching decisions regarding their care. The patient need not assume the role of primary decision-maker, nor are they obligated to actively engage in the informed consent process (Beauchamp and Childress 2001, 63). Rather, it is the duty of the

professional to acknowledge those choices should they be made. It is not necessarily the *duty* of the patient to make those choices, but simply the *right* to do so.

Determinants of Informed Consent

Many issues surround the determinants of autonomous choice. Standards of competence, and what precisely constitutes the process of informed consent are both issues subject to debate. The courts and medical professions have often equated informed consent with disclosure but Beauchamp and Childress contend that this approach obscures the complexities of the process (ibid., 79). In overemphasizing the role of the medical professional in providing information, the role of the patient in formulating the decision is negated or overshadowed. Offering a more comprehensive definition, Beauchamp and Childress present a tripartite formulation of informed consent, involving Threshold Elements (Patient Competence and Voluntariness), Information Elements (Disclosure, Recommendation, and Understanding), and Consent Elements (Authorization of Refusal) (ibid., 80). These elements are discussed below.

Threshold Elements (Preconditions)

Patient competence and voluntariness are the two threshold elements that stand as preconditions for the initiation of the informed consent process (ibid., 80).

A) Patient Competence

Patient competence is necessary for the validation of autonomous decisions. Beauchamp and Childress state that:

> Patients or subjects are competent to make a decision if they have the capacity to understand the information, to make a judgement about the information in light of their values, to intend a certain outcome, and to communicate freely their wishes to care givers or investigators (ibid., 71).

These characteristics are similar in nature to those of the autonomous individual (Beauchamp and Childress 2001, 72). Of course, this raises numerous issues as to how thresholds of competency are to be determined and by whom, as well as how to proceed in circumstances where a patient is deemed incompetent.

There are instances where one is competent in making decisions and executing particular actions in nonmedical contexts, but still deemed incompetent in the face of important medical decisions. In other situations, for example, with comatose patients and very young children, patients are deemed incompetent and subsequently some form of surrogate decision-making is permitted. Therefore, competency within a bioethical framework is specified to the circumstances and particular decisions at hand.

B) Voluntariness

Voluntary choices are those arrived at by an individual who is free of controlling forms of influence that direct the decision-making process. Beauchamp and Childress distinguish between influence and control, and assert that while overt control is influential, not all influences need be controlling or determinative (Beauchamp and Childress 2001, 93). In terms of the various forms of influence, coercion, persuasion, and manipulation are deemed most relevant in the health care context (ibid., 94). Coercion is a form of control exerted through plausible threats of harm. The degree of coercion is directly determined by the recipient's responses to the actions of the instigator. While coercion is based on an appeal to one's fears, persuasion is an appeal to reasoning and rational argument. The target individual comes to accept the persuader's beliefs as truth. Finally, manipulation is a form of influence that generally, within the medical setting, involves misrepresentation or the presentation of misleading information with the intention of directing the patient's decision towards a particular outcome (Beauchamp and Childress 2001, 95). The healthcare professional must

therefore remain aware of the manner in which they may exert undue influence in the patient's decision-making. It is their obligation to abstain from coercive or manipulative practices. Beauchamp and Childress concede that "reasoned argument" is an acceptable form of influence as it generally constitutes a fundamental aspect of information-sharing and recommendations given to patients regarding their course of care (ibid., 95).

Others such as Barilan and Weintraub take this one step further and argue that physicians must try to persuade patients to follow their recommendations. Medical professionals must also place themselves in the reciprocal position of remaining open to the persuasion of their patients. As "genuine self-determination can be exercised only through conscious rejection of persuasive attempts to overrule it," they contend that persuasion is a both a prerequisite and indeed an integral element of respecting patients' autonomy (Barilan and Weintraub 2001, 16). Failing to engage on this level with patients objectifies them, rendering them as obstacles to be avoided. "An exchange of arguments about the self and its preferences and values in order to achieve mutual understanding and solutions is the litmus test of respecting peoples as persons" (Barilan and Weintraub 2001, 18). Only by engaging in mutual discourse then is the patient fully recognized as an autonomous individual with desires, wishes and concerns of their own.

Information Elements

The information elements include: A) the disclosure of information relevant to the circumstances, B) a recommendation of a proposed course of action, and C) the patient's understanding of the information and recommendation (Beauchamp and Childress 2001, 80).

A) Disclosure

Beauchamp and Childress identify three different standards of disclosure. First, the *professional practice standard* is a model of disclosure that adheres to institutional or professional-specific criteria. It is left to the discretion of either the institution or professional body to determine what information is relevant. Such patterns of disclosure are often biased in their approach as they are rooted in the organizations and disciplines from which they are derived. They are directed specifically towards the professional's goals and often fail to account for the unique circumstances of the individual patient. Hence, this approach has the tendency to obscure the role of the patient as an autonomous decision-maker (Beauchamp and Childress 2001, 82).

Second, the *reasonable person standard* suggests that the amount and type of material provided by the medical professional to the patient are based on a model of what an archetypal "reasonable person" would want to know given the same circumstances. This pattern of disclosure raises the issues of defining *reasonable person*, and how precisely to move from such a theoretically derived framework into clinical practice. Although not without its moral limitations, this standard of reasoning is accepted in over half of the United States (ibid., 82).

Finally, the *subjective standard* is based on tailoring information disclosed to each individual patient. This approach takes into account, where known, the unique circumstances, beliefs, values, fears, and concerns of the individual, thereby maximizing the patient's potential for autonomous decision-making. While endorsing the moral superiority of the subjective standard of disclosure, Beauchamp and Childress contend that it lacks the capacity for full practical application. Ascertaining the precise needs of each patient would involve a time-intensive process that, simply put, "a doctor cannot reasonably be expected to do" (Beauchamp and Childress 2001, 83).

Beauchamp and Childress conclude that the process of disclosure, in moral terms, rests on the physician respecting the patient's autonomous choices, rather than simply deploying disclosure as a means of self-interested protection against future litigation (ibid., 81). This process involves a series of obligations. First, the medical professional is obliged to provide information that the patient is likely to consider essential. Second, supplementary information that the professional believes is essential for the patient to reach an informed decision is also presented. Finally, the professional must explain the process of informed consent itself, delineating both its scope and limitations (Beauchamp and Childress 2001, 81).

B) Recommendation

Following disclosure, the medical professional must provide a recommendation regarding the patient's plan of care. As previously noted, this may involve a form of persuasion that is within the professional's rights as a health care provider, so long as it does not involve coercive or manipulative control.

C) Understanding

Truly autonomous patients have understood the information presented in the disclosure process and comprehend the reasoning behind the professional's recommendations. This understanding involves the ability to rationally formulate decisions with a logical awareness of the potential consequences of these choices (ibid., 88). Medical terminology, and language proficiency may present barriers to understanding for many patients. Likewise, excessive or irrelevant information may present a difficulty in deciphering between options, and too little information will impede attaining a necessary level of understanding. The manner in which risks are presented

greatly impacts the decision-making process and therefore, health care providers must give this special attention (Beauchamp and Childress, 90).

Consent Elements

Consent elements involve the finalization of the informed consent process. Once the threshold and information elements have been fulfilled, the patient must arrive at a decision regarding the available options. Formal authorization is required for the professional to proceed with the agreed upon course of case management. This may also be the point at which the individual refuses all recommendations and thereby denies consent. These decisions, however, are not always free of dispute or conflict. Indeed, many cases have moved beyond the doctor's office and into the courtroom.

The case concerning *McFall v. Shimp* (1979) is a prime example of one such dispute. In this particular instance, David Shimp refused to undergo bone-marrow extraction to potentially prolong or save the life of his cousin suffering from aplastic anemia. The court, ruling in accordance with informed consent regulations, upheld Shimp's decision. The judge reasoned:

> For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence. Forcible extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends (McFall v. Shimp, quoted in Bordo 1993, 74 italics in original).

Although it may appear somewhat disturbing that Shimp refused to aid his cousin, it was legally within his power to do so. Certainly ruling to the contrary would invoke a slippery precedent. McFall died two weeks later.

Yet compare the case of *McFall v. Shimp* to that of woman who was subjected to an involuntary caesarean section. In this instance, Angela Carder, twenty-five weeks pregnant and terminally ill, was taken to court by the George Washington University Hospital. Against the wishes of herself, her husband, and the hospital's resident doctors, the hospital sought legal enforcement of her compliance to undergo the surgery. The court ruled that the woman's right to bodily integrity and right to not give consent could be dismissed, as even without the operation she had only "at best two days left of sedated life" (cited in Bordo 1993, 77). Both mother and fetus died shortly after. Angela Carder is not an isolated case. In March 2004, Melissa Rowland of Utah was arrested for allegedly committing murder when one of her twins was stillborn after she refused to undergo a caesarean. Thus while her right to refuse was respected, she was subsequently prosecuted for doing so. The manner in which these women's autonomy and subjectivity were "justifiably" pushed aside highlights the prevalence of the ideology of "woman as fetal receptacle", and the ways in which such ideologies influence the application of moral and legal principles. Court ordered obstetrical interventions, whether caesareans or sterilization, all represent a direct infringement upon the personhood of the woman involved, and a surrendering of her autonomy.

As with the other principles, the principle of respect for autonomy remains *prima facie* in nature, and can be overruled if and when stronger moral obligations persist. Interactions within the health care system are rarely neat and uncomplicated. Any ethical framework must therefore reflect the goals towards which it aims. The acceptance of respect for patient autonomy and the manner in which the principle is specified and directed towards a practical application will therefore vary within the different operative frameworks and circumstances at hand. Inevitably, conflicts arise with their attendant moral dilemmas in tow.

Critiques of Beauchamp and Childress

There are, however, those who assert that it is principlism itself that perpetuates moral complications in the medical arena. Some critics have argued that Beauchamp and Childress, and principlism in general, fail to offer a comprehensive and unified moral theory from which to confront the complex ethical quandaries presented in clinical practice (Clouser and Gert 1990, 227). Clouser and Gert argue that the principles act as artificially neat and tidy chapter titles and headings, grouping together disparate and often conflicting considerations, without subsequently offering any practical application or guidance (Clouser and Gert 1990, 221). In fairness, Beauchamp and Childress do not claim to offer such a cohesive theory (Beauchamp and Childress 2001, 15). As Lustig argues in their defence, they are instead aware that moral "algorithms" will simply not suffice in the complex web of medical relations and practices; hence the *prima facie* nature of the principles (Lustig 1992 489). "Beauchamp and Childress do indeed provide a 'systematic' account of the principles, but it is a 'systematicity' incompatible with theoretical monism " (ibid., 494). Thus, in their work they do not adhere to any one single philosophical platform. In fact, Lustig notes that Beauchamp and Childress come from very different theoretical standpoints, yet converge their opinions on a vast range of issues (ibid., 494).

Numerous feminist theorists have also criticized the moral framework advanced by Beauchamp and Childress, and the terrain of autonomy grounding their work. Two of the major criticisms have been that liberal conceptions of autonomy are overly individualistic and that "the ideal of personhood, implicit in much of the autonomy literature, [is] both unrealistic and pernicious" (Sherwin 1992, 137-138). As an alternative account of autonomy, feminist theorists have offered a relational approach that situates the individual in their broader social context, and takes into account the

impairment of autonomy through oppressive relations. Responding to their feminist critics, Beauchamp and Childress claim that their platform of autonomy is neither overly individualistic nor exceedingly concerned with reason or legal issues (Beauchamp and Childress 2001, 57). Beauchamp and Childress claim they "support calls for overturning oppressive socialization and relationships, and note that they [feminist theorists] promote relational autonomy and do not reject autonomy altogether" (Beauchamp and Childress 2001, 61). They thus contend that their framework is compatible with relational approaches, and is therefore immune to feminist critique. This rebuttal is dismissive and unconvincing as it "disregards the main thrust of the feminist critique" (Donchin 2001, 366).

Ells examines the debate between feminists and Beauchamp and Childress, and argues that while the latter are not without positive rejoinders, ultimately, "fundamental inaccuracies about the nature of people and moral problems underlying B&C's conception of autonomy render their theory morally unacceptable. ... [and attempting] to widen the focus to amend the theory's shortcomings is to destroy the theory" (Ells 2001, 419). While carefully noting that her framework is not free of its own ideological commitments, Ells targets not only the logical implications of Beauchamp and Childress' theory, but the ideology upon which is it based. Drawing from the work of Cheshire Calhoun, Ells contends that we must examine the reciprocal effects that history and theory have on one another (Ells 2001, 424).

