Reproductive Autonomy and Reproductive Technology

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Abstract
The emergence of new forms of reproductive technology raise an increasingly complex array of social and ethical issues. Nevertheless, this paper focuses on commonplace reproductive technologies used during labor and birth such as ultrasound, fetal monitoring, episiotomy, epidurals, labor induction, amniotomy, and cesarean section. This paper maintains that social pressures increase women's perceived need to such reproductive technologies and thus undermine women's capacity to choose an elective cesarean or avoid an emergency cesarean. Routine, normalized use of technology interferes with the possibility of choosing use of technology where best suited through misdirecting laboring women to use technological resources whenever possible. This normalized use of technology decreases risk tolerance and increases dependence on technology for reassurance, which bears significant implications for self-trust and self-confidence. My account encourages women's cultivation of autonomy as a capacity interconnected with our own attitudes and those of other persons; and as a function of cultivating trust and confidence in one's body.

Keywords: Embodied autonomy, relational autonomy, reproductive autonomy, reproductive technology, cesarean

1. Introduction

Discussions of *reproductive technology* in bioethics often center on cutting-edge fertility techniques involving embryo collection or donation, preimplantation diagnosis or screening, chorionic villus sampling, and ivf (*in vitro fertilization*). Feminist bioethicists draw out a large array of social and ethical issues relating to the use of these innovative technologies as they develop and become more complex (Wax 2006; Queenan 2011; NIH 2010; Hildingsson *et al.* 2002; Walker, Turnbull, and Wilkinson 2004; Berger and Sachs 2006). Less attention is paid to more commonplace reproductive technologies used during labor and birth such as ultrasound, fetal monitoring, episiotomy, epidurals, labor induction, amniotomy, and cesarean section. My use of the term "reproductive technology" aims to include these more commonplace uses of technology during reproduction, so it will refer to any medical intervention or medical monitoring concerned with reproduction. I aim to offer a feminist analysis of commonplace reproductive technologies to show that normalized or routine use of reproductive technology used during labor and birth compromises *reproductive autonomy*, autonomy concerning reproductive choices. My analysis considers the typical Western model of labor and birth a paradigm illustration of how social pressures compromise autonomy to skew laboring women's choices toward use of technology to "manage" their births. Social pressures increase women's perceived need to use reproductive technologies and hence both decrease risk tolerance and encourage dependence on technology for reassurance. Such pressures interfere with the ability to form and act on choices, which I argue undermines women's capacity to choose an elective cesarean or to avoid an emergency cesarean.

My account does not deny that use of technology can be necessary or often beneficial to ensure the safety and wellbeing of both fetuses and laboring women. Yet not all women need to use technology to the same degree; and sometimes women might decline use of technology without endangering themselves or their fetuses. My point is that routine, normalized use of technology interferes with the possibility of choosing use of technology where best suited through misdirecting laboring women to use technological resources whenever possible. This normalized use of technology creates a *technological imperative*. Following Sherwin (2004) I define a technological imperative as an imperative to use technology during labor and

birth such that physicians and laboring women do not feel confident to refuse its use in any particular instance. I argue that a technological imperative creates a dependency on technology for reassurance regarding labor and birth, which bears significant implications for self-trust and self-confidence. The paper proceeds as follows. Section 2 argues against the view that increased availability or selection of elective cesareans, those chosen prior to labor, demonstrate increased autonomy. I suggest that social norms and values about women and birth can render choices for elective cesareans less than fully autonomous. Section 3 relates such norms and values to pressures to use reproductive technology, which together decrease risk tolerance and increase laboring women's need to turn to technology for reassurance at the cost of undermining birth choices. Section 4 connects use of reproductive technology to a tendency to regard the fetus as a wholly separate moral entity. But a forced separation of pregnant women's interests from fetal interests seems to further undermine women's capacity to refuse use of technology. Section 5 offers a positive response to women's compromised reproductive autonomy, suggesting that cultivating self-trust and self-confidence can counter social pressures to use technology during labor and birth. This last point should not be understood to pin responsibility on women to change medical and technological practices impairing autonomy. Elsewhere I argue that physicians ought to acknowledge the impact of both their own and social pressures on women's choices during labor and birth as part of their moral obligation to respect patient autonomy (Burrow 2012).

My purpose in this paper is provide a feminist understanding of reproductive autonomy for the purpose of possessing and developing autonomy within challenging contexts. Thus I offer a relational model of autonomy recognizing that individuals' capacity to form and make choices is in no small way a function of our social relations, following an established approach in feminist philosophy[1] that is beginning to appear in traditional philosophy.[2] In promoting a relational view of autonomy I recognize that our capacity to choose is a capacity we possess in virtue of our social relations and social history; and that compromises to that capacity can result from oppressive or otherwise pernicious social forces. But I also show that cultivating trust and confidence in one's *body* is integral to resisting a socially encouraged dependence on technology during labor and birth. An embodied account of autonomy situates autonomy competencies in relation to bodily experiences and capacities. Hence, a significant implication of my view is that it connects embodied autonomy to relational autonomy. My account urges us to think of autonomy as a capacity interconnected with our own attitudes and those of other persons, neither of which are wholly separate from bodily skills and competencies.

