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A stigmatizing dilemma in the labour room: Irrationality or selfishness?

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Abstract

Nowadays, a considerable number of women have a negative or outright traumatic birth experience. Literature shows that being involved in decision-making and exercising autonomy are important factors in having a positive birth experience. In this article, I explore the hypothesis that some views characteristic of the biomedical model of childbirth may hinder women's involvement in decision-making, leading them to what I have dubbed as a 'stigmatizing dilemma'; that is, to be perceived and treated as either irrational or selfish when trying to exercise their autonomy in the labour room. I suggest that such a stigmatizing dilemma arises when the following views are uncritically and unqualifiedly endorsed: (1) childbirth is a process fraught with risk, particularly to babies; (2) labouring women's reports are unreliable and their subjective perspective does not constitute a valuable source of information; (3) medical knowledge and procedures are the safest means to give birth. In a scenario where (1)–(3) are strongly endorsed, if birthing women act according to instrumental rationality and want the best for their babies, they will be expected to just leave decisions to medical experts. Thus, not following expert directions might lead women to fall under the stigma of either irrationality or selfishness: they could be perceived and treated as either irrational, since they may not seem to seek the best means to accomplish their goal; or selfish, since they may seem to pursue goals other than the baby's health. I examine these stigmas in relation to two ideals: that of disembodied rationality and that of selfless motherhood. I also explore different ways in which the views and prejudices underlying this stigmatizing dilemma could be challenged.

KEYWORDS
birth, epistemic injustice, obstetric violence, obstetrics, prejudice, shared decision-making

1 | INTRODUCTION

As scientific research progresses, evidence is accumulating that childbirth is a traumatic experience for a considerable number of women. It has been estimated that 4% of women meet diagnostic criteria for Posttraumatic Stress Disorder after giving birth—a figure that rises to 18% in the case of at-risk populations, which include women who experienced physical difficulties during birth, or who presented a history of sexual/physical violence, childhood abuse or mental health problems.[1] Given these figures, researchers frequently

draw attention to the need to gain knowledge of the risk factors and predictors of such mental health outcomes for women after childbirth.

As highlighted by a recent systematic review, although the available evidence regarding predictors and outcomes of the childbirth experience is often complex and even contradictory—presumably due to the use of different tools and methodologies among analyses—a number of studies, as well as a large body of qualitative literature, support the idea that perceived control and quality of care during labour are key factors.[2,3] Not surprisingly, emergency medical procedures—such as caesarean section—increase the risk of women having a negative birth experience.[2,3] Notwithstanding this, another recent systematic review did not find them to be a determining factor; that is, the birth experience can be positive even when facing serious complications.[4] Women's subjective perception of obstetric procedures and the staff performing them, participation in decision-making processes, and other variables related to psychosocial support during labour have been found to be key aspects.[4]

Despite the fact that legislation in advanced countries acknowledges autonomy and participation in decision-making as patient rights, there seems to be a lack of concordance between theory and practice.[5,6] In practice, many women experience a negative or downright traumatic childbirth, which seems to be related to their lack of control and involvement in decision-making.

Now, can philosophical analysis help us in addressing this situation? The hypothesis I explore in this article is that difficulties women encounter when it comes to being involved in making decisions in the labour room might be linked to the following views: (1) childbirth is a process fraught with risk, particularly to babies; (2) labouring women's reports are unreliable and their subjective perspective does not constitute a source of valuable information; (3) medical knowledge and procedures are the safest means to give birth. I will argue that an uncritical and unqualified acceptance of these views jeopardizes women's involvement in decision-making: if they are assumed uncritically, women's involvement hardly makes sense. Furthermore, I will argue that their uncritical acceptance leads women into what I have called *a stigmatizing dilemma*: attempting to exercise their autonomy or to engage in a shared decision-making process can lead women to be stigmatized for either their irrationality or selfishness.

