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The ethics of consent during labour and birth: episiotomies

Marit van der Pijl [1,2,3,4] Corine Verhoeven, [1,2,3,4,5,6] Martine Hollander, [7] Ank de Jonge, [1,2,4,8] Elselijn Kingma [9]

For numbered affiliations see end of article.

Correspondence to
Marit van der Pijl, Amsterdam UMC Locatie VUmc, Amsterdam, 1081 HV, Netherlands;
m.vanderpijl@amsterdamumc.nl

Received 19 August 2022
Accepted 26 December 2022
Published Online First
30 January 2023

ABSTRACT

Unconsented episiotomies and other procedures during labour are commonly reported by women in several countries, and often highlighted in birth activism. Yet, forced caesarean sections aside, the ethics of consent during labour has received little attention. Focusing on episiotomies, this paper addresses whether and how consent in labour should be obtained. We briefly review the rationale for informed consent, distinguishing its intrinsic and instrumental relevance for respecting autonomy. We also emphasise two non-explicit ways of giving consent: implied and opt-out consent. We then discuss challenges and opportunities for obtaining consent in labour and birth, given its unique position in medicine.

We argue that consent for procedures in labour is always necessary, but this consent does not always have to be fully informed or explicit. We recommend an individualised approach where the antenatal period is used to exchange information and explore values and preferences with respect to the relevant procedures. Explicit consent should always be sought at the point of intervening, unless women antenatally insist otherwise. We caution against implied consent. However, if a woman does not give a conclusive response during labour and the stakes are high, care providers can move to clearly communicated opt-out consent. Our discussion is focused on episiotomies, but also provides a useful starting point for addressing the ethics of consent for other procedures during labour, as well as general time-critical medical procedures.

Linked

► http://dx.doi.org/10.1136/jme-2023-109193
► http://dx.doi.org/10.1136/jme-2023-109205
► http://dx.doi.org/10.1136/jme-2023-109210
► http://dx.doi.org/10.1136/jme-2023-109211
► http://dx.doi.org/10.1136/jme-2023-109212
► http://dx.doi.org/10.1136/jme-2023-109213

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To cite: van der Pijl M, Verhoeven C, Hollander M, *et al*. *J Med Ethics* 2023;**49**:611–617.

INTRODUCTION

A consistent theme among birth rights activists[1 2] and in research on negative and traumatic birth experiences is the invasion of labouring women's bodies without consent.[3–5] The extreme end of this spectrum is the forced caesarean section: a well-known, but rare phenomenon whose (il)legitimacy has sparked decades of bioethical discussion.[6] Many other procedures, however, are also administered without consent in labour, and much more frequently.

Unconsented procedures during labour and birth are known to be a worldwide issue, reported in several countries across the globe.[7] For example, in a recent Dutch study, 7% of women reported unconsented vaginal examinations, 36%–38% unconsented foetal monitoring and 42% unconsented episiotomies.[8] In other countries, similarly high numbers of unconsented procedures were found. For example, in Australia, 34% of the women reported unconsented episiotomies. In Italy, this was 39%.[9 10] Unconsented procedures feature prominently among cases referred to as 'disrespect and abuse' during labour and birth, or 'obstetric violence'.[11] Women in both the Netherlands and the UK report minimal information provision and a lack of choice regarding procedures such as episiotomies, which can be experienced as distressing and plays a significant role in self-reported negative and traumatic birth experiences.[12 13] The burden of unconsented procedures is not evenly distributed over groups,[14 15] matching widespread evidence of racial, socioeconomic and other disparities in maternity care.[3 16] Yet, despite the evidence, there is hardly any discussion in the literature on the ethics of consent for procedures in labour.

One may consider such discussion unnecessary: of course all procedures in labour, like all medical procedures, require consent. But the issue may be more complicated. Care providers frequently express surprise that consent should be necessary.[17] They cite, among others, the trusting relationship as grounding the permissibility of these procedures, and the diminished ability or desire of labouring women to engage in elaborate communication.[17] Indeed, there is some evidence that not all women want to give consent for every procedure.[13 18] Thus, neither the need for informed consent during labour and birth nor its procedural implementation (if needed) is as straightforward as one might expect. This may explain why disrespect and abuse in maternity care are such complex and prevalent phenomena.[8] It also shows this is a topic that needs urgent investigation.

