
Continuing Education Module

Birthing Ethics: What Mothers, Families, Childbirth Educators, Nurses, and Physicians Should Know About the Ethics of Childbirth

Jennifer M. Torres, MA


Raymond G. De Vries, PhD

ABSTRACT

This article discusses current ethical issues associated with childbirth in the United States. It provides a review of moral problems and ethical choices made by parents and health-care professionals during the prenatal, intrapartum, and postpartum periods. Ethical issues are identified and framed through a “naturalized bioethics” approach, as recommended by Margaret Walker and her colleagues, Hilde Lindemann and Marian Verkerk. This approach critiques traditional bioethics and gives attention to everyday ethics and the social, economic, and political context within which ethical problems exist. This approach provides the reader with the tools needed to critically assess the way ethical problems are defined and resolved.

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What makes a question an *ethical* question? How does an ordinary problem become an *ethical* problem? In the case of health care, the answer seems obvious: Ethical questions are those that are discussed by experts on television, radio, and on the pages of our newspapers—questions about stopping treatment for someone who is terminally ill, about physician-assisted suicide, about using embryonic stem cells to find new treatments for incurable illnesses. These are indeed difficult ethical problems,

but the moral problems of health care extend well beyond the issues that interest the media and ethical experts.

In our everyday lives, we constantly make judgments about what is “good” and “bad.” Movies, food, politicians, and schools—all are put on the continuum that stretches from bad to good. Of course, we sometimes use these terms to describe quality. When we say, “That was a really bad hamburger,” we are not assessing the moral integrity of

a piece of meat, we simply are commenting on its taste. But the terms “good” and “bad” often carry moral weight. Even in the case of a hamburger, the term “bad” may be a judgment of a chef’s integrity (was she using postdated meat?) or a comment on the morality of eating animals.

For those of us who work in and around birth, the terms *good* and *bad* are regularly, if unconsciously, used to make moral judgments. Think, for example, of the various definitions of a “good” mother. For some, a good mother is one who reads *What to Expect When You Are Expecting*, listens to her doctor, has regular prenatal appointments, eats well (no wine or soft cheeses!), gets to the hospital promptly when labor begins, and follows her obstetrician’s plans for a safe birth. For others, a good mother is one who takes charge of her birth experience, reads *The Official Lamaze Guide: Giving Birth with Confidence*, does not unthinkingly accept a medical specialist’s opinion about what is best for her and her baby (she may drink a glass of wine once in a while), hires a doula, creates a birth plan, and gives birth at home under the watchful eye of a skilled midwife.

This disagreement about what makes a good mother is well illustrated in readers’ comments in response to a November 2008 article in *The New York Times* about home birth. Read through these comments and you will see moral judgments everywhere. Advocates of home birth are called “granola heads,” “ignorant,” and “child abusers”; those who favor hospital birth are accused of being “uninformed” and of putting their babies at risk by subjecting them to routine medical interventions, including induction and rupture of membranes (see Scelfo, 2008).

This back and forth about the morality of motherhood illustrates that we all have ideas of “right” and “wrong” that go far beyond the questions that trouble ethicists. Ideas of rightness and wrongness are part of a person’s “moral order”—a shared set of understandings that define “what is good and bad, right and wrong, higher and lower, worthy and unworthy, just and unjust.” These understandings of goodness and badness are much more than personal “preference.” Indeed, the moral ideas we carry are “believed to exist apart from and above [desires, decisions, or preferences], providing standards by which human desires, decisions, and preferences can themselves be judged” (Smith, 2003, p. 20). Clearly, home birthers and hospital birthers come from different moral orders.

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Expanding our concept of an ethical problem to include the moral problems of everyday life strengthens the moral imagination we need to create “good” maternity care (in both senses of the word). This broader perspective encourages us to look more closely at the way ethical questions and their solutions are framed, and it allows us to examine the ethics of ethics. In her call for a “naturalized bioethics,” Walker (n.d.; see also Lindemann, Verkerk, & Walker, 2008) describes what this broader approach to ethical problems adds:

A naturalized bioethics seeks to uncover policies that are rigged in favor of hospital administrators, health policy makers, or other powerful people, and asks whether those policies can withstand moral scrutiny when rendered transparent to all parties. It asks whether a particular assignment or appropriation of professional responsibility can be justified in terms of such shared moral understandings as fairness, honesty, and respect, and whether all members of the health care team are in fact acting on those understandings. (Walker, n.d., p. 14)

Following Walker’s lead, we apply this approach to the moral problems associated with birth by asking, “What aspects of childbirth are seen to be ethically problematic (and which are not)? How do the proposed remedies to these ethical problems fit with, or challenge, existing social arrangements?”