2. Reproductive Autonomy

An increasingly popular view in the medical literature is that women are frequently opting for elective cesareans, those cesareans planned in advance of labor and performed at patient request.[3] The dominant view of obstetricians seems to be that maternal request is a major factor in driving the cesarean section rate upward (Weaver, Statham, and Richards 2009). Emergency cesareans are performed after what the medical community calls "trial of labor," or progression through labor in an attempt to give birth vaginally. If it is correct that women are more frequently electing for cesareans without undue forces undermining that choice, then it might appear that women are driving up cesarean rates through exercising their autonomy. If that were so, then one might think choices for elective cesareans reflect women's *increased* autonomy, a view many associate with more frequently exercising control over the body as an expression of self-governance. Below, I consider two responses challenging this view. I plan to separate the issue of control over the body from the issue of expanded choice to show that expanded choice need not increase autonomy; and that more control over the body need not increase autonomy. To appreciate this distinction I focus on elective cesareans, since the option of elective cesarean represents an obvious increase in women's birth options.

Increased Choice

Are women more frequently choosing elective cesareans? A startlingly large number of authors suppose that up to 20% of cesareans are elective (Fuglenes, Ølan, and Kristiansen 2009). Were this supposition correct, it would help explain why overall rates of caesarean delivery have risen over the last several decades. Rates in the United States, Canada, Australia, and the United Kingdom are now close to 30% and other countries' rates such as Puerto Rico, Italy, and Mexico have increased to nearly 40% (Walker, Turnbull, and Wilkinson 2002). Rising cesarean rates are quite alarming. The risk of maternal death associated with elective cesarean deliveries, while low, has repeatedly been shown to be many times higher than that of vaginal birth; one study in Great Britain reveals that women undergoing elective cesareans are twice as likely to die as women who give birth vaginally (Minkoff and Chervenak 2003). The risk of death for babies within the first month of birth born to low-risk women is low, but nevertheless it is nearly three times higher for those delivered by elective cesarean than vaginally (MacDorman *et al.* 2008). Given these risks, we might wonder whether requests for elective cesareans are truly autonomous. Why would women more frequently choose to put themselves and their babies at higher risk (even if that risk is not overall a high risk) through choosing cesareans?

The answer is that women are *not* choosing to elect for cesareans more frequently, contrary to common supposition. Significant leaps in interpreting available data are required to suppose that women request up to 20% of cesareans, since there is little credible data on elective cesareans. It is hard to document numbers of elective cesareans because criteria differentiating elective cesareans from medically indicated cesareans may not be consistent (Block 2007). But we have some positive indication that women are not driving up cesarean rates through increasingly choosing cesarean delivery. The largest nationwide survey of mothers in the United States reveals a very low number of elective cesareans at women's own request: 0.2% of first time mothers and 0.4% of first time cesareans (Declercq et al (2006) in De Vries, Low, and Bogdan-Lewis 2008). The data here suggest that only 2.5% of all cesareans are due to women's request (De Vries, Low, and Bogdan-Lewis 2008). If one looks at the common obstetrical view of elective cesareans, that it is a cesarean women request in the "absence of an identifiable reason," then a small but more recent study shows that no woman elects for a cesarean without what she perceives to be clinical or psychological reasons (Weaver, Statham, and Richards 2009).

Nevertheless, a not uncommon suggestion is that an increase in *number of requests* of elective cesareans evidences women's increased autonomy (see Bergeron 2007). Even if more women do request elective cesareans, we cannot assume that evidences increased autonomy. If women are increasingly choosing elective cesareans then women seem to be exercising their *capacity to choose* autonomously rather than increasing their autonomy. I uphold the view that autonomy is possessed to greater or lesser degrees as a capacity requiring competencies such as self-control, rational thought, freedom from systematic self-deception, care, intimacy, social interaction, introspection, imagination, reasoning, communication, and volition (see Christman 2008, 2004; Meyers 1989, 2004). More frequently expressing one's capacity of autonomy need not indicate any increase in any of those competencies. A person might more frequently ride her bicycle but a more frequent exercise of her capacity to ride a bike indicates no necessary change in that capacity. She may have the same mediocre capacity to ride a bike she always had and her more frequent bike trips may offer no great improvement. To assume that autonomy increases because it is exercised conflates the capacity with its exercise. So we cannot assume that more frequent exercise of the capacity of autonomy increases autonomy. Hence, it would be incorrect to assume that women's autonomy is increased because the number of elective cesareans has increased.

