

COMMENTARY

Vaginal Birth After Cesarean Section: Ethical Considerations for Midwives

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ABSTRACT

Vaginal birth after cesarean section (VBAC) and decisions regarding the safest mode and place of delivery can be contentious in contemporary obstetrics. The choice of birthplace adds additional layers to ethical concerns, particularly for midwives, who are often the only care providers attending birth outside the hospital setting. Current guidelines and evidence, drawing largely on obstetrical literature and the hospital environment, recommend hospital birth for anyone with a prior cesarean section. However, despite guidelines and care provider recommendations, a small proportion of women will continue to request midwife-attended homebirth. Ethical debates about VBAC have largely been inattentive to the desires of these women and the unique situation of midwives who may be presented with such requests. We will explore the ethical nuances of choice of birthplace for women planning a vaginal homebirth after cesarean section (HBAC). Analysis suggests that there may be implications to denying choice and some burden on midwives to continue to provide care for women planning HBAC, even when homebirth may not be considered the safest option.

Author's Note: The order of authors in this paper is alphabetical and not intended to relate to work done. This paper was a joint collaboration and authorship was equal and shared

KEYWORDS

midwifery, vaginal birth after cesarean section, VBAC, homebirth after cesarean section (HBAC), homebirth

INTRODUCTION

Vaginal birth after cesarean section (VBAC) can be a contentious issue in contemporary obstetrics and maternity care. Most clinical discussions about VBAC prioritize risk and safety for both the birthing woman and imminent newborn.¹⁻⁵ Despite dominating views that birth in hospital is the more favourable option, some women with a history of previous cesarean section still prefer and choose to give birth at home.^{6,7} This situation raises important ethical questions for maternity care providers, especially midwives, who are the only care providers in Canada (and in many other jurisdictions) who attend birth in out-of-hospital settings.

The principle framework is commonly applied to ethical questions that arise in health care. According to Beauchamp and Childress, beneficence is the principle that requires care providers to do good through actions that are in the best interest” of the client, and non-maleficence is the complementary principle that requires care providers to do no harm. The latter is considered the primary obligation of all care providers.⁸

Homebirth after cesarean section (HBAC) raises important questions about how best to balance “doing good” with “doing no harm.” We suggest that a narrow conception of these two principles and the privileging of beneficence and nonmaleficence may result in insufficient attention to autonomy, another of the core principles.⁸ When closer consideration is given to autonomy, there may seemingly be a burden on care providers to support women who elect to pursue HBAC.

Justice, the fourth principle in this model, emphasizes fairness and equality among individuals. The application of this principle may result in different obligations for obstetricians versus midwives, who offer out-of-hospital birth for their clients.⁹

This article provides a brief background on the current state of the literature on HBAC, followed by an ethical analysis that draws autonomy and justice into consideration along with beneficence and nonmaleficence. Ethical concerns such as reasonable decision making, maternal competence, maternal-fetal conflict, and conscientious objection are also addressed.

BACKGROUND EVIDENCE

Understandably, significant effort has been made in VBAC research to quantify the risks for both mother and baby.^{1,4,10-15} Given the proportionally lower rate of out-of-hospital birth compared with in-hospital birth in Canada

and elsewhere, there is almost no direct evidence on VBAC in out-of-hospital settings.^{6,11} Unfortunately, this makes it difficult to accurately discern from the literature the types, frequency, and severity of risks associated with VBAC at home versus VBAC in hospital.

In the absence of direct evidence, protocols and policies about place of birth tend to rely more generally on extrapolations from VBAC research. The challenges of interpreting the literature often include the following:

- Lack of rigorous methodology¹⁴
- Various types of care providers, models of care, and birth settings¹⁴
- Imprecise and nonstandard definitions of important adverse outcomes such as uterine rupture versus uterine dehiscence^{10,16}
- Comparison between populations with potentially significant differences (e.g., self-selection for homebirth by women who may have dispositions salient to low intervention versus self-selection for hospital birth by women who may have increased fear and anxiety over birth)
- Small sample sizes that make it difficult to generalize findings to larger populations, and/or to detect rare outcomes, such as maternal mortality^{6,17-21}