In our discussion of birthing ethics, we take you on a brief tour of the ethical problems associated with childbirth in the United States, looking at issues that have come to the attention of ethical experts and those that have not. We examine these ethical quandaries and proposed solutions through the eyes of social scientists unwilling to accept taken-for-granted ideas about what is and is not a moral problem.

A VERY SHORT HISTORY OF ETHICS IN HEALTH CARE

A critical approach to medical ethics requires a rudimentary understanding of the history of ethics in health care. Although it seems quaint to us now, ethical questions about health, illness, and

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medical care were once considered to be best left to the judgment of physicians. As experts on the body and its ailments, physicians were thought to be in the best position to decide on “good” and “bad” medicine, the duties of doctors, and the proper responsibilities of patients.

Seen from a 21st-century perspective, codes of medical ethics created in the 19th and early 20th centuries look more like descriptions of proper professional *etiquette*. These codes placed almost no emphasis on the obligations of physicians to patients, focusing instead on the duties of doctors to each other and to the need to eliminate “irregular” practitioners (Armstrong, 2007). In the late 1960s and early 1970s, old-fashioned medical ethics began to give way to a new interdisciplinary project called “bioethics.” Emerging alongside the “rights” movements of that era, bioethics changed the definition of what was and was not an ethical problem. Bioethicists were concerned about the potential for harm associated with clinical practice and medical research; they saw their mission as protecting vulnerable patients and research subjects from the power of medical institutions and new (and sometimes frightening) medical technologies (Fox & Swazey, 2008; Jonsen, 1998).

Bioethics replaced the notion that “doctor knows best” with theoretically grounded approaches to decision making in medicine. In order to help resolve the dilemmas that arise in health care, academic bioethicists have called upon a number of ethical theories—deontology, teleology, virtue theory, care ethics, feminist ethics, casuistry, to name a few (see Post, 2004, for more detail)—but the day-to-day work of bioethicists in the clinic and on research review committees is, for the most part, guided by a method of ethical problem solving known as “principlism.” First described in *The Belmont Report* (the product of a government commission assembled to make recommendations for the protection of research subjects from abuse at the hands of researchers), principlism sets forth three “basic ethical principles” that should “underlie the conduct of biomedical and behavioral research involving human subjects” (National Commission for the Protection of Human Subjects of Biomedical

and Behavioral Research, 1979, paragraph 1). These basic principles are:

1. *Respect for persons*: The acknowledgment of individual autonomy (i.e., the right to make decisions about what is done to one’s body—and recognition of the need to protect those, such as children and prisoners, with diminished autonomy).
2. *Beneficence*: The need to seek the well-being of an individual.
3. *Justice*: Fairness in distribution.

The principlist approach is more fully elaborated and explained by Beauchamp and Childress (2009) in their book, *Principles of Biomedical Ethics*. In this much-used, much-cited text, the authors (both of whom helped write *The Belmont Report*) set forth four principles: respect for autonomy, beneficence, nonmaleficence, and justice; furthermore, the authors recommended their use in deliberations about proper practice in research *and* in the clinic. Two things about this revision of the principles are worth noting. First, respect for *persons* has become respect for *autonomy*. This more narrowly defined principle lies behind the need to obtain “informed consent” from research subjects and patients. Before a health professional or researcher does something to a person’s body, that person must (a) understand what is to be done and (b) give his or her voluntary, uncoerced consent. The second revision—separating of the principle of beneficence into *two* principles: nonmaleficence (first, do no harm) and beneficence (do good)—serves to underscore the duty of physicians to avoid wittingly or unwittingly hurting patients in their care.

The principles are particularly useful in pluralistic and secular societies such as the United States. Although we citizens of modern, diverse societies may appeal to our own religious tradition or ideology in making moral decisions for ourselves, we are unable to convince others with different belief systems of the moral correctness of our position. The principles offer a way around this problem. Appeals to respect autonomy, to do good, and to be fair can be made by persons from very different moral traditions. For example, a Christian may justify the need to respect autonomy because of her belief that all humans are made in the image of God, while an agnostic may call upon humanistic values to support the same principle.

Our review of the ethical issues associated with childbirth examines the choices women and caregivers are asked to make in the prenatal, intrapartum,

and postpartum periods. You will notice that, in most cases, the principles (and especially the principle of respect for autonomy) are called upon to explain and justify ethical practices. This is testimony to the fit of the principles in the moral order of American society, with its stress on individualism and its faith in the power of the marketplace to deliver high-quality, low-cost health care (Wolpe, 1998). As we noted above, our review is intended to do more than just familiarize you with existing discussions about ethical problems in childbirth. By looking at the everyday ethics of childbirth—only some of which have come to the attention of ethicists—we also give you the tools to critically assess the way ethical problems are defined and resolved.

