

2018

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WOMEN'S RIGHTS IN THE HEALTH CARE SYSTEM: CAESAREAN DELIVERY ON  
MATERNAL REQUEST

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# WOMEN'S RIGHTS IN THE HEALTH CARE SYSTEM: CAESAREAN DELIVERY ON MATERNAL REQUEST

## ABSTRACT

This paper explores a systems-theoretical question on the 'resonance capacity' of medicine and law that has enabled a recent obstetric change. Insights from autopoietic theory guide my analysis of these subsystems' preconditions or self-referencing processes supporting obstetrics to take up pregnant women's requests for caesarean sections for social reasons. Previously, obstetricians performed caesarean sections on medical grounds only. That change became possible, it resonated with obstetrics, despite limitations imposed on obstetrics and law by these subsystems' unique codes and programs, and in light of law's self-determining individual. This paper argues that although the change represents a victory for women's human rights in challenging paternalistic medical decision making, paradoxically it extends medical control over childbirth by further displacing midwifery. However, obstetricians, midwives and pregnant women have been less empowered by the change. I interpret how structural limitations or preconditions affect the capacity of communications to resonate and contribute to society's evolution.

**Keywords:** autonomy, childbirth, law, midwifery, obstetrics, systems, women's rights

Childbirth is typically depicted as an extended period of pushing and groaning followed by intervals of pain-free calm as rhythmic waves of uterine contractions rise and fall and rise again. During the period of calm, a midwife checks with a monitor or Pinard horn the foetus' heart-beat. S/he commands 'push' at strategic moments. The anxious father-to-be rubs his partner's back while muttering heartfelt words of comfort. Eventually, a squealing infant is placed on the mother's abdomen and assisted to suckle at the breast. All discomfort is forgotten.

As an alternative childbirth option, some operating theatres have recently opened their doors to healthy pregnant women choosing to deliver their healthy infants via caesarean sections. For these women, the key to a good birth lies with surgery and epidural anaesthesia. That choice requires the pregnant woman to submit to operating theatre staff who stand gloved, gowned, capped and masked ready for action after draping the patient in theatre greens. A paediatrician and midwife hover near a strategically placed emergency resuscitation cot. Lights blaze on high beam. The germ-free theatre smells of sterility. All is subdued except for

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an occasional muffled banter among staff and beeping monitors. The expectant father looks on. The incision is made. The stunned infant is eventually tugged out of the lower abdomen, examined, wrapped, whisked off and bottle fed with cooled infant formula.

A pregnant woman in Australia may choose one of these ideal scenarios or a variation thereof. For now, according to Nelson,<sup>1</sup> medical science has not enough evidence to determine whether vaginal or surgical delivery is the better, although some have argued that passage through the birth canal provides infants with microbial and other advantages.<sup>2</sup> The choice is a pregnant woman's prerogative, providing the service is available, she has consented, risks are explained and she is able to pay for it.

Specifically, I explore the change, how obstetrics has accommodated Caesarean Delivery on Maternal Request ('CDMR') that is gaining popularity in both developed and developing nations.<sup>3</sup> I call on this development to explore the relationship between areas of social life or subsystems of society, medicine and law, following a brief introduction to specific insights from autopoietic theory. It is the systems-theoretical question about the resonance capacity<sup>4</sup> of medicine and law as function systems that interests me. I explore the structural obstacles that were overcome, setting in place preconditions allowing for, but not determining, this recent development. These systems have differentiated functions made possible by a unique code that distinguishes each system's programming; yet, coupling processes have inadvertently shifted pregnant women's requests from unacceptable to acceptable<sup>5</sup> for obstetrics. Specifically, I describe how medicine assigns meaning to the legal construct: the self-determining individual enabling her to choose her childbirth option. I argue that CDMR appears to be a victory for pregnant women's empowerment, regarding reproductive choice, their autonomous decision making and for dismantling medical paternalism; yet, their empowerment is qualified. CDMR further erodes midwives' and (pregnant women's) control of health or 'normal childbirth' by paradoxically extending obstetrics' control.

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<sup>1</sup> Erin Nelson, *Law, Policy and Reproductive Autonomy* (Hart Publishing Ltd Oxford, 2013) 192.

<sup>2</sup> A study reported in the Guardian Weekly UK 16 09 2016, 33 discusses findings such as 'Birth by caesarean was linked to a 15% higher risk of obesity in children compared with vaginal births' and scientists believe that babies born by caesarean miss out on exposure to bacteria in the birth canal that may ultimately change the body's metabolic rate – and even how hungry we feel.

<sup>3</sup> Stephen J. Robson, Woo Syong Tan, Adebayo Adeyi, Keith B G Dear, 'Estimating the Rate of Cesarean Section by Maternal Request: Anonymous Survey of Obstetricians in Australia' (2009) 36(3) Sept 8, 208.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1523-536X.2009.00331.x/full>

<sup>4</sup> Niklas Luhmann, *Ecological Communication* (Polity Press, 1989) 76.

<sup>5</sup> Luhmann, n 4.

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*Insights from autopoietic theory provide a way of conceptualising the relationship between systems and their evolution*

To set about my task, I call on insights from autopoietic (systems) theory as to how obstetrics and law have evolved to allow CDMR. These two systems are conceptualised as autonomous networks of communication, two of numerous functionally differentiated subsystems of society.<sup>6</sup> Luhmann explains,

Social systems use communication as their particular mode of autopoietic reproduction. Their elements are communications which are recursively produced and reproduced by a network of communications and which cannot exist outside of such a network. Communications are not 'living' units, they are not 'conscious' units, they are not 'actions'.<sup>7</sup>

Autopoiesis theory observes communications at the systems level, not human actions, thoughts or feelings.<sup>8</sup> Through networks of communication flow sets of 'possible expectations'<sup>9</sup> of which CDMR is included. I identify circular relationships involving obstetrics, law and midwifery by 'tracing their internal dynamics and external interactions'<sup>10</sup> to explain how CDMR became possible.

Exploring CDMR as communication transformed according to the health care system's internal structures may seem strange, given that I discuss a decision made by pregnant women about their choice of childbirth procedures. However, explaining obstetrics' complex, unpredictable evolution would be inadequate if attention was given to focusing on individuals' decisions alone. Individuals, 'body and conscious occurrences' belong outside obstetrics';<sup>11</sup> 'mind and body' are excluded from society.<sup>12</sup> Instead, autopoietic theory describes individuals as comprising 'psychic autopoietic systems'.<sup>13</sup> Halsall summarises our humanity's three dimensions: 'our consciousness (self-awareness); our participation in

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<sup>6</sup> Luhmann, n 4, 34-35.

<sup>7</sup> Niklas Luhmann, 'The autopoiesis of social systems'. In: Geyer F. & van der Zouwen J. (eds.) *Sociocybernetic Paradoxes* (Sage, 1986) 172-192.

<sup>8</sup> Andres Philippopoulos-Mihalopoulos and Thomas E. Webb 'Vulnerable bodies, Vulnerable Systems (2015) 11(4) *International Journal of the Law in Context* 445.

<sup>9</sup> Loet Leydesdorff and Sander Franse, 'The communication of meaning in social systems' (2009) 26(1) January/February *Systems Research and Behavioral Science* 114.

<sup>10</sup> Gunther Teubner, "'And God Laughed...." Indeterminacy, Self-Reference and Paradox in Law' 2011, 12 January 1 *German Law Journal* 386.

<sup>11</sup> Niklas Luhmann, *Introduction to Systems Theory* (Polity, 2013) 187.

<sup>12</sup> Philippopoulos-Mihalopoulos, n 8, 447.

<sup>13</sup> Annika Newnham, 'Shared Parenting, Law and Policy: Considering Power within the Framework of Autopoietic Theory' (2015) 11(4) *International Journal of the Law in Context* 427.