The most recently published Clinical Practice Guideline on Vaginal Birth after Previous Low Segment Cesarean, by the Association of Ontario Midwives (AOM), provides an overview of the current state of evidence on VBAC and VBAC in out-of-hospital settings.⁶ As per the points above, the Guideline concludes “that larger studies are needed to report on rates of VBAC at home compared to VBAC in hospital.”⁶ In the interim, obstetrical guidelines overwhelmingly recommend hospital birth, largely because of the potentially catastrophic outcomes associated with uterine rupture.^{6,13,14} The AOM guideline is unique in its concurrent acknowledgement of the risk of uterine rupture and its support for women making an informed choice of birthplace.⁶ The analysis in this article supports this position.

UTERINE RUPTURE AND RISK REDUCTION

Uterine rupture is arguably the most potentially catastrophic risk associated with VBAC.^{2-6,10,12-14,22} The incidence of uterine rupture in otherwise low-risk healthy women with a history of a single cesarean section varies in the literature. Some sources estimate it occurs as

frequently as 1 in 100 or 1 in 250, others as infrequently as 1 in 500.^{1,2,4,5,12,21} A robust informed-choice discussion about VBAC and place of birth requires more information than the rate and severity of uterine rupture.²³⁻²⁶

Denying the option of homebirth on the basis of a small probability of uterine rupture is an example of risk-aversion that is often agreeable to both care providers and maternity clients. Even with timely intervention, significant fetal and maternal morbidity and mortality can be associated with a rupture. Given the gravity of these risks and the current medicolegal climate, it is not surprising that many obstetrical associations explicitly recommend that VBAC take place only in settings equipped to perform an emergency cesarean section.^{6,13,14} However, the 2010 National Institutes of Health Panel on Vaginal Birth After Cesarean called for the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists to reassess the requirement that surgical and anaesthetic personnel be immediately available for all instances of planned VBAC.¹⁰ The panel cited the low level of evidence that supports this requirement and the barrier it poses to many women's gaining access to clinicians and facilities.¹⁰ For example, many women do not live in communities able to perform a cesarean section in less than 20 to 30 minutes.^{10,27-29}

The dearth of direct HBAC evidence that can be called upon to guide clinical recommendations has contributed to an impoverished dialogue about ethical considerations regarding place of birth.^{6,11,14,18,21} Although the intention to prevent or expediently manage uterine rupture is laudable, it is important to unpack some underlying assumptions and to acknowledge how certain strategies might deflect the practitioner's attention from important ethical concepts such as autonomy and informed choice.³⁰⁻³³ When primacy is given to the reduction of a particular risk, other risks and new risks may be ignored or obscured. Further, perceptions of risk can be distorted not only by a lack of topic-specific evidence but by biases that persist despite information to the contrary, such as the often assumed superior safety and desirability of hospital environments for all low-risk healthy women.^{14,34,35}

Despite the prevalence of hospital birth, current evidence indicates that beyond VBAC debates, planned

hospital birth (as compared with planned homebirth) for well women with uncomplicated pregnancies is associated with increased rates and severity of intervention.^{17,19,36-38} This kind of association is not well understood, but it may point to some iatrogenic effects. Discussions about HBAC do not yet account for whether giving birth in hospital may put women who are planning VBAC at different but significant risks compared to their homebirth counterparts. For example, continuous electronic fetal monitoring is associated with increased rates of cesarean sections. It is also possible that in practice, some providers have more conservative time thresholds for labour progress or a reluctance to augment slow labours, defaulting more quickly to cesarean sections. Worries that hospital birth may compromise the probability of successful VBAC may not be unfounded.^{18,39,40} Although the risk of a repeat cesarean section may seem preferable to the risk of uterine rupture, the client's perception may differ from that of the care provider. Attention to the autonomy of particular persons requires mutual engagement by the care provider and client in the discernment of risks and options and may even require care providers to act against their own inclinations.