RESPECTING PARENT CHOICE

All of the choices associated with childbirth begin with one choice: the choice to become a parent. With the advent of reliable contraception, conception is less often an unintended consequence and more a conscious choice. There is, of course, much discussion of the ethics of contraceptive choice, discussions that turn on questions about the moral status of egg, sperm, and fetus. This debate is not the topic of our essay. Here, we focus on the decisions and practices that parents confront after a planned or desired pregnancy has been confirmed.

Parents' Choices in the Prenatal Period

Prenatal testing I: Informed consent. Within the first months of pregnancy, a woman will face her first postconception decision: “Should I or should I not do prenatal testing?” She will be presented with several types of prenatal tests and may or may not be told that her initial choice will demand and influence further choices. Should she do some type of *screening test*, such as an ultrasound scan or a triple screen (a blood test for chromosomal abnormalities)? If the screen shows an abnormal result (or even if it does not), should she agree to a *diagnostic test*? The most common diagnostic tests are amniocentesis and chorionic villus sampling, both of which require an invasion of the womb and both of which increase the risk of miscarriage. Pregnant women also will be offered tests for conditions or diseases that may pose a risk to the fetus (e.g., HIV). Faced with all these options, it is important that women and their partners be given the information they need to make an informed choice. But *are* parents well-informed as they enter and make their way through this maze of prenatal tests?

Research on informed consent for prenatal testing shows that women often make uninformed decisions (Green, 1994; Rosenthal, 2006). In the case of screening and diagnostic tests, many women do not understand the condition(s) for which testing is being done, the characteristics of the test, the implications of the results, or the risks involved in the test itself (Hunt, de Voogd, & Castaneda, 2005; Marteau & Dormandy, 2001). With some tests—ultrasound tests, in particular—patients may not even be asked to review or sign an informed consent. None of the pregnant women in Mitchell’s (2004) study were asked if they wished to have or decline an ultrasound test, and most had no discussion with their care provider about the reasons for undergoing it. Mitchell discovered that many women misunderstood the purpose of the test, seeing it as a chance to “see” the baby and not as a diagnostic tool that could return abnormal results. The women also displayed poor understanding of the accuracy of ultrasound.

Informed consent often fails to provide information that matches parents’ interests, concerns, and values. Protocols for prenatal testing are typically based on a mythical “average patient,” ignoring the social, religious, and moral particularities of the parents in question (Marini, Sullivan, & Naem, 2002). Atkins (2008) found that health-care workers involved in counseling for prenatal testing did not take into consideration the patient’s situation or try to understand how this situation may affect her priorities or decisions. Individuals have complex and sometimes contradictory views on the different conditions and disabilities identified by prenatal tests, and the informed-consent process rarely allows patients the chance to work through these views before deciding whether or not to undergo the test (Bryant, Green, & Hewison, 2006; Gates, 2004).

Not surprisingly, parents and physicians have different perspectives on prenatal tests. For example, Hunt et al. (2005) found that doctors regarded the triple screen test as “just a screen”; for them, abnormal results indicated simply that more evidence was needed. Parents, however, saw the screening test results as a major change of course in their pregnancy.

Another important but often overlooked aspect of informed consent for prenatal testing is the way information about the tests is conveyed. Crucial, here, is information about risks and accuracy. Parents need to understand that no prenatal test is 100% accurate (Chachkin, 2007; Isle, 1995).

Screening tests, in particular, have a low level of accuracy. In detecting Down syndrome, for example, the triple screen test is 60%–80% accurate, and ultrasound tests are 31%–75% accurate. Diagnostic tests, such as amniocentesis and chorionic villus sampling, do much better (about 99% accuracy) but carry a risk of miscarriage (Chachkin, 2007). Although it is true that parents usually are given this information, it is presented in terms of odds or probabilities, even though research shows that the average patient has difficulty understanding information in this format (Gates, 2004).

Research on informed consent underscores the fact that information is not knowledge. Inundating parents with pages of information, standardized and presented in medical and statistical terms unfamiliar to laypeople, may meet the letter of the ethical requirement to respect autonomy, but it fails to provide the knowledge parents need to make an informed choice. An informed consent process that does not respect the social and cultural location of parents may cause them to agree to tests they do not prefer or to decline tests they would otherwise choose (Marini et al., 2002).

Prenatal testing II: Limits on choice? Respect for autonomy requires that parents be given accurate, understandable information about prenatal tests in a way that respects their values. But does respect for autonomy also require that parents have unlimited choice of prenatal tests? At present, we can use genetic testing to identify more than 500 different genetic conditions, not all of which are severe (Ekberg, 2007). Should we allow parents to test for hemophilia in order to prevent the birth of a daughter who would carry the disease, but not suffer from it (Boyle & Savulescu, 2003)? Should we allow amniocentesis to be used to test for chromosomal abnormalities in all women, and not only in women considered to be at increased risk for this type of condition (Kuppermann & Norton, 2005)?