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society (awareness of others)' and our biological existence.<sup>14</sup> These systems, however, are not unified.<sup>15</sup> That makes individuals inaccessible to social subsystems unless their communications, requests, thoughts and so on can be transformed to have meaning for the receiving subsystem. The psychical system belongs to the environment of social systems,<sup>16</sup> that I discuss further below. Describing humans as subsystems' environment opens the possibility of conceiving individualism in new ways.<sup>17</sup> Humans then are not 'the causal origin' of communications, or agents of action, but they do form part of the process of producing communications.<sup>18</sup>

The systems approach I take locates medicine's and nursing's disciplines and practices including obstetrics and midwifery as specialist networks of communication within the health care subsystem.<sup>19</sup> Law as well as the psychic system is conceptualised as an autonomous bounded system outside the health care system and comprising the health care system's environment. Obstetrics and law have differentiated functions based on separate, unique codes as they 'record, standardize and subject the code to practical verification'.<sup>20</sup> The health care system's code is the binary health/illhealth; for law it is legal/illegal. Only the health care system decides on 'health' and 'illness' issues; only the legal system on what is legal or illegal.<sup>21</sup> Far from being static, though, subsystems evolve by making new distinctions between the subsystem and its environment, 'between what is or is not relevant'.<sup>22</sup> How CDMR became relevant for the health care system is worthy of scrutiny, given that it raises tensions between obstetrics and midwifery, and health and illhealth, and has social effects.

The health care system and law, though autonomous, are co-dependent or interdependent subsystems.<sup>23</sup> Functional differentiation promotes an entire system's integration, under the assumption that other functions have to be fulfilled by other systems.<sup>24</sup> Though these subsystems are structurally coupled, they do not determine other subsystems' internal processes. Requests, or communications external to medicine; that is, from other subsystems

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<sup>14</sup> Francis Halsall, 'Niklas Luhmann and the Body' (2012) 18(1) *The New Bioethics* 16.

<sup>15</sup> Halsall, n 14.

<sup>16</sup> Luhmann, n 4, 29.

<sup>17</sup> Luhmann, n 11, 187.

<sup>18</sup> Philippopoulos-Mihalopoulos, n 8, 446.

<sup>19</sup> Annika Newnham, 'Shared parenting, law and policy: considering power within the framework of autopoietic theory' 2015, 11(4), *International Journal of the Law in Context* Int. J.L.C. 2015, 11(4), 426-443, 427.

<sup>20</sup> Luhmann, n 4, 77.

<sup>21</sup> Luhmann, n 4, 64.

<sup>22</sup> Newnham, n 19, 427.

<sup>23</sup> Luhmann, n 4, 42.

<sup>24</sup> Luhmann, n 4.

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(law, media, education, psychic or conscious systems and so on comprising medicine's environment), are generally ignored as 'noise' or turbulence unless the 'irritation' is transformed into a meaningful communication that resonates with established obstetrical operations and programs.<sup>25</sup> Two or so decades ago CDMR would have been distinguished as irrelevant, dismissed as 'noise', ruled outside normative obstetrical practices. No longer is that the case.

For CDMR to be transformed into obstetric practice, the request had to resonate with, or have meaning for, obstetrics' internal processes or 'transferred to a consistently *system-internal unity of self-reference and external reference*.'<sup>26</sup> Far from a straightforward transfer of information, communications become meaningful only via a system's internal, self-referencing ('reference to that which takes place in a system') processes.<sup>27</sup> Self-referencing processes involve calling on or activating preconditions triggered if and when an external communication resonates with a subsystem's internal processes. If a system were capable of determining the system/environmental relation of another system, the receiving system would be destroyed.<sup>28</sup> Self-referencing processes required for a system's evolution do not respond to factual conditions to make normative changes; instead, changes occur internally 'on the basis of autopoietic reproduction: the superimposition of norms onto norms.'<sup>29</sup> Systems evolve via self-referencing and re-entry processes, providing internal processes are able to accommodate or take account of 'irritations'. Communications must be transformed in order to resonate with internal norms and become meaningful for the receiving system. Resonance reduces redundancy,<sup>30</sup> while reserving the system's autonomy and enabling subsystems to remain socially relevant.

CDMR became a meaningful communication for the health care system only because it was transformed, reproduced or 're-entered' into the system<sup>31</sup> on the health care system's terms. The question arises: what self-referencing processes were in place to enable obstetrics to take up CDMR in the last few years when previously it was treated as irrelevant? Autopoietic production requires that a solution to a problem such as CDMR is comparable with other

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<sup>25</sup> See Luhmann, n 4, 116.

<sup>26</sup> Niklas Luhmann, *Observations of Modernity* (Stanford University Press, 1998) 17.

<sup>27</sup> Luhmann, n 11, 56.

<sup>28</sup> Niklas Luhmann, *Social Systems* (Stanford University Press, 1995) 18.

<sup>29</sup> Andreas Philippopoulos-Mihalopoulos, *Niklas Luhmann, Law, Justice, Society* (Routledge 2010) 71.

<sup>30</sup> Philippopoulos-Mihalopoulos, n 29, 187.

<sup>31</sup> Philippopoulos-Mihalopoulos, n 29, 87.

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solutions, but is dependent on the health care system's systemic structures<sup>32</sup> as discussed below. How CDMR became possible, how such requests were able to resonate with the health care system's internal structures, calls for an explanation at the systems level. What obstacles or blockages were overcome as the current health care system emerged from instances of communication? I explain how obstetrics with its heavy reliance on both technology and its coupling with the legal system has acquiesced to the CDMR. Below, preconditions are described in their historical context that situate CDMR as an extension of obstetrical care's evolution. For CDMR to have meaning within the health care system, it had to resonate with other preconditions or obstetrics' bounded, internal processes and operations established over time.<sup>33</sup> The first precondition requires situating obstetrics' uneven development alongside technological achievements. Secondly, I discuss the law's imperative, granting women their right to reproductive autonomy: the right to choose a mode of childbirth. Thirdly, I discuss why, given the strength of individualism, reversing the trend seems unlikely.

## PRECONDITIONS FOR CDMR DISPLACE OBSTACLES AND ENABLE RESONANCE

### *A Obstetrics is synonymous with technology*

CDMR must be seen in light of medicine's/obstetrics' contingent evolution over many centuries that established preconditions and made it possible. The foremost precondition was the historical medical intervention in childbirth that required constructing childbirth as a serious medical problem worthy of a specialist division (obstetrics) in response to high maternal and infant mortality and morbidity rates worldwide. Childbirth is now seen largely without question as a condition requiring medical supervision and/or intervention following centuries-long struggles between medicine (obstetrics) and nursing (midwifery), traceable to the witch-hunts of the fourteenth century.<sup>34</sup> Remnants of these tensions remain around such options as a home birth managed by midwives that is now an uncommon alternative in Australia to hospital-based midwifery and obstetrical practices.

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<sup>32</sup> See Niklas Luhmann, *Love a Sketch* (Polity Press, 2010) 2.

<sup>33</sup> Luhmann, n 32, 33.