In this paper, a multidisciplinary team of researchers (midwifery, obstetrics, philosophy/ethics) aims to properly address the under-researched questions of whether, when, how and under what circumstances consent should be obtained in labour. We focus our discussion on the use of episiotomy: an intrapartum procedure that involves an incision to enlarge the vaginal orifice. This discussion has broader relevance. First, it may apply to intrapartum procedures other than episiotomies where consent is also frequently lacking, and which are under-researched.[i] Second, our discussion is relevant for medical procedures outside obstetrics/midwifery that are different from the two domains on which the literature on informed consent mainly focuses: either large, very invasive, plannable procedures, such as abdominal surgery, or clinical research participation. Although we believe the arguments raised in this paper are applicable worldwide, the main focus of this paper is on high-resource settings. The research question for the current paper is: is consent for performing an episiotomy during

[i]For example, consent for vaginal examination, epidurals, foetal monitoring, augmentation of labour.

labour ethically required and, if so, how should this be procedurally implemented in maternity care?

First, we explain what an episiotomy is, as well as its use and consequences. Then we briefly recap the ethical requirement of informed consent distinguishing its intrinsic and instrumental role in respecting autonomy. We also review means of giving consent other than fully informed, explicit consent, particularly focussing on implied consent, opt-out consent, presumed consent and the right not to know. In the following section, we document the challenges and opportunities for obtaining consent posed by the particular nature of labour and birth, followed by challenges and opportunities posed by the specific nature of our focus-procedure, episiotomy. In the last section, we argue that the described challenges cannot undermine the moral need for obtaining consent, but do complicate its procedural implementation. We recommend an individualised approach where the antenatal period is used to exchange information and explore values and preferences with respect to the relevant procedures. Some women may want to consent to procedures in advance; others may only want to decide during labour and birth; some may want to do so on the basis of more information than others. Still, explicit consent should always be sought at the point of intervening, unless women antenatally insist otherwise. We caution against implied consent, due to the nature of labour and birth. However, if a woman does not give a conclusive response and the stakes are high, the care provider can move to clearly communicated opt-out consent.

WHAT ARE EPISIOTOMIES?

An episiotomy is a surgical incision in the pelvic floor to enlarge the vaginal orifice, made when the baby's head emerges during the second ('pushing') stage of labour. It can be performed to promote either the mother's or baby's health, or both. It is most often performed in order to facilitate (faster) birth of the baby in case of suspected foetal distress. An episiotomy is also commonly used to prevent severe perineal trauma, for example, during an assisted vaginal birth in order to protect the mother against (larger) tears through the rectum. Other indications can be a history of major perineal tears, high estimated foetal weight, breech birth, prolonged second stage of labour and shoulder dystocia.[19] The incision is generally done with scissors under local anaesthetic and requires repair by suturing. There are several types of episiotomies, the two most common being: 'median/midline'(a vertical incision) and 'mediolateral' (an angled/diagonal incision).[20] The current paper focuses on any type of episiotomy, independent of type or whether the cut was big or small; all involve a surgical incision. The procedure is associated with increased blood loss, swelling, infection, pain (in the immediate postpartum period and sometimes longer) and sexual dysfunction.[21] Precise numbers on consequences are difficult to obtain. Sexual dysfunction, for example, occurs frequently in women who recently gave birth, but its direct relation to an episiotomy is difficult to estimate.

Historically, the perceived benefits of an episiotomy led to its routine use, but this has become controversial.[20] Based on the existing literature, the WHO included the following statement in their most recent intrapartum guidelines (2018): 'Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth'.[22] Even so, it is still a widespread procedure with large international variations in incidence: in first births, 6% in Sweden, 7% in Denmark, 24% in Iceland, 35% in Norway, 38% in the state of Hesse, Germany, 41% in Malta, 46% in the Netherlands, 46% in Finland, 47% in Ireland and 68% in Belgium.[23] The ambiguity of relevant indications and the variable use of alternative interventions such as applying warm compresses or suggesting other birthing positions[22] may be significant factors in explaining the wide variation in the procedure's incidence.[24]

INFORMED CONSENT

The ethical requirement of informed consent embodies respect for patient autonomy and bodily integrity.[25] Consent is morally transformative: it changes the nature of an act from, for example, assault, to permissible touching or treatment. Consent should be (1) voluntary (ie, free from coercion or pressure) and (2) adequately informed. Voluntariness requires that patients have and know they have alternative options, including the option to decline, and that there is no pressure to consent. The information requirement is discussed in detail below, but ideally it requires patient involvement throughout the decision-making process by means of information exchange between care provider and patient. This should culminate either in the patient's voluntary informed consent, or refusal, or in choosing an alternative option.[26]