Typically, these questions are framed in terms of the autonomy of the woman and her partner, emphasizing their right to choose which tests they will use. Less often discussed, but clearly implicated here, are questions of justice and nonmaleficence. Fair distribution of health-care resources requires limits on patient demands—not everything a patient can afford should be done (Callahan, 2003). Further, “doing no harm” demands consideration of the ways false-positive and false-negative results

of prenatal testing can, in Rothman’s (2001) words, “spoil the pregnancy” (p. 184).

We need to better understand how the attitudes parents have about prenatal tests are affected by cultural perceptions of illness and disability and available economic and social support for living with a disabled child (Rothman, 2001; Ward, 2002). The very idea of informed consent assumes that all information relevant to medical decision making is included on the consent form, ignoring all the ways parents use other sources of information (e.g., the experiences of friends, cultural attitudes, and recommendations from Web sites) in making their choice.

Because many of the conditions that can be identified by prenatal testing cannot be treated, the use of a prenatal test sets up a second choice: If parents learn that their baby has a medical problem, what should they do?

Treatment of abnormality. If a woman learns that the baby she is carrying has problems, she must decide what to do. Autonomy and its limits are again put in play. Should parents be allowed to terminate a pregnancy when the diagnosed condition of the fetus is not severe (as in the example of a baby girl who is a carrier of hemophilia)? Should parents be allowed to terminate pregnancies in the case of mental retardation (Vehmas, 2002)? Who should be allowed to define conditions that are “severe”?

These questions speak to the adequacy of using “quality of life” as a criterion for decisions about terminating a pregnancy. Quality of life is a useful starting point in cases such as these (e.g., it confirms our moral intuition that a pregnancy should not be terminated simply because the fetus is a boy and the parents prefer a girl), but we quickly run into problems when we use this criterion to assess which conditions make life not worth living (Atkins, 2008). Research shows that individuals with disabilities and their families live satisfying lives; often when a disabled person has a low quality of life, it is because of a lack of social resources for people with disabilities (Alderson, 2001; Asch, 1999). Furthermore, cross-cultural research shows that the same condition can be seen as more or less debilitating in different cultures (Rothman, 2001). If the general view toward disabilities is that they impair one’s quality of life, and if parents and the practitioners who are guiding parent decisions have no experience living with disabilities, the decision will be bent in a particular direction. The practice of prenatal

testing and selective termination makes matters worse by constructing and reproducing biases against disability.

Patient Choice in the Intrapartum Period

Informed consent. The choices parents make during labor and birth concern the use of medication and obstetrical procedures. As with prenatal testing, women are often asked to choose, without adequate information about medications and procedures (Rosenthal, 2006). Consent forms for pain medications, to mention just one example, often do not describe the labor-altering effects and side effects of these drugs (Lowe, 2004). In many cases, procedures are used—think “electronic fetal monitoring”—without offering information about the value and/or danger of the procedure and with no opportunity to use an alternative method (Wood, 2003). Baker, Choi, Henshaw, and Tree (2005) found that, in addition to inadequately informed consent, women generally felt a lack of control over the birth process. Ongoing controversy about the adequacy of many of the interventions used in birth today complicates the problem of informed consent in labor and birth (Goer, 1995; Hartmann et al., 2005; Lothian & DeVries, 2005; Wood, 2003).

Another important issue in the intrapartum period is the degree to which women have the capacity to give consent while laboring. This question is raised most often with regard to the use of pain medications during birth, particularly epidurals. Some research shows that there are no differences in capacity between women with mild and moderate pain, and that women can recall accurately consenting to epidurals (Brooks & Sullivan, 2002). Others believe that the pain, suffering, and fear experienced during labor are barriers to capacity (Rosenthal, 2006). This issue becomes particularly acute when parents have birth plans that indicate they do *not* want medication, but then, in the midst of labor, a woman asks for a drug to relieve the pain. Some believe that denying medication under these circumstances violates a woman’s autonomy; others insist that a woman’s autonomy is violated by providing the medication, because this act ignores her long-term preferences (Brooks & Sullivan, 2002).

Patient Choice in the Postpartum Period

Treatment of prematurity or severe illness. It is a sad fact of life that some parents will face the difficult and emotionally charged situation of having a preterm baby or a baby with a serious illness.

Caught in this circumstance, parents are required to make difficult choices about starting, or forgoing, intensive care.