But one might point out that surely women's autonomy is increased by introducing the option of an elective cesarean. One might argue that more options expand autonomy and so women possess greater autonomy with the introduction of elective cesarean as a birth option. Having the option to request an elective cesarean in advance of labor offers women the choice of meeting their fears about labor and birth

since it allows women to avoid perceived risks associated with vaginal labor. The riskiness of labor and birth is now emphasized to such a degree that women fear vaginal birth, associating it with death and serious injury for the self or fetus (Weaver, Statham, and Richards 2009). And so rather than risk either, women may choose an elective cesarean. An elective cesarean also offers a promise of convenience.[4] Walker, Turnbull, and Wilkinson (2004) found that 53% of 148 women surveyed strongly agreed or agreed with the statement "People tend to think of cesarean section as a more convenient way to give birth," and 44% strongly agreed or agreed with the statement "Cesarean section is now seen as a routine way of having a baby." The option of scheduling birth expands choice in light of maternity leaves, work schedules, financial needs, or the needs of other children. Scheduling can also offer a tax benefit, as the high rate of cesareans in December highlight (Lo 2003). I do not dispute that having the option of a cesarean increases choice. Increasing options increases one's capacity to form and act on choices, which is central to possessing and exercising autonomy. Yet, not all instances of increased choice indicate increased autonomy.

We should be hesitant to accept the claim that offering the option of elective cesarean increases autonomy. My point is not to deny that the option to choose an elective cesarean is a live option. A live option is a practical option that is pursuable in practice. Options that are available but not practically pursuable are not live options. So women might have the option of walking whenever and wherever we like because we have a right to personal liberty. But that right does not amount to having a live option to go wherever we like, whenever we like. It is not a live option for most women to walk down a poorly lit alleyway at night or to stroll through certain streets while wearing revealing clothing because women predominantly fear stranger violence. Women's autonomy is diminished by fear of stranger violence (Burrow 2012). But women arguably have a live option to pursue cesarean. The Association of Gynecologists and Obstetricians recommends against physicians offering the option of an elective cesarean to their patients (ACOG 2005). But that in itself does not seem to reduce women's perception of the availability of elective cesareans. Women are commonly aware of the option of an elective cesarean because it is socially promoted, especially through media highlighting cases of Hollywood stars who are "too posh to push" (Feinmann 2002). Moreover, we can expect physicians will still discuss the option of an elective cesarean in the case of patients who have previously undergone a cesarean delivery, since many hospitals in the Unites States persist in upholding policies against pursuing vaginal birth after cesarean (Yang *et al.* 2009).

I suggest that the option of an elective cesarean, even if it is a live option, need not increase autonomy because it is not free of coercive factors undermining autonomy. Autonomy is undermined through threat, coercion, manipulation, or other undue pressures undermining choice formation and pursuit. This matters to autonomy since a key part of why autonomy is valuable is that it is self-protective. Autonomy protects values that are central to one's self so autonomy protects the self from forces harmful to who one is (McLeod 2005). If women's desires for elective cesareans unreflectively result from oppressive expectations or views of women's bodies, then those social pressures interfere with women's ability to form and act on choices in their own best interest. The most common reasons women pursue elective cesarean are fears concerning pain, fetal distress, future sexual dysfunction, and stress incontinence (Christilaw 2006). These fears are threats to autonomy if they are driven by oppressive circumstances. Fear of loss of sexual pleasure following vaginal birth is concerned with male sexual pleasure, not female pleasure. Socialization in femininity encourages women to be concerned with meeting others' expectations, particularly expectations arriving from oppressive ideals of beauty or feminine sexual availability (Wolf 1991; Frye 1983; Bartky 1990). Fear of vaginal labor is no small part a function of living in a society that, as Iris Marion Young (2005) points out, undermines the power of women's bodies. Since social pressures devalue women's bodies, they undermine women's trust and confidence in their bodily abilities (Burrow 2009). These oppressive social norms and values undermine women's capacity for autonomy through orienting women's desires toward pleasing others and instilling distrust in

women's bodily competencies and skills. If women's choices for elective cesarean result from such social pressures then women's reproductive autonomy is compromised.

Control

Elective cesareans offer an unprecedented choice of when and how to give birth. It is not uncommon to take this idea further to argue that having the choice of an elective cesarean increases autonomy because it expresses *control* over a woman's own birth – she can choose to avoid labor altogether and can plan the time and day of birth well in advance. Increased control over pregnancy and childbirth has been interpreted as progress for women, a means of liberating women from their bodies (de Koninck 1998, 171). I challenge this view because the choice to pursue an elective cesarean need not liberate women from their bodies; and liberation from the body is far from an ideal pursuit of autonomy. I maintain that pressures to use reproductive technology reduce autonomy through undermining choice formation and pursuit. The point is not that technology reduces control over the body but that offering control over reproduction comes with social expectations birthing women will use this control. To draw out this separation of ideas I first present the view that technology reduces control over women's bodies and then show that autonomy seems to be more of a matter of acting through one's body rather than controlling it.