Asking for consent respects the patient's autonomy and bodily integrity both instrumentally and intrinsically.[27] Instrumentally, because the communication required for consent entails disclosing risks, benefits and alternatives of treatment options to the patient. Discussing these aspects can unveil patient preferences previously unknown to the care provider. This ensures that the treatment plan is aligned with the patient's values. Intrinsically, because asking permission before one invades another's body gives explicit recognition that this body is the other person's to govern and command. This means that even when the care provider and patient discussed all benefits, risks and values and it is clear the patient will consent, it is still important to ask for consent at the point of intervention.

Informed consent is not just an ethical, but in many countries also a legal requirement. In theory, the latter realises the former. In practice, there can be tension between the two. 'Ticking the box' or putting a signature on a form may legally seem to secure consent, but often falls short of ethical consent.[28 29] Rather than actually involving the individual and respecting their autonomy, which is the main principle supporting informed consent, it may instead undermine it.[29] This can lead to care providers' perceiving informed consent as a legal nuisance without true meaning. It could also diminish (all forms of) trust, due to the suspicion that legal documents raise among patients.[28] Since the ethical ought to underpin the legal, our focus in this paper is on the concept of ethical consent.

How can a patient give consent? Most of the consent literature focuses on the ideal of explicit, informed consent: the patient is asked for consent only after being involved in the decision-making process and having received and understood all relevant information about risks and benefits of, and alternatives to, the proposed procedure. Consent, if given, is explicitly communicated: in writing, verbally or both. The relevant context is often large plannable therapeutic procedures, such as surgery, or clinical research participation.[30]

But in practice, consent procedures nearly always fall short of this ideal. It is widely recognised that practical difficulties make fully informed consent impossible to implement. For example, providing a lot of information is not always better as it can leave patients overwhelmed and lost. Patients also frequently seem to forget or misunderstand some or all of the information given.[31] The information requirement therefore needs to be tailored to the cognitive ability and preferences of the individual patient: it needs to be relevant and comprehensible.[32] In practice this means care providers need to tread a fine and individualised line between giving too much and too little information; between helping the patient decide and interfering too much; and furthermore judge what is and is not relevant given this particular patient's situation, preferences and values.

The above means patients routinely consent to procedures based on limited to no information. Some authors therefore separately distinguish 'simple consent': where patients consent to non-minimally or minimally invasive procedures—such as a blood draw or a general practitioner's physical examination—without (hardly) any information. This consent can still be genuine because the procedure is minimally risky and shared background knowledge constitutes much of the relevant information.[33] We do not formally distinguish simple consent and informed consent, however, because we consider the former to be the extreme end of the consent spectrum—with the regulative ideal of fully informed consent at the other end.

Although information provision is the standard for obtaining consent, patients can invoke the right not to know. When a patient wishes to receive limited or no information about a certain procedure, this wish should be honoured, but only on the condition that 'not knowing' is not likely to cause any serious harm for self or others. The right not to know can only be activated by the patient and can never be presumed.[34] The right not to know does not undermine the ethical ideal of informed consent or patient autonomy: when the patient wishes not to know and consents to or refuses a procedure, the patient makes a voluntary autonomous decision, not on the basis of information, but on some other basis, such as complete trust in the beneficent judgement of their care provider.

Compared with the information requirement, the question of how consent can and should be directly communicated has received little discussion in the literature. We distinguish three ways of giving consent other than explicit (verbal or written) consent: (1) implied consent; (2) opt-out consent; and (3) presumed consent.

Implied consent does not involve a verbally or non-verbally communicated 'yes' or 'no', but instead is clearly communicated through the patient's actions, which implies agreement to the procedure.[35] Examples include: rolling up one's sleeve for an injection or blood draw; starting to fill out an optional survey (which implies consent to be surveyed); or voluntarily moving in a certain position that is required for a procedure to be carried out. For actions to constitute implied consent, several conditions have to be met: patients must know (roughly) what is going to happen and must be sufficiently informed and aware of their rights to know they have (other) options.