Parental participation in these decisions is circumscribed by both regulation and by the behavior of medical personnel. The decision to start treatment is governed by the “Baby Doe regulations” promulgated in the United States in 1984, which stipulate that physicians must provide life-sustaining treatment to viable infants. These regulations have proven frustrating to parents who feel that they have no control over the fate of their child and that their wishes are ignored (Paris, Schreiber, & Moreland, 2007). After neonatal intensive care begins, parents continue to feel excluded from decision making. Hentschel, Lindner, Krueger, and Reiter-Theil (2006) discovered that, in 25% of cases, the staff made the decision to restrict ongoing care without knowing the wishes of the parents. Anspach (1993) found that neonatal intensive care unit (NICU) staff members go through the motions of giving informed consent, but in fact, they are manipulating parents to consent to decisions the care providers have already made.

Although we Americans value choice, it is reasonable to question whether our moral order, with its emphasis on autonomy and the freedom to choose, is actually better for the parents of compromised newborns. According to Orfali and Gordon (2004), doctors and nurses in French NICUs, unlike their counterparts in the United States, regularly make life-and-death decisions for newborns without consulting parents. Interestingly, these researchers found that the French parents were more satisfied with the care they and their baby had received than were American parents. Why? The paternalistic French staff focused more on emotion work, helping the parents to cope with their child’s critical illness, while in the United States, the staff remained aloof in the name of protecting parental autonomy.

Contraindications and the choice to breastfeed.

The choice to breastfeed is made among a welter of conflicting cultural attitudes, misinformation, and structural constraints. In the United States, a significant number of people find breastfeeding disgusting, leading to harassment of nursing mothers and legal controversies about the permissibility of breastfeeding in public (Forbes, Adams-Curtis, Hamm, & White, 2003). Others believe that mothers who feed infant formula to their babies are

acting irresponsibly, causing formula-feeding mothers to report feelings of guilt (Robin, 1998).

Medical evidence shows that breastfeeding is best for mother and child, but public access to this information is lacking. Recognizing that much misinformation about breastfeeding comes from health-care professionals (see Blum, 1999), the American Academy of Pediatrics (2005) developed a list of medical conditions that are and are not contraindications to breastfeeding. But medical evidence goes only so far when cultural attitudes are unsupportive and when women who work have no place and time to breastfeed or to pump milk for later use. In 2003, 66% of women initiated breastfeeding, but only 44% exclusively breastfed in the hospital. At 12 months, only 19% of mothers were breastfeeding (Jackowitz, 2007; Li, Darling, Maurice, Barker, & Grummer-Strawn, 2005; Ross Products Division, 2003; Ryan & Pratt, 1991).

Given this situation, what is our ethical obligation? Respect for autonomy dictates that we should respect women's choices, but what do we do if these choices are harmful to infants? What should we do when we recognize that these choices are constrained by misinformation and structural barriers? For the most part, bioethicists have ignored these questions, limiting themselves to giving advice and creating guidelines. But here, and in the ethical problems discussed above, we see that our moral obligation to provide mothers with the knowledge they need to choose wisely requires more than a consent form. Mothers need to understand all the social factors that influence and limit the choices they make.

Male circumcision. In the United States, parents of a newborn boy are asked to decide—shortly after birth—if he should be circumcised. There is conflicting evidence about the medical justification for male circumcision. In their review of the literature, Benatar and Benatar (2003) found insufficient evidence to support circumcision as a prophylactic procedure *and* insufficient evidence to conclude that circumcision is child abuse. Given this state of the evidence, they stated the decision should be left up to the parents. Others disagree with this conclusion, claiming that parental consent is not enough because the autonomy in question here is the autonomy of the child (Cruz, Glick, & Travis, 2003; Hampton, 2003; Hill, 2003). As with the procedures described above, there are studies that show parents are not given enough information

to make an informed choice. Adler, Ottaway, and Gould (2001) found that nearly 40% of parents felt they were not given adequate information about circumcision. Furthermore, 46% of parents with an uncircumcised boy and 15% of parents with a circumcised boy reported that no medical provider discussed circumcision with them.

Patient Choice in the Perinatal Period

Some ethical issues span the perinatal period, belonging to no single stage. In most cases, these issues revolve around decisions initiated during the prenatal period and acted on during labor and birth or postpartum.

Nonmedically indicated surgical birth. One of the most talked-about ethical issues in this category is nonmedically indicated surgical birth (NMISB), sometimes referred to as cesarean delivery on maternal request (CDMR). There is no precise estimate of the number of NMISBs in the United States. The use of surgical births in the United States is rapidly increasing: In 2005, 30.2% of U.S. births were accomplished surgically (Hamilton et al., 2007). However, it is difficult to distinguish between elective and medically indicated cesarean births. Background information assembled for a 2006 National Institutes of Health State-of-the-Science conference on CDMR concluded that CDMRs make up 2.5% of all surgical births (D'Alton et al., 2006); others believe the number is less than 1% (Declercq, Sakala, Corry, & Appelbaum, 2006). More interesting, perhaps, is the fact that 84.5% of U.S. obstetricians had performed or were willing to perform an NMISB (Wax, Cartin, Pinette, & Blackstone, 2005).