2 | LAYING THE GROUNDS FOR A STIGMATIZING DILEMMA

The three views I have just introduced are characteristic of biomedicine and a biomedical model of birth. In this article though, I mainly focus on the second and third ones, as they are related to prejudices. Regarding the first of these views, however, we must not lose sight of the fact that the biomedical model of birth is risk-centred. In it, birth is usually regarded as an almost pathological process,[7,8] full of risks, particularly for the baby.[9] The biomedical discourse focuses on risk management to preserve health, and its notion of health is often too focused on physiology and thus neglecting both wellness and mental health. In addition, women's well-being is often presented in opposition to babies' health.[10] This view is important because it is the background against which decisions are made: given the high risks involved in childbirth, especially for the baby's physical health, it seems that we must be extra cautious in the choices we make.

Now, let us focus on these other aspects of the biomedical framework that are linked to prejudice. I am interested here in what could be termed as *the unreliability prejudice*; that is, the fact that patients are regarded as unreliable sources of information and their subjective reports lack value or utility. Nowadays, women's self-reports are too often dismissed in clinical settings.[11] This is an issue that has recently gained prominence in philosophy, in the area of social epistemology. In this regard, the notion of *epistemic injustice*, introduced by the contemporary philosopher Miranda Fricker in 2007, is useful for conceptualizing the problem. An individual, or a group of individuals, suffers an epistemic injustice when their capacity as subjects of knowledge is wronged due to prejudices; for example, a black person may suffer a credibility deficit due to racial prejudices. The philosophical analysis of epistemic injustice has been linked to the sociological analysis of stigma.[12,13] Stigma has an epistemic dimension when stigmatized individuals or groups of individuals are wronged as subjects of knowledge—when their reports are called into question; when it is assumed that they cannot contribute relevant information to a discussion; when they are stripped of the interpretative resources to understand their own experience, and so on.

One kind of epistemic injustice is testimonial injustice. The above example of the black person is an example of this type of injustice. Fricker states that "a speaker suffers a testimonial injustice just if prejudice on the hearer's part causes him to give the speaker less credibility than he would otherwise have given".[14] It has been argued that pregnant women suffer testimonial epistemic injustice in clinical contexts when experts diminish the epistemic privilege which they have over their own bodies.[15] It has also been argued that labouring women suffer from testimonial injustice. Sara Cohen Shabot, another contemporary philosopher, recounts her own childbirth as an example of it:

> "I'm in active labour," I said, bending, kneeling, hugging my partner's legs through an incredibly strong contraction. "Rooms are all busy," the midwife responded. "I'll need to check you to know if you're really in active labour. You'll have to wait if not." "But I am!" I almost cried. "Can't you see?" "I'll need to examine you vaginally," she responded, inflexible. That was the end of the conversation. […] I was 8cm dilated, the exam showed: in active labour indeed. I long considered that first, extremely painful, vaginal examination (one of many to follow) to have been the first violent, unnecessary procedure that I underwent

> during that labour, but as I reflected on it more, through theories of epistemic injustice, it became clear that the violence began earlier: when I knew something about my labour (through my body, the painful ripening of my cervix) and was not heard. My knowledge, my embodied certainty (throughout my labour), was firmly dismissed by the medical staff.[16]

In the biomedical framework, subjective perspective plays a very small part. Patients' first-person reports are often discredited, seen as unreliable and as having little value and utility. This happens to be the case in medical practice in general, as well as in obstetrics in particular.[17] Usually, biomedicine attributes greater value to what is regarded as *objective evidence*; for example, results of laboratory tests, imaging techniques, etc. than to subjective reports, which hardly qualify as *evidence*. Objective evidence can be relied upon, while subjective, patient-reported information does not enjoy the status of reliable evidence.

There are several prejudices among the reasons why patient testimonies are discredited. In this regard, the philosophers Havi Carel and Ian James Kidd highlight "the presumptive attribution of characteristics like cognitive unreliability and emotional instability."[17] If these prejudices can be found when considering medical attitudes toward patients in general, it is not difficult to appreciate that in the case of labouring women they can become exacerbated: the little value usually attributed to first-person reports is accentuated by the fact that labouring women are conceived of as extremely dominated by emotions, overwhelmed by the intensity of the experience and the loss of control over their own bodies.[18]

The unreliability associated with labouring women is twofold. On the one hand, they are denied the possibility of having knowledge about birth because they *only* have access to their subjective perspective, which is neither a source of evidence nor reliable. On the other hand, their first-person reports are unreliable because they are tainted by their extreme emotionality and lack of control over their own bodies. In contrast, medical experts have not only reliable knowledge—acquired through their professional training, as well as through objective observation and measuring instruments—but also reliable cognitive faculties, which place them in a privileged position to evaluate available evidence, assess risks, and deliberate on the procedures to be followed.