<sup>34</sup> Barbara Ehrenreich and Deirdre English, *Witches Midwives and Nurses* (The Feminist Press 1973). Larsen, A-C. (2018) Women's rights in the health care system: caesarean delivery on maternal request. *Journal of law and medicine*. 25(2) 448-464



Childbirth has been largely subsumed under obstetrics' control following a culmination of unpredictable processes<sup>35</sup> often involving technologies, another precondition for CDMR. A range of technologies – surgery, scans, amniocentesis, monitoring, forceps, vacuum extractions, surgical procedures, with ultrasound, foetal monitoring, episiotomy, epidurals, labour induction and so on – is now accepted without question particularly those instruments used to assess a pregnancy's progress. Obstetricians, with specialist and scientific expertise, implement, monitor and evaluate these interventions. Technology simplifies and reduces complexity,<sup>36</sup> exposing what was hitherto unknown. These procedures including caesarean sections are now expected in maternity health care centres. Technology reduces its target, for example, the foetal heart, to beeps and lines on graphs, thereby producing irrefutable evidence from electronic readings and scan results. Once surgery was accepted as the solution to obstetrical problems and rendered a relatively safe procedure, its practice was standardised. CDMR has become possible only as a contingent extension of obstetrics' use of technologies including surgery to solve childbirth problems.

Surgical and other technological interventions in childbirth, though, have a chequered history including complex struggles over scientific knowledge, medical and midwifery practice, and gendered issues. Although obstetrics' control of childbirth appears synonymous with technological developments, Willis<sup>37</sup> cautioned against technological determinist arguments to explain medical control or dominance. New techniques, according to Willis, such as the forceps delivery that at times had dire and lethal consequences, slowed down obstetrics' involvement.<sup>38</sup> For example, as a result of interventions, British women were more likely to die during labour in the early 1930s than in 1880.<sup>39</sup> General practitioners whose training was often inadequate<sup>40</sup> contributed to the sorry story of maternal and infant deaths. Faulty knowledge and practices, mistakes, avoidable problems, pain, infections and the development of scientific and evidence based knowledge on obstetric care, all in need of a solution, are all part of obstetrics' complicated history. Obstetrics came eventually to rely on scientific

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<sup>35</sup> Evan Willis, *Medical Dominance* (George Allen & Unwin 1983); Also see Ehrenreich and English, n 34.

<sup>36</sup> Luhmann, n 26, 6.

<sup>37</sup> Willis, n 35, 122-23.

<sup>38</sup> Willis, n 35, 121. Willis argues that by the 1930s, midwifery was subsumed under medicine's control 122.

<sup>39</sup> Malcolm Nicolson and John E. E. Fleming, *Imaging and Imagining the Fetus: The Development of Obstetric Ultrasound* By (The John Hopkins University Press 2013) 57.

<sup>40</sup> Nicolson and Fleming, n 39, 58.

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understandings of infection control, anaesthesia, biology and disease to find solutions to problems and more problems requiring more solutions and so on.<sup>41</sup>

Over the decades, the obstetric net was cast wider with technologies' assistance. As medico-scientific knowledge became increasingly complex, attention turned to preventing illhealth before and during pregnancy. Signs and symptoms of reproductive illhealth broadened to include potential problems. Technologies such as the 1950s' ultrasound, which was far from a neutral intervention, changed the status of mother and foetus in antenatal care: assessments included the foetus' welfare.<sup>42</sup> Medico-scientific-technological analyses serve not only to solve problems, it multiplies them.<sup>43</sup>

Obstetrics has come to rely heavily on technologies as a visit to an obstetric operating theatre, a delivery ward or a neonatal intensive care unit would attest. Technologies have come a long way and are a tool in saving lives. Medicine's ownership of obstetric technologies, however, has secured its control over, and management of, pregnancy and childbirth.

Obstetrics' established history of successful surgical intervention into childbirth therefore is a precondition for CDMR. That transformation has been neither straightforward nor predictable; it is an open question at first,<sup>44</sup> as outlined above. Once surgery, however, was made relatively safe, obstetricians were liberated to perform surgery for non-life threatening conditions.<sup>45</sup>

*Resolving paradoxes: health/illhealth slippage allowing for obstetrics to surgically treat a non-medical problem*

Obstetrics resolves problems or blockages 'produced by paradoxes and, despite extreme fluctuations, achieves stability'.<sup>46</sup> As with all components of autopoietic systems, obstetrics functions according to binaries: health/illhealth, doctors/nurses, midwifery/obstetrics, public/private, male/female<sup>47</sup> and so on. The binary health/illhealth is generally associated with midwifery and obstetrics (with technological intervention) respectively. Midwives

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<sup>41</sup> Niklas Luhmann, *The Reality of the Mass Media* (Polity Press, 2000) 78.

<sup>42</sup> Nicolson and Fleming, n 39, 254.

<sup>43</sup> See Luhmann, n 4, 78.

<sup>44</sup> Luhmann, n 32, 6.

<sup>45</sup> See for example Thomas Schlich, 'The Technological Fix and the Modern Body Surgery as a Paradigmatic Case' in Ivan Crozier *A Cultural History of the Human Body in the Modern Age* (Bloomsbury, 2014 Vol 6) 72.

<sup>46</sup> Teubner, n 10, 385.

<sup>47</sup> Newnham, n 13, 430.

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manage, monitor and assist women carrying healthy pregnancies to term and who are likely to deliver spontaneously: normal deliveries are aligned with 'health.' Conversely, surgical childbirth was a last resort, reserved for obstetrical emergencies and performed by obstetricians for conditions located on the side of 'illhealth': problem deliveries needing technological assistance. Abnormalities or illhealth in pregnancy remain obstetrics' exclusive domain. The 'health' domain, however, is fluid as obstetricians do manage some 'normal' deliveries.

Healthy pregnancies, if left alone, are unlikely to require medical intervention. However, as obstetrical knowledge and practice became increasingly complex, as evidence alerted obstetricians not only to illhealth (problem pregnancies) but also to preventing illhealth, childbirth was established firmly on the illhealth (or sickness) side of the health/illhealth divide. Medicine determines what is illhealth based on criteria it has designed: it is illhealth because it is illhealth' and not 'health' is the tautology at the heart of medicine. Where healthy pregnant bodies are seen through the prism of medicine as illhealth needing to be returned to health, structures and technologies – operating theatre, intensive care, hospital bed, nurses, anaesthetist, paediatrician and so on – stand ready.

However, at the boundaries of the health/illhealth is a grey area, paving the way for discretionary decision making. It is at that point that CDMR's resonance with obstetrics becomes possible; that is, health is transformed to illhealth. The boundaries between the two subsystems (obstetrics and midwifery), though circumscribed, are also porous. Power is diffused.<sup>48</sup> In Philippopoulos-Mihalopoulos'<sup>49</sup> words, 'power is dispersed, externalised, communicated to its environment, at the same time reinforced and debilitated, divided between two operabilities which remain individually inoperable'.

CDMR exemplifies obstetrics' erosion further into midwifery's domain, mining 'normal' or 'health' and securing further control of 'normal' deliveries. CDMR extends obstetrics' domain with some midwives' support as obstetricians only carry out the procedure made possible by subsuming health under the auspices of illhealth to overcome blockages and revolve the health/illhealth paradox.

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<sup>48</sup> Philippopoulos-Mihalopoulos, n 29, 129.

<sup>49</sup> Philippopoulos-Mihalopoulos, n 29, 130.

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The health/illhealth paradox arises in decision-making requiring emergent blockages to be resolved.<sup>50</sup> The paradox draws on distinctions that remain unnamed, concealed behind other distinctions.<sup>51</sup> For example, what constitutes illhealth (removing the prior blockage for CDMR) may be concealed behind such distinctions as improving maternal mortality rates/not improving maternal mortality rates; avoiding infant morbidity/not avoiding infant morbidity; what the public wants/what the public rejects<sup>52</sup>; technology confirms/technology discards; pain/no pain; rights/no rights. To ‘endow communications with meaning,’ creative ways are found to conceal the system’s paradoxical existence.<sup>53</sup> If the paradox cannot be resolved, a further operation is needed to ‘deparadoxify’, to remove emergent blockages in decision making. The further response may be to call on law, for example, that is discussed below.