Should healthy women be allowed to choose a surgical birth? Several researchers have found insufficient evidence to support the practice of NMISB (D'Alton et al., 2006; McFarlin, 2004; Wax et al., 2005). Their data show that vaginal birth is safer (McFarlin, 2004; Wax, Cartin, Pinette, & Blackstone, 2004), leading them to the reasonable conclusion that healthy women should not be allowed to choose surgical birth (Miesnik & Reale, 2007). On the other hand, there are physicians and patients that believe NMISB is a misnomer (Wax et al., 2005). They cite a variety of indications for a surgical birth, including prevention of pelvic floor injury, concern for fetal death or injury, fear of childbirth, the preservation of sexual function, and avoidance of pain. Also mentioned by those in favor of NMISB are nonmedical factors,

including convenience and availability of the desired health-care provider.

As in other childbirth choices, the question of NMISB comes down to how to best respect a woman's autonomy. The National Institutes of Health State-of-the-Science conference concluded that there was not enough evidence to recommend for or against NMISB, although the panel acknowledged that the evidence supporting the claim that vaginal birth damages the pelvic floor was very weak and that risks to mother and baby increase with each subsequent surgical birth (National Institutes of Health, 2006).

Interestingly, the two major professional associations of obstetricians—the American College of Obstetricians and Gynecologists (ACOG) and the International Federation of Gynecologists and Obstetricians (FIGO)—have different opinions of the ethics of allowing women to choose NMISB. Appealing to the autonomy principle, ACOG (2008) concludes, “If the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than vaginal birth, he or she is ethically justified in performing a cesarean delivery” (p. 246). However, FIGO downplays autonomy, looking instead to the principles of non-maleficence and justice. FIGO's Committee for the Ethical Aspects of Reproduction and Women's Health (2006) noted that cesarean section “is a surgical intervention with potential hazards for both mother and child” and “uses more resources than normal vaginal delivery” (p. 55); therefore, the committee concluded, “At present, because hard evidence of net benefit does not exist, performing cesarean section for non-medical reasons is not justified” (p. 57).

It is reasonable to inquire about the information a woman uses to make her decision to have a NMISB (De Vries, Kane Low, & Bogdan-Lovis, 2008). A woman's choice is informed, not just by the medical information on a consent form, but by cultural ideas, the organization of maternity care, and the societal limitations on women's lives. Ideas—correct and incorrect—about women's bodies, about pain, about the value of surgery in preserving “ideal” bodies play an important part in a woman's choice. When a woman chooses surgical birth for cosmetic or sexual functioning reasons, is this a “free” choice (Christilaw, 2006)? Maternity care options also constrain choice: In most places in the United States, for example, a healthy woman who wishes to have a home birth will be unable

to find a midwife or obstetrician who will accompany her. Finally, the demands of work and a career influence the decision for and against surgical birth. Is a woman practicing autonomy when she schedules a cesarean section to coincide with her holiday leave from work because she does not have maternity leave (Bergeron, 2007)?

Prenatal planning: Birth plans and consent for birth and postpartum procedures. Another issue of particular import to childbirth educators is the practice of making decisions about labor, birth, and postpartum procedures before labor begins. Prenatal education plays an important role here, because it can be a source of unbiased information for mothers and families. Unfortunately, childbirth education often fails in this role. Carlton, Callister, and Stoneman (2005) found that hospital-based prenatal classes were more focused on socializing women to hospital routines than on educating them about their options. There are structural reasons for a less-than-objective childbirth education curriculum, most notably hospital sponsorship of childbirth education classes (Morton & Hsu, 2007). Nonetheless, lack of thorough and objective prenatal education can lead a woman to consent to something during labor that she would not have consented to had she been given complete information (Rosenthal, 2006).

Many pregnant women are also faced with the decision of whether or not to harvest and store cord blood. Although there are no studies of the consent process for cord-blood storage, Armson (2005) raises several ethical issues about the practice. Most pressing is the question of costly long-term storage of cord blood, given the fact that it is not clear that it is a useful source of stem cells for treating older children and adults.