Unfortunately, I do not have space here to further elaborate on these views. Note, however, that it is not my aim to assess how frequently and deeply they permeate contemporary obstetrics—although I think that, according to the literature mentioned, there are good reasons to believe that they have a non-negligible presence, and that is why they are relevant. For they set the background for the dilemma I deal with in the remainder of this paper. Before moving on, let us summarize:

(1) Birth is fraught with risks, particularly for the baby. Labouring women's well-being is often opposed to babies' health.
(2) Labouring women have no knowledge of birth and their reports are unreliable. Their subjective perspective lacks value and utility. They are dominated by emotions and the loss of control over their own bodies.
(3) Medical knowledge and procedures are reliable; they are the best means for a safe birth. Medical experts have objective evidence about childbirth and the cognitive resources necessary to assess it.

Now, my point is that the more strongly—the more uncritically and the less nuancedly—these views are endorsed, the less room there will be left for shared decision-making to even make sense. Uncritical acceptance of these views leads to what I have called *a stigmatizing dilemma*. If (1)–(3) are strongly endorsed, then a birthing woman who wants the best for her baby and acts according to instrumental rationality will be expected to just leave decisions to the medical experts. Briefly put, exercising instrumental rationality requires acting according to the best available means to achieve one's ends. If a birthing woman is in an unreliable epistemic position and medical experts are the ones who hold knowledge and resources, delegating decision-making to them is the best thing she can do to achieve a safe delivery—all the more so given a high-risk scenario, where human lives are at stake.

I suggest that If we are fully committed to (1)–(3), and a labouring woman questions medical decisions and wants to exercise her autonomy or engage in a shared decision-making process, she comes to face a stigmatizing dilemma: her questioning medical decisions could lead to the stigma of either instrumental irrationality or selfishness. On the one hand, if her ultimate goal is preserving the baby's health and she questions medical decisions, she could be perceived as violating the mandate of instrumental rationality that tells her that she should pursue the best means to achieve her ends. On the other hand, her questioning medical decisions may not be indicative of instrumental irrationality, but of selfishness: she might be questioning medical decisions because delivering a healthy baby is not her ultimate goal.

Let us now address these two stigmas. I begin with the first one: irrationality.

3 | THE IDEAL OF REASON AND THE STIGMA OF IRRATIONALITY

Rationality has long been understood in a disembodied way and in clear opposition to emotion.[19] The split between reason and emotion is a characteristic trait of the foundations of Western culture,[20] as is the association of women with emotionality.[21] There is no doubt that throughout history women have suffered the stigma of being too unstable or too emotional. The perception of women as irrational beings even permeated the beginnings of obstetrics, as can be seen in the debates surrounding the alleged influence of the uterus on women's cognitive abilities.[18] Needless to say, the same pernicious conception of the uterus can be found in psychiatry, in hysteria. As the contemporary philosopher Stella Villarmea provocatively phrases it, "when a uterus enters the door, reason *must* go out the window."[22]

Rationality also goes hand in hand with self-control, control of impulses and of one's own body, which is also an aspect that differentiates us from animals. From these coordinates, it is not difficult to appreciate that a woman in labour might be perceived as extremely irrational: she is dominated by her emotions and she has apparently lost self-control. Labouring women definitely do not seem to fit in the paradigm of disembodied, classic rationality.

Building on this conception of rationality and having set (1)–(3) in place, it would seem that the only sign of not being utterly irrational that would be left for women is to demonstrate their practical rationality by delegating their decisions to medical experts. If we uncritically endorse that medical knowledge and procedures are the best means to deliver a healthy baby, we can hardly say that if a woman has the goal of giving birth to a healthy child and goes on to question medical decisions, she would be acting in accordance with reason.