Through valorizing the principle of autonomy, a narrow and "lopsided" vision is created, perpetuating the tendency to discount other solutions. Moreover, "we come to believe that people are as our theories describe them. Our own experiences of ourselves as otherwise are either not attended to or attended to as abnormal and

flawed" (Ells 2001, 424). The autonomous individual becomes one of stable mind and fixed body. Susan Wendell eloquently challenges this ideal and argues that:

> The realization that 'autonomy' and 'independence' are unattainable goals for some people, even when they are defined in ways that take some kinds of disability into account, calls in to question the value of these in any scheme of virtues and moral goals. Should a society have ethical ideals that are universally applied but which some people are precluded from because they have certain kinds of bodies? (Wendell 1996, 149).

In their continued reliance on a narrow ideology of autonomy and independence, and silence on a broader range of moral issues and human traits, Beauchamp and Childress reinforce an atomistic and isolated individualism (Ells 2001, 425).

Donchin contends that psychological and material dangers may also be incurred as a result of the individualizing tendencies of prevailing standards of autonomy. In maintaining a front of independence, individuals may deny the fulfilment of their most important needs, leading to "repression of one's own dependencies, disavowal of interdependencies, and disparagement of those whose physical and emotional labours are needed to sustain the illusion of independence" (Donchin 2001, 375). The latter of these is witnessed in the devaluation of caring work in western society. While physicians and specialists are afforded a great deal of prestige, nurses, midwives and other health care workers are relegated to the middle or lower rungs of the hierarchy of medical authority. In terms of material dangers, once again we are confronted with the issue of conflicts between individualistic formulations of autonomy and the principle of justice. The ill are often made dependent on social resources for their survival and are thus considered burdens to the system, perpetuating the equation of productiveness with autonomy (Donchin 2001, 375).

Similar to the exclusionary workings of individualistic ideologies, Beauchamp and

Childress' overemphasis on the role of rationality and impartiality obscures other facets

of human experience.

> For instance, beliefs that rationality (1) distinguishes humans from other
> animals, (2) makes people responsible, and (3) is unaccompanied by
> emotion, incline us to forget or ignore that (1) there are other important
> features of human life aside from rationality, (2) responsibility is
> sometimes shared and includes factors other than rationality, and (3) our
> emotional experience attends all our experience and sometimes an
> emotional response is appropriate (Ells 2001, 425).

With regards to impartiality, it is often assumed that when arbitration is

necessary, involving an impartial mediator is the best approach. This is not always the

case. For example, if a comatose person is not able to consent to treatment, some

argue that it should be someone close to the person who should make decisions

regarding the course of care. They, rather than a stranger to the patient, are more apt to

choose actions in accordance with the values and beliefs of the individual. Moreover, a

continued emphasis on the notion of impartiality reinforces the concept of an idealistic,

objective positioning from which to make judgements, moral or otherwise (Ells 2001,

426). This approach is problematic in two respects. First, it reinforces the purported

objectivity of science and medicine, negating the socio-political structures they are

embedded in, and a product of. Second, ideologies of impartiality obscure the broader

web of relations informing patients' decisions. In the complex arena of health care

ethics, this highlights the need for an approach that moves beyond abstract

individualism, emphasizes interdependence, and accounts for a wider range of moral

problems and human characteristics.

Conclusion

This exploratory chapter does not offer a comprehensive or conclusive account of the intricacies of Beauchamp and Childress' approach to principlism and autonomy. Nor does the brief examination of the debates surrounding principlism cover the complexities involved in the multitude of discussions in bioethical journals and texts. While some - such as Clouser and Gert - deem principlism to be logically incoherent, others such as Ells and Donchin focus their criticisms at specific principles within the system, criticisms that extend into the very ideologies upon which the theory itself is based. Briefly introduced in this chapter, and examined in more detail in the next, many feminists assert the need for a critical examination of the unacknowledged assumptions influencing mainstream conceptions of autonomy. In doing so, they offer an alternative configuration positing autonomy as relationally derived. Thus, my intention has been to provide the necessary background information relevant in clarifying the arguments to follow; more specifically, that relational approaches to autonomy and informed choice exhibit a greater form of moral excellence, both theoretically and practically, compared to mainstream conceptions of autonomy and informed consent.

CHAPTER THREE

RELATIONAL AUTONOMY:
A FEMINIST THEORETICAL APPROACH

"What have I to say about freedom of the self? ... *all* the components of
the philosophy of the self in the West have ... had a liberating effect ...
but ... this philosophy was undermined by ... unforeseeable, repressive
aspects having to do with phallocentric and colonial patterns of speech ...
Might it not be necessary to do two things at once: to emphasize both the
permanent value of the philosophy of rights, and, simultaneously, the
inadequacy, the limits of the breakthrough it represented?"

(Helene Cixous, cited in Code 2000, 181, italics in original).

Feminism and Autonomy: A Love-Hate Relationship

Over the years, feminists have presented a multitude of perspectives and

approaches in advancing their respective theories, critiques, and reconfigurations of the

notion of autonomy. As with mainstream theorists, there is no univocal, definitive

approach. In the 1970s many feminists viewed the concept of autonomy as liberating

and only criticized its traditional association with the list of inherently masculine traits.

By the 1980s other feminists deconstructed standard formulations of autonomy as

isolating and atomistic (Friedman 1997, 40). "Thus, the predominant tendency for

feminist philosophers writing about autonomy in the 1980s and early 1990s was both to

criticize mainstream theories of autonomy for their male-oriented neglect of interpersonal

relationships and to propose the development of an alternative, relational concept" (ibid.,

47). Interest in a relational approach to autonomy continues to flourish, witnessed in its diverse applications in such fields as feminist legal and bioethical theory.

Feminist critiques of liberal notions of autonomy can be categorized into four general criticisms (Friedman 1997, 41-42). First, many argue that it is overly individualistic and negates or downplays the role of social relations in the development of autonomy skills. Given women's traditional association with "nurturance and relationality", individualistic autonomy positions women's lives on the peripheries of ideal forms of independence and self-governance (ibid., 42). Chodorow (1978) and Gilligan (1982) have greatly influenced this line of discussion (Friedman 1997, 43). Chodorow contends that, as children, we are all subject to a gendered socialization process. Girls are raised to be like their caregivers, their mothers. The later process of separation and individuation is therefore not as extreme for girls as it is for boys. While girls retain more of their relational identities, boys undergo a greater degree of differentiation (Friedman 1997, 43). Similarly, Gilligan examined the gendered differences in moral development and asserts that women are more likely to adhere to an ethic of care, stressing one's relationships rather than strict autonomy. Thus in emphasising the "masculine" independent nature of the autonomous individual, traditional approaches foster and perpetuate an attitude of competitiveness and conflict with others. Adopting an individualistic approach to autonomy, therefore, cannot account for the manner in which we come to understand ourselves nor can it fully accommodate the presence of influential relations, whether familial, socio-political, or institutional.

Second, postmodern arguments have targeted the notion of the cohesive and stable self presupposed in traditional conceptions of autonomy. Code argues that "twentieth-century psychological, linguistic-philosophical, and historical-material evidence radically unsettles the ideal of unified, self-determining subjectivity" (Code

2000, 182). In its assumption of contractual forms of relations between unchanging equals, liberal autonomy, in its pure, ideal form, overshadows the destabilized and fluid subject.

A third criticism is that traditional accounts of autonomy assume that the self is transparent and accessible to the individual. Psychoanalytic theories argue that this is not the case and "self-knowledge can never be a matter of easy or immediate introspection. This is partly because aspects of oneself may be disavowed, sometimes unconsciously, and partly because the 'meaning' of the deliverances of introspection is always dependent on an interpretation" (Grimshaw 1988, 103). Genuine self-mastery and determination are therefore largely unattainable ideals.

Finally, others argue that traditional autonomy presupposes and valorises a disembodied and exceedingly rational individual. This point is of great significance for feminists since, historically, women have been associated with the body and emotions. With regards to bioethics in particular, Diprose argues that there has been the contradictory tendency to forget the body. "It is assumed that biomedical ethics regulates, not so much relations between bodies (discursive and human), but relations between self-present, autonomous, disembodied individuals" (Diprose 1994, 1). Yet illness and other changes in one's body, such as those accompanying pregnancy, often correlate with a distinctly altered sense of self (Diprose 1994, 104; Young 1990). "Because they deal on a very concrete level with illness and pain, medical practices are imbued with the capacity to alter profoundly self-conceptions by transforming bodies and identities" (Casper and Berg 1995, 401). Maintaining a form of mind-body dualism not only obscures the significance of embodied experience, but also, as suggested by Foucault, the manner in which our subjectivities are inscribed through the disciplinary practices of the medical world (Diprose 1994, 21).

These critiques are only several of many. While presented as distinct and separate arguments, within any one theorist's approach there may be a great deal of overlap. There are no neat lines defining the plethora of stances taken. What is clear, however, is that individualistic theories of autonomy are problematic on a number of symbolic and socio-political levels.

Sherwin and The Politics of Autonomy

In her approach to relational autonomy, Susan Sherwin addresses the political issues surrounding individualistic theories. Her work is particularly salient to the project at hand as she does so within a framework of feminist health care ethics. In assuming an overtly political stance, her work functions as a lens through which to view issues of oppression and inequality in the health care context. She is explicit that her use of the term *relational* moves beyond the realm of one's individual relationships, to include relations that operate in the broader social and political sphere (Sherwin 1998, 19). As she states:

> ... I prefer to politicize the understanding of the term *relational* as a way of emphasizing the political dimensions of the multiple relationships that structure the individual's selfhood, rather than to reserve the term to protect a sphere of purely private relationships that may appear to be free of political influence (ibid., 19, italics in original).

As with Cixous, Sherwin is "doing two things at once". On the one hand, she identifies the inherent value of the notion of autonomy and the essential role it plays in terms of health care practice. On the other hand, Sherwin regards individualistic approaches as deeply flawed and she denounces the manner in which they serve to promote and sustain oppressive social relations. Her approach thus aims to alleviate some of the core issues presented in traditional notions of autonomy without abandoning the principle of respect for patient autonomy altogether.

Sherwin argues that the principle of autonomy is often maintained at an elevated moral status such that it is presented in conflict with the other principles (Sherwin 1998, 25). For example, the principle of justice is often viewed as potentially infringing upon individual freedom and autonomous action. Given the atomistic tendencies of classical notions of autonomy, a prevailing sense of conflict is perpetuated, when "in fact, autonomy language is often used to hide the workings of privilege and to mask the barriers of oppression" (Sherwin 1998, 25). Individuals are seen as self-created, free from the workings of the social and political institutions that structure their daily existence. An over-emphasis on individual motivation obscures the role that oppression plays in the lives of those who experience it. Success or failure becomes directly correlated with one's capacity and willingness for self-determination; the "Just World" myth is perpetuated. Visions of the structures supporting and enhancing the privileged status of a select few are blurred. "In camouflaging the nefarious instrumental purposes served by steadfast adherence to ostensibly fair principles and the nature of peoples' emotional investment in the status quo, the 'high ground' of moral scruples becomes an unassailable refuge for the beneficiaries of social stratification and elitism" (Meyers 2000, 161-162).

In contrast, relational approaches expose the influential role that social and political factors play in the development of the capacity for self-governance. If justice "is defined in terms of its opposition to oppression" then it is no longer viewed as diametrically opposed to the principle of autonomy (Sherwin 1992, 82; Sherwin 1998, 25). Some debate remains, however, about the boundaries between our intersectional identities and our personal autonomy. "...A little reflection on everyday life reveals that autonomy *sometimes* results in the *severing* of relational ties – that it does sometimes disconnect us from others, including those who are closely related to us" (Friedman

1997, 55, italics in original). It is therefore essential that different *types* of relationships, and the contingency of them, be recognized (ibid., 56). Relationships may vary over time, and in any given relationship one party may benefit more than another. Furthermore, while some relationships aid in furthering an individual's autonomy, others prove detrimental.

The Relational Self

At the root of the concept of autonomy is a plethora of philosophical quandaries concerning the nature of the Self (Sherwin 1998, 35). Is there a transcendental authentic Self? If we are all socially constructed, can the authentic Self be resurrected in the light of postmodern subjectivities? If not, then what? Given the infusion of autonomy theories with presuppositions concerning the elusive Self, any reconfiguration of classical approaches must also begin with rendering explicit its perception of the Self. Mainstream theories of individualistic autonomy presuppose a self that is stable, independent, and transparent, yet "curiously, despite its focus on individuals, standard interpretations of autonomy have tended to think of selves as generic rather than distinctive beings" (Sherwin 1998, 35). Characterized as generic, interchangeable equals, the uniqueness of the individual is disavowed. In adopting a relational approach, an alternative to the faceless self must be offered. Relational accounts accommodate the specifics of the individual and highlight the manner in which we are all socially embedded and, to a great extent, constructed by these social forces. The self is not static. It is not a predetermined given. It is ever changing and involves an ongoing process influenced by the life experiences of the individual. Likewise, autonomy is not a given, but a range of skills developed or stunted through the socialization process (Sherwin 1998, 36).