In recent years, many women have used birth plans to inform hospitals and caregivers of how they wish their labor to proceed, including a list of things such as acceptable interventions, who should be in the birth room, and preferences for breastfeeding or bottle feeding. In her review of the history of birth plans, Lothian (2006) found that, along with the development of medicalized birth and more restrictive hospital policies, templates for birth plans became checklists of medical interventions. Research findings demonstrate that no differences exist between women with and without birth plans, as far as their level of fear, pain, sense of control, or overall experience is concerned (Shaw, 2002). Women report

that the choices expressed in a birth plan are often illusionary and superficial, because these best-laid plans are quickly dismissed when a caregiver decides they are not appropriate (Shaw, 2002).

The very existence of birth plans points to a lack of trust and an imbalance of power between the patient and the practitioner. A birth plan should be an agreement between a woman and her care provider, not a weapon in an adversarial struggle (Lothian, 2006; Shaw, 2002). Childbirth educators stand in a position to help work toward this goal, because they often are the ones who discuss birth plans with pregnant women and their partners. Educators need to find a way to encourage women and caregivers to come alongside each other, allowing caregivers to see birth plans as the reasonable attempt by women and their partners to respond to an imbalance in power, to allay their fears, and to express their desires for a “good” birth.

PROFESSIONAL RESPONSIBILITY

The rights of childbearing women are mirrored by the responsibilities of the professionals who care for them. If women have claims based in autonomy, nonmaleficence, beneficence, and justice, caregivers have an obligation to see that those claims are met. There are better and worse ways of fulfilling these obligations. For example, it is common practice to use a nondirective approach when offering genetic and other prenatal counseling. This “value-neutral” approach is seen as the best way to protect parents’ autonomy: Just provide the facts about the condition and available treatment options and let the parents decide. Although this appears to be the best way to avoid biasing, or taking over, a parent’s decision, value neutrality may result in simply presenting facts while failing to address the particular and personal values of parents. This does not help parents to make the best decision (Atkins, 2008) or to consider all options (Caniano, 2004), raising serious questions about the wisdom of this approach (Hunt et al., 2005).

Maternity caregivers must be sensitive to the influence they have over women’s birth experiences. Carlton et al. (2005) found that a laboring woman’s decision to change from an unmedicated to a medicated birth is affected, in part, by feeling a lack of support from nursing staff. They urge perinatal nurses assisting women during labor to be aware of the influence of their care. Nurses also play an important role in preserving a woman’s sense of dignity during childbirth, particularly by helping

her to maintain the level of control she desires (Matthews & Callister, 2004; Regan & Liaschenko, 2007). These studies focus on the role of nurses—who play a critical, often underappreciated, role in determining the procedures used for birth—but the results apply to any caregiver who spends a significant amount of time with a laboring woman, including a childbirth educator who has been invited by a student to accompany her during childbirth.

Professional codes of ethics—such as those issued by the American College of Nurse-Midwives (2004), ACOG (2004), and Lamaze International (2006)—define the overall responsibilities of caregivers to those in their care. Key ethical principles shared by all three of these groups include promoting the well-being of the patient/client, practicing informed consent, respecting the patient’s/client’s right to privacy, providing only those services for which the professional is qualified, and having respect for diversity.

Professionals in each of these three groups are instructed not to discriminate based on any of the following characteristics: race, ethnicity, national origin, sex, sexual orientation, age, marital status, political belief, religion, lifestyle, socioeconomic status, and mental or physical disability (ACOG, 2004; American College of Nurse-Midwives, 2004; Lamaze International, 2006). How well do professionals follow this injunction not to discriminate?

De Marco, Thorburn, and Zhao (2008) found that nearly one in five women in their study experienced discrimination during prenatal care, labor, or birth. These women felt that they were treated differently because of their personal characteristics. Discrimination was experienced most often by women who did not have employer-sponsored insurance coverage and who were younger than 20 years or older than 35 years. Spidsberg (2007) found that lesbian women in her study often encountered an over- or underfocusing on their sexuality: Sexuality was discussed at times when it was not necessary or appropriate and avoided at times when it was appropriate. The lesbian women in Spidsberg’s study also reported that they were often responsible for guiding interactions because care providers were uncomfortable with their sexual orientation.

Women from immigrant populations also suffer unfavorable discrimination. In a study of Latina immigrants, Gurman and Becker (2008) found that, although most of the women in their study were satisfied with the maternity care they received, many

of them had difficulty communicating because of a language barrier. This included not being offered an interpreter, having to wait several hours for the interpreter, having to schedule prenatal appointments around the interpreter's schedule, and having negative experiences with interpreters.

The codes of ethics of both the ACOG (2004) and Lamaze International (2006) warn that using sponsored materials and participating in commercial promotions can create bias. In a review of the literature, Wall and Brown (2007) found evidence to support the notion that accepting a gift from a pharmaceutical company increases the likelihood that a physician will prescribe that drug to patients. Lothian (1997) points out that when childbirth educators use sponsored materials in their classes, they participate in the marketing of that product. In effect, the educator becomes a part of a company's marketing arm, commercializing the educator-student relationship (Lothian, 1997; Wall & Brown, 2007).