Now, is there any way to escape from this conclusion? What if she gives credit to her own subjective perspective, to the knowledge she has of her own body due to the privileged perspective she has of it? What if she knows what she has to do? Actually, it seems rather bold to assume that women are *completely* unaware of what is going on in their own bodies during birth and of what may be necessary for birth to progress normally; for example, to know when to push, when to walk, or what position to adopt. True: labouring women seem far from the paradigm of disembodied, classic rationality—a paradigm which is nevertheless highly questionable—but given that childbirth is a natural process and has thus been subject to evolution for a very long time, it would be pretty surprising if the state of mind in which labouring women find themselves were entirely inadequate for the aim of giving birth. Quite the opposite; it has been suggested that the state of consciousness that labouring women go through may precisely be what facilitates the normal course of labour.[23–25] If one adopts such a naturalistic account, it becomes easier not to flatly dismiss labouring women's first-person reports and their agential capacities. Endorsing too narrow a view of rationality and agency can lead us to stigmatize those who do not conform to this ideal, to consider them unfit to make their own decisions, and to reject the information they report on their own bodies.

Thus, if we come to accept that labouring women have some knowledge—and that their perspective is not flawed by their emotionality and lack of self-control—about the proper means to give birth, they would indeed exert their instrumental rationality by acting upon it. To argue that women also possess knowledge of their own childbirth is not tantamount to undervaluing medical knowledge. My point is that women's first-person reports should also be considered a source of information, rather than being plainly dismissed as subjective and irrational. Recognizing women's epistemic capacities not only removes us from epistemic injustice, but also puts them in a better position for decision-making, as they will not always be entirely dependent on the third-person information that experts convey to them. In saying this, I do not mean to simply reject medical knowledge of birth; indeed, there are situations in which it is *extremely* useful. However, we should not overlook the fact that this knowledge is often constrained by a risk-centred view of birth; and sometimes "too much knowledge"; for example, too much data, as sometimes happens when employing continuous foetal monitoring, which stresses women and makes them afraid of something going wrong, can paradoxically even be harmful.[26] I also do not mean to say that *all* labouring women are by default in an optimal state of mind for childbirth: unfortunately, in some cultures the experience of childbirth is shrouded in a halo of fear. Properly attending to the subjective aspects of birth involves providing adequate emotional support to women and offering them the security and reassurance needed for birth to progress normally.

So, to sum up: labouring women who question medical decisions may be seen as irrational—a conception fuelled by the traditional disembodied view of rationality—if it is uncritically assumed that they lack knowledge and that medical means are always best for managing risk in childbirth. One way to avoid this is to recognize that women also have embodied knowledge of their own childbirth and that technical means may not always be best for managing risk, as illustrated by the fact that continuous foetal monitoring can be counterproductive due to the stress it causes some women.

Now, there is another aspect to consider when addressing decision-making in childbirth: the role of values. The point I want to make here is that we cannot simply dismiss a person's rationality when conflicting values may be involved. Decision-making is always value-laden. Values guide us to choose the right course of action. If they are not shared by the people involved, discrepancies may arise as to what is the right thing to do. This means that not every disagreement with expert opinion is a sign of irrationality; it may be indicative of a conflict in values and the goals pursued. A woman who puts her own well-being and health before that of her child may be acting in a perfectly rational manner: she may well be weighing risk differently to other people, according to their own values. We could of course question the ethical character of her values and decisions—doing so is beyond the scope of my paper, though. However, I want to emphasize that we must be extremely careful not to adopt a stigmatizing attitude toward women who care about anything other than the baby's health—an issue that I address in the next section. Firstly, because judging which sacrifices might be ethically required of women is by no means a simple matter, and, what is more, because women have a right to autonomy, and depending on the legislation of each country, it may not even be legally possible to question birthing women's decisions at all, even if they involve a fatal outcome for the baby.[27] Let us not forget that in shared decision-making, what is shared is the process of deciding—the final decision still belongs to the patient.[28]

