

Ethical Perspectives on Decision-Making and Personal Autonomy within Obstetric Care

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Abstract

For many expectant mothers, decisions concerning the setting and manner of childbirth represent some of the most meaningful choices they will make during pregnancy. Contemporary ethical standards emphasise the importance of honouring women's autonomy and tailoring birth plans to individual needs. Yet, in day-to-day clinical practice, genuinely upholding these principles can be difficult. Decisions about labour and delivery inevitably involve potential risks and repercussions—not only for the pregnant woman and her baby, but also for the clinicians involved and, at times, for other patients. This raises pressing questions: what does genuine respect for a woman's autonomy actually entail within obstetric care? How should clinicians navigate situations in which a patient rejects recommended interventions or asks for options that fall outside established clinical protocols? And where, ethically, do the boundaries of autonomous decision-making lie? In this clinical ethics round table, perspectives from service users, midwives, obstetricians, philosophers and ethicists are brought together to examine these issues through two hypothetical—but realistically grounded—cases.

Keywords: Ethics- medical, Obstetrics, Personal autonomy, Informed consent, Decision making

Introduction

Case 1

Felicity, aged 44, is pregnant with her first child. Her medical background includes longstanding anxiety, depression, and a body-mass index of 40. Despite these factors, her pregnancy has progressed smoothly, although her fetus is measuring large—above the 95th percentile. At her current gestation of 39 weeks, she has been advised to consider induction at 40 weeks because of age-related risks. However, Felicity is strongly inclined toward a low-intervention birth. She refuses continuous fetal monitoring and hopes to labour and deliver in a birthing pool. She also prefers to avoid an epidural.

During her appointment, she declines the proposed induction. She expresses concern that induction may lead to a cascade of interventions, including a heightened likelihood of an unplanned caesarean section. She is also anxious about the possibility of uterine hyperstimulation or the induction failing, ultimately resulting in the operative birth she wishes to avoid.

The key issue is how her maternity team should approach and respond to Felicity's clear refusal of the care that has been recommended.

Case 2

Rosa is 37 and approaching full term in her second pregnancy. Her previous labour was extremely distressing. She progressed rapidly at first, arriving at a midwifery-led unit already 8 cm dilated, but later transferred to the main delivery suite due to poor advancement in the second stage. This birth culminated in an emergency caesarean section following an unsuccessful forceps attempt and was complicated by a severe haemorrhage of 1800 mL. Her recovery was

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lengthy and difficult, and her infant was left with a minor facial mark from the instrumental delivery.

In her current pregnancy, the only notable complication has been anaemia, treated successfully with an iron injection; her haemoglobin level is now borderline normal at 105 g/L.

Despite the physiological stability of this pregnancy, Rosa is deeply fearful as the birth approaches. She describes her previous experience as terrifying, marked by confusion and a belief that she might die. She now wishes to plan a home birth and has stated that if hospital attendance is mandated, she would opt to give birth unassisted rather than return to a hospital environment. She also stresses that she would refuse the use of forceps or a caesarean section under any circumstances.

The central question is how her maternity team should respond to her request for a home birth, given the potentially substantial risks involved.

Safoora Teli

Lived experience/service user perspective

For many women, opting for a birth plan that sits outside standard clinical recommendations is rarely a casual or impulsive choice. Their preferences are often shaped by significant personal history, careful investigation, and a desire to avoid repeating negative experiences. Choosing a path that differs from conventional guidance can be emotionally taxing, may invite disagreement from loved ones, and frequently places them in situations where they anticipate resistance from healthcare professionals or feel as though they must defend their decisions, sometimes to the point of considering stepping away from maternity services altogether.

When these circumstances arise, maternity teams have a crucial chance to counter the impression that they are in opposition to the mother's wishes. Rather than being seen as challengers, they can position themselves as allies—clinicians whose role is to enhance safety and offer reliable support throughout pregnancy, during labour, and after birth.