Meyers offers an in-depth analysis of the nature of an autonomous and authentic, yet relational self, and Sherwin explicitly draws upon Meyers' approach and implements it in her own work (Sherwin 1998, 34). Meyers proposes a procedural form of autonomy and a set of concomitant competency skills. All individuals are socially situated and inscribed by their relationships, yet Meyers insists that this does not entail abandoning the quest for the authentic self. As many philosophical discussions on constructivist theories have left me pondering the nature of my own existence, I believe that Meyers' approach offers a hopeful and visionary perspective from which to confront deeply existential quandaries. She proposes:

> ... that we redirect our attention – away from the internal structure of the authentic self and toward the process of constituting an authentic self. Thus, I recommend viewing the authentic self as the collocation of attributes that emerges as an individual exercises self-discovery and self-definition skills (Meyers 2000, 154).

The autonomous, authentic self is thus a work in progress. Autonomy is hindered by restrictive social relations, and also in our failure to recognize the intersectional (relational) nature of our identities. Meyers understands that we all belong to a number of groups, some of which are privileged and others marginalized. These are not closed spheres and this multiple positioning is crucial in the movement towards developing one's autonomy skills. "To have an intersectional identity is to belong to a number of groups and not to belong wholly to any. Thus, groups members can use their experience of alienation to gain critical insights into the norms and values of different social groups" (Meyers 2000,163). The tensions created between an individual's positioning in a variety of spheres, coupled with an explicit awareness of that multiple standing, fosters the potential for increased self-awareness (Meyers 2000, 164). Yet given the common discourse surrounding the self and autonomy in the West, many do not even recognize the intersectional process that constitutes the development of their

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identity. Lacking such knowledge of the self undercuts one's authenticity and autonomy competency. Thus, Meyers challenges the purely individualistic account of autonomy and the authentic self as a metaphysical, transcendental given. In their place, she offers a procedural form of autonomy and an intersectional self, both viewed as evolving processes based on the development of a repertoire of skills and furthered enhanced by their employment. Self-discovery, definition, and direction are all necessary characteristics of the autonomous individual (Meyers 1989, 80). Thus, autonomy competency includes:

- ❖ the capacity for self-reflection and introspection,

- ❖ the ability to imagine possible scenarios of a given outcome and to conceive of alternative options,

- ❖ memory of past experiences of the self and others from which to draw insight,

- ❖ communication skills,

- ❖ the ability to engage in analytic exercises,

- ❖ volition – "resistance and resolve" - to see choices to their end, and

- ❖ interpersonal skills (Meyers 2000, 166; see also Meyers 1989, 76-97).

Politics of Oppression

Arguably, those living with oppressive forces face greater obstacles in the development of autonomy skills and the opportunity to exercise them has been more limited. When confronted again with interactions fraught with power dynamics, the ability to successfully assert one's beliefs or opinions may present a troubling impasse. The development of self-trust is an essential component of autonomous decision-making

(McLeod and Sherwin 2000). For those whose selfhood has been continually undermined, in overt or subtle ways, acquiescing to another's suggestions may appear to be the only option. This is not to imply that people in very oppressive circumstances are devoid of all forms of intentional action, as "the targets of oppression seldom experience themselves solely as victims. They often defy others' bigotry by valuing their association with the group that others systematically penalize and by upholding its traditions" (Meyers 2000, 154-155).

Other theorists adopt a platform of standpoint epistemology and conclude that marginalized groups are in a better position to recognize and combat the injustices of social stratification. bell hooks suggests that marginality offers a position from which to radically critique and resist the forces which structure a system of oppression (Bar On 1993, 87). While recognizing the value of the situated knowledge of marginalized groups, it is essential to not romanticize this positioning (Sherwin 1998, 38). For many socially marginalized people, the struggles encountered in daily existence may prevent them from engaging in any form of concerted, deliberate activism. While perhaps not having a lot to lose by challenging the status quo, individuals may rightly feel that losing what little they have would be dire. Bar On reasons that:

> Although the empowerment of its own members is an important goal for every marginalized social group, by claiming an authority based in epistemic privilege the group reinscribes the values and practices used to socially marginalize it by excluding its voice, silencing it and commanding its obedience to the voice of the dominant group (Bar On 1993, 97).

She holds that the right to have one's voice heard is a matter of justice and not one of epistemic reverence (ibid., 97). Thus, when engaging in anti-oppression politics, it is essential that stereotypical images voiding marginalized groups of competency are not produced, yet at the same time one must not diminish the obstacles presented in a socially stratified system. One must further refrain from representing individuals of

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marginalized groups as a monolithic culture. Identities, autonomy, and power relations are all subject to the ebbs and flows of relations that constitute them.

There are thus numerous complexities when engaging in an analysis of the relationship between self-governance and oppression. In fact, Sherwin reasons that a preliminary distinction must be made between agency and autonomy. Agency is associated with reasonable decisions (Sherwin 1998, 32). For example, a pregnant woman who is in an abusive relationship and chooses to have an abortion to avoid further involvement with her partner, can be said to be exercising agency. Her decision is a rational one. If the woman is competent, informed, and free of coercion, her decision conforms to traditional standards of autonomy (Sherwin 1998, 33). Nevertheless, given the oppressive nature of her particular relationship, Sherwin maintains that this decision falls short of being fully autonomous. It is insufficient to base standards of autonomy solely on specifics of interactions between the health care professional and the patient. Respecting patient autonomy to its fullest extent is to reach beyond the informed consent process and actively engage in highlighting and dismantling oppressive forces that structure the lives of many. It involves developing requisite autonomy skills and encouraging autonomous actions in those denied the opportunity to previously do so.

Sherwin's Analysis and the Principle of Respect for Patient Autonomy

Sherwin carefully parses out the positive and negative aspects of the principle of respect for patient autonomy. A return to traditional, paternalistic practice is out of the question and thus the maintenance of such a principle is necessary in the movement towards patient-centred care. Yet in facilitating such a movement, the standard

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formulation of the principle will not suffice. In fairness, the principle is invaluable in terms of the emphasis it places on informed consent and the protection it offers to patients and research subjects. Integrating a relational approach to autonomy thus does not entail entirely dismissing the principle, but rather a reworking of how it is theoretically conceived and implemented in practice.

In her analysis of the shortcomings of the informed consent process, Sherwin examines four criteria of autonomous decision making: 1) competency, 2) reasonable choice from the set of options provided, 3) disclosure of relevant information, and 4) freedom from coercion. Although classified somewhat differently than the grouping of determinants outlined by Beauchamp and Childress (Beauchamp and Childress 2001, 80), their respective categories are nevertheless closely aligned. Thus, Sherwin's critique of these four elements holds sway with respect to the process as proposed by Beauchamp and Childress. Sherwin challenges the framework in that "it is assumed that these criteria can be evaluated in any particular case, simply by looking at the state of the patient and her deliberations in isolation from the social conditions that structure her options" (Sherwin 1998, 26). While on the surface these conditional elements may appear benign, if issues of oppression and discrimination are ignored, these very four criteria, meant to protect the rights of the patient, may serve to undermine rights and reinforce damaging stereotypes and oppressive positioning of the disadvantaged.

The competency criterion has drawn a great deal of scrutiny, especially within feminist circles. Competency is often directly correlated with the ability to make rational decisions, wherein emotions and rationality are seen as mutually exclusive properties. Beauchamp and Childress declare that "in health care, the problem is to distinguish emotional responses from cognitive responses and to determine which are likely to be evoked" (Beauchamp and Childress 2001, 94-95). While this must be taken into consideration in the process of risk disclosure, the propensity of this overarching

dichotomy to shear women and other disadvantaged groups of any claims to rationality must be recognized. If competency is denied to marginalized groups based on stereotypical beliefs, the inclination may be to revert to paternalistic practices rather than engage in the development of the individual's autonomy skills. Sherwin adds that "it is hard to see ... how ... important life decisions are improved if they are made without any emotional attachment to the outcome" (Sherwin 1998, 46 n.12). Thus, in any situation where standards of rationality are imposed, one must ask who is setting the standards and whose purposes are thereby being served (Sherwin 1992, 141). Health care providers must remain aware of preconceived notions they hold of disadvantaged groups and the manner in which such stereotypes can influence and direct their judgements regarding an individual's competency (Sherwin 1998, 26).

Sherwin points out that the very set of options from which people have to choose may itself be problematic. Options that the individual would have optimally desired may not be available due to previous policy decision-making or resource shortages. Certain constraints will be imposed on all individuals with regard to available options, given financial and practical considerations. Sherwin insists, however, that socially marginalized groups, by definition, are more likely to be disadvantaged by existing institutional policies (Sherwin 1998, 27). Decision-makers are often of a privileged status and the voices of the oppressed are seldom heard within the boardrooms where policy is determined. Briggs and Mantini-Briggs cite "differences in the distribution of medical services and the way individuals are treated based on their race, class, gender, or sexuality as *medical profiling*" (Briggs and Mantini-Briggs 200, 10 italics in original). Thus, options may exist which are simply not offered due to physician bias. It is therefore essential that one carefully examine both the theoretical basis underpinning current standards of rationality, and recognize that the set of available options may be constructed in a way such that it *a priori* limits the possibility of autonomous choice.

The process of informed consent requires that patients are provided with relevant information on known risks and benefits of a given course of treatment. As argued by Beauchamp and Childress, different approaches exist in the determination of adequate information disclosure (2001, 81-83). Morally, the optimal approach is to tailor the discussion to the individual and their personal beliefs, values, and needs. Strict reliance on this approach is problematic for two reasons. First, Beauchamp and Childress contend that patients are often unaware of the kind of information they need or want, and second, the professional cannot precisely determine the information needs of each individual (ibid., 83). Given the indeterminacy of this approach, they reason that it cannot provide a solid foundation for the development of ethical theory or medical policy. Sherwin takes a different approach to information disclosure and once again highlights the political nature of the dynamics involved in the process. She offers her criticism on two levels. First, as with the predetermined set of options, the information available is often circumscribed by decisions and regulations implemented prior to the individual's encounter with the medical professional: "Again, research, publication, and education policies largely determine what sorts of data are collected and, significantly, what questions are neglected; systemic bias unquestionably influences these policies" (Sherwin 1998, 27). Second, she asserts that the power differentials embedded in the physician-patient relationship infringe on the professional's capacity for determining the information needs of the patient, especially of those from marginalized groups. This power differential may also constrain the patient's sense of validity in any questions they may have. Moreover, health care providers often lack communication skills to effectively engage with patients on such a level of discourse (Sherwin 1998, 24).

The issue of effective communication is further complicated in a culturally diverse society where health care providers meet with people from a variety of backgrounds and mother tongues.

> The way in which an individual interprets or understands their disorders will depend, not upon individual whim or fancy, but significantly upon the classifications of illness which are available within a culture and by reference to general cultural values concerning appropriate behaviour (Turner 1995, 209).

Language barriers often impose misunderstandings, and cultural differences may invoke varied symbolic meanings associated with the decisions at hand. This is vividly illustrated in Rapp's analysis of genetic testing counselling where "local metaphors of pregnancy, birth, and parenthood do not necessarily translate easily into the realm of medical discourse" (Rapp 1988, 147). What is deemed a syndrome in North America may not be so easily defined when it is not recognized as such within other cultures, highlighting how the "truth" of biomedicine is not necessarily recognized as such by everyone. In *Testing the Woman, Testing the Fetus,* Rapp quotes a genetic counsellor who asks:

> How do we convey a chromosome risk when a low-income pregnant Afro-Puerto Rican woman experiences a 100 percent chance of running out of food stamps this month, a 25 percent risk of having one son or brother die in street violence, and an 80 percent chance of getting evicted by the end of the year? A one-in-180 chance of having a child with a chromosome abnormality at age 35 is probably the best odds she's facing (quoted in Rapp 2000, 69).

To facilitate culturally sensitive care, whether it be through in-house education, affirmative hiring practices, or the use of translators, health professionals must develop a heightened awareness of the diversity of their patients' backgrounds.

Finally, Sherwin tackles the difficulties associated with determining whether or not an individual is indeed making a decision free from coercion. She argues that this can be especially difficult and "the task becomes even trickier if the choice is in a sphere that is tied to her oppression" (Sherwin 1998, 27). Sherwin lifts the issue of coercion beyond the immediate physician-patient relationship and the particular decision at hand to include broader socio-political factors that may inhibit the individual's sense of choice

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and freedom. For example, she targets cosmetic surgery and issues in reproduction and childbirth. Other avenues of possibility must be explored, securing "options that will not further entrench their existing oppression ... " (Sherwin 1998, 38). Often socialized to place their self-worth in their beauty and capacity for motherhood, many women may not feel they have a real choice regarding the options available to them (Sherwin 1998, 28). A failure to recognize this denies the potential for true self-governance. Diprose criticizes Sherwin's approach to these issues on two specific levels. She contends that:

> ... in attempting to minimise medico-patriarchal control over women's reproductive lives, [Sherwin] assumes there exists choices about reproduction which are freely made and uncontaminated by patriarchal discourse; she assumes atomised individualism. Connected to this, and perhaps more disturbing, is that in claiming that specific instances of reproductive practices constitute a general pattern of attitudes which undermine the social position of women (1989: 65), she risks blaming women who participate in these practices for the social subordination of women in general (Diprose 1994, 16).