Secondly, because there is often no real opposition between women's values and their babies' needs: respecting women's values and supporting their agency contributes to safe childbirth.[24] In this regard, it is worth mentioning the findings of a recent systematic qualitative review on what matters to women during childbirth:

> most women around the world hope for a labour and birth experience that enables them to use their

> inherent physical and psychosocial capacities to labour and give birth to a healthy baby in a clinically, culturally, and psychologically safe environment with continuity of practical and emotional support from a birth companion(s), and with kind, sensitive clinical staff, who provide reassurance and technical competency. Most women place a high value on their capacity to give birth physiologically (expressed variously as 'normal' or 'natural', or without technical or pharmacological interventions) for the short and longer term physical and psychological wellbeing of themselves, their baby and their family; however, they also acknowledge that birth can be an unpredictable and potentially frightening event, and that they may need to 'go with the flow'. Even where intervention is needed or wanted, women usually wish to retain a sense of personal achievement and control by being involved in decision-making.[29]

If we regard childbirth as full of risks for the baby, consider that the right thing to do is to minimize such risks at *all* costs and assume that it can be accomplished by medical means, then we could actually be blocking the autonomy of those labouring women who do not share this view. Note that I do not mean that women do not, or should not, want to minimize the risks to the baby, but it turns out that women are, in fact, concerned about several different things in childbirth—and all of these come into play, with a varying weight, in assessing the course of action to be taken and in establishing preferences regarding birth outcomes.

So, to conclude before moving on to the next section: prejudice should not lead us to perceive women's intentions to be involved in decision-making and to exercise their agency and autonomy as a sign of irrationality. To this end, it is key to recognize that women also have some knowledge about their own bodies, as well as their own values guiding their actions. As we have seen in this section, the ideal of disembodied rationality may make it difficult for us not to adopt a stigmatizing attitude toward women in labour, who do not meet this ideal. Let us now address another ideal in the next section—that of motherhood—which may also make it difficult for us to respect the actions and decisions of women who do not show the selflessness that is supposed to be distinctive of mothers.

4 | THE IDEAL OF MOTHERHOOD AND THE STIGMA OF SELFISHNESS

The emergence of the stigma of selfishness is closely connected to the normative ideal of motherhood. According to this ideal, mothers are, and must be, selfless beings. "The ideal mother and the ideal, potentially pregnant female are culturally framed as selfless women who have abandoned—or at the very least are prepared to abandon—their former, childlike, and self-centred selves for a higher version of womanhood."[30] In this regard, birth is conceived of as the first sacrifice a mother has to make for her child: it is a rite of passage.[31]

This view can certainly be found in significant cultural elements, such as the religious conceptions of childbirth which "bind morality to embodiment through their view that suffering in birth is a legacy of Eve's 'fall'".[30] Although, of course, not all women and not all caregivers share it, some of them actually do, as we can appreciate in the following excerpt from Kaylee, a respondent from a study on women's perceptions of birth decisions:

> Childbirth is messy. It is, you know? It's never pretty. That's a sacrifice you make, that's your rite of passage. … If you're not ready to sacrifice your body for this child, then what are you really willing to sacrifice for this child, and why are you having children? … I mean, why wouldn't you want to have your body go through whatever it has to [in order] to give birth?[30]

Failure to meet this ideal can lead to the stigmatization of women. Those who are not passive and question medical decisions may be stigmatized for not meeting the mother's ideal of self-sacrifice. In this regard, it has been suggested that motherhood is sometimes used as a *weapon*, as a means to gain leverage and control over women who disagree with medical experts. As the sociologist Nicole Hill recounts,

> During a research project I recently completed, one doula explained to me that when a healthcare provider uses what she calls "the dead baby card" (the threat that whatever the birthing person was refusing to do would kill their baby), they are no longer providing information about risks and benefits of a given procedure; instead, the health of the baby is being used to guilt or scare an individual into compliance.[32]