Ultimately, authority over decisions about how and where to give birth belongs to the woman herself. By choosing to diverge from standard guidance, Felicity and Rosa have already affirmed that they recognise this autonomy. It is important that their care teams explicitly acknowledge this personal agency and centre their approach around the individual rather than around preconceived categories or assumptions.

Every interaction should begin from a place of empathy. The teams need to remain aware of the emotional fragility that can accompany late pregnancy, especially for individuals with previous traumatic experiences or existing mental health concerns. Communications perceived as adversarial can escalate anxiety, provoking a stress response that may intensify the urge to disengage from clinical care.

Using fear to influence decisions is neither ethical nor conducive to thoughtful, informed choice. Rosa's previous hospital birth was deeply distressing, leaving her feeling unsafe and exposed. Any conversation about possible complications in her current pregnancy must therefore be handled gently. The discussion should start by recognising the impact of her past trauma, and only after reinforcing their intention to help her achieve a calm and secure birth should clinicians introduce information about potential risks.

Ideally, Rosa should have been offered psychological support following her first delivery. Although this may not be the right moment to explore her trauma in depth, the team can still provide mental health resources and simple strategies to support her well-being. Open-ended questions may help identify what she is comfortable with—such as whether she might consider going to the birthing unit earlier or later in labour. If she remains firm in her desire for a home birth, the team could look at other safety-focused adjustments, such as optimising her iron levels or placing a cannula in advance. Her acceptance of iron treatment suggests she is open to interventions when she views them as meeting a clear need.

While the clinicians' aim is to minimise risk, it is important to acknowledge that not all predictive markers are reliable. Growth scans have margins of error, and being an older mother or having a higher BMI does not automatically mean a more complicated labour. Induction, likewise, may precipitate further interventions. Felicity is giving birth for the first time, and there is every possibility that her labour may proceed smoothly. However, if she feels dismissed or pressured, the emotional impact could be long-lasting, mirroring Rosa's experience and potentially shaping her mental health, early parenting journey, and future pregnancies. Each woman should be encouraged to create a birth plan that reflects her own priorities and circumstances. She must feel that her perspective—not the labels assigned to her—guides the decision-making process. When maternity teams demonstrate genuine respect, validation, and advocacy rather than categorising or disregarding

concerns, trust grows. Should unforeseen interventions become necessary, recommendations from trusted caregivers are far more likely to be accepted.

Clinicians should concentrate on understanding what Rosa and Felicity are comfortable with rather than dwelling on what they decline. Felicity feels safe within a clinical environment and is therefore more open to needed interventions if she perceives her team as supportive. Rosa does not wish to return to hospital but welcomes midwives at home, and if she senses compassion and respect from them, she may be more willing to consider hospital transfer if it becomes essential.

Forcing or coercing women during birth-related decision-making strips them of control, often leaving psychological scars and perpetuating mistrust in maternity services. By contrast, when women consistently feel listened to, respected, and empowered to make choices at every stage, their birth experience becomes more positive, meaningful, and strengthening.

*Claire Litchfield, Anna Madeley
Midwifery perspective*

Modern professional training and policy frameworks emphasise that midwives should uphold and facilitate birthing decisions that fall outside standard recommendations. Yet the extent to which midwives genuinely feel empowered to do this in daily practice remains uncertain. Many describe a persistent anxiety that, should an avoidable adverse event occur, they may be blamed or face disciplinary consequences. When confronted with challenging or disturbing clinical situations that stretch the limits of their professional remit, midwives may also encounter a sense of moral distress.

In case 1, those caring for Felicity could experience a tension between honouring her preferences and adhering to their long-standing commitment to safeguard physiological birth processes [1]. At present, no formal mechanism exists that would allow midwives to decline involvement in situations where women pursue non-normative birth plans, highlighting a gap that warrants broader discussion.

Some National Health Service organisations attempt to bridge this gap by offering structured birth-options counselling—often delivered by a consultant midwife and sometimes organised through a dedicated clinic. Within these sessions, women can develop detailed and explicit care plans, which in turn give attending

midwives a clear framework of organisational backing. These plans frequently seek to lower risk or reinforce safety, often through negotiated elements. For example, in case 2, midwives might propose that Rosa accept intravenous access during labour or postpartum medications aimed at reducing haemorrhage risk. The National Institute for Health and Care Excellence recommends such clinics primarily for counselling individuals requesting a caesarean birth without a medical indication [2], but many services also extend them to support those choosing other non-standard options.