### *Medicine and the law are structural couples*

Autonomous systems, medicine and law, do not function in isolation.<sup>54</sup> Subsystems evolve, although how they change cannot be pre-determined. The relation between subsystems is a complex matter as a subsystem’s environment is produced along with the subsystem.<sup>55</sup> Medicine and the law as functionally differentiated autopoietic systems work as structural couples, necessarily to remain socially relevant. Systems resonate or are activated through structural coupling processes<sup>56</sup> that involve ‘no contact, no intersection, no input-output’.<sup>57</sup> Coupling or bonding ‘indicate a temporary interlocking of independent units.’<sup>58</sup> A system’s internal self-referencing processes is interlocked or coupled with an external reference functions only because the ‘system has a binary code’.<sup>59</sup>

Another precondition for CDMR then was the development of legal protections around consent, information and associated risks that are capable of activating law’s binary code: lawful/unlawful. Law as a subsystem of society has no direct factual input in medical

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<sup>50</sup> Michael King and Chris Thornhill *Niklas Luhmann’s Theory of Politics and Law* (Palgrave Macmillan, 2003) 21.

<sup>51</sup> King and Thornhill, n 50, 20.

<sup>52</sup> King and Thornhill, n 50, 22.

<sup>53</sup> King and Thornhill, n 50, 22.

<sup>54</sup> Newnham, n 13, 426.

<sup>55</sup> Philippopoulos-Mihalopoulos, n 29, 87; Luhmann, n 11, 55.

<sup>56</sup> Luhmann, n 11, 88.

<sup>57</sup> Philippopoulos-Mihalopoulos n 29, 131.

<sup>58</sup> Luhmann, n 28, 222-223.

<sup>59</sup> Luhmann, n 26, 16.

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decision-making.<sup>60</sup> It does not deliver the law;<sup>61</sup> yet, it is structurally coupled with medicine and other subsystems. Law enables medicine by opening space where ‘law is set up as a question, while allowing for a range of answers to flow in without prior notions of causal link’.<sup>62</sup> Although coupled subsystems may use the same words, each system constructs the meaning of the words differently.<sup>63</sup> The legal system does not communicate directly with medicine. It does not provide normative instructions about its practices. Each system’s self-referencing processes impose both limitations and avenues for contingent developments.<sup>64</sup> Although each system is autonomous, unique and bounded – law is law, and obstetrics is obstetrics – they function on a continuum,<sup>65</sup> ‘predicated on a certain structural rupture needed for the accommodation of environmental uncertainty’.<sup>66</sup>

The legal system’s function is to enable other systems to carry out their autopoiesis by providing an external reference point.<sup>67</sup> Consent, a normative legal requirement for any medical intervention, provides a bridge between law and medicine. Without a pregnant woman’s written consent, secured voluntarily, a caesarean section could not be performed without court approval. As part of the rupturing process, the legal system provides no factual input into which procedure is carried out.<sup>68</sup> That is left to obstetricians. The legal system supports any procedure, however ‘irrational,’<sup>69</sup> providing a patient’s consent is secured, she is informed of all risks<sup>70</sup> and practices conform to normative standards. Surgery is now standard, normative treatment for many medical and non-medical problems. That which has become normative is freed from ‘being an exception or being false’.<sup>71</sup> The relationship, however, between law and obstetrics is one of rupture and contingency not causation.<sup>72</sup>

Law’s concerns become obstetrics’ problem if the possibility of litigation arises. Providing legal criteria are met, and criminal conduct or incompetence are ruled out, health practitioners are legally protected. A patient’s consent generally protects obstetric practices in the face of

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<sup>60</sup> See Philippopoulos-Mihalopoulos, n 29, 71.

<sup>61</sup> Philippopoulos-Mihalopoulos, n 29, 68.

<sup>62</sup> Philippopoulos-Mihalopoulos, n 29.

<sup>63</sup> Newnham, n 13, 428.

<sup>64</sup> ?\*see Philippopoulos-Mihalopoulos, n 29, 51.

<sup>65</sup> Philippopoulos-Mihalopoulos, n 29, 132.

<sup>66</sup> Philippopoulos-Mihalopoulos, n 29.

<sup>67</sup> Philippopoulos-Mihalopoulos, n 29, 70.

<sup>68</sup> Philippopoulos-Mihalopoulos, n 29, 71.

<sup>69</sup> See Luhmann, n 26, 6.

<sup>70</sup> See *Rogers and Whitaker* (1992) 175 CLR 479; [1992] HCA 58.

<sup>71</sup> Luhmann, n 4, 78.

<sup>72</sup> Philippopoulos-Mihalopoulos, n 29, 68-69.

disappointments or adverse events to stabilise social expectations.<sup>73</sup> The law also protects patients from interventions they may not want. A surgical procedure performed without a patient's consent or judicial intervention amounts to trespass in law.

The performance of caesarean sections, a major surgical procedure with potential risks, now mostly passes without incident. However, the possibility of litigation in medicine in general always lurks. In 2012–13, new public sector medical indemnity claims numbered about 950, which was less than the four previous years; new private sector claims amounted to about 3,300, a similar figure to the previous 2 years. Closed public sector claims rose slightly than in any of the previous 4 years (about 1,500); whereas, 'private sector claims closed each year rose continually from about 2,400 in 2008–09 to 3,800 in 2012–13.'<sup>74</sup>

#### *The development of women's rights supports pregnant women's decision making and CDMR*

Another precondition for including CDMR in obstetric communications is the foundational human rights principle: autonomy.<sup>75</sup> The practice of CDMR gives rise to arguments about women's right to privacy and autonomy enshrined in the *International Covenant on Civil and Political Rights* as well as the right to reproductive health, and the right to benefit from scientific progress enshrined in the *International Covenant on Economic, Social and Cultural Rights*. Specifically, the international human rights requirement not to discriminate against women is defined in Article 1 of the *Convention on the Elimination of all Forms of Discrimination against Women* ('CEDAW').<sup>76</sup> As women have specific needs around reproductive health issues, discrimination is illegal, but possible. Laws, policies, or practices making a 'distinction, exclusion or restriction' impairing or nullifying women's access to health care services without reasonable justification are likely to be discriminatory.<sup>77</sup>

CEDAW's statement is worth quoting in full,

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<sup>73</sup> Philippopoulos-Mihalopoulos, n 29, 71.

<sup>74</sup> AIHW 'Australia's Medical Indemnity Claims 2012–13. Safety and Quality of Health Care' (2014) no. 15. Cat. no. HSE 149. Canberra: AIHW <http://www.aihw.gov.au/publication-detail/?id=60129547940>

<sup>75</sup> Elisabeth Wicks, *The State and the Body Legal Regulation of Bodily Autonomy* (Bloomsbury, 2016) 6.

<sup>76</sup> The Convention defines discrimination against women as "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."  
<http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>

<sup>77</sup> Rebecca J. Cook and Veronica Undurraga, 'Article 12' in *The UN Convention on the Elimination of all Forms of Discrimination against Women A commentary* Edited by Marsha A. Freeman, Christine Chinkin and Beate Rudolf (Oxford University Press, 2012) 311-332.

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Persistent stereotypes that inhabit women's equal access are those that consider women to be incompetent and irrational decision-makers, lacking the capacity for medical and moral agency and self-determination, so they are denied the opportunity to make their own health care decisions.<sup>78</sup>

Further, if an obstetrician were to deny a woman lawful care on a basis of conscientious objection that objection may be 'indirectly discriminatory.'<sup>79</sup> The CEDAW Committee does not deny health providers the option of exercising their conscience, but requires State Parties to inform women of all options, and to refer women in good time to providers who do not object, to ensure access to lawful care.<sup>80</sup> Satisfying a pregnant woman's request for health care avoids any concerns about indirect discrimination. On the face of it, CDMR has legal support from the human rights community.