Iris Marion Young (2005) takes two approaches to arguing that use of technology undermines autonomy as a means of reducing autonomy through increasing bodily passivity and alienation. First, Young argues that use of medical technology during labor and birth removes women's control over their own bodies because monitoring and instrument use render women physically passive through restricting movement or positioning. Use of equipment such as monitors or administration of pain-relieving drugs typically restrict women's freedom to walk or explore birthing positions and often require women to remain in a bed attached to equipment (58). Continuous electronic fetal monitoring requires a woman to lie in a bed with monitors strapped across her midsection; use of an epidural, heart rate monitors or intravenous injection similarly restrict laboring women's movement. Young's discussion of passivity fails to mention cesarean sections, but it easily applies. A cesarean section is uncompromising in rendering women passive during birth because it is a surgical intervention requiring physical extraction of a woman's fetus from her uterus and the use of anesthetic (or multiple anesthetics), heart monitors, and intravenous drip before, during, and after the surgery. In requiring a woman to remain physically passive, such procedures and monitoring take away a woman's control of her own body.

Second, Young points out that the use of technology during pregnancy and labor undermines autonomy because it devalues a woman's own knowledge of her body, its contractions and the movement of the fetus inside her. Laboring women's reports are rendered inconsequential when information gathered through technology is the acclaimed standard. Young's point is to show that the experience of pregnancy and birth is alienating and objectifying since use of technology transfers control over the process of labor and birth to its expert users, medical personnel (58). Following Young's line of reasoning, an elective cesarean section demonstrates the ultimate loss of control over a woman's labor and birth. The pregnant woman relinquishes all control to the surgical team preparing and performing her birth well in advance of her labor. In this case, as in the case of passivity above, Young considers autonomy at least partly a matter of having and expressing control over one's body. So according to Young's analysis, elective cesareans decrease autonomy by removing control from the pregnant woman and handing it over to medical personnel. A corollary of Young's view is that increased control over one's body increases autonomy. While I am sympathetic to Young's view that the body is critical to having and exercising autonomy, I am hesitant to accept that control *over* one's body expresses autonomy.

Assuming that autonomy is a matter of controlling the body separates agents from their bodies. This separation implies that agentic properties lie outside of bodily properties. Catriona Mackenzie (1992) presents an embodied view of autonomy holding that autonomy competencies are rooted in bodily

capacities. One's view of one's body creates a "bodily perspective" revealing the meaning and significance of one's body to oneself. The relationship between one's bodily perspective and one's capacities and abilities are complex, which Mackenzie acknowledges; her point is that one's ability to form and exercise choices relies upon competencies that are rooted in one's bodily experience (Mackenzie 2001). On this view autonomy cannot be an expression of control over one's body but is an expression of one's capacity to choose *through* the body. As an embodied view of autonomy, Mackenzie holds that self-governance depends on possessing and developing bodily capacities. In appealing to this view of autonomy I uphold the view that acting through the body is a better expression of autonomy than controlling one's body. This point does not intend to dismiss the issue of control as a concern for autonomy. In what follows, I plan to show that encouraging control of reproductive capacities through use of technology undermines autonomy through undermining self-trust and self-confidence in women's bodily abilities to labor and birth.

3. Reproductive Technology

Pressures to use reproductive technology impair autonomy if women face a burden of refusing technology, which I argue is implicit to a technological imperative. In what follows I suggest that a heightened sense of risk attached to fears concerning vaginal birth is assuaged through use of technology throughout labor and birth. Yet the choice to birth vaginally is compromised if women are unaware that use of technology used during labor is likely to increase the chance of an emergency cesarean. Most women prefer to avoid emergency cesareans in the aim of pursuing a vaginal birth (Block 2007; Werkmeister *et al.* 2008). Women have good health reasons for wanting to avoid emergency cesarean delivery. Overall, cesarean sections are linked to a higher risk of postpartum antibiotic treatment; maternal morbidity and mortality; increase in fetal mortality rates; and an increased number of babies admitted to intensive care units compared with babies born through vaginal deliveries (Villar *et al.* 2006).[5] But women in labor are in a vulnerable position. Vulnerability accentuates women's need for reassurance during labor and birth, which technology all too readily supplies. As I argue below, a need for technological reassurance is associated with the current and dominant approach to labor and birth, active labor management.

In 1969 Kieran O'Driscoll and colleagues introduced active labor management as an exploratory means of reducing the number of "prolonged" labors by keeping labor less than 12 hours and operative delivery rates to a minimum (O'Driscoll, Jackson, and Gallagher 1969). Active labor management has since proved successful as a means of reducing labor time. But it does not reduce the number of medical interventions involved during labor and birth; rather, use of medical technology tends to increase with active management of labor. The introduction of active management of labor saw 40% more women receive artificial oxytocin, a 12-fold increase in the number of women requesting epidural anesthesia, and an increase in cesarean section rates (Lothian and Grauer 2003). This increase in interventions is linked to the time limit active labor management sets. A normal birth used to be considered 36 hours in the 1950's, dropping to 24 hours in the 1960's, and to 12 hours in 1972 when active management was introduced (O'Herlihy 1993). In the years since the introduction of active labor management, diagnoses of dystocia ("failure to progress") have more than tripled (Block 2007, 21). To address dystocia, medical staff usually offer synthetic oxytocin. Synthetic oxytocin severely increases the intensity and duration of labor contractions, speeding up labor and ramping up women's pain, sometimes to unbearable levels. Many women request epidurals to block out this pain. But once an epidural is administered, labor rarely progresses. Randomized, controlled trials show that epidurals increase dystocia and, relatedly, the frequency of primary (first-time) caesareans (Thorp *et al* 1993; Ramin *et al* 1995). Dystocia is the single most important factor in the escalation of caesarean section rates for two reasons. *Primary* caesarean births predominantly result from dystocia; and the majority of *repeat* caesareans result from primary cesareans (Porreco and Thorp 1996).