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INFORMED CHOICE AND AUTONOMY

Informed choice is the primary way clients exercise autonomy in the health care setting, and it is central to the Canadian model of midwifery care.^{8,9,23-26,41-43} The AOM defines informed choice as "the exchange of relevant information between client and health care provider, which allows for decision making by the client that is 'informed, reasoned, and uncoerced.'"⁴⁴ Informed choice is by definition client centred; the care provider facilitates a non-authoritarian exchange of information, empowering the client to function as the primary decision maker. Both the nature of the information shared and the way in which it is provided are important; informed choice is intended to be a process as well as an outcome.^{42,45}

In bioethics, informed choice is regarded as inevitably value laden because individuals make choices based on their own values, beliefs, desires, and goals.⁴⁶ Accordingly, the care provider's burden lies in ensuring that appropriate information has been provided and is understood, rather than in directing how people decide to apply that

information to their decision making.

NONMALEFICENCE AND AUTONOMY

The process of informed choice requires midwives to include an overview of available evidence as well as explain how the evidence is interpreted and applied in practice. Through this process, many women who are planning a VBAC will choose hospital birth. Regardless of recommendations and information, however, some women will choose to have their babies at home.^{6,7,23} Some care providers contend that refusing to facilitate a client's plans for an HBAC ultimately avoids harm and promotes good, fulfilling the obligations of both nonmaleficence and beneficence.³⁵ Although there may be benefits associated with proximity to emergency surgical intervention, a hospital as place of birth may also be associated with harm. Some women will interpret a lack of caregiver support for their choice of birthplace as disregard for their autonomy and their capacity for decision making.

To illustrate this point, consider the example of a maternity care provider who opts (using the rationale that the care provider's and client's values do not align) to discontinue a woman's care because the woman plans to pursue HBAC. The care provider perceives giving birth at home with a uterine scar as unacceptable owing to the short window of opportunity to minimize trauma to the woman and newborn should a uterine rupture occur; the care provider believes that termination of care is supported by the obligation to do no harm.

What might be missing in this application of nonmaleficence is the recognition that coercive action can sometimes be embedded in "best interests" and "avoiding harm." In this scenario, the woman must either comply with the care provider or change her plan. Either way, new and unanticipated vulnerabilities and harms can emerge. The threat of discontinued care can be experienced as coercive rather than helpful. In particular, the therapeutic alliance between care provider and client can be undermined.^{29,47,48}

Some women might acquiesce to recommendations but feel compromised. Some women may search for another skilled attendant willing to attend an HBAC, but often no one will be available. Some women may feel forced to accept

care that is suboptimal by their own measures and to explore the option of an unskilled attendant at a homebirth or even the option of an unattended homebirth—indisputably the option that puts her and the imminent baby at greatest risk.

According to Beauchamp and Childress,⁸ beneficence and nonmaleficence ought to be considered in conjunction with autonomy rather than in place of autonomy. Overt coercion for the sake of beneficence or nonmaleficence is considered unacceptable.¹⁵ Although it has been argued that women have a right to an unattended homebirth, planning an unattended homebirth is ethically distinct from feeling forced into one because other options (such as hospital birth) are perceived to be unacceptable.⁴⁹

McLeod and other feminist theorists have contended that reproductive health care should allow women a reasonable range of available options that provide opportunities to cultivate and express their self-trust and autonomy.¹⁷ This is arguably the most robust way to fulfill the obligations of nonmaleficence and beneficence, in conjunction with autonomy. Of note, autonomy is

increasingly emphasized as the core ethical principle; respect for persons should be leveraged above obligations towards beneficence and nonmaleficence. This sentiment is captured well in the following quote by Kotaska:

The caregiver's responsibility is not to take over decision making when people feel trauma over past experiences but to support and optimize their self-determination.

Modern ethics does not equivocate: maternal autonomy takes precedence over medical recommendations based on beneficence, whether such recommendations are founded on sound scientific evidence or the prehistoric musings of dinosaurs.... the locus of control has, appropriately, shifted to the patient/client in all areas of medicine.... Informed choice is the gold standard in decision making, and it trumps even the largest, cleanest, randomized controlled trial.... Science supports homebirth as a reasonably safe option. Even if it didn't, it still would be a woman's choice.⁵⁰

ADDITIONAL ETHICAL CONSIDERATIONS

Beneficence, Maternal Competence, and the "Reasonableness" of Homebirth After Cesarean

While informed choice is a laudable ideal, some caregivers might question whether informed choice is appropriate in all clinical situations or whether acting in a client's best interests may require overriding a client's wishes. In bioethics, overriding informed decision making is justified only when the client is deemed incompetent.^{8,51} It is well established in Canadian jurisprudence and health care that an individual is assumed to be competent unless proven otherwise.⁵¹⁻⁵³ Overriding a client's decision to have an HBAC is moot unless there are true concerns in regard to mental incapacity. When competency is not an issue, a care provider cannot refuse to provide care when the requested option is deemed to be reasonable.^{11,29,51,53} This raises questions of whether HBAC can be perceived as a reasonable option and who makes the determination of reasonableness.