In opt-out consent, there is no active verbal or non-verbal action or communication that states or implies consent; rather the giving of consent is made the default choice, and the not-giving consent requires verbal or non-verbal action.[36] For example, in the Netherlands, the perinatal data of all pregnant women are automatically (and anonymously) stored in a national database for the purpose of monitoring and research. All pregnant women are informed of this in the antenatal period, and told that their care provider will deregister them if they object. Again, there are strict requirements for not-opting-out to constitute consent: patients need to be informed that they are consenting by not opting-out; what they are consenting to by not opting-out; and what they need to do to opt-out. Moreover, the opportunity to opt-out needs to be realistic and feasible (in terms of time and ease).

Both implied and opt-out consent thus meet the two requirements for consent: there is an information requirement (patients must know what they are consenting to and what constitutes consent) and a voluntariness requirement (patients must have feasible alternatives to consenting, know they have these alternatives and not feel pressured in consenting). We also emphasise that all forms of consent have a scope: rolling up one's sleeve to receive intravenous fluids does not imply consent for anything else being administered, and consenting to a vaginal examination does not mean consent for additional internal actions, such as amniotomy. Finally, it is important to not confuse consent with compliance, particular for its implied and opt-out versions. Compliance means that a patient passively submits to a procedure, for example, because they believe they must do what the care provider says; they have not been given information or feel pressured; or because alternatives to consenting are made difficult. It is crucial—particularly in the context of this paper—to recognise the difference between consent and compliance.[37]

Situations can occur where patients are unable to consent, for example because they are unconscious. Here, treatment can still be permissible if the care provider can legitimately presume consent. But there are essential requirements for this exception to informed consent to be valid: there needs to be a medical emergency; the procedure is needed to prevent significant harm to the patient; and it needs to be impossible or impractical (ie, because it incurs medically unacceptable delay) to obtain consent from the individual or a third party who is authorised to consent on the individual's behalf. Finally, there should not be any reason to suspect that the patient would have refused if there was an opportunity to provide consent.[38] For example, consent can reasonably be presumed when an individual is brought into the emergency room unconscious and care providers have to perform a life-saving blood transfusion, but not if the patient is a known Jehovah's witness.

We finish our discussion of consent by emphasising the important role of trust in ethical consent procedures. Trust, much more so than a legalistic approach, is relevant and essential to the ability to give informed consent.[39] At one extreme, patients may take a small role in the decision-making process and consent because they trust the care provider to 'do the right thing'. At another extreme, patients may want to take full control of the decision-making process—but then they still tend to trust, when consenting, that they are not being manipulated; that the care provider gives honest information and advice; that the care provider will act in line with their decision, etc.[29] In turn, demonstrating respect for consent and autonomy demonstrates trustworthiness, and thereby builds trust.

O'Brien *et al* identified three inter-related forms of trust relevant during labour and birth: trust in self, trust in the relationship and trust in the system.[40] Trust in self influences the way women make choices. Women with a high trust in self are often more confident and make more autonomous choices. Factors such as age, the quality of the relationship with the care provider, trust in one's own intuition and prior birth experiences influence the level of trust in self of labouring women, but it is also highly influenced by the second form of trust: trust in the relationship. Trust in the relationship covers the interaction between two individuals; in this case the patient and the care provider. A lack of trust undermines communication and consent because of fear and suspicion; too much trust may lead to situations in which information important to giving consent is not exchanged.[41] For example, the patient may consent to a procedure without knowing its (possible) consequences, trusting that the care provider had shared such information if relevant. However in retrospect, the patient may have wished to decide differently had they known about the possible consequences. To build trust in the relationship, time and personal attention is needed. The latter is closely related to the third form of trust: trust in the system. Women can develop distrust in the care environment due to various reasons. Care providers may face systemic obstacles, such as lack of resources and time, to build and maintain trusting relationships with their patients. A system of care that devalues relationships due to protocols and guidelines can jeopardise the climate of trust which in turn can erode the system's ability to meet the ethical requirement of informed consent.[40 42]

We need to be aware that the more we depart from the ideal of fully informed, explicit consent, the more important the role of trust

seems to be. Consent is then based on the assumption that the care provider knows what is most important to the patient, and that non-explicit communication between the two is successful. This is more easily realised when the care provider knows the patient well, suggesting that the ethical requirement of consent is an independent argument in favour of continuity of care.[43] Indeed, when a patient has no trust in the system, it may still be possible to build up a trustful relationship with a particular care provider in the antenatal period, and this may be essential to realise adequate care. However, it also poses complications because it is difficult to guarantee whether this care provider will also be present during birth.