Note that I do not want to question the fact that emergency medical procedures are indeed sometimes necessary to save babies' or women's lives. However, the stigma of selfishness can be exploited to stifle the autonomy of women in childbirth. This is more likely to occur when childbirth is conceived of as an inherently risky process. A Canadian study on care providers' strategies for minimizing risk in the management of childbirth found that "care providers who relied on surveillance, interventions, and plotting courses that emphasized risk were more likely to exert their control and feel strong through minimizing women's power and control and, ultimately, their integrity."[33] This study highlights that some care providers frequently talk about "pulling the dead-baby card" when they felt that their need for control was more important than that of the woman's, whether or not the baby's life was really at risk. "'Well, you don't want your baby to die, do you?' We call it pulling the dead-baby card. We really want you to do this thing […] Some were for things that were not life-or-death situations."[33]

Through the stigma and accusation of being selfish by putting the baby's life at risk, any decision-making process is undermined. In my view, the fact that this card is pulled not only shows adherence to a conception of childbirth as a process fraught with risks—for the card is even pulled in the absence of a life-threat—but the assumption that women must adopt the passive, selfless role that is proper to them. Women who do not comply might be thus labelled as both bad patients and bad, selfish mothers, and discriminated against. Going beyond this, it might seem that when women express concern for anything other than the baby's health, they are not living up to what the ideal of motherhood demands from them. Consider the following passage from Havi Carel and Ian James Kidd's paper on epistemic injustice in healthcare:

> "That really, really hurts," says the woman who has just given birth. The doctor is sitting by her splayed feet, which rest on stirrups either side of him. He is stitching her vagina, his face inches away from her body. A crowd of doctors and nurses surround the baby lying a few feet away. [...] But none of them seem to hear, or respond to, the woman's complaint. She repeats: "That hurts. Are you using anaesthetic?" "No", the doctor replies calmly, "there is no need to. I'm nearly finished". The woman is too exhausted to persist and she says nothing more. It is hard to imagine another situation in which we would not offer pain relief to someone having a needle pushed through their genitals. But in this case the woman's testimony is not acted upon. Her pain is either not fully registered or not considered worthy of response.[17]

I agree with the statement that it is hard to imagine another situation in which we would not offer some kind of pain relief to someone being stitched up and complaining about pain. But I would add that it is even difficult to understand the reasons for someone not to offer anaesthesia in *this* situation. Are we dealing here with a case of epistemic injustice or with something else? Does the dismissal of this woman's report have to do with a prejudice about the unreliability of her expression of pain? Is it even possible that doctors and nurses do not *believe* her words when she complains that she is in pain? In my view, the fact that her complaint is dismissed does not merely stem from her not being attributed credibility, but rather from her failing to meet the ideal of motherhood. Is it maybe a *small* sacrifice she has to make to prove her selflessness as a mother? Perhaps her pain should not matter, as it should pale in comparison with the joy of having given birth to a healthy child?

The stigma of not being a good mother, or a good patient either, is exacerbated in contexts of stark social distance between patients and care providers. In such contexts, "women's near complete submission and compliance during the birth process"[34] has been documented. "Not pushing as instructed or changing birth positions are viewed as transgressions that warrant castigation according to providers and sometimes women themselves".[34] Labouring women are expected to be compliant and do whatever it takes to deliver their baby, even if that means enduring slaps or pinches from caregivers as a way of encouraging them to push. Some acts of mistreatment are seen "as 'supportive' practices to help mothers through the birthing process."[35] This is how a 26-year-old Ghanaian woman put it when asked about the acceptability of nurses carrying out such practices:

> Sometimes when [labouring women] are told to push, they don't push, they will be lying there doing nothing. So, to avoid being tagged that those on duty caused the death of so and so number of children they will do whatever it takes.[35]

When this woman was asked how she would feel if this happened to her, she replied, "If it's for a reason to save my baby I will accept it."[35] The fact that not only caregivers, but even some women, believe that those who do not obey expert directions deserve to be mistreated might be indicative of the pervasiveness of the social stigma to which women who do not adopt the expected role are subjected.