The reason some women choose HBAC is not well explored and is likely complex. For some women the desire for HBAC may result from a previous hospital birth experience perceived as undesirable. Some authors contend that women who choose homebirth are either misinformed or unable to make a clear, rational decision.³⁵ From this perspective, a care provider may contend that one of the primary reasons a woman is seeking an HBAC is that she is traumatized by a previous negative birth experience? Trauma from previous birth experiences as a possible reason women make certain birth choices regardless of risk or caregivers' recommendations has been explored in the literature.^{48,54-56}

That some women do cite previous negative experiences as a factor in current birth plans does not indicate incompetence in the sense of extreme psychiatric or mental incapacity.⁵¹⁻⁵³ The caregiver's responsibility is not to take over decision making when people feel trauma over past experiences but to support and optimize their self-determination.^{8,51-53} Simkin and Ancheta suggest that supporting some women's choice to give birth at home will reduce the anxiety that can stem from giving birth in hospital, where the previous birth experience or cesarean section took place.⁵⁷ To override a woman's decision to have an HBAC in favour of a hospital birth is to suggest that women are unreliable in their self-assessments and that intervention is warranted to help them make the most reasonable choices. In contrast, the choice of some women to give birth at home may not be intrinsically linked with fear or avoidance of hospital birth but may instead be related to an affinity for the positive attributes of home, including

feelings of comfort and safety.^{19,38,58,59}

At present, the rate of cesarean sections is approximately 30% in Canada, and the rate of cesarean sections is significantly higher for women who already have a uterine scar from a previous cesarean section.^{6,13,14} The current rates of cesarean births exceed the World Health Recommendation of 15%.⁶⁰ Although some women's fears are perceived as overreactions or as unreasonable, it could be argued that these fears are well grounded, and attempts to minimize primary and secondary cesarean births are in fact reasonable.

It is also possible that there is an iatrogenic component to cesarean birth in hospital. Some research indicates that women are more likely to deliver by cesarean section if they give birth in hospital instead of at home, even if they plan a vaginal birth in either setting and even if they are planning a VBAC.^{17,20,36-38}

The College of Midwives of British Columbia states the following:

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 understanding, skills and motivation necessary to take responsibility for and control of their own health.⁷⁶¹

Feminist theory on autonomy and informed choice asserts that women are morally competent agents and that social conditions supporting engagement with relevant options and meaningful decision making should be cultivated rather than conditions that critique and control women's choices.^{24,33,42,43,45,62} Vaginal homebirth after cesarean section is not just "about" the outcomes of birth but is also about decision making and the right to self-determination. It may be that part of the good that can be offered to women with prior cesarean sections—and part of the harm that can be avoided—is the maintenance of a range of VBAC and birthplace options. Care providers and regulatory bodies need to carefully consider the implications of limiting choice.^{26,29}

Conflicting Obligations

Whereas many people agree that a woman ought to have the right to choose her place of childbirth and mode of delivery, other people have raised concerns about the

potential risks to the fetus, concerns that can give rise to feelings of conflicted obligations.^{35,63-67} According to Canadian law, personhood and the rights associated with personhood are not ascribed to the fetus while it remains inside the mother's body, but maternity care providers are generally expected to attend to both maternal and fetal interests.^{30,33,64}

According to Beauchamp and Childress, parents have a prima facie prerogative to decide on behalf of their children what risks should be taken. The state is sanctioned to override a parent's interpretation of this duty only in exceptional and extreme circumstances.^{8,68} It is well accepted that parents' "decisions for their children are a function of lifestyle, values, and beliefs. In addition, any particular parenting cannot be measured against some ideal standard of perfect parenting."⁶⁸ According to Fentiman, "Different decisions by different parents are both expected and encouraged in a free and open society."⁶⁶