Where no such clinic or planning support exists, midwives may feel personally vulnerable and more acutely aware of the risks they shoulder. Workplaces that lack resources for homebirths or midwifery-led units, or that enforce strict adherence to clinical protocols, may make it practically impossible for midwives to assist women pursuing non-normative care within the constraints of their employment. Consequently, women may feel pushed toward private maternity services, freebirthing, or reluctantly agreeing to institutional expectations.

From the standpoint of professional regulation and law, clinicians are obliged to deliver person-centred care, even when individuals decline recommended interventions or choose paths not reflected in clinical guidance. Professional codes explicitly state that supporting women in decisions that diverge from standard care is part of ethical practice [1, 3], and these codes provide protection from regulatory or legal repercussions when informed decision-making and consent processes are properly upheld. Legal precedents and statutory rights further affirm women's authority to determine where and how they give birth, including their right to choose the level of engagement with perinatal care—with whom they receive care, how much of it they accept, or whether they opt out entirely. Crucially, they cannot be coerced into actions that surrender bodily autonomy simply because a clinician disagrees with their reasoning or perceives their choice as risky, irrational, or potentially harmful. Decisions issued by both domestic and European courts reinforce these protections and highlight the importance of dynamic consent practices and the presumption of mental capacity unless proven otherwise. These matters hold substantial importance for women [4, 5] and shape their decisions—whether that means refusing suggested interventions, leaving care systems altogether, or choosing increasingly unconventional

options. The tension between legally supported autonomy and institutional strategies that encourage compliance is well documented [6], as are the long-term consequences these dynamics may have on future decision-making [7]. Together, these factors illustrate the complexity faced by midwives who strive to honour personalised, and particularly non-normative, choices such as those represented in these two cases.

Brenda Kelly, Lawrence Impey
Obstetric perspective

Every individual has both a moral and a legal entitlement to refuse medical care, and clinicians are ethically obliged to offer the best possible support within the boundaries of what the person is prepared to accept. Providing truly effective care requires taking time to understand what matters to the patient, listening carefully, engaging openly, and establishing trust.

A central part of this process is exploring why a person has chosen a particular labour and birth plan—their aspirations for the experience, the anxieties shaping their thinking, and how well they grasp the implications of stepping away from recommended maternity pathways. Equally important is determining what level of risk they find tolerable and which outcomes they prioritise. Decision-making in these situations often reflects a balance between what the mother believes is most beneficial for her physical and emotional well-being and the possible implications for the baby. Clear, comprehensible communication of the best available evidence is essential to support meaningful, informed choices.

Because childbirth is a normal physiological process, forecasting risk is inherently uncertain, and large numbers of interventions may be required to avert a single serious outcome such as stillbirth. Creating a respectful, psychologically safe environment for these discussions is vital, as it helps maintain engagement with maternity services—something that is crucial, since withdrawing from care can inadvertently heighten the risk of stillbirth. Many common interventions, such as induction of labour, are designed to maximise fetal safety but can also impose physical or psychological burdens on the mother, with possible downstream consequences for long-term mental health.

In Felicity's case, her risk of stillbirth rises after 40 weeks—most noticeably between 41 and 42 weeks—primarily because of her age. Her pregnancy has been straightforward so far, which lessens this risk but does

not remove it; the absolute risk remains small, roughly 1 in 100. Labour induction does not increase her likelihood of caesarean birth, but it does introduce a more medicalised experience that may detract from her sense of agency or the personal meaning of the birth. Opting not to induce labour slightly raises the risk of stillbirth, and Felicity also needs to be aware that prolonged gestation at age 44 may raise the chance of intrapartum complications—such as fetal distress—even if labour begins spontaneously, which might diminish her hoped-for birth experience regardless.