Diprose raises some relevant issues in her criticism and these merit further discussion. Does Sherwin indeed revert to the very framework that she is attempting to correct and render women complicit in their own oppression? Certainly, Sherwin envisions a space where women will experience greater freedom of choice, freer of patriarchal influence. This does not imply that she invokes a utopic idealism of sorts. A choice free from oppressive forces does not necessitate the reinstatement of atomistic individualism any more than one that is coerced. Autonomous individuals and their decisions, pried free from oppressive influences, are no less situated. They are, however, repositioned in circumstances apt to aid in the development of their competencies and in which to better exercise such skills.

Diprose's second criticism concerning Sherwin's alleged implication of some women's collaboration in patriarchal oppression may not be so resolvable. Seemingly, there is a tension created with regard to the issue of false consciousness and the

ramifications of one person's decisions on society as a whole. From one outlook, Sherwin argues that women's decisions to engage in practices involving cosmetic surgery or new reproductive technologies need not imply a false consciousness on their part as, indeed, their decisions may be rational given the conditions of their lives (Sherwin 1998, 33). In drawing attention to the socio-cultural influences that may be directing an individual's decisions, however, the importance of broadening the scope of autonomy and the determinants of its presence is stressed.

From another outlook, Sherwin asserts that "because the autonomy of some may well be affected by the choices of others, we need to recognize the interpersonal implications of current practices on the autonomy of future patients" (Sherwin 1998, 43). The importance of examining our actions and choices within the broader social context is thus exemplified. We must not only question how that context influences our decisions, but how our decisions may subsequently influence the context itself. It is a reciprocal relationship. It is about justice. Thus, the issue is not of laying blame, but moreso of accepting responsibility. This distinction may of course present a slippery slope, and therefore Diprose's criticisms are valid and must be taken into careful consideration. Even so, it is important to recognize the manner in which cultural beliefs and medical practices become naturalized or taken as common sense givens. Power differentials are not stable, fixed entities unto themselves. They are an evolving dialectic. "As patients, women demand as well as comply; when sufficient numbers make similar demands, they may well affect the course of medical practice" (Sherwin 1998, 41). As will be explored in the next chapter, the shift from home to hospital-based childbirth and the pervasiveness of obstetrical and reproductive technologies are prime examples of the social process of normalization.

Building on Foucauldian theory, Sherwin maintains that the rhetoric of choice may be co-opted to further the naturalization of certain procedures, subsequently reinforcing the disciplinary power asserted within the medical field (Sherwin 1998, 28).

> Unless we find a way of identifying a deeper sense of autonomy than that associated with the expression of individual preference in selecting among a limited set of options, we run the risk of struggling to protect not patient autonomy but the very mechanisms that insure compliant medical consumers ... (Sherwin 1998, 29).

This point draws attention to the manner in which choices are constructed and constrained. It also calls into question the ontological possibility of a genuine expression of freedom of choice. The view from nowhere does not exist and likewise, the decision from nowhere is illusory. While in some respects this may seem to consign us to a postmodern quagmire of unravelled certainties, this need not be the case. Rather, it is about raising awareness. "Clearly, contemporary bioethicists cannot afford to play with the bombs of relativism, let alone postmodernism, anymore" (Tong 2002, 427). To move forward, it is essential that health care professionals and patients together recognize these external influences and how they structure the available options and the decisions made regarding them. One must also question the role that bioethics itself has played in perpetuating this underhanded form of paternalism. It speaks for the need to re-examine how mainstream ethical theory has influenced health care practice and the role it plays in fostering the disciplinary power and very structure of hierarchical authority within the medical institution.

Mainstream bioethicists continue to emphasis individual rights within a micro-level frame of reference. The focus remains on specifics of the physician-patient relationship. McGrath challenges this form of mainstream bioethics and contends that it offers only a "band-aid" approach to the issues surrounding patient autonomy. Certainly, some protection is afforded by the principle of respect for patient autonomy but "the

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solutions to dilemmas are explored from within the very discourses (professionalism and biomedicine) that created the problems in the first place" (McGrath 1998, 523). Furthermore, in their adherence to a platform of individualism, traditional bioethicists reflect the dominant approach in public health policy. The emphasis is placed on the individual to assume responsibility for their health and well-being. "Don't smoke. Eat low-fat, low-cholesterol foods. Watch your alcohol consumption". The list goes on and on.

Tesh argues that this nexus of individualism and blameworthiness allows for health policy makers to adopt the least politically disruptive course of action (Tesh 1988). It places the obligation on the individual more so than targeting the social, political and environmental factors that contribute to the health conditions of a given population. In accordance with the 'Self-Other' dichotomy, upheld by theories of individualistic autonomy, epidemiological risk categories likewise structure oppositions of 'normal' and 'abnormal' across the wider population (Peterson and Lupton 1996, 55). "In a parallel fashion, autonomy-focused bioethics concentrates its practitioner's attention on the preferences of particular patients, and it is, thereby, complicit in the individualistic orientation of medicine" (Sherwin 1998, 31). Despite attempting to hold medical professionals accountable for their actions, individualistic bioethicists may maintain the status quo. This form of individualism may render patients increasingly marginalized and vulnerable as they come to view themselves as blameworthy for their conditions and experience their decision-making as an isolated process (Sherwin 1998, 31).

In confronting the isolating and obscuring tendencies of individualistic approaches to autonomy, the need for a theory that recognizes the roles of power and authority in social relations is made explicit. Sherwin argues that feminist relational approaches respond to this calling. Adhering to the principle of respect for patient autonomy, such an approach moves beyond individualism to critically analyse the

widespread implications of oppression and inequality. Relational approaches thus integrate an deliberate positioning of the individual whose health care decisions are in question. In the process of facilitating informed decision making, it is essential that the individual be recognized as precisely that: an individual. In doing so, the specificity of their lived experience and social context becomes central to the health care relationship. For those facing oppressive conditions, be they based on issues of race, class, gender, (dis)ability, sexual orientation, or a combination of such elements, the process of making an autonomous decision may not be as straightforward as it initially appears to the health care provider.

In the majority of situations, the supposed egalitarian relationship between health professionals and patients is absent or vestigial. As physicians are afforded a highly valued and prestigious positioning within Western society, it is most often the case that those under their care are coming from a less secure and privileged space (Sherwin 1998, 22). "A principle insisting on protection of patient autonomy can be an important corrective to such overwhelming power imbalances" (ibid., 22). If this principle, however, is based on the assumption of a contractual relationship between equals, the power differentials existent in the physician-patient relationship are obscured. In not acknowledging the broader web of social relations, other confounding factors are marginalized to the periphery of the decision-making process. Thus, while the movement away from overt paternalism has furthered the development of patient-directed care and offered increased protection in vulnerable circumstances, the process of informed consent, as it stands, does not respect patient autonomy to its fullest extent (Sherwin 1998, 24).

Beyond the Journal and into the Clinic:
Integrating a Relational Approach in the Health Care Context

The implementation of a relational approach is fraught with numerous considerations that are not easily tackled. In the complex process of facilitating informed consent, it is essential that health care providers become familiar with the specificity of their patients' lives, values and beliefs. In some instances, this entails spending more time fostering the development of clients' autonomy skills (Sherwin 1998, 42). The need for this is often sacrificed, given time and funding constraints. Nevertheless, Dodds emphasizes the importance of broadening the scope of those relational approaches that continue to conflate autonomy with rational decision-making. Respecting nuances of autonomy involves holding the medical field accountable for its great potential to enhance individuals' autonomy skills (Dodds 2000). She insists that if respect for patient autonomy remains strictly focused on the "front end" of health care - in terms of facilitating informed choice - it fails "to explain the importance of providing support for people in coming to terms with their altered circumstances as part of the protection and respect for autonomy" (ibid., 231). She does recognize logistical quandaries in attempting to fully integrate such an approach. More research is needed that engages in questions pertaining to the delegation of responsibility for the promotion of individuals' competency; how, and if, such an expanded vision of autonomy could be integrated into the existing system; and "the familiar issue of the importance of autonomy promotion, protection, and respect relative to other ethical considerations and legitimate demands on resources" (Dodds 2000, 232). Beauchamp and Childress correctly maintain that physicians cannot be expected to engage with every patient on such an intensive level. What they did not ask, however, is how a more comprehensive form of care could be integrated. Failing to address how this issue could be resolved reflects their continued

adherence to the medical model as it stands. This omission lends further credence to the argument that while they claim that relational approaches are compatible with their theory, Beauchamp and Childress do not fully examine the implications of social relations for their account of autonomy (Ells 2001). It is insufficient to acknowledge feminist critiques and then move on, failing to recognize that relational critiques have a much deeper and dismantling effect on their ethical framework. Thus, while Dodds offers no conclusive arguments regarding the full integration of relational approaches to health care, her willingness to raise the questions is valuable. Such questions are essential if bioethical theories are to move beyond the journal and into the clinic. Numerous medical anthropologists and sociologists have questioned the utility of bioethical theory distanced from realities of medical practice and the relationships constructed within the health care context (Kleinman 1999; Marshall 1992). Feminist philosophers have likewise called for increased collaborative and interdisciplinary research. "Empirical information about exactly how sexism and power imbalances are manifested challenges our theories" (Holmes 1989, 7). A feminist relational approach to bioethics is a step towards this. In recognizing the multitude of potential influences and relationships in the development of autonomy, the social and political is brought to the fore.

In the next chapter, the midwifery model of care and the process of informed choice will be examined. Midwifery's unique philosophy offers a perspective from which to view the merits of integrating a relational approach to autonomy within the health care context. Not only does such an approach have profound implications on the care giver-client relationship, but also on how the mother-fetus relationship itself is perceived. In presenting material derived from midwifery journals, and publications of women's birth narratives, the potential for practical application of relational theory will be examined.

CHAPTER FOUR

RELATIONAL AUTONOMY APPLIED:
INFORMED CHOICE AND
THE MIDWIFERY MODEL OF CARE

The relational aspects of midwifery become central to the entire caregiving experience. While knowledge and skills are important to safe and appropriate care, it is within the context of a deep commitment to the woman that the midwife performs these competencies. The moral impulse of the midwife is focused on the woman. The concerns of significant 'others' such as partners and family are part of the woman's 'story,' yet the woman remains central. ... Women express a confidence in themselves that comes from knowing their midwife well and feeling that their midwife knows and respects them.

(James 1997, 183).

In Canada, we are currently witnessing the resurgence of midwifery practice as a viable form of maternal care. Across the country, provinces are implementing legislation regarding the professional status of midwives. The history of midwifery is fraught with numerous tensions and continues to be confronted with many issues. There are ongoing debates whether regulation has led to increased accessibility and improved the status of women's reproductive autonomy and birthing options. While much of this debate lies beyond the scope of this project, it is imperative that these tensions be recognized for the impact they have on the face of maternal care. Given the ways integration into the health care system is changing the face of midwifery, emphasising the benefits of its approach to care is an important task. What makes midwifery so special is a question whose answers must be held in the forefront of care as midwives make their journey through the integration process.

> Making one's philosophy explicit gives substance to commitment, guides thinking about actions, and influences resulting decisions. Wiedenbach, [a nurse theorist and Certified Nurse-Midwife], advocated explicit articulation of one's philosophy to facilitate close examination of beliefs and values and to allow exploration of the degree to which they are reflected in attitude and action (VandeVusse 1997, 43).

Certainly, contemporary midwifery emerged out of, and still adheres to, a deeply-rooted philosophical commitment to pregnancy and birth as natural and profound experiences. Nonetheless, potential co-optation and medicalization of midwifery practice, increased distancing between the midwife and client, and further augmentation of a governing hierarchy, collectively linger as a threatening presence. This is not to deny that midwifery, like any other profession, will not be subject to a natural evolutionary process as it moves forward. Its underpinning philosophy must be embodied in practice if the spirit of midwifery is to be maintained. The intention here is not to impose a dichotomy of good versus bad midwifery. As an exceptional model of care seeking to promote to its professional status, however, the articulation of a moral foundation that promotes women's reproductive autonomy is essential.