Still, some have argued that care providers have a special responsibility to protect the fetus or newborn when they perceive the mother's decisions to be putting the fetus or potential newborn at undue risk.^{35,63} Feminist bioethics generally rejects this framework of maternal-fetal conflict and instead approaches birth as an unavoidably interconnected process.^{64,66,67} Through this interconnection, any detriment to the woman is likely to incur detriment to the fetus. This does not exclude harm to maternal autonomy, which can permeate into the future parenting and care of the newborn. Accordingly, midwifery organizations make explicit their commitment to the primacy of women's decision making in pregnancy and refute the conflict of maternal and fetal interests, as in the following statements:

Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn.⁶⁹

Midwifery is emancipatory because it protects and enhances the health and social well-being of women, which in turn protects and enhances the health and well-being of society.⁷⁰

Further, even when attending to the interests of the woman is not simultaneously attending to the interests of the fetus or newborn, maternal decision making is considered to be paramount, and the interconnectedness of woman and fetus is not described as adversarial. This is shown in the following passage from the Midwives Alliance

of North America philosophy:

We recognize the limitations of traditional codes of ethics that present a list of rules to be followed. Therefore, a midwife must develop a moral compass to guide practice in diverse situations that arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women. ... Midwifery care is woman-led care with informed choice and a clear set of values at its core. Decision making is a shared responsibility with the goals of healthy women and babies....We value the mother and her baby as an inseparable and interdependent whole and acknowledge that each woman and baby have parameters of well-being unique to themselves.⁷¹

Although a full account of the tensions between women's rights and fetal interests is beyond the scope of this article, it is worth noting that midwives, compared with other care providers, may have a greater duty to protect the choices of women, owing to midwives' professional, clinical, political, and social responsibilities as advocates for, and protectors of, woman-centred care.^{24-26,44,45,61,69-71}

Uterine rupture in low-risk women is generally unpredictable, which presents difficulty for clinicians; at the same time, the majority of women (approximately 75%) who are good candidates for VBAC are successful in their VBAC plans.⁶ If there were a certain way to discern which of the "good candidates" would be the 1-in-100 to 1-in-500 exception whose child's birth will culminate in emergency measures to manage a uterine rupture, there might be some (contentious) grounds for supporting the overriding of a woman's decision because of undue risk to herself and her imminent newborn. However, there is yet no way to determine which woman in a group of equally low-risk women will experience a rupture, nor is there a proven way to mitigate risk to the woman and her fetus or newborn.^{4,5} Further, as it currently stands, women are widely permitted to choose for themselves even if the care provider considers the choice to be a poor one.

This discussion does not eschew or change the reality that women's pregnancy-related decisions and behaviours can sometimes be morally difficult for practitioners, but the means to address this is not via the limiting of choice.

Conscientious Objection and Beneficence

One of the additional issues in the debate on HBAC is the difficult position a client may put her care provider in

if the provider does not agree with the client's choice.^{35,49,72} There is no requirement for midwives to recommend HBAC; in fact, it could be argued that owing to the risk of uterine rupture, it behooves midwives to recommend hospital birth over homebirth. However, health care patients already frequently choose against the recommendations of care providers. This is well supported in the literature on autonomy.^{8,29,30,32,68,72,73}

Beauchamp and Childress, as well as Card, have observed that conscientious objection has recently garnered more attention in health care and is increasingly being leveraged as grounds for withdrawing or refusing care.^{8,74} In the past, conscientious objection has been used as an argument for care provider nonparticipation in medical services such as contraceptive prescribing and abortion services. In this scenario, practitioners may feel that they are not overriding the decision of the client but exercising their personal rights to follow their own beliefs and values.⁷⁴⁻⁷⁹ We suggest that conscientious objection with regard to

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place of birth may be contentious, as are other care refusals that infringe on reproductive self-determination.⁷⁶⁻⁷⁸

Although supporting HBAC may be uncomfortable for some practitioners, support for autonomy requires health care providers to support choice even when it may be against care providers' recommendations, may be against beliefs about "best care," and makes care providers uncomfortable owing to their own principles.^{72,75} Examples include discontinuing life support, declining to administer blood products even if they may be life-saving, and choosing to continue a pregnancy when it puts the mother's life at risk. This happens in the other direction as well. For example, a physician who is a Jehovah's Witness may decline to administer blood products but would not be able to decline to administer a needed blood transfusion to a patient who has consented to it.