However, it is not necessary to look at countries featuring marked social inequality to find that women cannot easily get involved in decision-making. A mixed methods study on Norwegian women identified "not being seen or heard"—which encompasses a lack of participation when decisions were made during labour and a feeling of being left alone—as one of the major themes embedded in the participant's negative experiences of childbirth.[36] More to the point, a recent survey conducted in Switzerland, involving more than 6000 women, estimated that approximately one in four had experienced some kind of informal coercion during labour—which can be employed to urge women to accept obstetric interventions. Informal coercion "encompasses a range of measures on the continuum between self-determination and formal coercion, including inducement, persuasion, manipulation, pressure, and threats."[37] One form of informal coercion involves not having enough time for decision-making. In this regard, around 80% of women who had an instrumental birth or an episiotomy felt that they were not given enough time to make their decision. Emergency caesarean section was found to be associated with the highest rate of informal coercion: 37% of women who had an emergency caesarean section reported feeling intimidated—that is, they responded in the affirmative when asked whether they "had been made anxious that something could happen to me or my child if I did not agree to the procedure"[35]—which sounds rather like pulling the dead baby card again.

If childbirth is conceived of as a process full of risks and women are expected to put babies' health before everything else—to even put everything else aside, whether necessary or not—questioning medical instructions or decisions can be interpreted as a manifestation of selfishness, which leads to the stigmatization of women who do not conform to the ideal of motherhood. The uncritical acceptance that childbirth is a process fraught with risk, particularly to babies, makes it remarkably difficult for women to care about anything other

than the baby's health without falling into the stigma of selfishness. The use of the dead baby card demonstrates this point well—and it is also a display of the obedience expected from women during childbirth.

5 | CONCLUSIONS

Supporting women's agency and involvement in decision-making in childbirth is an important aspect in promoting women's mental health after giving birth. However, some prejudices and views may stand in the way of doing this. Caregivers should therefore be alert to any prejudices they may consciously or unconsciously harbour, so as not to adopt a stigmatizing attitude toward birthing women. First of all, birthing women's perspectives should not be dismissed on the basis of an overly narrow conception of rationality that leads them to be stripped of their agency. Secondly, the right course of action should not be prejudged, since every decision involves values and these can sometimes be conflicting. Needless to say, the self-sacrificing ideal of motherhood should not be used as a weapon to coerce the freedom of women in childbirth.

In addition to being alert to prejudice, it is also necessary to adopt a critical stance toward some views characteristic of the biomedical model of childbirth, since they can lead women who question medical decisions to what I have called *a stigmatizing dilemma*; i.e., to be perceived and treated as being either irrational or selfish. As I have argued, for autonomy and shared decision-making to even make sense, it is necessary to reconsider any, or all, of these views. My suggestion is that the following points are a good place to start and deserve serious consideration:

(1) Childbirth sometimes presents risks, but it is a natural process that usually progresses normally. In addition, women's well-being and health promotes babies' well-being and health.
(2) Childbirth is an emotionally intense experience, but women's subjective perspective is not inherently flawed and unreliable due to their emotionality. Women are knowledgeable about what is going on in their own bodies, and their reports should be taken into consideration.
(3) Medical knowledge and resources are sometimes extremely helpful, but medical experts are not the only ones with the knowledge and resources required to assess the best means for safe childbirth. Moreover, medical procedures are not always necessary and, when unnecessary, may increase the risk instead of reducing it. Psychosocial support for women is a key element in promoting the normal course of labour and thus reducing risk.

Finally, I want to once again stress that this paper should not be taken as head-on opposition to the medical model of childbirth. However, some views of this model should be critically analysed — and this must be done in accordance with the evidence available. Such evidence shows that the lack of adequate psychosocial support and involvement of women during childbirth has serious costs both for their mental health and for the course of the childbirth itself. In the labour room, the need for medicine to be both evidence-based[10] and values-based becomes especially compelling.[38] For evidence suggests that taking women's values and needs into consideration, and supporting them, not only results in greater subjective satisfaction, but also in fewer risks, fewer interventions, and better health outcomes for them and their babies.[39]

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Data sharing is not applicable to this article as no data sets were generated or analyzed during the current study.

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