As conforming, consuming citizens in a liberal democracy, any interference in the decision to buy an available service would challenge obstetrics' autonomy and women's autonomous, reproductive rights. Whatever she decides and consents to, providing she is not coerced, is an expression of a pregnant woman's autonomy. The political and legal systems have evolved internally to support the construction of 'a liberal, individualised form of autonomy'.<sup>81</sup> Thus, obstetrics with its technological interventions works also in tandem with notions of autonomy and individuality.<sup>82</sup> Law, as with all systems, is required to meet societal expectations and to guarantee some semblance of stability.<sup>83</sup>

Promoting women's choice as to what is done to her body is also captured in case law:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages. ...<sup>84</sup>

For Wicks, the liberal conception of autonomy with its focus on individualism is 'the most appropriate way of protecting an individual's rights and freedom'.<sup>85</sup> Every adult with

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<sup>78</sup> Cook and Undurraga, n 77, 325.

<sup>79</sup> Cook and Undurraga, n 77, 326.

<sup>80</sup> Cook and Undurraga, n 77, 326.

<sup>81</sup> Wicks, n 75, 4.

<sup>82</sup> See Luhmann, n 26, 7.

<sup>83</sup> Philippopoulos-Mihalopoulos, n 29, 70.

<sup>84</sup> Judge Cardozo referring to another context in *Schloendorff v Society v Society of New York Hospital* (1914) 211 NY 125-126.) <http://www.lawandbioethics.com/demo/Main/LegalResources/C5/Schloendorff.htm>

<sup>85</sup> Wicks, n 75, 4.

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decision-making capacity has ‘an absolute right to consent to, or refuse, medical treatment’.<sup>86</sup> That right extends to the right to make ‘irrational’ decisions, such as requests to have healthy limbs surgically removed, that has legal support. Technological interventions also have an unavoidable side effect of accommodating ‘irrational’ requests.<sup>87</sup> Thus, CDMR is not one of a kind. Lord Donaldson MR confirmed in the 1992 case of *Re T*, that the legal right of choice ‘is not limited to decisions which others might regard as sensible’.<sup>88</sup> A pregnant woman exercises her autonomous right in deciding her birthing option that is synonymous with: ‘freedom to live as one chooses’. Details, however, as to what autonomy means and its requirements remain debatable.<sup>89</sup> An individual’s freedom to decide to have a medical procedure is restrained legally by his or her ‘capacity, voluntariness and sufficient information’.<sup>90</sup> The medical system accommodates other surgical procedures for non-medical reasons such as cosmetic surgery, gender realignment or removing healthy limbs on request. According to Wicks,<sup>91</sup> at the ‘heart of individual autonomy’ is the freedom to make wrong choices. These requests and CDMR have been transformed, providing procedures are conducted according to a ‘do no harm principle’,<sup>92</sup> as a non-moralising response to a request.<sup>93</sup>

#### *Positioning rights on the health care system’s boundary*

CDMR falls firmly on the side of both women’s rights and Australia’s international human rights obligations to provide health care. It’s worth pausing a moment to position rights in relation to the health care system. Certain rights have legal support under the *Sex Discrimination Act* 1984 (Cth). Rights facilitate structural coupling of law, politics and the health care system. However, for Luhmann, universal human rights play a different role to that of third values in society: human rights are, paradoxically, the ‘signifier for the exclusion of human beings from society’.<sup>94</sup> Human rights enable individuals to move between

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<sup>86</sup> Wicks, n 75, 4.

<sup>87</sup> Luhmann n 26, 6.

<sup>88</sup> Wicks, n 75, 4.

<sup>89</sup> Wicks, n 75, 3.

<sup>90</sup> Wicks, n 75, 5 cites cases.

<sup>91</sup> Wicks, n 75, 45.

<sup>92</sup> Wicks, n 75, 46-47.

<sup>93</sup> See William Rasch, *Niklas Luhmann’s Modernity The Paradoxes of Discrimination* (Stanford University Press, 2002) 146.

<sup>94</sup> Philippopoulos-Mihalopoulos, n 29, 155.

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functionally differentiated systems as required.<sup>95</sup> Human rights became the *grid* on which humans could move and through which their access to various systems is secured. Rights enable everyone to access systems, but it is up to the systems themselves whether or not, and on what terms, access is granted.<sup>96</sup> In health care, no one ought to be excluded as rights to health care are supposedly universal and inalienable,<sup>97</sup> though in practice they are not.

At the same time, the health care system must retain its integrity. It cannot be colonised by another system or threatened by processes that undo functional differences via ‘dedifferentiation’<sup>98</sup> processes. Rights do not belong to a particular system, but they occupy a space at the boundary of systems.<sup>99</sup> Rights provide a fall-back position for all involved, a ‘ruptured connection’.<sup>100</sup> Rights are a defence for patients against expanding state intervention<sup>101</sup> and for requesting medical interventions. Following Luhmann, Philippopoulos-Mihalopoulos sums up this point by positioning rights on the other side of the health care system’s boundary. Rights operate both as an opening for attention while insulating the system from other systems (protect women’s rights and autonomy from any attempt at regulating). Paradoxically, rights recast the ‘universal and particular’.<sup>102</sup> The state is unlikely to regulate birthing options by denying women the right to choose surgical intervention for any reason.

*Psychic (conscious) autopoietic systems are located in society’s subsystems’ environment*

CDMR involves individuals, those pregnant women submitting requests to obstetricians. Rather than, for example, interviewing women to ask how or why they would make such a request, autopoietic theory requires that individuals as psychic autopoietic systems are positioned outside other subsystems’ environment. For individual pregnant women to find an obstetrician willing to perform a caesarean section, the request must resonate with those of the internal operations of the health care system. Similar to other autopoietic systems, psychic systems ‘use their existing communications’<sup>103</sup> to find meaning. A pregnant women’s

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<sup>95</sup> Gert Verschraegen, ‘Human Rights and Modern Society: A Sociological Analysis from the Perspective of Systems Theory’ (2002) 29(2) *Journal of Law and Society* 280.

<sup>96</sup> Luhmann, Niklas, *Law as a Social System* (Oxford University Press, 2004) 135.

<sup>97</sup> Verschraegen, n 95, 268.

<sup>98</sup> Philippopoulos-Mihalopoulos, n 29, 154.

<sup>99</sup> Philippopoulos-Mihalopoulos, n 29.

<sup>100</sup> Philippopoulos-Mihalopoulos, n 29, 156.

<sup>101</sup> Philippopoulos-Mihalopoulos, n 29, 154.

<sup>102</sup> Philippopoulos-Mihalopoulos, n 29, 156.

<sup>103</sup> Newnham, n 13, 427.

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decision to have a caesarean section is informed by a multitude of social and cultural factors, preconditions, and support structures. Such reproductive decisions implicate women's relationships, both personal and public.<sup>104</sup>

A pregnant woman's decision regarding the choice of birthing options is a complicated cultural and social matter. A pregnant woman's decision, however, is influenced by a 'network of relationships': 'their intimate relationships with partner and with other family members, (including children), their relationships with healthcare providers (physicians, nurses, midwives and others) and their relationship with the healthcare system'.<sup>105</sup> Other influences include her family's history of childbirth, friends' experiences, celebrities' reported experiences, her values and beliefs, financial concerns and resources, and her capacity to seek out conducive services. These complexities inform, consciously or otherwise, a woman's decision. Decisions have a cultural and temporal dimension. Twenty years ago, CDMR was unlikely. Women can only take part in a transaction if they have something (pregnancy), do not have something else (access otherwise to a surgical birth) and want it.