Another component of conscientious objection that is

cited by some is the compromised trust between a client and a midwife when they disagree on the best course of care. In a variety of contexts, there are times when a midwife and a client may not be a good match for each other, and there is regulatory guidance on how to dissolve relationships and ensure the continued quality of care for the client via another provider.⁸⁰ However, Weijer et al. note that disagreements between patients and caregivers rarely erode trust to a degree that requires an alternative pairing; rather, when there is already a lack of trust and effective communication, disagreement can exacerbate feelings of distrust and dissatisfaction with care.⁷²

Justice and the Unique Position of Midwifery

The fourth concept of the principlism includes justice, a concept that emphasizes fairness and equity among individuals.^{8,9} Midwives are the only providers in Canada who offer and support both homebirth and out-of-hospital birth.^{25,26,41,61,69} While obstetricians may recommend hospital birth for all women planning a VBAC, they need not contend with additional ethical considerations regarding choice of birthplace. In terms of both risk assessment and relational accountability, there may be a burden on midwives to attend HBACs even when they have advised clients against this option.

In discussing homebirth, Chernivak et al. argue that "obstetricians should recommend hospital-based delivery and respond to refusal with 'respectful persuasion.'"³⁵ Respectful persuasion is not supported in contemporary bioethics and may be held suspect as thinly veiled paternalism.^{8,9,24,32,33} In addition, this perspective does not take into account the principle of justice, wherein a range of choices must be offered equally and fairly to all women. Again, this does support "recommending" HBAC but challenges abuses of informed choice processes and the defensibility of service refusals.

CONCLUSION

Care providers who seek to limit the choice of birthplace to hospital settings for women planning VBACs are likely motivated by the desire to provide the best care for their clients. Many care providers may perceive such limitations as justifiable in terms of mitigating the risk of uterine rupture. Albeit uterine rupture is the primary concern and can be catastrophic, it is unusual and ethically questionable for a care provider to be granted the ability to override a client's decision making in regard to her health care. This ought to be of particular concern to midwives,

who offer both home and hospital birth and who provide a relational approach to informed choice.^{24,42,45,62} At present, many women planning a VBAC accept recommendations to give birth in hospital; for a variety of reasons, however, a small number prefer to maintain their plans for homebirth.

The College of Midwives of Ontario (CMO) has specifically stated that midwives cannot deny the option of homebirth for women with a prior cesarean section,⁶¹ as follows:

The CMO maintains that the most appropriate person to decide on place of birth for VBAC is the client, after carefully considering the risks and benefits of her options. In support of clients making informed decisions and midwives meeting the minimum requirements set out in CMO standards, the CMO expects midwives to provide primary care for clients planning VBAC in all settings, including home.⁸¹

Midwifery as a profession has a clinical and political history of being especially attentive to women's reproductive self-determination.^{24,42,70,71,82} With this in mind, interprofessional regulatory bodies need to consider the ethical implications of limiting the choice of birthplace. It is important to keep in mind that in health care decision making, clients are permitted to choose differently from their care providers and should be supported in their choices. Informed choice, then, should be the point of enforcement, and coercion should be avoided.

A superficial analysis of the core ethical principles of nonmaleficence and beneficence would lead some to conclude that home VBAC should not be supported. However, a deeper ethical analysis that includes a respect for autonomy reveals that this reading is flawed, as more than the risk of rupture needs to be considered. The decisions to give birth at home and to have a VBAC are complex and value laden—as they should be—the ultimate values and decision making being in the hands of women. To fulfill the ethical concept of nonmaleficence conservatively, midwives should recommend against HBAC, particularly in cases in which additional factors are an issue (such as time for transport). However, a recommendation against a course of action is not ethically sufficient to actually curtail decision making. To maintain the therapeutic alliance, women must be confident that regardless of recommendations, their decisions are ultimately supported.

Given this analysis, midwives should feel confident of both their ability and obligation to recommend against

homebirth and still fully support women who choose this option.

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