Midwives are uniquely positioned in that the women they deal with are often 'low-risk'. Thus, while there may be a great deal of overlap with standard bioethical theory and practice, midwifery further requires its own moral framework aligned with its philosophy of care, distinct goals, and the women and families midwives care for (Frith 1996, 1-7). To this end, the goal of this chapter is to highlight one facet of this model: the process of informed choice and the concept of autonomy that supports it. Autonomy lies at the heart of bioethical theory and therefore, in the development of an ethics of midwifery care, adopting this as a starting point provides a solid foundation from which to build upon. While this may seem to valorise the principle of autonomy, I will argue that the manner in which autonomy is supported within the midwifery model of care does not necessarily position it so that it supersedes the value of other moral principles.

Midwifery in Canada

The historical analysis of midwifery in Canada itself has been subject to historical shifts. Early feminist historians posited that the decline of midwifery was a direct result of the medical profession actively wresting childbirth from the hands of women, while physician historians emphasized the benefits that the medicine had to offer and the role women themselves played in the transition to hospital-based births (Mitchinson 2002, 69-70). More recently, other accounts take into consideration other influential factors, and thus move the discussion beyond the physician versus midwife dichotomy. Together, they offer a more comprehensive approach accounting for the nuances at play in the erosion of midwifery care in Canada.

By the end of the nineteenth century the role of midwives as birth attendants had sharply decreased in Canada and their popularity among the public was waning. "Nevertheless, pockets of them still worked within immigrant communities, in isolated areas, in maternity homes on the prairies, and among the poor and First Nations" (Mitchinson 2002, 70). While midwives in Newfoundland continued to practice within the mainstream well into the first half of the twentieth century, the situation in Ontario was very different. In the classic article "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795-1900", Biggs argues that the rise of the medical profession as an autonomous body had great implications for the practice of female midwives (Biggs 1983).[4]

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[4]In a recent article, Biggs reflects on her previous work regarding the "missing midwives" and notes "the *absence* of the stories of different groups of women" (Biggs 2004, 18 italics in original). Broadening her perspective, she argues that "... many models of midwifery have existed in both pre- and post-Confederation Canada, and their demise was intimately tied to particular configurations of professional interests, race, colonialism, class, industrial development, and regional politics. Thus no singular history of midwifery exists but rather many" (Biggs 2004, 19). While the image of the community midwife has played an important role in the development and defining of the new midwifery, it is essential that this icon does not overshadow the historical diversity of midwifery in Canada (Biggs 2004, 22).

While some doctors supported midwifery services for rural settings, public and professional support of midwifery declined once the medical profession was more established. Biggs maintains that the rise of obstetrics was essentially based on the medical profession's ability to undermine the status of midwifery, while simultaneously redefining pregnancy and childbirth as a medical event. Three primary means of "undermining and redefining" were at play (Biggs 1983, 21-35). First, through the establishment of various legislative acts, the practice of midwifery became illegal without a license. Second, newspapers and journals often presented midwives as dirty, dangerous, and reckless, thus undermining their credibility as "healers". Moreover, in their alliance with the elite, upper classes, the medical profession reinforced their standing as a privileged and superior form of care. Finally, laying claims to scientific rationalism, and associated techniques and instruments, such as the forceps and anaesthesia, obstetricians were able to redefine both the process and management of birth.

The erosion of midwifery was not due strictly to its opposition by the medical profession. Connor, in response to Biggs' analysis of the "missing midwives", insists that there were varied opinions among physicians regarding the practice of midwifery and while legislation changed several times throughout the century, midwives were generally able to practice with impunity. Moving beyond the "physician versus midwife" dichotomy, Connor points to several other influential factors. For example, not established as a formal profession or organization with standard training programs, the practice of midwifery was not passed on to younger generations (Connor 1994, 122). Furthermore, while the use of forceps and anaesthetics is often seen as motivated by physicians' desire to eradicate midwives, Connor asserts that in Ontario this was not necessarily the case, as both resources were used sparingly and with great caution (ibid., 122-125).

Expectant women also played an active role as they sought out the pain relief offered by physician attended, hospital-based births, and "thus any 'redefinition' process of childbirth was not wholly a physician- dominated act nor was it designed to eradicate midwives" (Connor 1994, 125). While Connor's historical account is useful in that it does take other contributing factors into account, it has been subject to criticism. Dodd and Gorham reason that:

> Once the [medical] profession had established the need for an exclusive and scientifically based education as a prerequisite for practicing medicine, and had established dominance over obstetrical technologies, it could assert authority over fields formerly dominated by women without openly attacking individual women practitioners (Dodd and Gorham 1994, 6).

Indeed, by the 1950s medical professionals had assumed almost full responsibility for the attendance of childbirth. In 1926, 17.8 percent of women in Canada gave birth in hospitals; by 1950, 76 percent did so (Mitchinson 2002, 175).

The counterculture and women's movement of the 1970s witnessed a renewed interest in midwifery care. Increased dissatisfaction with medical intervention, coupled with the saddening "realization that Canada was the only industrialized member of the World Health Organization that did not have professional midwives widened interest in midwifery ... [contributed] to a political environment primed for consideration of change" (Rooks 1997, 423). The homebirth movement was a result of this calling. Women choosing to birth at home did so in attempts to restore pregnancy and childbirth to the emotional and social elements stripped away by institutionalised care (Kaufman 1998, 997). Similar to their predecessors, midwives were often friends of the birthing woman. Yet given that choosing a home-birth was often politically motivated, there were distinct differences to the manner in which midwifery was practiced in the past (Kaufman 1998, 997). Generally, the midwives were well-educated, formed study groups, and accessed

current information on obstetrical practice. Some had formal training, and others learned

through self-study and apprenticeship (Kaufman 1998, 997). They were childbirth

activists. As their clientele grew, so did organizations lobbying for official recognition of

midwifery. Today, across the country, numerous provinces have implemented formal

legislation regarding the professional status of midwives (see Table One below).

Table 1 - Midwifery Legislation in Canada

Province	Legislated	Funded	Fee for Service	Home/Hospital/Birth Centre
Alberta	Yes	No	Yes	Home/Hospital/Birth Centre
British Columbia	Yes	Yes	No	Home/Hospital
Manitoba	Yes	Yes	No	Home/Hospital
Newfoundland and Labrador	No	No	No	Hospital (remote areas only)
New Brunswick	No	No	No	Home
Northwest Territories	No	No	Yes	Home
Nova Scotia	No	No	Yes	Home
Nunavut	Partially (One pilot project in 2002)	Partially	No	Birth Centre (only in Rankin Inlet)
Ontario	Yes	Yes	No	Home/Hospital
Prince Edward Island	No	No	Yes	Home
Quebec	Yes	Yes	No	Birth Centre
Saskatchewan	Yes	No	Yes	Home
Yukon	No	No	Yes	Home

Source: Hawkins and Knox, 2003.

In its transition from a social movement to a recognized profession, however,

midwifery is once again undergoing distinct changes. Integration into the medical

system has brought to midwifery external paradigms that serve to both facilitate and

restrict practice (Sharpe 2001). The implementation of regulatory policy and governing colleges has meant an increasing amount of bureaucratisation and attendant paper work. Negotiated requirements concerning documentation and record keeping now direct interactions with clients and frame the exchange in a defined manner (Sharpe 2001). More paperwork also entails a busier schedule and potentially less time to devote to each client. Having gained hospital privileges, midwives are now bound to protocols and policies to which the needs and wishes of the client may become secondary (Bourgeault 2000, 191). Thus, while regulation has increased occupational autonomy on a collective level, it may have subsequently decreased the autonomy of the individual midwife (Westfall 2002, 52).

Midwives are also encountering a new client base, previously foreign to midwifery practice. "Many midwives in the new midwifery in Ontario ... lament that women may now choose midwifery care without knowing anything about midwifery as a social movement or about the clinical practices that arose from midwifery's organized challenge to the biomedicalization of pregnancy" (MacDonald 2001, 264). The new midwifery is not merely a product of imposed policies and texts (Sharpe 2001), but also influenced by the manner in which clients negotiate between the boundaries of the midwifery and medical domain; central to this are the ways in which clients understand and apply the tenet of informed choice (MacDonald 2001). MacDonald argues that emphasizing the primacy of informed choice in the midwifery model of care highlights women's agency in their decisions to engage with medical technology (MacDonald 2001, 248). Such negotiations, however construed, are contentious for many who feel that this blurring of boundaries is detrimental to midwifery care as a distinct alternative to contemporary, pathologizing models of birth.

Some have challenged the regulation of midwifery and its integration into the health care system for its marginalizing effects on unregulated birth attendants. For those attending births outside of the system, their continued practice faces the perils of litigation. Such is the case with Gloria Lemay, who in 2002, "was found guilty of criminal contempt of court for practicing midwifery in spite of a court injunction that had been in place since 2000"; the charges were brought against her by the College of Midwives of British Columbia (Westfall 2002, 51). She was sentenced to five months in jail.

A growing number of women believe that the modern midwife is less of an ally in the pursuit of a non-invasive, self-directed approach to pregnancy and childbirth (Westfall 2002, 54). Others point to the increased distancing, and shifting power dynamics, between the midwife and her clients. Bourgeault contends that in midst of 1970s, "the terms 'caregiver' and 'client' may not [have been as] appropriate in describing the roles of each, as a far more egalitarian, friendship-oriented relationship existed than these terms connote" (Bourgeault 2000, 178). Some opponents of regulation contend that the registered midwife is more correctly termed a "med-wife". In August 2002, *The Vancouver Province* ran an article entitled, "Unassisted birth: No midwife, no hospital ... no safety net?" attesting to the small underground movement of those choosing to birth without assistance. While the numbers are minimal, they may be on the rise if regulated midwives are forced into urban centres where the necessary hospital support is available.

While these changes may seem to paint a bleak picture of the new midwifery, it is essential that they be tempered with the challenges of the past. Through examining the practices of "granny" midwives in Labrador and Newfoundland, Benoit asserts that theories condemning the professionalization of traditional female occupations tend to form a romanticized picture of historical lay midwifery (Benoit 1989). While the

regulation has indeed led to a substantial change in midwifery practice, the ostensibly

independent practicing granny midwives also lacked autonomy on a number of levels.

As community midwives, the grannies generally received little, if any, remuneration for

their services. Often they had to travel long distances to women's homes, only to find

them unequipped for the birth. The grannies also lacked the ability to schedule work

leaves or exchange information with other midwives. The fact must not be overlooked

that regulation has led to an increased level of professional recognition, protection, and

support. Greater accessibility and spheres of operation, including government

sanctioned homebirth, and improved stability and compensation for their services are

also benefits of legislation. Through the tenacity and determination of many women,

midwifery established itself as a self-governing profession, and thus despite post-

regulation negotiations and shifting relations, the midwifery model of care, as a whole,

has endured (Bourgeault 2000, 191).

Philosophy of Birth

Physicians, nurses, midwives, and other health care workers are increasingly

offering collaborative care, and as a result, differences between the midwifery and

medical models of care may not be as readily manifest as in the years prior to regulation

(Rooks 1999, 370). Indeed, as previously discussed, it is for this reason that many have

critiqued the integration of midwives into the health care system at large. Thus, in

highlighting the more distinct facets of care, it is essential once again to reinforce that

these are ideals. There is a great deal of variation amongst midwives and physicians

alike, and therefore all differences are relative (Rooks 1999, 370). The intention is not to

present either of the professions as monolithic cultures, but rather to highlight the distinct

philosophies and beliefs supporting their *conceptual* frameworks of pregnancy and birth.

Likewise, in examining the midwifery tenet of informed choice, in light of the preceding

discussion surrounding informed consent, we are dealing with models subject to variation. In offering this comparison, the aim is to illustrate a continuum of choice and demonstrate how the integration of a relational approach to maternal care enhances and empowers the expectant woman.

Physicians attend to a broad base of women, both low and high risk. As experts in pathology, they are more likely to focus on potential complications or risk factors. Certainly many women encounter serious health issues associated with pregnancy and therefore one cannot reasonably deny the utility of such care. The development of new diagnostic procedures, however, has led to an increasingly narrow range of what is considered normal in pregnancy and childbirth (Rooks 1999, 371). The woman and fetus are often regarded as two distinct patients, with the interests of one pitted against those of the other. Consequently, the fetus requires an advocate, someone to ward off any potential adverse effects. Under the medical model, this advocate is the physician. "This representation of maternal/fetal relations discounts the fetus' actual dependence on the pregnant woman even for its biological survival, nullifies her own agency, and redefines the agendas of obstetricians and researchers" (Donchin 2001, 371). Reasonably, one cannot argue that physicians do not recognize the importance of pregnancy and childbirth in women's lives, but actively engaging on this level with women is often deemed beyond the scope of their practice. Reducing the totality of the woman's life to its biological dimensions often renders the woman passive in the sense that the embodied experience is obscured: "... These expectations ... of patient passivity are so routinely a part of hospital life that this dynamic is rarely questioned" (McGrath 1998, 521).