THE NATURE OF LABOUR AND BIRTH

The context of labour and birth is unlike the usual healthcare setting in a number of ways. This not only poses challenges, but also presents opportunities, for obtaining informed consent.

First, and uniquely, during labour and birth the health and interests of two (future) individuals are at stake: mother and child. But there is only one person who is the direct subject of proposed procedures, and is able to consent or decline. Even if a procedure is solely focused on the future baby, the mother retains the ultimate authority to consent, decline or seek an alternative, because it is her body that is interfered with.[6ii]

Second, maternity care is one of very few areas of medicine in which treatments involving (risk of) harm are regularly carried out on one individual (the mother) with the sole aim of benefitting the health of another (the future child). In other fields of medicine where individuals are treated and/or harmed for the benefit others, that is, organ donation or the research context, stringent consent requirements are in place.[44] Maternity care should be no different.[45]

Third, in maternity care, care providers' work involves the most intimate and socially sensitive body parts of their patients. Examinations on these body parts can be experienced as particularly complicated and invasive; perhaps much more so than the care provider, for whom these examinations are routine, realises. Moreover, the social meaning of these body parts leaves a very small margin for error because invasion of these body parts without consent is an, unfortunately, relatively widespread and well-known social phenomenon with a specific degrading, humiliating and dehumanising meaning. The medical setting cannot fully escape this connotation.[45] This too means that extra care is needed to ensure one only touches and invades these body parts with consent.

Fourth, the nature of labour means time and capacity for discussion and information provision can be limited; both because some decisions are time-critical, and because the woman may be preoccupied, tired and/or in pain. Some studies show evidence of women not being able to recall information and consent procedures postpartum due to the intensity of labour.[46] This is frequently used to suggest or argue that women lack decision-making capacity in labour.[47] However, such a suggestion is illegitimate according to both the literature[48 49] and the judiciary[46]; labouring women ought to be considered capable of making decisions, even when in pain or highly medicated. Just as other patients who frequently are overwhelmed, tired and in pain are normally considered capable. Only in rare situations, for example, in case of severe cognitive impairment or a state of unconsciousness, can patients, and women in labour, be judged incapable of making a decision. Nevertheless, it is legitimate to think that the nature of being in labour does, sometimes, pose challenges for information provision and other communication relevant to giving consent. Sometimes rather than always, because there is large variation among women and their labours; not everything is time-critical, and not all women are exhausted or 'in the throes of labour'; some are well-rested; some are in between contractions; and there is a large variation in how women manage, cope with and experience pain.

Fifth, in labour and birth, the labouring woman is not primarily interacting with the healthcare system because she is passively undergoing a procedure—such as surgery—but because she is actively doing something: she is giving birth. This can compromise women's willingness to communicate. Some women believe interference and requests for communication are themselves interventions that adversely affect the labour process. Some therefore indicate not wanting to know or be troubled during labour and birth, not even for informed consent.[18] Indeed, if communication induces fear or anxiety in women this isdirectly counterproductive to labour's hormonal flow.[50] This may be one reason why care providers are reluctant to worry women with (extensive) discussion and information. Especially if they believe the woman, if asked, would consent anyway. However, disturbance, fear and anxiety can not only be induced by words, but also by other interferences, such as unexpected touch or intervention. These can have particularly dramatic effects in labour given our earlier comments on socially sensitive body parts.[45] Research on negative and traumatic birth experiences also indicates women can suffer as a result of not having been involved in decision-making.[12] Finding the right balance between neither disturbing unnecessarily nor failing to respect autonomy and bodily integrity, is therefore a key practical challenge perhaps unique to labour and birth.

Sixth and last, labour is also relatively unique in the healthcare context because, although its precise timing and course is unpredictable, the fact that it will occur is almost always known many months in advance. Moreover, women have many planned care interactions during this period: the WHO recommends at least eight antenatal contacts; in high-resource settings, women often have 11–14.[51] This leaves ample time and opportunity for preparation, discussion and information exchange in advance of the potentially time-critical and challenging conditions of labour.

THE NATURE OF THE PROCEDURE

In addition to the challenges and opportunities related to the nature of labour and birth, which are pertinent to all decision-making during labour, we also identify challenges and opportunities specific to (procedures such as) episiotomy.

