

The paradox of choice: Antenatal screening and decision-making

Dobelli (2013) cites an experiment in which a supermarket displayed 24 flavours of jelly, which customers could taste and then buy at a discount; the next day, the experiment was repeated with six flavours. The supermarket sold 10 times more jelly on day 2. Why? The huge diversity on day 1 made customers indecisive and they bought nothing. This illustrates the paradox of choice.

But how relevant is such a phenomenon when it comes to making choices about the use of reproductive technologies, which aim to enable people to choose whether to avoid the birth of a baby with a disabling condition? And to what extent are midwives influential in families' decisions? A decade ago, Lindsay (2006: 23), herself a midwife, made an uncompromising stand and said that women should not be encouraged to make choices, as excessive choice could not only cause confusion and unhappiness, but 'the more options we have, the more difficult it is to make a decision and the more regret we are likely to feel if our choices turn out to be wrong ones'.

This may seem a draconian view, especially in the context of, for example, screening for Down syndrome, where fully autonomous and informed decision-making is typically advocated. However, Tsouroufli (2011: 432) cites studies raising concerns over whether such decision-making can even exist in the context of antenatal screening, identifying 'women's difficulties in opting out, lack of time to present information and the very offer of screening as limiting women's choices'. There seems to be an implicit assumption that the provision of Down syndrome screening within routine antenatal care is both beneficial and empowering. In her own study of 57 taped clinical consultations

involving pregnant women, midwives and health care assistants discussing first semester screening at a one-stop clinic, Tsouroufli (2011) found that staff awareness about the challenges of such screening could contribute to informed decision-making.

However, in a study carried out in the Yorkshire and Humber region, Ahmed et al (2013: 745) found that 'midwives varied in the degree to which they believed it was their role to (1) discuss rather than just provide information and (2) to check women's understanding of the information provided.' Time constraints seem to be a recurring theme in studies into midwife-woman discussions on reproductive choice options.

But can we assume that all women value to the same extent the option of making a choice over their reproductive health? Not according to the findings of van den Heuvel and Marteau (2008), who reported that, while Western 'individualistically orientated countries' placed a high value on informed choice, it was less highly valued in 'non-Western, more collectivist countries'. For example, parental choice in antenatal screening decisions was viewed more favourably in northern European countries compared to southern European and Asian countries. This finding was echoed by Ahmed et al (2013: 747) who noted that some women may not be used to being offered choices, with one midwife singling out Asian women as an example: 'They've not had a choice of who they marry, what job they do or education, and then suddenly we expect them to make choices.'

In the context of increased migration of peoples and its associated multiculturalism, the cultural dimension is one which could represent a growing challenge to midwives in their attempts to help navigate pregnant women through what, to some, will be a labyrinthine landscape dotted with a diversity of choice options.

But is it even right to assume that most

pregnant women would prefer not to give birth to a disabled child? For example, there are some in the Deaf community who feel that genetic technology might place their distinctive Deaf culture—with its own language, customs and values—under threat. Thus, anthropologist Nora Ellen Groce (1985), in her book *Everyone Here Spoke Sign Language*, describes her investigation of hereditary deafness in Martha's Vineyard, Massachusetts. For around 300 years, up until the early 20th century, the population contained a relatively high number of profoundly deaf people. Groce notes how almost everyone, hearing and deaf alike, used an efficient sign language, and writes: 'The most striking fact about these deaf men and women is that they were not handicapped, because no one perceived their deafness as a handicap.' Considering this perspective, attempts to eradicate genetic 'handicap' could be interpreted, by some, as discrimination.

Many Western governments confer on their citizens the right to make certain reproductive decisions. While this may be seen as a freedom, a perpetual challenge is how to resolve the paradox of choice. **BJM**

Ahmed S, Bryant LD, Cole P (2013) Midwives' perceptions of their role as facilitators of informed choice in antenatal screening. *Midwifery* 29(7): 745–50. doi: 10.1016/j.midw.2012.07.006

Dobelli R (2013) *The Art of Thinking Clearly: Better Thinking, Better Decisions*. Sceptre, London

Groce NE (1985) *Everyone Here Spoke Sign Language: Hereditary Deafness on Martha's Vineyard*.

Harvard University Press, Cambridge, MA

Lindsay P (2006) Midwives should not offer women choice in childbirth. *Midwifery Matters* 108: 23–4

Tsouroufli M (2011) Routinisation and constraints on informed choice in a one-stop clinic offering first trimester chromosomal antenatal screening for Down's syndrome. *Midwifery* 27(4): 431–6. doi: 10.1016/j.midw.2010.02.011

van den Heuvel A, Marteau TM (2008) Cultural variation in values attached to informed choice in the context of prenatal diagnosis. *Semin Fetal Neonatal Med* 13(2):99–102. doi: 10.1016/j.siny.2007.12.010

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