While the principle of informed consent is operative within the medical model, the physician is more likely to assume the role of primary decision maker regarding the

woman's course of care. Concern with the particularities of individuals' lives is confined to securing the necessary information for the proper facilitation of the informed consent process (Donchin 2001, 372). This approach maintains respect for autonomy at the "front end" of care. The notion of a woman's autonomy beyond the delivery room is not of major concern. In fairness, medical professionals cannot be held accountable for the entirety of their patients' lives. At the same time, it highlights how the notion of autonomy generally adopted within the medical model is an individualistic one.

The midwifery model, in contrast, offers a more comprehensive, holistic approach to maternal care. The midwifery model of care recognizes the process of pregnancy and childbirth as potentially profound psychological, social, and spiritual events in a woman's life:

> Pregnancy results in a *mother* as well as a baby. It is important that the woman's transition into motherhood is a positive experience, that she and all members of her family make emotionally healthy adjustments to each pregnancy and birth, and that she has the means to acquire the necessary information, skills, support, and self-confidence needed to successfully assume the roles and responsibilities of motherhood (Rooks 1999, 373, italics in original).

The woman and fetus are seen as inextricably linked; attending to the psycho-social needs of the woman benefits the two of them. Moving beyond a biomedical perspective enhances the autonomy of women during pregnancy, childbirth and their lives as new mothers. "The argument for midwifery is not set against the appropriate use of technology in obstetrics, but against an overshadowing of midwifery skills – and, not least of all, women's ability to give birth – by an ideology of 'machine-minding'"(Burtch 1994, 225). With its broadened perspective of the magnitude of the birthing experience, midwifery care guides women into motherhood through a process of self-empowerment. The birth of a child is a new beginning and endowing women with a sense of self-trust

and strength is essential in fostering not only health babies, but also healthy women and families.

Trusting the Woman

The development of a reciprocal form of trust within the midwife-client relationship is paramount. It is not only essential that the woman trust her midwife, but that the midwife trusts the woman to know what is best for herself. Indeed, this may present difficulties within the relationship and simply allowing the woman to make decisions that the midwife does not agree with can be challenging and even create overt conflict. This is perhaps more of an issue now than in the past as midwives are meeting with a broader range of clients in this era of legislation and professional regulation. Many women are coming to midwives simply for the sake of having a midwife, rather than out of political, spiritual or philosophical motivations. As such, midwives encounter some women with perspectives that differ widely from the midwifery philosophy of a non-interventionist approach to pregnancy and childbirth. Indeed, this not only affects the caring relationship midwives have with their clients, but transforms midwives' daily practice as they are increasingly confronting "negotiations with medical technology" (MacDonald 2001). Conflicts of interest can and will arise in any form of health care relationship, whether it be with a midwife or general practitioner. Trusting the client to know her body and what she needs is essential. Thorstensen argues that there are times when meeting a woman's desires are more important than adhering to a strictly non-interventionist approach: "For some women, this may be the first time they have received any measure of trust and respect, which may be far more important in moving towards increased self- respect than negotiating the labor without pain medication" (Thorstensen 2000, 406). Reading into this statement, we can see that at the heart of this matter is fostering a woman's sense of autonomy in the broader sense. It is not

about this choice or that choice, but about the experience itself and the woman's life as a whole. Given the reciprocity of trust in the midwife-client relationship, should any complications arise which necessitate overriding a woman's wishes for her own safety "the client knows that the restrictions are truly necessary and not just a convenience, a convention or a caregiver's own preference" (Hawkins and Knox 2003, 7). While such restrictions may remain a point of contention between the midwife and client, generally the woman can trust that were other options available, the midwife would have presented them

When evaluating the outcomes of midwifery care, it is essential that both the short- and long-term effects be examined (Kennedy et al. 2004, 19). In terms of its immediate effects, the importance of developing a trusting relationship and shared knowledge base may be illustrated by the following example. A midwife is attending a stalled labour and asks the woman what is standing in the way of her birthing the baby (Kennedy et al. 2004, 18). The woman reveals that her mother wants to visit right after the baby is born, yet the woman wishes a week to herself before her mother's visit. The midwife encourages the woman to call her mother. The woman does so and returns to quickly have the baby. The midwife admits that the physical activity also likely helped the labour progress; however, some important issues are raised by this example. First, the midwife actively encouraged the woman to assume control and responsibility for her life beyond the delivery room. Second,

> ...the midwife ... had clinically observed a stalled labor, but also knew the answer for its protraction may lie with the woman. This is a different position from the objective 'clinical gaze' of modern medicine described by Foucault. This application of shared knowledge and engagement may be a key in understanding how midwives achieve positive outcomes (Kennedy et al. 2004, 20-21).

Similarly, the potential long-term effects of the midwife-client relationship are mirrored in the words of one midwife, describing her care for one woman over many births:

> When given the opportunity at every moment, she engaged sharing ... it affirmed to her that someone was listening ... . That had not been her previous experience in her births prior to the fourth baby. So while I was learning from her in a unique way over those years, she was gaining more and more empowerment about her right as a woman to be heard, and that was beginning to carry over into other aspects of her children's health care with pediatricians and emergency room visits ... I think she was learning through the relationship that we had over time that not only was it her right, but she should demand to be listened to and [she] was becoming a very strong woman (quoted in Kennedy et al. 2004, 20).

This story, while perhaps exceptional, vividly illustrates the nature of the relationship developed between midwives and their clients. First, actively engaging with the woman, the midwife fosters the woman's sense of autonomy that subsequently flows into other aspects of her life. Second, this example demonstrates the reciprocal nature of the midwife-client dyad; not only does the woman learn from the midwife, but the midwife herself learns from the woman. Honouring the knowledge that women bring to the relationship is indicative of the minimized power differential embedded within the midwifery model of care.

Informed Choice

While the medical model of informed consent purportedly maintains and respects the autonomy of the patient, it may retain more of its paternalistic predecessor than its adherents would wish to admit. The process of informed consent is not simple, nor perhaps, as innocuous as one would think. Even if disclosure is facilitated and the patient understands the associated risks and benefits, it potentially maintains the patient as a "passive recipient". Although "informed consent ... is a considerable evolution on the historical paternalistic standard of care," (Valerio 2001, 71) it still does not fully

attend to the power differential present in the physician-patient relationship. Despite the mutual exchange of information, the notion of choice may remain rhetorical or nominal.

Informed consent suggests that there is a pre-determined set of options from which to choose and it is presented as the right to relevant information, and the right to opt out. "In order that women should be given a free choice in such matters they should be allowed to *opt for* testing rather than having to *opt out* of what is an established procedure" (Towler and Fairbain 1998, 103 italics added). In withholding consent, the patient is often seen as acting contrarily to medical advice and deemed non-compliant (Towler and Fairbain 1998, 92). Draper asserts that this form of reasoning is nonsensical; when a patient consents to a procedure they are deemed competent, so their judgement in refusing consent should likewise be considered valid (Draper 1996, 27). Moreover, "the absence of explicit coercion at the time of making a decision does not make that choice free" (Dodds 2000, 224). Viewed in this light, informed consent is not necessarily a process that is easily defined or attained. Autonomy, as portrayed and defended under the platform of informed consent, does not account for the greater network of social, political, and familial relations at play (Dodds 2000, 217). The manner in which the physician-patient relationship itself may affect the woman's sense of autonomy is similarly obscured. Faced with an institutional setting where her opinions are often seen as emotionally founded, and therefore irrational or unqualified, a woman's competency is often questioned. A dilemma is created as how best to approach the issue. Does one accept the constraints of informed consent or deny its platform and risk being judged incompetent? (Dodds 2000, 218). Despite criticisms of the informed consent process and the notion of autonomy that supports it, standard allopathic care has seemed slow to move in an alternative direction.

The midwifery model of care, in contrast, offers a unique and practical approach to the decision-making process: a process that responds and attends to many of the issues surrounding the standard practice of informed consent. A central tenet of the midwifery model of care is the notion of informed *choice*. As with comparisons between the medical and midwifery models themselves, the distinctions between informed consent and informed choice are at times quite subtle, and at others more pronounced (Valerio 2001, 71). "Understanding locations of power in decision making and distinguishing informed choice from informed consent provides a context for defining and outlining the process of informed choice" (Valerio 2001, 72). It is similar to the process of informed consent in that a mutual exchange of information is facilitated. Informed choice, however, is more reflective of an ideal approach to autonomous decision-making as the choices rest primarily in the hands of the client. Implementing *choice* as the operative term highlights the possibility of the patient presenting potential options as well as emphasising a fuller range of self-directive action: the right to consent *or* refuse treatment options (Sherwin 1998, 46 n.9). "Informed choice is an inherently politicized notion, given the centrality of choice as an organizing concept and goal of the broader women's health movement (of which midwifery is a part)" (MacDonald 2001, 254). While certain regulatory policies may place restrictions on some options, such as who is eligible for homebirth, generally, the pregnant woman is situated as the primary decision-maker and the process of informed choice aims to actively empower and engage her throughout the process.

Shannon Valerio outlines three essential components of informed choice: (1) Autonomy, (2) Responsibility, and (3) Accountability. *Autonomy*, as within the informed consent framework, is the right to self-determination. Nevertheless, as defined and manifested within midwifery philosophy, autonomy is recognized in all its complexities.

In Beauchamp and Childress' terms, this would signify a *subjective standard* of disclosure (Beauchamp and Childress 2001, 83). It involves more than the mere provision of a risk and benefit analysis. Within the process of disclosure, "effective communication entails providing accurate, objective, relevant and culturally appropriate information that considers each individual client's situation, including values, goals and beliefs" (Valerio 2001, 72). In providing culturally sensitive care, the midwife must subject herself to critical self-examination of ideologies and stereotypes she holds aboutother cultures. She must inform herself of culturally specific knowledge, and actively engage with clients for greater understanding of how these beliefs and values play out in the lives of individual women (Campbell and Campbell 1996, 457). Midwives recognize the constraints external influences may have on the client's autonomy and how even the desire to "please the midwife" may come into play (Valerio 2001, 73).

Responsibility is a shared component of the informed choice process. It requires that both the midwife and the client actively participate in the process of informed choice and in the facilitation of full disclosure. This may entail mediation or resolution of differences of opinion between the two. A fortified relationship of trust between the midwife and the client, as previously discussed, is thus an essential element of this mutual responsibility. The midwife and woman must both maintain a reasonable level of commitment to the evolving process of disclosure and informed choice as further concerns or changes arise.

The third element, *accountability,* "refers to how the client and midwife must acknowledge that informed choice has occurred" (Valerio 2001, 73). While legally it is the midwife who is held professionally accountable, recognizing this as a shared duty emphasizes the client's position as the primary decision-maker. It encourages the woman to assume responsibility for her plan of care. The process of informed choice

should be well documented, including what precisely has been disclosed on the part of the midwife, as well as questions raised by the client (Valerio 2001, 74). Recording questions allows the midwife to later confer with the woman regarding earlier concerns she may have voiced. This ensures that the woman has indeed understood the issues under question and may also serve to reinforce a sense that her concerns are valid. Kennedy et al. argue that on the part of the midwife this also entails "accountability to reflect, to continue to learn, to change when needed, and to revolutionize systems to improve care for women" (Kennedy et al. 2004, 19). In this sense, the responsibility of the midwife is not only to respect and enhance the autonomy of her individual clients, but also to engage in furthering her own knowledge, and the movement towards women-centred care.

Maintaining awareness of the complexities of informed choice is another facet of accountability; choices arrived at are subject to periodic re-evaluation. This emphasizes the women's right to withdraw consent at any point. Likewise, the College of Midwives of British Columbia's Code of Ethics states that, so long as the client is not in labour, a midwife may withdraw should she feel in unable to provide further care. However, in doing so, the midwife must make attempts to secure alternate care for the client. Moreover, "implied consent, or general consent, such as the client broadly consenting to any and all actions, is not acceptable" (Valerio 2001, 74). This alleviates many concerns regarding the restrictive and potentially coercive nature of informed consent. Women who have not had the opportunity to develop or exercise their autonomy skills are thus encouraged to do so and empowered to actively participate in preparing a plan of care.

These three components are reflected in a verbatim excerpt from The College of Midwives of British Columbia's Philosophy of Care:

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❖ Midwifery is holistic by nature, combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of a woman's reproductive health experience.

❖ Midwifery promotes decision making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. Midwives recognize women as primary decision makers.

❖ Midwifery actively encourages informed choice throughout the childbearing cycle by providing complete, relevant, objective information to facilitate decision making. The practice of midwifery enables women to develop the skills and motivation necessary to take responsibility for and control their own health.