#### *Relieving pregnant women's anxiety*

Another precondition involving the psychic system stems from concerns depicting childbirth as a dangerous and painful 'disease' similar to obesity,<sup>106</sup> for example, for which surgery also provides a solution. Childbirth is an event often associated with anxiety. As a pregnant woman's anxiety cannot be contradicted, it is difficult to remove.<sup>107</sup> Where there is anxiety, there is vulnerability.<sup>108</sup> Vulnerability affects social systems including psychic systems, opening new communicative possibilities.<sup>109</sup> Surgery, the caesarean section, emancipates the pregnant woman from unpredictable, biological constraints associated with anxiety. But rather than empowering women, surgical intervention into a 'healthy' bodily function displaces women's and midwives' control of the process.

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<sup>104</sup> Nelson, n 1, 59.

<sup>105</sup> Nelson, n 1, 59.

<sup>106</sup> Karen Throsby 'Obesity Surgery and the Management of Excess: Exploring the Body Multiple' (2011) 34(1) *Sociology of Health and Illness*, 1.

<sup>107</sup> See Luhmann, n 4, 128.

<sup>108</sup> Philippopoulos-Mihalopoulos, n 8.

<sup>109</sup> Philippopoulos-Mihalopoulos, n 8, 456.

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At the same time ‘autopoiesis de-individualises the individual’<sup>110</sup> and society evolves. More problems are produced needing solutions that produce more problems.<sup>111</sup> For example, to feel better connected with her infant, a mother following a caesarean delivery, may request that she assist in their infant’s delivery by being the first person to touch the infant (maternal assisted delivery) and to have the infant placed on her chest.<sup>112</sup> Breast milk is also now as commodity for sale.<sup>113</sup>

### *The pregnant woman as an autonomous decision maker with choices*

The popularity of CDMR confirms at first glance that in reproductive matters women’s autonomous decision making reigns supreme. An obstetrician upholds ‘respect for patient autonomy through addressing preferences’.<sup>114</sup> Much depends, however, on how autonomy is defined. Nelson,<sup>115</sup> for example, suggests that women’s autonomy in reproductive matters would be increased if autonomy was equated with the number of options available. However, adding the surgical option for convenience to the list of choices does not necessarily enhance autonomy.<sup>116</sup> Instead, issues of autonomy and pregnant women’s decision making ought to be considered as the end-point in the highly powerful medico-technological context within which pregnancy and childbirth are now situated.<sup>117</sup> Given the prowess and power of the medico-technological enterprise and the popularity of CDMR, women’s autonomy in childbirth appears diminished rather than enhanced.<sup>118</sup>

The matter of choices on a list is also paradoxically problematic for the autonomous decision maker. Where a patient is given a choice, the possibilities may be used to justify paternalistic or coercive practices.<sup>119</sup> Our understanding of consent and any legal consequences is founded on notions of ‘a self-interested actor, making self-interested choices, for self-interested

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<sup>110</sup> Philippopoulos-Mihalopoulos, n 29, 177.

<sup>111</sup> Niklas Luhmann, *The Reality of the Mass Media* (Polity Press, 2000), 78.

<sup>112</sup> <http://www.couriermail.com.au/news/queensland/i-delivered-my-own-bub--by-csection/news-story/8e6adb90f66df985f34340aa668fb7a0>

<sup>113</sup> Sarah Farnsworth 2017 ‘Milk money: Indian company looking to sell breast milk to Australia’ 15 Jun 2017 <http://www.abc.net.au/news/2017-06-15/indian-company-neolacta-looking-to-sell-breast-milk-to-australia/8619020> 22 June 2017.

<sup>114</sup> Sylvia Burrow, ‘On the Cutting Edge: Ethical Responsiveness to Cesarean Rates’ (2012) 12(7) *The American Journal of Bioethics* 44.

<sup>115</sup> Nelson, n 1, 192.

<sup>116</sup> Nelson, n 1, 193.

<sup>117</sup> Nelson, n 1, 193.

<sup>118</sup> Nelson, n 1, 193.

<sup>119</sup> Erin Nelson, ‘Reconceiving Pregnancy: Expressive Choice and Legal Reasoning’ (2003-2004) *McGill Law Journal* 609.

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ends.’<sup>120</sup> That liberal choice paradigm supports medico-legal systems. Although the language of choice has intrinsic appeal,<sup>121</sup> offering people choices does not necessarily provide an avenue for happiness. For example, Barry Schwartz<sup>122</sup> in his ‘The Paradox of Choice’ proposes that American culture has ‘become more individualistic than it was, perhaps as a by-product of the desire to have control over every aspect of life.’<sup>123</sup> The accompanying expectation of perfection will inevitably fail. A perfect birth is an illusion.

The option of CDMR as a highly desirable choice for some pregnant women once it was deemed a relatively safe obstetrical procedure. That option goes hand in hand with making the experience of childbirth as individualized and pleasant as possible. Acceptable no longer are rows of beds in dormitory-style wards where patients’ privacy relies on ill-fitting curtains surrounding each bed. Some maternity wards now offer single en suite accommodation resembling a 5 star private hotel experience for women with health insurance cover. Women’s right to privacy/autonomy includes her right to make choices about her body including the mode of delivery in a desired setting. Care providers must now provide ‘an optimal environment in a surgical setting’.<sup>124</sup> Not all pregnant women are ‘afforded equality of opportunity to engage with systems’, whatever the outcome may be.<sup>125</sup>

### *CDMR escapes external regulation*

CDMR is not formerly regulated. It falls outside other areas such as assisted reproduction including surrogacy that are heavily regulated by various State mechanisms.<sup>126</sup> Except for the Northern Territory, Australian states and territories have banned human reproductive cloning.<sup>127</sup> Research on human embryos is also governed legally. Western Australia, for example, has the *Human Reproductive Technology Act 1991* (WA), referring to a range of objectives including section 4 (b) ‘adherence to standards in the practice of reproductive technology that are proper and suitable’; and discourage[ing], and if required ... prohibit[ing], developments or procedures that are not both proper and suitable’ (s 4 c). Section 4 (d) (iii) requires ‘that the welfare of participants is properly promoted; and (iv) that

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<sup>120</sup> Nelson, n 119, 613.

<sup>121</sup> Nelson, n 119, 617.

<sup>122</sup> Barry Schwartz, *The Paradox of Choice Why More is Less* (HarperCollins Publishers Inc 2016).

<sup>123</sup> Schwartz, n 122, 215.

<sup>124</sup> <http://www.couriermail.com.au/news/queensland/i-delivered-my-own-bub--by-csection/news-story/8e6adb90f66df985f34340aa668fb7a0>

<sup>125</sup> Philippopoulos-Mihalopoulos, n 8, 455.

<sup>126</sup> Wicks, n 75, 43.

<sup>127</sup> Nelson, n 1, 247.

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the prospective welfare of any child to be born consequent upon a procedure to which this Act relates is properly taken into consideration.’ Reference is also made to community standards in 4(e) to be ‘taken into account in the practice of reproductive technology.’ Required for access to treatment involving these technologies is specific medical criteria.<sup>128</sup> CDMR falls outside legislation or policy. For the most part, medicine as with society’s other subsystems is not susceptible to direct, outside control.<sup>129</sup>

*Economic system is unlikely to attempt to intervene with obstetrics*

So entrenched are the preconditions that CDMR is unlikely to be regulated. However, as the health care system consumes about 10% of Australia’s Gross Domestic Product,<sup>130</sup> CDMR would become a target for attention if it resonated with politics and the economy, couched as unnecessary costs to the health care system – alone and along with over-servicing and/or if adverse events associated with caesarean section extended beyond an acceptable level.