Physicians who routinely employ active labor management encourage a technological imperative. A technological imperative promotes technology as the key means of ensuring that labor is progressing normally. Monitoring through technology, the standard form of active labor management, is typically presented as a means of "avoiding disaster." But technological monitoring sets up laboring women for a cascade of technological interventions. Fetal monitoring is illustrative. Fetal monitoring is only warranted in high-risk pregnancies (Johanson, Newburn, and Macfarlane 2002). Yet fetal monitoring is used in 93% of births, including healthy, low-risk pregnancies (Yang *et al.* 2009). The American College of Obstetricians and Gynecologists (2006) recognizes that routine fetal monitoring is the most common obstetric procedure today and that it has not achieved its clinical goals of reducing perinatal mortality or risk of cerebral palsy. Fetal monitoring is not innocuous and may prove harmful (see Cook, *this journal*). Moreover, use of fetal monitoring is positively associated with increased emergency primary caesareans in low-risk women (Alfirevic, Devane, and Gyte 2006). It is also associated with increased use of instrumental delivery such as forceps and vacuum extraction (Pateman, Khalil, and O'Brien 2008). Fetal monitoring is but one form of technological intervention implicated in increased emergency cesareans. The introduction of synthetic oxytocin to speed up labor typically demands use of continuous electronic fetal monitoring, often increases epidural use, and frequently leads to primary cesarean sections and so repeat cesarean sections. Even while this cascading effect may be well known to physicians, I doubt patients are typically informed that the introduction of such technology will likely result in use of further technology. If that is correct, then failing to provide that information directly bears on women's ability to form and act on choices. Laboring women tend to perceive use of technology to advance better outcomes and thus assuage fears concerning vaginal birth and so "[w]omen go along with technologies because they believe it will benefit their fetus or child – concerns of their own well-being and rights are secondary" (Hemminki 2006). But merely presenting women with the choice to elect for use of technology in any one case does not answer the deeper worry that laboring and birthing women may not feel able to *refuse* technology.

A technological imperative limits choices if it entails that women perceive themselves as taking too large a risk in refusing use of technology. Women who are encouraged to pursue technology before and during pregnancy are encouraged to view pregnancy as risky and this heightened sense of risk affects choices concerning labor and birth. During pregnancy, women become dependent on technology to alleviate fears associated with pregnancy. Technology is regarded as a means of reducing risk and providing reassurance that one's pregnancy is progressing normally. This view of technology is encouraged in medical environments normalizing use of technology, even if that technology was originally intended for high-risk cases. What often begins as use of technology for high-risk cases over time becomes routine, normalized use of technology even in low-risk cases where the need for assessment and reassurance is questionable. Prenatal screening is a case in point. This screening can consist of maternal serum screening to detect issues such as open neural tube defects; chorionic villus sampling to identify certain genetic traits such as Trisomy 18; and nuchal translucency screening to identify Down's syndrome. Such forms of prenatal screening were offered for decades to high-risk pregnant women but now are recommended by the American College of Obstetricians and Gynecologists and the Society of Obstetricians and Gynaecologists of Canada for *all* pregnant women regardless of age, disease history, or risk status (Seavilleklein 2009). Even before pregnancy, screening is recommended as a means of selecting for embryos to avoid genetic "defects" or to otherwise select for a "normal" child; often only those embryos thought to be "normal" will be transferred and allowed to develop (Lippman 1991). Pre-implantation screening and prenatal screening encourage women to turn to technology for reassurance. Use of such technology is seen as a means of "avoiding disaster" and a key means of reassuring women that is encouraged in the medical community.

A need for reassurance is fueled by the view that, just like preimplantation or prenatal screening, labor and birth require technological oversight. A fear of risk is heightened in hospital environments because hospital delivery rooms are set up to address high-risk labors and many procedures treat low-risk women

as having *potentially* high-risk labors (Sherwin 2004). In such an environment, women are more likely to rank risks higher and so more easily turn to technology for reassurance (Lippman 1991, 30). Thus women are more susceptible to a heightened sense of risk and so a need for reassurance that renders refusing use of technology difficult, if not impossible. This heightened sense of the riskiness of declining technology increases women's dependency on technology during labor and birth just as it does during pregnancy. Furthermore, offering control over reproduction through technology creates expectations women will use this control, especially if women are anxious about their options for reproductive health care (Lippman 1991; Thornton and Lilford 1994). The expectation is that medical technology is *necessary* to ensure the safety and wellbeing of the fetus. And so laboring women turn to technology for reassurance rather than, say, appealing for more support during labor and birth.[6] A need for technology is in effect created because reassurance is met through use of technology, and technology is seen as the sole possibility for reassurance. Reassurance may amount to avoiding labor and birth altogether in the case of an elective cesarean; or use of technology resulting in a cascading effect undermining women's desire to avoid an emergency cesarean.