The lack of consensus on indications for performing episiotomies means there are significant differences between care providers in when and why they think an episiotomy is indicated. This has resulted in large variations in the incidence of episiotomy (inter) nationally.[23 52] When a baby appears to be in distress, the foetal heart rate monitor provides information about the state of the baby's health, but is known to be inaccurate.[53] An episiotomy can expedite the expulsion of the baby, but it is often unclear by how much and whether this will make a clinical difference in the long-term outcomes. Alternative preventive and acute actions for some indications are also available, such as changing birthing position.[22] This leaves considerable room for care providers' own perspectives and values, influenced by contextual factors and previous experiences, to affect their judgement. Care providers may not be aware of factors influencing their own perspective and actions, making it challenging to address these subconscious patterns.[54]

[ii]After birth, the baby is still unable to consent. Parents usually need to consent on its behalf. Unlike prior to birth, however, the parental right to decide for the baby after birth is grounded in their parental rights and can therefore, unlike decision rights grounded in maternal bodily autonomy/integrity, be removed or overridden under certain circumstances.

These issues pose two challenges. First, although care providers may attempt to provide objective information, there are unavoidable aspects of subjectivity and judgement to the information and recommendations they provide. This means that another care provider might have judged differently in the same situation. Second, where there is subjectivity in weighing risks and outcomes, respect for autonomy requires that evaluations and decisions are made in light of the patient's, and not in light of the care provider's values. Women have views on episiotomies: a study investigating birth plans showed that 'no episiotomy' is commonly mentioned by women in their birth plans.[55] In reality, it is unlikely that all these women would never want an episiotomy under any circumstance; instead it may often indicate a desire for more reluctant use of episiotomy. It is questionable to what extent care providers are, in practice, able to attune their recommendation to the individual patient. Talking with women about their preferences is needed to improve this.

A CONSTRUCTIVE PROPOSAL

We have reviewed (1) the rationale for informed consent, including practical limits on the information requirement; different ways of giving consent other than explicit communication; and its relationship to trust; (2) challenges and opportunities for obtaining consent due to the relatively unique nature of labour and birth; and (3) challenges and opportunities due to the specific nature of our focus procedure: episiotomies.

Our first question was whether consent is necessary for episiotomies. It may strike some as surprising that such a question needs serious engagement—but it does. It is difficult to imagine that 43%[8] of women who had an episiotomy in a high-resource setting would report not having explicitly consented to this procedure, if care providers were genuinely convinced that consent for this procedure was (always) required. Indeed, care providers actively express doubt about the need for gaining consent, and experience challenges in obtaining it.[17 56] Nonetheless we argue that, yes, consent is necessary for all types of episiotomies, under all circumstances, and that all women, regardless of personal characteristics or cultural background, are entitled to it.

Why might care providers doubt the need for consent? First, there is apparent disagreement concerning the invasiveness of an episiotomy; some care providers believe it is not, and therefore consent can be presumed.[iii] Here, we simply disagree: an episiotomy invades tissue and leaves a wound requiring suturing. It is therefore invasive. Moreover, the sensitive nature of involved body parts, as discussed, is such that even touching requires consent. Finally, the arbiter of invasiveness for the purposes of consent requirement should surely be the person experiencing the procedure and its consequences; not the person executing it.[27] Not only do substantial proportions of women indicate being upset by undergoing an unconsented episiotomy,[8] they also mention it in narratives on traumatic birth experiences.[12]

Second, some care providers believe consent is not needed because they believe they only perform episiotomies when actually necessary, or because they know the woman would agree anyway. This presumes a degree of confidence in care providers' judgement of necessity that is clearly unwarranted, given the wide variation in episiotomy rates and other evidence showing that not all perceived necessary episiotomies were actually necessary in hindsight.[23] It also overlooks that necessity itself cannot be determined independently from the patient's values.[57] Finally, even if all proposed episiotomies were necessary and congruent with the patient's values, such that the patient would indeed agree anyway, consent would still be required. This is due to the intrinsic value of consent as communicating respect for autonomy. This, we argue, is particularly important in care during labour and birth, given the combination of the social sensitivity of the relevant body parts and their all-too-frequent social violation,[45] as well as the fact that many episiotomies harm the mother for the benefit of the baby's health.