For some, CDMR is a victory for pregnant women over medical dominance and paternalism. Although obstetricians have fought and won the historical battle over midwifery for power and control of pregnancy and childbirth, now pregnant women are asserting their right to choose surgical intervention, to use advances in medical science and technologies to their advantage. In asserting their rights, pregnant women’s requests displace medical dominance (paternalism), positions that have dominated critiques. The complex relationship between medicine and its clients and women’s capacity to demand minor adjustments confirms the ‘bidirectional nature of medicalisation’.<sup>131</sup> Some pregnant women, however, prefer not to embrace a surgical intervention.<sup>132</sup>

The CDMR satisfies an individual pregnant woman’s human rights. She is an autonomous consumer who consents voluntarily to surgery after being fully informed of any risks. However, describing the medical system as being manipulated by the more powerful subsystem (the psychic system) gives the ‘illusion of compatibility’ between the needs of pregnant women and the medical system’s response.<sup>133</sup> All requests or messages are imperfectly ‘translated’ (in reality recreated) within the receptor system; what will be rejected

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<sup>128</sup> Nelson, n 1, 249.

<sup>129</sup> Teubner, n 10, 377.

<sup>130</sup> <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547594>

<sup>131</sup> Nelson, n 1, 193.

<sup>132</sup> Nelson, n 1, 193.

<sup>133</sup> see Newnham, n 13, 428.

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or accepted depends on the receiving system's normative framework: 'what the system or person can understand and process and what they want to hear'.<sup>134</sup>

Pregnancy and child birth became medicalised for a reason. That is, childbirth was medicalised in the bid to save the lives of mothers and infants. At some point, obstetrics extended beyond saving lives under immediate threat. The medical response became a solution to a social problem that promises to be time-saving and pain and effort free. At the same time, functionally differentiated systems rely on binary codes that bring 'speed, efficiency, predictability.'<sup>135</sup> Elective caesarean sections meet these requirements.

### *Situating CDMR as a health care procedure; regulation is unlikely*

The medico-legal arena now accommodates pregnant women's right to request their birthing options, including recently CDMR that is gaining ground.<sup>136</sup> In Australia, the percentage of babies born by caesarean section in 1996 was 15.5%, by 2006 over 31%,<sup>137</sup> and in 2011 the private hospitals rate reached 43%, though it was at 30% in public hospitals.<sup>138</sup> The Western Australian rate in 2013 was 34.3 per cent (11,648 women), but the range varied across maternity sites from 16.3 to 55.2 per cent.<sup>139</sup> Australia's National Maternity Services Plan noted that a contributing factor to the high rate of caesarean sections was a lack of support for vaginal births following a caesarean section and emphasised the need to prevent (presumably unnecessary medically) many primary caesarean sections.<sup>140</sup> Low-risk women are at an increased risk of interventions including caesarean sections when under obstetricians' care.<sup>141</sup> Interventions tend to serve health care interests of convenience, profit-making and staving off the prospects of litigation should anything go wrong. Action rather than inaction generally fares better legally. Further, Erin Nelson<sup>142</sup> describes harrowing USA examples of forced

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<sup>134</sup> Newnham, n 13, 426.

<sup>135</sup> Newnham, n 13, 429.

<sup>136</sup> CDMR is the American terminology that I will use here. The Australian and New Zealand College of Obstetricians and Gynaecologist refers to the surgery as Caesarean Section on Maternal Request.

<sup>137</sup> Robson et al, n 3, 208.

<sup>138</sup> Sam McCulloch, 'The Cold Hard Truth: Why Australia's C-Section Rate Is So High in Birth' (2016) <http://www.bellybelly.com.au/birth/why-australias-c-section-rate-is-so-high/>

<sup>139</sup> Department of Health, 'Western Australia's Mothers and Babies' (2013) 31<sup>st</sup> Annual Report of the Western Australian Midwives' Notification System [http://rph.health.wa.gov.au/~media/Files/Corporate/Reports%20and%20publications/Perinatal%20infant%20and%20maternal/WA\\_Mothers\\_Babies\\_2013.ashx](http://rph.health.wa.gov.au/~media/Files/Corporate/Reports%20and%20publications/Perinatal%20infant%20and%20maternal/WA_Mothers_Babies_2013.ashx)

<sup>140</sup> Commonwealth of Australia, National Maternity Services Plan (2011).

[https://www.health.gov.au/internet/main/publishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/\\$File/maternityplan.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/$File/maternityplan.pdf)

<sup>141</sup> McCulloch, n 139.

<sup>142</sup> Nelson, n 1, 183.

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surgical intervention with judicial approval against pregnant women's wishes. Australia has not followed that lead, though Nelson warns that cases may not have come to the public's attention.<sup>143</sup>

Australia's caesarean rate is not touched by international recommendations. The growing rate of caesarean sections stands outside the World Health Organisation's ('WHO') general recommendation that 10-15% of births require surgical intervention to reduce maternal deaths, stillbirths and associated morbidity.<sup>144</sup> Further, and despite Australia's high caesarean rate, Australia's infant mortality rate (deaths/1,000 live births) has slightly improved only (4.97 in 2001 and 4.43 2014),<sup>145</sup> as did maternal mortality that was 8 in 1990 and 6 in 2015.<sup>146</sup> The perinatal mortality rate is uneven: for infants of Aboriginal mothers it was 20.5 per 1,000 infants born compared to 7.1 per 1000 infants of non-Aboriginal mothers.<sup>147</sup> These statistics caution against attributing Australia's relatively low infant and maternal mortality rate to rising numbers of caesarean sections. Similar warnings resounded decades ago when McKeown<sup>148</sup> argued that a population's health status is profoundly affected by 'broad economic and social conditions' rather than specific medical advances. Though that general proposition has been heavily criticised, aspects of McKeown's argument have since been found to be sound.<sup>149</sup>

Few, however, would dispute that accessible, high quality reproductive healthcare is essential for women's health. Without quality care, hundreds of thousands of women die from complications associated with pregnancy and mismanaged childbirth.<sup>150</sup> For example, in 2010, Sub-Saharan Africa ('SSA') had the highest maternal mortality ratio of low-and middle-income countries at 500 maternal deaths per 100 000 live births, with Malawi's MMR

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<sup>143</sup> Nelson, n 1, 189.

<sup>144</sup> Sam McCulloch, 'The Cold Hard Truth: Why Australia's C-Section Rate Is So High in Birth' (2016) *Birth* <http://www.bellybelly.com.au/birth/why-australias-c-section-rate-is-so-high/>; 'The OECD report compares results from the 13 participating countries. Australia was observed to have ... a high rate of caesarean section (more than 300 per 1,000 live births) ... compared to other OECD countries in the report.' <https://www.safetyandquality.gov.au/wp-content/uploads/2014/09/Media-Release-OECD-report-finds-variation-in-common-procedures-across-Australia.pdf>

<sup>145</sup> <http://www.indexmundi.com/g/g.aspx?c=as&v=29>

<sup>146</sup> <http://data.worldbank.org/indicator/SH.STA.MMRT>

<sup>147</sup> Department of Health, n 139.

<sup>148</sup> Colin Binns, Seung Wook Lee and Wah-Yun Law 'Thomas McKeown: A true public health pioneer' (2012) 24(6) *Asia-Pacific Journal of Public Health* 893-895.

<sup>149</sup> Binns, Lee and Law, n 148.

<sup>150</sup> Nelson, n 1, 60.

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estimated at 675 deaths per 100 000 live births.<sup>151</sup> Poor management during labour and delivery contribute to: ‘35 newborns per every 1000 live births die every year in SSA’.<sup>152</sup> ‘One in four babies worldwide are delivered without skilled care’.<sup>153</sup> Without obstetric or midwifery assistance, a labouring woman is vulnerable to nature’s whims and her biological, economic and social circumstances. Childbirth may be dangerous. Clearly, sound health care management principles including caesarean sections performed in emergencies save lives.