Social, political, and cultural forces pressure women to use reproductive technology because not to do so is seen as irresponsible or irrational (Sherwin 2005; Seavilleklein 2009). The argument can be captured as follows. The Western stereotype is that responsible pregnant women will make any sacrifices necessary for the health and wellbeing of their fetuses (Mullin 2005, 98). If availing of any and all medical technology leads to the safest labor and birth, and women take unnecessary risks in refusing medical interventions, then refusing use of technology evidences irresponsibility or plain irrationality. The implicit reasoning is that it is both responsible to do what is safest for oneself and one's fetus; it is rational to promote the wellbeing of oneself and one's fetus; and use of technology is the best means of doing what is responsible and rational. Laboring women correspondingly face a burden of refusing technology instead of accepting its use. Not to pursue reproductive technology is then characterized as taking an unnecessary risk. Women will be less inclined to take risks if they are subject to subtle, continued pressured to do "everything that is safest" for themselves and their fetuses where "everything that is safest" is implicitly understood as using whatever forms of medical technology are available.[7] The problem is not that women wish to choose what is safest for themselves or their fetuses but that pressures to use technology prey on women's desires to do what is safest and in doing so, compromise autonomy.

Women's autonomy is compromised since a technological imperative highlights the riskiness of refusing its use, thereby decreasing risk tolerance and increasing dependence on technology for reassurance. These are socially constructed attitudes that compromise autonomy because each undermines women's ability to choose use of technology. That is, a socially constructed dependence on technology renders women less than able to refuse its use. The upshot is that these outside forces pressure women toward using technological interventions and monitoring at the cost of their ability to pursue a vaginal birth. Now it is not my aim to discourage use of technology where medically indicated; and I do not deny that use of technology may be necessary in high-risk cases to ensure the health and wellbeing of pregnant women. The problem is not that technology is a part, or even a regular part, of labor and birth. When medically indicated, use of technology can prevent morbidity and mortality in both birthing women and their babies. The problem is that a fear of refusing use of technology pressures birthing women to elect for technological medical interventions even when they are not medically indicated. A corresponding worry is that if cesareans become a normalized outcome of the birthing process, obstetricians' skills at vaginal delivery may decline and thus create more need for cesarean deliveries, which threatens autonomy through putting the option of vaginal delivery out of reach for most women (Lyerly, Little, and Faden 2008).

4. Relational Autonomy

A liberal view of autonomy considers a person autonomous so long as one is capable of forming and acting on decisions based on reasons, beliefs, values, and preferences that are truly one's own (Christman 2008). Contrary to the traditional liberal model of autonomy, a relational model of autonomy holds that autonomy is a matter of interdependence and relations (MacKenzie 2000). Accounts of relational autonomy differ concerning the role of social and contextual influences on autonomy. Relational autonomy theorists may regard social contexts as either constitutive of autonomy since social relations constitute the self and the self is the site of autonomy; or contributory to autonomy since social relations contribute to those capacities and competencies necessary to autonomy (see MacKenzie and Stoljar 2000b). But it is not my aim to weigh into the debate. It is enough for my purposes here that relational autonomy recognizes that choice formation and pursuit can be fostered or undermined within certain sorts of social contexts. My aim is to show that the normalization of reproductive technology encourages a view of labor and birth separating the interests of pregnant women from those of their fetuses. This separation of interests flows from use of technology that monitors and represents the fetus as a separate physical entity. I suggest that separating women and fetal interests further undermines women's autonomy through impairing women's capacity for self-trust and self-confidence.

A technological imperative encourages a separation of interests through promoting a model of a pregnant woman as a vehicle for the fetus' birth or a 'maternal environment.' Modern obstetrics predominantly regards a pregnant woman as not an agent of her own labor but as a female body (or its birthing parts) plus a separate entity, the fetus (Mattingly 1992; Rothman, Poldre, and Cohen 1989; Overall 1993; McLeod 2002b). On this model, the laboring woman is seen as a 'container' or 'life support machine' for the fetus and the patient of interest becomes the fetus, which devalues the laboring woman and disregards her interests (Petchsky 1987). Viewing a "maternal environment" as a passive host for the fetus places the laboring women as a backdrop against which physicians can focus on the fetus. The maternal environment view is strengthened by the normalization of reproductive technologies. Technology that situates a pregnant woman along with all other observers as a wholly separate person places her in an artificial relationship to her fetus as someone whose autonomy does not extend to include its life inside of her. Ultrasound and fetal monitoring, widely used throughout pregnancy, promote the view long before labor that a woman's fetus is an entirely separate entity of concern (Karpin 1992; Petchsky 1987).