These tenets highlight the commitment midwives have towards their clients in promoting informed choice. Care is individualized. The philosophy of midwifery aims to enhance women's autonomy competency and offer them the setting to exercise such decision-making skills. The woman is respected within the wider cultural and social context of her life. Pregnancy itself is not static, but a continually evolving state. It is not exclusively a biological process, but involves a social and psychological evolution. In their appreciation of the significance of motherhood for many women, midwives honour the multiple dimensions of the lived, embodied experience.

The promotion of informed choice is enhanced on many levels throughout the midwifery approach. "Practicing midwives and student midwives have the privilege and challenge of having informed choice woven into the very fabric of the model of midwifery care" (Valerio 2001, 74). The length of time spent with each client, and the protection of birth as a normal process are the warp and weft of this fabric. Midwives spend a great deal of time developing a relationship with pregnant women during the course of their care. A pilot study conducted in Quebec in 1990, comparing women's experiences with midwives to those under the care of physicians, found that "the mean number of prenatal visits was similar for the two groups (11.4 midwifery visits and 10.8 physician visits), but

the average length of the first visit (78 minutes versus 33 minutes) and especially of the subsequent ones (66 minutes versus 19 minutes) was notably different" (De Koninck et al. 2001, 63). This time-intensive approach allows both the midwife and the woman to develop a greater understanding of one another and fosters an atmosphere of openness that is essential for full disclosure. It also lends the woman considerable time to voice her beliefs and values, and to raise any questions or concerns she may have without feeling rushed. While the amount of time devoted is intensive, and restricts midwives in terms of the number of women they are able to attend at any given time, it simultaneously, and more importantly, allows the space to offer a comprehensive and holistic form of care. Within the week following the birth, midwives generally make two home visits. At two weeks postpartum and six weeks later, subsequent meetings are arranged either at the woman's home or midwife's office (Rooks 1997, 272). This continuity of care, central to the midwifery model, honours the birth of a child as the beginning of a series of life adjustments and a multitude of decisions that will need to be made. In this respect, the notion of expanding the continuum of autonomy beyond the front end of informed choice is essential.

"Risky Business": Side Effects and Moral Judgements

Despite significant advances in medical procedures and knowledge, pregnancy is still considered a risky business. The labelling of women as either high or low risk now dominates much of the discourse surrounding standard prenatal care (Saxell 2000, 87). The rise of new diagnostic technologies has precipitated a redefining of the dangers associated with pregnancy. Through such measures as ultrasound and amniocentesis testing, medical attention has shifted from risks to the expectant woman to those of the fetus (Queniart 1992, 161). Likewise, there is an increasing preoccupation with medical issues that may arise as a result of present risk factors. The

manner in which health care professionals present such risk factors to those under their care can be deeply influential in the decision-making process and raises the dilemma once again of how subtle forms of coercion may come into play. When risks such as the potential for amniocentesis testing to cause a miscarriage are presented as possible "side effects", a moral judgement is imposed. The test or procedure itself, whether it is amniocentesis, ultrasound, or caesarean, is seen as the central good. If informed decision-making is based on autonomy and non-coercive guidance, then special attention must be given to the process of risk disclosure.

Examining facets of risk presentation and perception offers yet another point of differentiation between the midwifery model of care and that of the biomedical field. Within the midwifery model of care, risk-scoring systems and their attendant labels are subject to great scrutiny. "Most risk factors, even if they are strongly associated with outcomes in populations, do not predict adverse outcomes very well for individuals" (Murphy cited in Saxell 2000, 88). The dangers associated with generalizing parturient care are emphasized. It has therefore been "recommended that clinical judgements be used in determining treatment for individual women, risk tools only being a useful adjunct" (Saxell 2000, 89). The purpose of risk-scoring systems is thus to aid, not govern, the development of a plan of care. The limited utility of the screening process should be disclosed to expectant women, thereby easing any undue stress or anxiety created by such labels.

Caregivers must pay heed to women's perceptions of risk and risk discourse. "Even though notions of risk are presented as well defined by the medical profession, differing cultural, and moral beliefs result in conflicting perceptions" (Saxell 2000, 91). The social implications that such knowledge may have for a woman need be considered

(Donchin 2001, 372). The words of one woman capture the influential and potentially coercive impact a high-risk label can have on the decision-making process:

> I think it kind of leads people to believe that they need more help and they can't help themselves as much. It takes some of the control out of decision making because you've already been labelled something ... and you have to leave it up to your so-called experts to decide. And if they want to they'll let you help in the decision making, but because they're experts they'll have the final word. That's what the term does to women who are labelled high risk. It takes their power and control away (cited in Saxell 2000, 97).

Perhaps the real risk, then, defined by such screening systems, is the risk of rendering women increasingly vulnerable to the directives of another. As attested to by Donchin, "a slide into more dependent modes of relationship may have less to do with psychological needs inherent in the illness experience than with the institutionalized setting, especially if it intensifies inequalities between patient and staff" (Donchin 2001, 376). Yet physicians often present risk information in such a way that arouses women's fears thereby ensuring patient compliance (Saxell 2000,91). "In many instances, the distinction between risk factors and actual pathology has been lost, and women with 'high-risk factors' are treated as though they have actual complications" (Rooks 1999, 371). These anxieties perpetuate the "doctor knows best" ideology and diminish the sense of competency many women feel in terms of personally guiding their plan of care (Sherwin 1992, 139).

In contrast, within midwifery practice there is no appealing to, or obsession with, women's fears. "Rather than protecting a woman from her fears, they emphasize the importance of giving her the opportunity to deal with them" (Kennedy et al. 2004, 21). In the words of one midwife:

> ...when people said, 'I can't do it,' instead of saying, 'Yes you can,' and sort of being confrontational with them, which I think initially I thought was an empowering thing to do ... I found [myself] saying, 'OK' – just accepting that ... not trying to talk them out of what they are feeling about

something, but just validating that their feelings are valid ... they usually come around to grappling with it and moving ahead ... (Kennedy et al. 2004, 18).

Remaining aware of potential complications, midwives pay strict attention to detail. "This process of supporting normalcy could aptly be described as the art of doing 'nothing' well" (Kennedy 2000, 12). The midwife thus remains on guard for the presentation of risk elements in a hands-off, non-interventionist manner. "The *possibility* of complications is not allowed to preempt all other values associated with women's experience of bearing and giving birth to a child" (Rooks 1999, 370 italics added). Midwifery philosophy valorises and protects pregnancy and birth as normal, non-pathological processes in a woman's life. In doing so, it may serve to alleviate some of women's concerns and subsequently offer them a broader sense of choice.

As the diversity of fetal risks is flaunted recklessly in the mainstream media and medical discourse, the pregnant woman has come under increasing surveillance. Canadian law does not recognize the fetus as a legal person possessing rights, and thus, legally, a woman's right to autonomy and bodily integrity cannot be overridden on the basis of her pregnancy. However, given the medical model's propensity to view the fetus as an individual patient, the autonomy of pregnant women is often rendered secondary (see Duden 1993). This ultimately leads to a situation where the woman herself is often blamed for any problems associated with her pregnancy. Yet many risk-scoring systems do not account for social dynamics that may be influencing an individual woman's health (Saxell 2000, 89). Other contributing factors affecting maternal and fetal health, such as domestic violence, poverty, environmental pollution, and barriers to adequate prenatal care, are obscured. In focusing primarily on the individual physical factors of a woman's history, it reduces her pregnancy to its "biomedical dimensions", neglecting the social positioning, and psychological process, of the woman entering

motherhood (Queniart 1992, 171). The medicalization of pregnancy and childbirth negates the influence that the woman's life beyond the walls of the physician's office may hold on her overall health, values, beliefs and ultimate choice in care.

When choice is presented in such a constructed manner, and fears regarding risk are played upon, it demands a great deal of self-assurance and determination on the individual's part to exercise her assertiveness and control. The presence of self-trust is central to the development of autonomy and the facilitation of informed choice. It reinforces one's ability to make decisions (McLeod and Sherwin 2000, 262). For those faced with oppressive life circumstances, however, self-trust is often diminished and this greatly infringes upon one's sense of autonomy. Recognizing the relational nature of women's lives is therefore imperative. Midwifery philosophy incorporates such an approach, and through developing an atmosphere of trust allows women to feel more at ease in discussing what may be deeply personal and intimate matters. The importance of this can perhaps be best illustrated through the example of pregnant women in abusive relationships.

Domestic Violence and Pregnancy:
What You Don't Expect When You're Expecting

"For now, just sit back, relax, and enjoy the beginning of one of the most exciting and rewarding adventures of your life" (Murkoff et al. 2002, 106). So goes the romantic imagery of pregnancy painted by mass media and popular pregnancy guides. While indeed for the majority of women, it brings with it a sense of hope and wonder, "for many women ... pregnancy is not the hoped for pensive, reflective, nurturing time, but a time of increasing threats and abuse and a time of accelerating, more aggressive, more life-threatening domestic violence" (Hunt and Martin 2001, 112). According to the Violence Against Women Survey, conducted in 1993 by Statistics Canada, twenty-one percent of

women – approximately 560,000 - with a history of domestic abuse, reported that the violence persisted during their pregnancies (Health Canada 1999, vii). A further forty percent reported that the violence began during pregnancy (ibid., 3). Of these faceless numbers, approximately 100,000 suffered miscarriages or internal damage as a result (Health Canada 1999, 3). Abusers may exert their control in many forms throughout the childbearing cycle. During pregnancy, for example, they may deny women access to prenatal care, food, and emotional support. During labour itself, they may attempt to control decision-making surrounding interventions and pain relief (ibid., 4). The lives of these women are a far cry from the woman, illustrated on the cover of *What to Expect When You're Expecting,* nestled in her rocking chair, flipping through the pages of a pregnancy guide.

Why do women stay? The question itself is contentious as it may seemingly implicate the individual woman in her own abuse through her "failure" to extricate herself from a violent relationship. Yet it can also be asked with a genuine concern for the motivations behind choosing to do so (Friedman 2003, 143). A woman may stay in an abusive relationship for a number of reasons. Perhaps she feels powerless or that she is the one to blame for the violence, and believes that her partner will change if only she does not provoke the abuse. Financial resources, education and alternative means of support may not be available or she may be unsure how to access them. These concerns may persist for any woman in an abusive relationship and pregnancy certainly magnifies such matters.

The decision to continue a relationship with an abusive partner may be determined by other influential life factors. For example, leaving a violent relationship may be more difficult for recent immigrants. They may have been denied access to

language classes and therefore lack the necessary communication skills to negotiate the need for support and resources (Health Canada 1999, 8).

> Batterers of immigrant women almost always threaten that the abuse victim will be deported if she leaves the violent relationship. Deportation is an omnipresent threat to immigrant women, regardless of their immigration status, because of distrust of the government, ignorance of immigration law, and deception by abusers (Orloff 1996, 477).

Likewise, not disclosing the presence of an abusive relationship to her health care providers may be based on a number of factors. "… For the battered woman of color, domestic violence may be a relatively unimportant issue in comparison to a serious health problem or issues of economic survival" (Campbell and Campbell 1996, 459). As a minority woman, she may fear being further stigmatised by the clinician if she reveals the abuse (Campbell and Campbell 1996, 458). She may also be from a culture where legally a man's word is taken as truth, and she fears she will not be believed (Orloff 1996, 478).

Similarly, women living in rural or physically isolated areas face numerous issues in attempts to seek help or leave an abusive situation. The "don't talk" rule of many small rural communities silences many (Adler 1996, 463). Anonymity is a rare commodity in isolated communities and thus calls to the police, or crisis hotlines should they exist, may likely involve interacting with relations or friends of the abuser, ultimately infringing on "the old boys club" (ibid., 464). Adler contends that the pressure to remain in a couple is intensified in small towns, where single women "may be seen as a threat to the stability of other couples" (ibid., 464). As many rural communities have no shelters for abused women, women may encounter geographical barriers in accessing services and support, and thus leaving an abusive partner may mean leaving the community as a whole.

These examples illustrate how questioning women's motivations in residing in abusive relationships can indeed be the first step in exposing the socio-political structures that limit their sense of choice and freedom. We have also seen why many women do not voluntarily disclose a history of domestic violence to their health care providers. Another question must be asked if the estimate is correct that four to twenty percent of all pregnant women are assaulted (Health Canada 1999, vii): why do many clinicians fail to routinely screen for domestic violence? Personal experiences with domestic violence (or lack thereof) necessarily influence their ability or willingness to detect abuse. Professionals' stereotypes may likewise sway their clinical judgement. "Potent myths include a belief that battering only affects a small percentage of the population; occurs in certain ethnic, cultural, or age groups; happens only in 'problem' families; is usually associated with drugs and alcohol; and rarely occurs in pregnancy" (King and Ryan 1996, 437). The individualizing philosophy of the medical system, and lack of formal training all serve to further impede the identification of abusive relationships (Bell and Mosher 1998, 214 – 218). "The manifestations of abuse on the body, or the mind, lie within the medical gaze; a 'fractured arm' or 'depression,' for example, are the diagnoses made. But what is occluded is the social context: the abuse in women's lives, the cause of these injuries" (Bell and Mosher 1998, 216). When psychological and physical ailments are presented, and abuse goes unrecognised, the underlying issues are obscured and more applicable forms of care are overlooked, thus exposing the woman to further harm. It could reasonably be argued that the woman has duties as a patient to disclose all the relevant information in order to receive proper care and thus the onus cannot be placed entirely on the professional. However, given the emotional and psychological damage often precipitated by violence, one can empathize with the woman's situation.