Consent is therefore necessary for episiotomies. That said, the necessity of consent does not automatically mean that every woman must give explicit, fully informed consent during labour. The aforementioned challenges and opportunities of labour, particularly the sometimes diminished desire and capacity for communication, speak against that. Also, care providers might not be aware that there are ways of giving consent other than explicit, fully informed, verbal or written consent. We therefore make the following constructive proposal, which has three important aspects. First, we recommend adequate use of opportunities provided by the antenatal period to exchange information, build trust and explore values and preferences. Second, we recommend employing different ways of giving consent other than the regulative ideal of fully informed, explicit consent. Third, we recommend tailoring information, communication and consent to the individual.

The indication for an episiotomy can be relatively time-critical, and labour, as discussed, is often not the optimal time for elaborate information exchange. We therefore recommend starting this process in the antenatal period. Information exchange in advance means that less information needs to be exchanged in labour. Care providers may object that they do not want to overburden women with information in advance or induce unnecessary anxiety. However, women often wish to have more information about the procedure in advance.[13] Furthermore, anxiety levels for episiotomies are lower after receiving information about episiotomies, compared with before.[58] Currently, information provision about episiotomies during antenatal care is often perceived as inadequate by women, although not all women mind.[13 58] So this is a clear opportunity for improvement.

The antenatal period should also be used to effectively explore women's values and preferences relevant to episiotomies, so that care providers can better attune their individual recommendations and judgement. Ideally, the judgement of when an episiotomy is necessary is made mainly in light of the patient's values rather than the values of the care providers and/or the system they work in, even though many women will agree with the care provider's judgement. The required exploration of the patient's values should surely not be left to the midst of labour, given the challenges for elaborate communication at that time.

Women may also have views on whether and how much information they wish to receive before and during labour, as well as whether and to what extent they want to be 'interrupted' during labour.[18] Here too, we recommend that the antenatal period is used effectively to assess whether women have preferences about this. It may be good to write this down in a birth plan. This enables the care provider to tailor both information provision and consent procedures to women's individual preferences through effectively employing different ways of giving consent.

For example, some women may indicate that they want (elaborate) discussion and information during labour and will always want to give explicit consent prior to a procedure. If so, that should happen. Some of these women may overestimate, or change their mind about their ability and willingness to engage in extensive communication in labour. We will discuss below what should happen in such cases.

It is also possible that there is limited time in an emergency situation or that women desire very limited interruption during labour,

[iii] Dutch consent law states that where procedures are not invasive, consent can be presumed.

but do want to be alerted that a procedure is about to take place. In this case, explicit simple consent functions well: the care provider makes clear that they recommend an episiotomy; asks whether it is ok to proceed; and waits for an answer. Relevant background information should have been exchanged in the antenatal period.

Some women may want to provide consent in advance: they expect that they do not want to be disturbed during labour by any interaction at all and may not even wish to know a certain procedure is about to happen. In that case they exercise their right not to know and make the autonomous decision to leave all the decision-making to the care provider. As argued, that is not against the spirit of consent or lack of autonomy. But it is important that care providers in such instances provide women with as much information antenatally as they are willing to hear, and do their best to uncover and act in light of the patient's wishes. It is worth bearing in mind that this form of consent relies heavily on trust in the care provider and the system. This can be a problem if continuity of care is lacking and the trusted care provider is not present at the birth. Women can and have the right to change their minds and take decision power back at any time during pregnancy or labour and these preferences may change, especially in case of transfer between care providers. We emphasise that advance consent is possible but should not be the goal of the antenatal conversation as explicit consent is preferred during birth. Advance consent should only be used at the woman's explicit request.

Presumed consent is only appropriate for episiotomies when the requirements apply, such as on the rare occasion that women are not conscious, no representative (such as a partner) is able to consent on their behalf, it is deemed an emergency and it is genuinely believed that the woman would have consented to the procedure.

We consider implied consent not appropriate for episiotomies. Implied consent requires that women communicate clearly through their actions—such as rolling up a sleeve for a blood draw—that they are consenting to an intended procedure. This requires that they are informed about what is happening and have clear options for non-verbally communicating both when they consent to and when they decline the procedure—for example, by not rolling up their sleeve which blocks the procedure. We consider that the practical circumstances of labour leave insufficient scope for women's clearly communicating consent through their actions: they are often in a supine position, having their socially sensitive body parts exposed,not to show that they consent to an episiotomy, but because they are in labour. This places the care provider at significant risk of mistakenly assuming the woman is implying consent when in fact she is not. Therefore, implied consent is not appropriate for episiotomies.