Rosa's previous traumatic birth plays a defining role in her current preferences. Supporting her to shape a birth plan that feels safe and empowering may aid her psychological recovery. Considering her earlier labour progress, she has at least a 70% probability of achieving a straightforward vaginal birth. A home birth could potentially offer the most calming environment for her, enhancing her chance of a positive outcome. However, birth remains unpredictable, and Rosa carries a 1 in 200 risk of uterine scar rupture during labour. Should this occur at home, the danger is severe: there is a greater than 50% probability of stillbirth and substantial risk to Rosa herself due to internal haemorrhage. Immediate transfer to hospital would be essential to optimise survival for both mother and baby.

Although fostering optimism is important for Rosa's emotional well-being, it is equally essential to talk through emergency scenarios and set out a shared plan for how and when a hospital transfer would be recommended. Establishing in advance whether she would consent to transfer on clinical advice is crucial. These discussions could be deeply distressing for Rosa, making additional mental health support and repeated conversations important. If she ultimately chooses a home birth, she must receive full support—since disengaging from maternity care or freebirthing entails far greater risks. Caring for her at home would require considerable resources; if a crisis arose, the limitations of a home setting could intensify the trauma for both Rosa and the attending clinicians. Any advance refusals of intervention must be reviewed to ensure they remain appropriate in an emergency.

Engaging with non-normative birth choices is often a complex process that requires specific training, emotional insight, and time—frequently spanning multiple appointments. These demands intersect with the needs of other patients and with staff capacity; allocating extensive resources to one individual may strain care

provision elsewhere, potentially fostering tension in already pressured systems. Not all clinicians feel equipped or safe to provide care outside standard guidance, and distressing experiences in these contexts may hinder their ability to support future patients.

Ultimately, balancing maternal autonomy with professional responsibilities requires careful, compassionate communication and a nuanced grasp of the associated risks. A supportive environment that encourages informed decision-making and thoughtful contingency planning is crucial—even when plans diverge from conventional approaches. Such an environment promotes the well-being of both mothers and caregivers and helps reduce the risk of trauma while enhancing the likelihood of positive birth experiences.

Rebecca CH Brown and Elselijn Kingma

Philosophical perspective

The cases described can understandably be challenging for healthcare providers, but this does not suspend the application of fundamental ethical principles; in fact, these principles are central to determining how to best support someone choosing to give birth ‘outside the guidelines’.

Pregnant individuals, like any competent adult, maintain an almost absolute right to refuse medical treatment [8]. In maternity care, autonomy is particularly important and also especially vulnerable to being compromised, given that such care involves socially sensitive body parts and often aims to prioritize the health of one person (the baby) potentially at the expense of another (the mother) [9]. The autonomy of laboring individuals is at risk because it is frequently inadequately respected [9, 10]. The role of maternity care professionals is not to coerce or manipulate but to facilitate genuinely autonomous decision-making by the pregnant person.

A crucial aspect of this is fostering, rather than undermining, trust, which requires supportive communication, attentiveness to the pregnant person’s concerns, and consistent reassurance that their right to make decisions about their own body will be upheld. However, in cases outside standard guidelines, healthcare providers often worry about risks to both mother and baby. The ethical and professional challenge is to provide safe, equitable care while respecting autonomy and maintaining trust.

Draft Dutch guidelines, developed through extensive ethical analysis, recommend that healthcare providers

follow these steps when responding to requests for care outside guidelines [11]:

Box 1. Recommendations for health professionals in responding to requests for care outside guidelines [11]

1. Approach the request or refusal openly, aiming to identify underlying concerns, which can often be addressed through effective communication.
2. Provide relevant, unbiased information, including gently correcting misinformation and explaining if a proposed approach is not recommended.
3. Collaborate with the pregnant person to develop the safest care plan aligned with their wishes, ensuring the entire care team is informed and supportive.
4. Clarify that the pregnant person can revise their decisions at any time, with regular but non-intrusive check-ins.
5. Document clearly any deviation from medical recommendations, including reasons and agreed-upon plans, to protect providers and facilitate team coordination.

