Consent and episiotomies: do not let the perfect be the enemy of the good

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We read commentaries on our feature article 'The ethics of consent during labour and birth: episiotomies'[1] with gratitude and interest. Nearly all commenting authors agree that consent for in-labour procedures is necessary and ideally given at the point of intervening.

Both Shalowitz & Ralston and Stirrat note that this is already required by professional statements and guidelines in the USA[2] and UK[3], respectively, but also note that practice does not yet conform. The Americans authors helpfully emphasise the importance of multilevel institutional measures for closing this gap, including consent policies and reporting mechanisms, as well as ongoing education.[2] The UK writer seconds the role for education within wider shared decision-making and informed choice approaches, and generously commends our paper for close study by all maternity care providers.

Others add a cautionary note. Lee applauds all our recommendations, but notes our proposals cannot fully secure autonomy because of, among others, epistemic injustice and other power differentials.[4] Kumar-Hazard and Dahlen worry that opt-out consent is equal to substitute decision-making; weakens women's rights; and is open to abuse.[5] Nelson and Clough object to our willlingness to work within a flawed conceptual framework, which ought to be challenged.[6]

We agree that there are limits to what our proposal can do. It cannot rectify unequal distributions of epistemic credibilities, either in general or in any particular interaction. Risk communication is never neutral;[7] "even the most well-meaning healthcare professionals could unwittingly wield influence over birthing women's values and preferences through the way they present rationales for obstetric interventions such as episiotomies".[4] Both issues can compromise women's autonomy as well as the validity of their consent. Nor is our proposal immune to abuse, for example of "the doctrine of medical necessity".[5] Consent and decision-making procedures alone can do only so much to address all these issues. The epistemic climate in which knowledge is produced and shared presents a separate significant challenge. Abuse, already an undisputed ethical failing, is another.

We have more difficulty with Nelson and Clough's and much of Kumar-Hazard and Dahlen's commentaries. We agree with the former that legal consent and capacity frameworks have many shortcomings and limitations – and indeed it could be useful to turn the analysis around, as it were, to illuminate them. But we set ourselves a specific, constructive task: to improve the situation for women (large numbers of whom are presently undergoing episiotomies without consent), and healthcare providers (who, even if willing, lack guidance on how to feasibly respect ethical autonomy and consent requirements in messy practice). Very significant improvements can be made working within existing, widely accepted ethical norms; that, not legal change, was our aim.

We disagree with Nelson and Clough that we are 'exceptionalising or 'othering' labouring women',[6] or failing to note limitations on consent or continuity with broader problems in healthcare; we discussed the (practically unattainable) ideal of fully informed consent, as well as a spectrum of practical consent requirements throughout clinical practice—not all of which has had equal attention in the ethical literature.[1] For the same reason we disagree with Kumar-Hazard and Dahlen that we are weakening consent requirements or women's rights; our proposal is consistent with existing ethical consent practice.[5]

But Kumar-Hazard and Dahlen mostly oppose our (specific and limited!) endorsement of opt-out consent which they equate with substitute decision-making.[5] That equation is incorrect; opt-out consent leaves room for a woman's dissent, which should be heeded. Substitute decision-making does not. As a result much of their commentary is misdirected: our article agrees with and exemplifies their legitimate demand: to "strive for a standard of care that centres on informed consent before considering exceptions.[5]"

Perhaps some of these disagreements stem from a difference in approach, however: Nelson and Clough interpret ours as an attempt to 'facilitate legal clarity', and both they, and Kumar-Hazard and Dahlen, take a distinctive (albeit contrasting!) legal approach. We explicitly limited our discussion to ethical, not legal, consent requirements.[1]

Mumford rejects opt-out consent: in the (limited) scenarios where we proposed it, surrogate consent should be sought instead. She also notes capacity judgements in labour are difficult and necessary, and proposes the CURVES model as a useful aide. The mnemonic stands for: Choose & Communicate, Understand, Reasoning, Values, Emergency & (no) Surrogate.[8]

We welcome the suggestion of also consulting a surrogate decision-maker before moving to opt-out consent—indeed a partner is very often present. We disagree, however, that this should replace opt-out consent. Mumford's proposal overlooks two key aspects of autonomy and the labour context that we emphasised. First, that asking consent expresses intrinsic respect for autonomy.[1 9 10] This function is not fulfilled (quite the opposite!) by surrogate or presumed consent. Second, some women are unwilling or unable to communicate much in labour, but are nonetheless paying attention and able to express objection.[1] Presumed or surrogate consent is inappropriate in that scenario. For the same reason, we express reservations about the CURVES method, women would be expected to briefly explain their reasoning, leaving their capacity in question if they do not. Women may have other things to do when pushing out a baby.

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Brione applies our approach to another intervention in labour: vaginal examinations (VE).[11] She rejects a role for opt-out consent because the 'careful limits' […we outline] 'do not transfer'[11]; VE, she argues are rarely, if ever, time-critical. Whilst one should never say never in obstetrics, we agree to the general dissimilarity Brione notes regarding typical indications for episiotomies and VE. We also agree that, as described by Brione, current consent practices surrounding VE seem to fall far short of ethical requirements. But this does not invalidate our suggestion about the wider applicability of our paper. On the contrary: Brione's careful, thorough and accurate application of our criteria to reject opt-out consent for VE demonstrates the potential for their wider application, whilst also illustrating that such application needs to engage the substance of the analysis rather than simply transpose conclusions.

Last (but not least!), Lanphier and Lomotey-Nakon constructively elaborate the role of racial, socioeconomic and other disparities in maternity care systems, and consequently the ethical need and mechanisms for making health care systems trustworthy.[12] We agree.

To sum up: neither informed consent alone, nor our proposal, can solve every problem in maternity care. Commenting authors noted several limitations and further challenges. But nearly all agree our proposal is a very significant and realistic step in the right direction, which can significantly improve the situation for vast numbers of women and healthcare providers. We particularly emphasise the importance of multilevel institutional support and ongoing education in its implementation,[2 3] and want to draw attention to our original discussion of the intrinsic value of asking consent: this retains significant value even among many other shortcomings and (perhaps especially) power differences.[1] Our practising healthcare providers, finally, emphasise that within the reality of a busy maternity ward there are very many challenges. We should not let the perfect be the enemy of what nearly all commentators agree is a very significant improvement, which has potential for (well researched and suitably modified) application to other interventions in labour.

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