A history of abuse often precludes a woman's capacity to envision the power to claim and control her life as her own (McLeod and Sherwin 2000, 272). Most certainly this will influence a woman's interactions with her health care providers. With a diminished sense of self-trust, respect, and worth, an abused woman may be more willing to acquiesce to the professional's suggestions. She may also be less likely to ask questions, even if presented with information she does not understand. Abuse will also likely affect how she feels about her body. She may be experiencing a great deal of concern and guilt about bringing a child into an abusive home. Yet, "paradoxically, pregnant women have a higher risk of experiencing violence during pregnancy than they do of experiencing such problems as pre-eclampsia, placenta previa or gestational diabetes – health concerns for which they are routinely screened" (Health Canada 1999, vii-viii). Failing to recognize the social context of this woman's life and the oppression she faces has dire consequences. "By allowing the patient to defer to the physician's judgement, the physician would be perpetuating her self-distrust and risking that the care the patient receives is inconsistent with whatever goals and values the patient has that are relevant to her choice" (McLeod 2002, 149). Thus, what may be considered a sign of trust in her health care provider may, in fact, be a sign of the woman's sense of the power differential embedded in this relationship (Campbell and Campbell 1996, 458). Midwifery attends to this issue in that general forms of consent are not acceptable and the woman is actively engaged, fostering a sense of self-governance within the broader sphere of her life. It is important that her autonomy skills be developed either in conjunction with the health care professional or a counsellor. Abuse does not preclude the ability to choose for oneself but can severely undermine the belief that one has the capacity to do so (McLeod 2002, 149). Interestingly, Lee Saxell cites:

> A survey in Canada of 125 family physicians found that while 90% believed that identifying psychosocial risk factors in pregnancy was 'very

important', the frequency of inquiry about these problems (abuse in the relationship, alcohol or drug use, etc.) was much lower. This is confirmed by two other studies estimating that 10% of women appear abused, while physicians identify only 1 in 10 of these (Saxell 2000, 90).

For many women, pregnancy is a time when they are more likely to come in regular contact with health care professionals and given this, the professional is in a situation to offer support. As many abused women's social ties have been severed or eroded as a result of a controlling partner, health care providers may be their only accessible help (Health Canada 1999, 15). Moreover "if the current trend in the government defunding of community services for abused women continues, it is reasonable to project that increasingly, women will turn to physicians for assistance since physicians may be the only resource available to them" (Bell and Mosher 1998, 211). Quite obviously there is a need to develop the requisite communication skills and support services to aid women living in such circumstances.

As abusive relationships often shroud women in guilt and shame, it is unlikely that they will voluntarily disclose the violent nature of their domestic lives. When health care providers routinely screen for violence, and directly ask rather than use written reports, women are more likely to disclose abusive relationships (Adler 1996, 465; Espinosa and Osborne 2002, 310). Failing to implement such practices reinforces the oppressive forces constraining the woman's life and right to self-determination. "For example, her choices around conception may be affected by: sexual coercion or control by her abuser, unwanted pregnancy (as a result of coercion), and becoming pregnant to try to stop the abuse" (Health Canada 1999, 2). An autonomous individual is one whose life and actions are based on choices that are free from overt control and coercion. Abuse not only endangers the woman's health, but directly undermines her capacity for self-determination. Health professionals must recognize the pervasiveness of abuse

during pregnancy, and routinely screen for violence in a manner that diminishes the

stigmatisation (King and Ryan 1996, 437).

While studies revealing the capacity of midwives for identifying the presence of

domestic violence are lacking, the model of care fosters an atmosphere of openness and

trust between the midwife and client.

> As experts in women's health whose particular expertise is in sexual and
> reproductive health, nurse-midwives have a unique relationship with
> women, acting both as competent health care providers and women-
> centered advocates. ... This pivotal position in the health care of women
> affords nurse-midwives the unique opportunity and responsibility to
> assess and intervene in the area of domestic abuse (King and Ryan
> 1996, 436).

Midwives must adopt a non-judgmental approach in screening for violence in order that

the woman does not feel further alienated (Hunt and Martin 2001, 23). Martin and Hunt

contend that the time-intensive nature of the midwife-client dyad may allow for the

development of a therapeutic relationship that "allows midwives the opportunity to ask

more difficult and more intimate questions" (Hunt and Martin 2001, 133). To avoid

further stigmatisation, it is recommended that midwives open discussions of domestic

violence with a statement emphasizing that they encounter many women who are in

abusive relationships and that their motivations in asking are not to target the individual

woman. In doing so, rather than pathologizing or individualizing the issue, domestic

violence is politicised.

The intention behind this illustration has been to highlight the importance of

integrating a relational approach to autonomy. Women's lives must be recognized in all

their complexities. Given the nature of the midwife-client relationship, an atmosphere of

trust and empowerment is developed. This then allows for greater disclosure on the part

of the client and lends to her sense of self-determination. The ability of midwives to

facilitate disclosure regarding domestic abuse remains inconclusive, and a woman may

still not reveal that she is being harmed despite the nature of the relationship with her midwife. Nonetheless, "childbirth is, or can be, if not skewed in its meaning by a medical reconstruction, a powerful self-affirming, and memorable event whose meaning is not isolated but resonates throughout all of the woman's subsequent experiences as a woman and as a mother" (Overall 1987, 106). A positive birth experience has been shown to enhance a woman's sense of self-esteem and emotional well-being (Harvey et al. 2002, 261), and women under the care of midwives consistently rate greater satisfaction with their experience than those of women under the care of a physician (Harvey et al. 2002; De Koninck et al. 2001). Perhaps midwifery, with its process of informed choice and the trust it places in the hands of the woman, may initiate the restoration of her sense of autonomy in all its complexities.

Conclusion

Relational autonomy demands that the social structures maintaining oppression be re-worked, that individuals be recognized within a broader matrix of social relations, and that the development of autonomy competency is fostered. It is not simply enough to advise individuals how they may negotiate within such structures. Placing the responsibility solely in the hands of the individual also places any blame for undesired outcomes on that same individual. Recognizing the social relations - including possible oppressive forces in women's lives - is the first step towards enhancing autonomy. "Health care by itself cannot, of course, correct all the evils of oppression ... However, [healthcare professionals] must understand the impact of oppression on relational autonomy and make what efforts they can to increase the autonomy of their patients and clients" (McLeod and Sherwin 2000, 276). The relationships one has with others can either foster or hinder a sense of self-trust. Health care providers must be aware of how those relationships impact a patient's autonomy. They must strive to personally form a

relationship with patients that further enhances their skills and power to actively engage in the decision-making process in a manner that is both personally meaningful and relevant.

The midwifery model of care, and its intersections with relational approach to autonomy thus resolves many of the issues raised within a model of informed consent. Midwives cater to the individual and her unique circumstances. They support the pregnant woman through her decision-making and simultaneously seek to empower her as she makes the transition to motherhood. Recognizing the relational nature of women's lives, midwives strive to be aware of the potentially oppressive and constraining forces, while highlighting the positive resources that may have emancipatory and empowering elements. Emphasizing the process of informed choice as a shared responsibility between the midwife and her client diminishes the power differentials within the relationship. "By making visible the ways in which autonomy is affected by social forces, especially oppression, relational autonomy challenges assumptions common to much of bioethical literature that autonomy be viewed as an achievement of individuals" (McLeod and Sherwin 2000, 260). Similarly, while midwives valorise a woman's right to guide her plan of care and recognize the individuality of the parturient experience as uniquely her own, they honour and respect her life as a mother, daughter, friend, and partner.

CHAPTER FIVE
MOVING TO WOMEN-CENTRED CARE

Choice and autonomy, while not to be conflated, are inextricably bound, and through the midwifery model of care, both are potentially maximized. Continuity of care, the process of informed choice, and the protection of birth as non-pathological, allow for a distinct alternative to that of the medical model. Shifting the notion of autonomy and respect for the individual away from an atomistic perspective, midwives recognize the broader narrative of women's lives. Women are respected, honoured, and empowered through the relationship as they move into motherhood. The importance of this cannot be stressed enough, and its potential to inform other health care practitioners is immense.

The midwifery and medical models are, at least conceptually, best viewed as complementary, rather than mutually exclusive entities (Rooks 1999, 370). "Both of these are valid and important; the extent to which one or the other should be given priority varies with different women" (Rooks 1999, 373). However, the relational approach embedded within the midwifery model of care may provide a guiding map in the movement towards a more holistic and comprehensive women-centred care. The process of informed choice, the care given in risk presentation, and centralizing the woman as the primary decision-maker all serve to facilitate self-directed choice. The manner in which midwifery enhances, promotes, and protects women's autonomy on an individual level is exceptional. It may thus serve as a model for other health practitioners for how they may, on an individual level, improve the caring relationship.

It has also been demonstrated that positive relationships, such as those between midwives and clients, promote autonomy and self-governance. Recognition of this on an organizational level may provide the groundwork for further inter-professional and interdisciplinary approaches to health care. In countries where midwives care for the majority of low-risk women, and physicians attend to those with more serious medical issues, maternal and infant outcomes are exemplary (Kennedy 2000, 14). More research must be undertaken to examine how precisely a more collaborative care could be offered and the implications this may hold. Certainly the power of the medical institution is fierce, and the possibility of complete co-optation of midwifery is a factor to be taken into consideration. Yet if the two fields were valued for the expertise and skills that each brings to the health care system, thereby diminishing the hierarchical positioning between professions, perhaps an environment could be created where the best of both could be preserved.

Supportive communities and social settings likewise contribute to the development and employment of autonomy skills. Thus in terms of health promotion, there is valid reason to argue for the creation of health care teams, where members from different areas of specialization come together to facilitate care. As mentioned earlier, no individual caregiver can be responsible for all facets of their patients' or clients' lives. The burden of this may be lifted, however, through the development of such collaborative teams. In stressing the need to broaden respect for autonomy beyond the front-end of health care, this may be one potential step towards that expanded vision.

The relational approach supported by the midwifery model of care thus offers a potentially innovative approach to healthcare. However, as with the medical profession, midwifery is subject to the effects of socio-political and institutional influences. In comparison to the historical rise of physician authority, we see parallels to what is

currently emerging post-regulation. As an underground movement in the 1970s,

midwives were, in a sense, regulated by the women they attended (Bourgeault 2000,

180). This can easily be compared to the 'bed-side' phase of medicine, where patrons

governed the caring relationship. As physicians moved into the hospitals, however, a

distinct shift in the power dynamics between doctors and patients occurred. Many argue

that this is similarly the case with midwives and their clients today. There are valid

concerns that regulation risks re-invoking not only the medical model it criticizes, but

also the power differentials inherent to this system. If the "moral" impulse shifts the

focus away from the woman towards strict professional obligations and protocol, then

what is now an exemplary form of care may be lost. "Contradictory themes of legitimacy

and co-optation" permeate the past, present and future of midwifery practice (Bourgeault

2002, 175). The purpose here is not to condemn regulation but rather to raise

awareness of the contemporary issues confronting midwifery so that its philosophical

commitments may be preserved. As Mary Sharpe declares:

> There is no place for complacency or resting. We require a tireless
> vigilance to maintain what some would say are midwifery's gains, and
> others would call our compromises. And we must continue to examine
> our practices in order to recognize how we, for better or worse, are
> implicated in the rulings of our profession (Sharpe 2001, 57).

Despite considerable achievements made within the women's health movement,

of which midwifery is an integral part, many inequalities and injustices persist. With

increasing medicalization and the expanding frontier of new reproductive technologies,

the terrain of contemporary women's health will continue to shift and confront moral

obstacles. "To a great extent, 'Doctor Knows Best' has been replaced by 'Bioethicist

Knows Best'" (Dresser 1996, 156). Thus is it not only the practice and organization of

health care professionals that serve to benefit from relational approaches to autonomy,

but mainstream and feminist theorists alike. Health care ethicists must also look

themselves in the mirror and ask what oppressive structures that they may be reinforcing in valorising their moral judgements and ideologies. How we approach these issues, the theories we bring to them, can, and will, influence how we feel and live in our bodies, and how we view those of others.

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