Applying these guidelines to Felicity and Rosa, the provider should first identify each person’s underlying concerns (step 1). For Felicity, understanding her desire for minimal interventions, her values, and beliefs enables the provider to give accurate, unbiased information on the risks and benefits of induction (step 2). While expressing concern is acceptable, it must be accompanied by a clear commitment to respect her choices and provide care in any scenario (step 3). If Felicity maintains her preference against induction, the provider should work with her to design the safest care plan consistent with her values, covering decisions like when she might consider induction and her preferences regarding fetal monitoring (steps 3–5), ensuring the plan is documented and communicated to the team.

For Rosa, understanding her beliefs and previous experiences is critical (step 1), particularly given her past negative encounters, so trust-building and reassurance are essential [12, 13]. Her provider should sensitively inform her of the risks associated with her chosen mode of delivery, such as uterine rupture, while respecting her preference for these risks over alternatives (step 2). Developing a care plan (step 3) may include options such as an alongside midwifery unit or intermittent auscultation, revisiting the plan as needed (step 4), and sharing it with the team (step 5). Team members with concerns should be reassured that Rosa’s values have been carefully considered and that supporting an attended

home birth, rather than an unassisted birth, represents the safest achievable option for her and her baby [11].

Cases like those of Felicity and Rosa may be unsettling for providers, but the measure of success is not persuading women to follow recommended care; it is enabling informed autonomous decisions and using team experience to deliver the best possible care consistent with those decisions.

Dominic JC Wilkinson and Helen Turnham

Clinical ethics

The previous commentaries have addressed many of the key ethical issues in these cases, but if these situations were brought to a clinical ethics committee, our goal would be to help clinicians identify and separate several distinct ethical questions.

Autonomy and resources

The two cases illustrate different ways autonomy can be challenged. In the first case, patients refuse recommended treatment, whereas in the second, patients request options that clinicians do not endorse or offer. Ethically, a distinction is often made between negative autonomy—the absolute right to refuse treatment—and positive autonomy—the notion that patients do not have an inherent right to demand treatment, especially when resources are limited or other patients' care could be affected. However, in practice, the distinction can be unclear. Refusal of treatment can also have resource implications, requiring additional monitoring or alternative care. Similarly, requests for specific treatments may coincide with declines of other options. For instance, Rosa's unwillingness to deliver in hospital means her choices realistically are either a supported home birth or a riskier unassisted birth, rather than a simple comparison of hospital versus home birth.

Resource limitations—whether physical (e.g., delivery suite space), personnel (staff availability), or financial—are ethically relevant but challenging to apply in individual cases. Unlike decisions about scarce drugs or organs, resource allocation in maternity care is rarely an all-or-nothing choice, and drawing clear, non-arbitrary boundaries is difficult. Providing requested resources for an individual may not harm others, but repeated cases could impact overall care delivery. Denying women access to options available to others, such as home birth or cesarean section, on these grounds alone is ethically problematic. The core question is whether the benefit, particularly in terms of respecting the woman's

autonomy, justifies providing the requested resource—a complex ethical judgment.

Woman versus fetus

Another general limit to autonomy arises when a choice may harm someone else. Childbirth decisions outside guidelines are often seen as ethically challenging because of potential fetal or future child harm. However, in contexts such as the UK, a woman's right to make decisions about her body and birth generally takes precedence over fetal considerations [14]. While concern for the child is ethically relevant and often motivates both the woman and healthcare recommendations, it should not restrict the choices of women like Felicity or Rosa. Coercion—forcing Felicity into induction or Rosa into hospital birth—is ethically unjustified.

Nevertheless, discussing potential risks to the fetus or future child is important, as clinicians may have trained or worked in settings where women's autonomy is more constrained. Such discussions can help clinicians understand the UK approach and allow reflection on whether a woman's choices conflict with their personal values. Providing opportunities for self-reflection can reduce moral distress and clarify available options, including supporting the woman's choice despite personal disagreement [15], or exercising conscientious objection if alternative clinicians are available to provide care.

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