The feminist point is that dividing concern for fetal interests from women's interests relies on a suspect separation of interests. Implicit to the view that the fetus is a separate entity is that women's interests in their own health and wellbeing ought to be suppressed or at least considered secondary to that of the fetus. Separating interests promotes the view that the fetus is a separate patient, in which case doctors have a duty to weigh fetal rights and needs against those of the pregnant woman (Chervenak and McCullough 1996). In such an environment women are expected to regard themselves as decision makers for a separate entity, the fetus, and not as decision makers for a tightly connected unity, the self and fetus. This view is reinforced by models of pregnant women as responsible from the moment of conception to produce perfectly healthy fetuses through monitoring and controlling their activities, food and supplement intake, and so forth (Hildingsson *et al.* 2002). Such models of responsibility devalue women's interest in their own fetuses through upholding an artificial separation of interests. The implicit assumption is that women need to be told what their responsibilities are toward their fetuses because their responsibilities toward themselves do not already include responsibilities toward their fetuses. Asserting how women ought to be responsible toward their fetuses as if they were separate objects of moral consideration encourages a separation of moral responsibility. This separation of interests disrespects and devalues women's ability to choose their best interests in conjunction with the best interests of their fetuses while placing fetal interests first. We saw in the last section that the expectation medical technology is necessary to ensure the safety and wellbeing of the fetus can mean that laboring women perceive themselves as taking too large a risk in refusing its use. Underlying this heightened sense of risk is that

women must choose medical monitoring or interventions not for their own sake but for the sake of the fetus. In a separation of interests scenario, women's interests tend to lose out.[8]

If physicians aim to pursue use of technology during labor and birth – including cesarean – then women may not believe they have non-technological options to pursue. In that case, trusting one's own experiences may not seem to be an option. Women are particularly vulnerable to physician authority since women are socialized to defer to others' judgments rather than immediately trust their own. That self-distrust inclines women to defer to their physicians' suggestions at the expense of their values and goals and in favor of those of their physicians (McLeod 2002, 115). It is important to appreciate that distrust comes easily to those who feel vulnerable. Laboring and birthing women are vulnerable as selves inextricably bound in their own health and wellbeing with that of another being. They are also vulnerable to physicians' preferences. I argue elsewhere that physicians have motivations to perform emergency cesareans in borderline cases because of fears of complaint, litigation, and rising medical insurance premiums (Burrow 2012). This "defensive medicine" approach weighs against respecting the interests of pregnant or birthing women in favor of meeting physicians' own agendas. It is not uncommon for physicians to manipulate information about a medical situation to obtain the results they wish (Whitney and McCullough 2007). The feminist concern is that physicians' power to unduly influence patients can combine with a preference for defensive medicine to unduly pressure women toward cesareans. In a society encouraging feminine deference to physician authority, we should be worried that women's ability to avoid a cesarean is compromised by these external pressures.

So far we have seen that autonomy is not simply a matter of choosing freely and acting on our choices, it requires possessing the ability to act within concrete social and political contexts that may undermine choice and action. I want to extend this point to show that not only self-trust but also self-confidence are necessary to actively resist pressures attached to a technological imperative. Diana Meyers (1994) argues that autonomy importantly requires attaining skills of resistance and resolve. I maintain that women cultivate autonomy by learning to resist expectations of deference and to resolve to act otherwise. These skills are grounded in not only a positive attitude of self-trust but also self-confidence. Self-confidence in one's body may have to be cultivated over time and with concerted attention so as to overcome social pressures affecting women's possibility for choice formation and exercise. This point is integral to appreciating how women can challenge a technological imperative. Self-confidence seems to be a source of the *resolve* to allow one's body to labor and birth despite social pressures to use technology and *resistance* to technological pressures to hasten birth or otherwise follow the ideals of active labor management. This account is consistent with viewing the impact of a technological imperative according to a relational autonomy perspective since it allows us to recognize that the fetus and pregnant woman are thoroughly attached and that the health and wellbeing of each are intimately related.

Trust and self-confidence seem closely connected because both trust and self-confidence seem opposed to self-doubt. Doubt undermines the capacity to trust self-evaluation since we have nothing else to go on but confidence in our ability to form good self-evaluations. Self-trust seems to require at least a willingness to rely upon or depend upon oneself as well-intentioned or competent (Govier 1993). But also, self-trust seems to be a matter of recognizing the risk of self-sabotage and still possessing an optimism about one's own motives to do what is good for oneself (McLeod 2002a, 2005; Jones 1996). Accounts such as these focus on our motives or intentions but say little about trust in one's body. I suggest that self-trust requires relying upon oneself and possessing optimism not just about our motives but importantly, relying upon one's body to act in certain ways. On my view, relying on our abilities to act in certain ways, even if challenged by social pressures or particular others, is essential to possessing autonomy.[9] Relying on ourselves when threatened by damage or sabotage from others is an important litmus test of self-trust, and this reliance can be as much about our body as it is our motives.