Much of the same applies for opt-out consent: this is rarely appropriate because active labour is not a circumstance that easily facilitates the necessary 'ease' for women to opt-out of an episiotomy. However, the stakes in labour are high: an episiotomy may save a baby's life during labour and it is not unreasonable to assume that women usually care deeply about this.[45] In addition, the labouring process may leave some women subresponsive or unresponsive. Therefore, there is a limited, circumscribed place for opt-out consent. Only if consent has explicitly been asked but the woman has not given a response, and there is a very clear conviction by the care provider that the episiotomy is necessary and congruent to the woman's likely wishes, would it be ok to move to opt-out consent. Of course, the conditions for valid opt-out consent need to be met: it needs to be communicated clearly what is going to happen; that a woman can opt-out; and how she can opt-out. The woman must also have adequate time to opt-out. For example, 'I really think an episiotomy is necessary, but I am not getting a clear response from you. So, unless you tell me you object, I will do the episiotomy on the next contraction. If you DO NOT want me to do an episiotomy, please say no, or give some other sign'.

CONCLUSION

Unconsented episiotomies are alarmingly common, such as reported by 43% of women who had an episiotomy in the Netherlands.[8] It is difficult to imagine such frequencies would occur if care providers were convinced of the necessity of consent. Birth activists criticise unconsented procedures but do not give constructive advice on how care providers can obtain consent in the unique circumstances of labour. We made a proposal to improve consent for episiotomies that acknowledges the challenges posed by the context of labouring women.

First, we argue that despite its challenges, informed consent is necessary for episiotomies (and many other intrapartum procedures). In our arguments, we place particular emphasis on the intrinsic value of consent as demonstrating respect for autonomy, which requires asking for consent even if a care provider is sure the episiotomy is congruent with the woman's values and convinced the woman would consent. This is particularly important during labour and birth given the combination of the social sensitivity of the relevant body parts and their all-too-frequent social violation, as well as the fact that many episiotomies harm the mother for the benefit of the baby's health. These very aspects also mean the role of trust in birth warrants particular attention—and demonstrating respect for autonomy is an important aspect of building trust.

However, the fact that consent is necessary does not mean that that consent always needs to be explicit, or that the maximum information requirements of ideal consent always need to be met. The context of labour and birth poses numerous unique challenges that make the regulative ideal of fully informed consent frequently unattainable as well as undesirable. To improve consent for episiotomies, we recommend, first, adequate use of opportunities provided by the antenatal period to exchange information, build trust and explore values and preferences. Second, employing different ways of giving consent other than the regulative ideal of fully informed, explicit consent. And, third, tailoring information, communication and consent procedures to the individual.

Author affiliations
[1]Amsterdam UMC location Vrije Universiteit Amsterdam, Midwifery Science, Amsterdam, The Netherlands
[2]Midwifery Academy Amsterdam Groningen, InHolland, Amsterdam, Netherlands, Amsterdam, The Netherlands
[3]Amsterdam Public Health, Quality of Care, Amsterdam, The Netherlands
[4]University of Groningen, University Medical Center Groningen, Department of General Practice & Elderly Care Medicine, Groningen, The Netherlands
[5]Department of Obstetrics and Gynaecology, Maxima Medical Centre, Veldhoven, The Netherlands
[6]Division of Midwifery, School of Health Sciences, University of Nottingham, Nottingham, UK
[7]Amalia Children's Hospital, Department of Obstetrics, Radboud University Medical Center, Nijmegen, The Netherlands
[8]Amsterdam Reproduction & Development research institute, Amsterdam, The Netherlands
[9]Department of Philosophy, King's College London, London, UK

Twitter Marit van der Pijl @maritvanderpijl

Acknowledgements We want to thank Annette Rid, Danielle Bromwich and Rebecca Brione for their comments and useful discussion regarding this manuscript.

Contributors All authors equally contributed to setting up the aim of the paper, the outline of the paper and the arguments raised in the paper. MvdP and EK wrote the manuscript, with the support of all other authors (CV, MH and AdJ). All authors have contributed to and approved the original and revised manuscript. EK is the guarantor of the study.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this study.

ORCID iDs
Marit van der Pijl http://orcid.org/0000-0002-5291-5988
Elselijn Kingma http://orcid.org/0000-0001-9787-3198

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