A pregnant woman’s request for a caesarean section for non-medical reasons cannot be guaranteed. An Australian study confirmed, however, that about 80 percent of specialist obstetricians surveyed would satisfy a woman’s request for a caesarean section for non-medical reasons.<sup>154</sup> Not all pregnant women, though, have the means or inclination to request a caesarean section. CDMR is not universally available; it is not a standard procedure. Its extent remains unclear. It is available for some pregnant women.

Nonetheless, according to Nelson,<sup>155</sup> some professional obstetric organisations have expressed a level of concern about the practice of CDMR. The International Federation of Gynaecology and Obstetrics states that ‘surgical intervention without a medical rationale .... [falls] outside the bounds of best professional practice [and] .... should be undertaken only when indicated to enhance the well-being of mothers and babies and improve outcomes’.<sup>156</sup> However, the language in some US policies is vague, leaving open the possibility of CDMR in a range of cases.<sup>157</sup>

Similarly, the Royal Australian and New Zealand’s College of Obstetricians and Gynaecologists’ position opens the door for CDMR,

A small number of pregnant women may prefer a caesarean section to vaginal birth for various non-medical reasons. Women considering elective caesarean section, where there

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<sup>151</sup> Jacob Mazalale, Christabel Kambala, Stephan Brenner, Jobiba Chinkhumba, Julia Lohmann, Don P Mathanga, Bjarne Robberstad, Adamson S Muula, and Manuela De Allegri ‘Factors associated with delivery outside a health facility: cross-sectional study in rural Malawi’ (2015) May; 20(5) *Tropical Medicine and International Health*, 617.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4433497/>

<sup>152</sup> Mazalale, Kambala, Brenner, Mathanga, Robberstad and Allegri, n 151, 617.

<sup>153</sup> United Nations The Millennium Development Goals Report (2015 p 39.)

<sup>154</sup> Robson et al, n 3, 211.

<sup>155</sup> Nelson, n 1, 192.

<sup>156</sup> International Federation of Gynecology and Obstetrics, FIGO Statement on Caesarean Section’ (January 2007), at [www.figo.org/Caesarean](http://www.figo.org/Caesarean); <http://www.figo.org/news/new-guidelines-caesarean-births-0012240>

<sup>157</sup> International Federation of Gynecology and Obstetrics, n 156.

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does not seem to be a medical reason, should discuss this decision with their doctor or midwife. There are some risks and benefits to this decision for both mother and baby...<sup>158</sup>.

Despite these official positions, the approach I have taken to exploring the highly controversial subject of CDMR does not establish whether obstetrics has rightly or wrongly responded to consumer demands or evaluate whether the health care system meets current needs. Further, I have not identified risks or adverse events commonly associated with surgical procedures or its advantages to mount an argument for or against CDMR. If I were to mount an argument recommending denying a pregnant woman her request for a caesarean section, I would be howled down as a pre-modern Luddite, cruelly wanting women to suffer during childbirth, patronising in promoting an idealised version of womanhood in childbirth, or callous and indifferent to the fears many pregnant women face. To deny a woman the benefits of technological developments in health services is to invite disapproval for violating her rights.

On the other hand, an argument for CDMR would parade not only its benefits (control, convenience and certainty), but its gains: releasing women from biological constraints having to wonder, watch and wait, associated with vaginal deliveries and allowing in options to choose their mode of delivery. I am also not suggesting that women who request a caesarean section are pawns manipulated for financial gain. However, a pregnant woman's decision is made against the back-drop of uneven doctor/patient power relations and the medico-technological enterprise. That is, decision making power, though diffused, remains the prerogative of obstetrics. Consequently, I call for doubt and disquiet around the increasing incidence and popularity of CDMR, which appears largely unchallenged as it erodes midwifery's domain.

To expect medicine to reverse or halt the process is to underestimate the power of self-referential processes of medicine and over-estimate the capacity of other systems (law and economics) to intervene. Medicine couples with law to keep intervention at bay. Medicine has developed its own processes of self-evaluation, of understanding what it does and its role in society. It responds to problems only in ways that it knows how. Willing consumers demand the perceived easy way out.

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<sup>158</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2016)

[https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOG-MEDIA/Women's%20Health/Patient%20information/Caesarean-section-pamphlet.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women's%20Health/Patient%20information/Caesarean-section-pamphlet.pdf?ext=.pdf)

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The rise of CDMR is at first glance a cause to celebrate women's right to autonomy, an expression of her reproductive rights in opposition to medical paternalism when all decision making, especially regarding technologies was the province of obstetricians. However, rather than only a representation of women's new-found power, it contributes subtly to empowering obstetrics. Obstetric intervention rather than valuing the course of natural events has gained ground. Obstetricians motivated in part at least by fear of the possibility of litigation, for example, are protected. What becomes problematic is the instance where a pregnant women's choice is used to justify further interventions.<sup>159</sup>

*Medicine, its art and craft, has scientific and technological backing.*

CDMR became possible only after preconditions were established. Childbirth has to be adapted to changed societal conditions<sup>160</sup> with non-interference from other subsystems. The rise of individualism and women's rights diffuse any other rights, collective rights, for example.

CDMR is not a random response, but a response that has the support of social expectations.<sup>161</sup> As the health care system has evolved, so too has society become more complex.<sup>162</sup> It gradually alters – sometimes with abrupt surges ‘every meaning uttered becomes a selection from an increasing range of other possibilities; everything which is determinate involves a higher degree of selectivity’.<sup>163</sup> CDMR is associated with the bid for a perfect birth and control. CDMR resolves definable problems around the functional necessities for the health care system.<sup>164</sup> The concept of CDMR removes childbirth from the vagaries of purely individual experience (reliant on only doctor/patient relationship) and fixes it in social expectations,<sup>165</sup> made possible by autonomous decision making, consent and an individual's right to do whatever they like with their body.

Childbirth has evolved into a legal-medical-technological management problem, although challenges cannot be discounted. All childbirths, not only emergencies, are now in some settings candidates for surgical intervention on request. At least three networks of

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<sup>159</sup> Nelson, n 119, 609.

<sup>160</sup> Luhmann, n 32, 36.

<sup>161</sup> Luhmann, n 32, 21.

<sup>162</sup> Luhmann, n 32, 19.

<sup>163</sup> Luhmann, n 32, 19.

<sup>164</sup> Luhmann, n 32, 21.

<sup>165</sup> Luhmann, n 32, 27.

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communication (legal, medico-technological (scientific), psychic (cultural)) intersect in contingent ways for CDMR to be accepted.

## **Conclusion**

Although a pregnant woman's individual, social and cultural interests contribute to her decision about an appropriate childbirth, the power of the medico-technological complex to sway decisions must be acknowledged. Long established preconditions, layer upon layer, have contributed to the possibility that women's requests for surgical intervention will resonate with obstetrics' internal self-referencing processes. With resonance, communications are transformed into normative operations and become relatively stable. For some pregnant women, CDMR exemplifies an achievement of the self-determining individual with human rights to do whatever they choose with their bodies. The private/autonomous rights of women to choose their mode of childbirth appears to have disrupted medical decision making. Paradoxically, however, the extension of medico-technological intervention further into childbirth erodes maternity and midwifery practices that fall on the side of 'health'. What appears as a major achievement for pregnant women in shifting decision making power from obstetricians to pregnant women who want to be liberated from bodily constraints, also can deny satisfaction associated with bodily achievements. Finally, given CDMR's popularity and support, maternity hospitals are unlikely to establish a regulatory framework around CDMR that is now in some maternity hospitals an accepted practice.

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