We trust ourselves to perform many natural functions unless our abilities are called into question, either by others or because of limits revealed by our own bodies. Fearing the natural process of one's labor and birth reveals doubt in bodily competencies that lessen self-confidence and self-trust. Facing inappropriate expectations such as ideals of deference, women cultivate autonomy by learning to resist those expectations and to resolve to act otherwise. These skills are grounded, at least partly, in positive attitudes of self-trust and self-confidence. Confidence that one's body can labor and birth successfully while refusing certain uses of technology fosters trust in one's ability to do so. Both self-confidence and self-trust in this context resist social pressures for women to choose technology for reassurance. I maintain that women who foster self-trust and self-confidence to pursue technologically unassisted vaginal births challenge a technological imperative undermining autonomy. An extensive, multidisciplinary working group in the United Kingdom published a consensus statement encouraging a positive focus on "normal" birth in response to rising cesarean rates (Werkmeister *et al.* 2008). The group's consensus is that such a birth starts spontaneously, progresses spontaneously without use of drugs, and results in a spontaneous delivery, so long as none of the following are employed: induction of labour; epidural or spinal anaesthetic; general anaesthetic; forceps or vacuum; caesarean section; or episiotomy **(**258**)**. While a "normal" birth may not always be possible or desirable, trusting one's own judgments and gaining confidence to pursue non-technological options during labor and birth each foster autonomy.

In a culture encouraging women's deference to authority, the choice to trust one's own body to labor and birth spontaneously may not be a live option. We must acknowledge that in cultures encouraging women's deference to authority, the choice to trust one's own body to labor and birth without certain uses of technology may be difficult or impossible in practice. And regardless of cultural expectations, women may be unable or unwilling to resist pressures, normalized in society and recommended on physician authority, to *need* whatever technology is available. Such oppressive forces undermine self-trust and self-confidence, further frustrating women's reproductive autonomy. These last points suggest that developing autonomy despite certain social and cultural pressures may not be within the reach of all women and certainly not all women equally. Even so, we should not give up hope that women can counter autonomy-undermining technological practices during labor and birth. Pregnant women often care deeply about the health and wellbeing of their fetuses. A relational account of autonomy recognizes the intimacy of the relationship between pregnant women and their fetuses. Women's choices to refuse or use technology are not simply choices in their own best interest but also, and inextricably, choices about their fetuses. Hence, encouraging self-trust and self-confidence in the body is not just a means of promoting autonomy, it is a means of promoting a view of women and their fetuses as bodily interconnected beings.

5. Conclusion

I have argued that pressures to use technology as a means of monitoring and progressing labor and birth impair reproductive autonomy through undermining women's choice to refuse technology or to otherwise selectively pursue technology. Technology offers a promise of control over one's body but serves to undermine autonomy through playing on women's fears and uncertainties regarding a technologically unassisted, vaginal birth. Moreover, feminine socialization in deference combines with pressures to comply with physician authority to further erode autonomy. Because these elements are so closely connected we might even say that women encounter a *cultural imperative* to distrust and lack confidence in their bodies and so to seek reassurance through technological monitoring of labor and birth.[10] Fostering autonomy within this social context requires countering fears both of a technologically unassisted or minimally assisted birth and questioning a socially encouraged need to depend on technology for reassurance. My account shows that cultivation of self-trust and self-confidence can challenge these fears and dependencies so as to promote autonomy. A significant implication of my account is that respect for women's reproductive autonomy requires more than upholding availability of choice. On my account, respect for autonomy demands close attention to those social and cultural elements that impair women's ability to resist a technological imperative.[11]

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Notes

1. For an overview see (MacKenzie and Stoljar 2000a).

2. See Christman (2004); Anderson and Honneth (2005).

3. Elective cesareans are frequently described as CDMR (cesarean delivery on maternal request) to emphasize that pregnant women request but physicians do not recommend, elective cesareans. Ethical guidelines support the view that physicians should not recommend elective cesareans, such as those laid out by the American College of Obstetricians and Gynecologists. But since there is little empirical data on whether physicians in practice *avoid* recommending or suggesting elective cesareans, we should be hesitant to suppose that women always request elective cesareans. Hence, I prefer to use the more neutral term "elective cesarean."

4. And not just for pregnant women. Wax *et al* (2005) found that 8.3% of obstetricians surveyed cited convenience as a reason for preferring elective cesareans. Preferring patients opt for an elective cesarean can be preferable in light of clinical staffing volumes, availability of beds, and other patients' needs. Encouraging a cesarean instead of waiting for a vaginal labor to progress can deter maternity ward "traffic jams" by balancing staffing levels with clinical volume (Minkoff and Chervenak 2003).

5. This finding should not lead us to believe that *overall* maternal morbidity, fetal mortality, and so forth are increasing; many other factors contribute to their overall decline among laboring and birthing women.

6. Support during labor and birth is positively associated with better outcomes. See (Sauls 2006).

7. Routine medical surveillance during pregnancy introduces pressures on women to bear the responsibility to submit their bodies to medical interventions to produce the best children possible (Kukla 2005).

8. Coe and Altman's article in *this journal* illustrates how recent mandatory ultrasound laws force a separation of interests granting more importance to fetal interests than women's autonomy.

9. I present an account of bodily-rooted autonomy skills elsewhere (Burrow 2009).

10. Thanks to Hilde Lindeman for introducing the idea of a cultural imperative.

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