Lothian (1997) also discusses the important case of infant-feeding formula. Hospitals and doctors' offices continue to pass out free samples of formula, and some childbirth professionals distribute materials sponsored by formula companies. Research has shown that when these marketing materials—most especially infant formula samples—are given to new mothers, they have a negative effect on breastfeeding initiation, duration, and exclusivity (Howard et al., 2000; Kaplan & Graff, 2008; Rosenberg, Eastham, Kasehagen, & Sandoval, 2008).

SOCIAL ETHICS

We began this article by noting the need to pay attention to everyday ethics and to look beyond narrow definitions of ethical problems and the solutions offered by bioethicists. Behind our critique of bioethical problem-defining and problem-solving is a skepticism about the heavy emphasis on autonomy and patient empowerment found in bioethics. Do not get us wrong—we are in favor of balancing the power differential between birthing women and their caregivers, but we are concerned about an approach to bioethics that revolves around autonomy.

There are two reasons for our concern. First, emphasis on autonomy too often results in the abandonment of patients (or, in our case, parents) by health-care professionals. We saw this in Orfali and Gordon's (2004) comparison of the treatment of parents in French and American NICUs. French parents, treated in ways that American bioethicists would label paternalistic, felt cared for, while

American parents, given a lot of information and a lot of autonomy, felt abandoned. Bosk (1992) also observed this in his study of genetic counseling, in which counsellors, in the interest of being nondirective, would give parents only information and not advice. In his assessment of the informed consent process, Hedgecoe (2004) sums up this concern:

...the conventional understanding of consent fails to recognise the social embeddedness of such a process. . . . [H]owever noble the goal of patient autonomy, this is sometimes experienced by patients as abandonment. (p. 127)

Second, the focus of bioethics on individual autonomy and case-by-case problem-solving hides the political, economic, social, and cultural aspects of ethical problems. Keirns, Fetters, and De Vries (in press) provide examples of how money is implicated in ethical problems:

...the ethical problem of who should have dialysis (and therefore be allowed to live), which led to the 1960s "God committees," was not ultimately solved by bioethics. Rather, the problem was resolved when the U.S. Congress decided to pay for dialysis for all Americans. Similarly, the Quinlan and Cruzan cases—each involving a woman in a persistent vegetative state kept alive by artificial means—were manifestations of the fee-for-service medicine of the 1970s and 1980s, in which patients feared being forced to endure over-treatment, suffering, and the bankrupting of their families in the course of their deaths. These cases led to judicial and legislative determinations that patients (or their legally designated decision-makers) can request removal of a ventilator or a feeding tube even if death will result.

Ethics also can be marshalled to protect the interests of a profession, as we saw in ACOG's use of the autonomy argument to defend the use of surgery to deliver healthy babies from healthy women (De Vries et al., 2008). When bioethics becomes the favored mode of understanding problems in the clinic, the social, economic, and political context of those problems disappears.

We close by acknowledging the danger in a sociological approach to bioethics. When we rightly point out that ideas of good and bad, right and wrong are products of different moral orders, it is easy to conclude that "everything is relative."

The bioethics of birth is about more than helping mothers accommodate to the existing system of maternity care; it is about challenging that system to promote better birthing.

We do not believe this to be the necessary outcome of sociological analysis. Building a maternity care system that is safe, fair, and respectful of women requires a moral imagination informed by a sociological analysis that exposes the corrupting influence of powerful interests and cultural ideas that demean women. The bioethics of birth is about more than helping mothers accommodate to the existing system of maternity care; it is about challenging that system to promote better birthing.

REFERENCES

- Adler, R., Ottaway, S., & Gould, S. (2001). Circumcision: We have heard from the experts; Now let's hear from the parents. *Pediatrics*, 107(2), eE20.
- Alderson, P. (2001). Down's syndrome: Cost, quality and value of life. *Social Science & Medicine*, 53(5), 627–638.
- American Academy of Pediatrics. (2005). Breastfeeding and the use of human milk. *Pediatrics*, 115(2), 496–506.
- American College of Nurse-Midwives Ad Hoc Committee on Code of Ethics. (2004). *Code of ethics of the American College of Nurse-Midwives*. Retrieved October 5, 2008, from <http://www.acnm.org/display.cfm?id=483>
- American College of Obstetricians and Gynecologists. (2004). *Code of professional ethics of the American College of Obstetricians and Gynecologists*. Retrieved October 5, 2008, from http://www.acog.org/from_home/acogcode.pdf
- American College of Obstetricians and Gynecologists [ACOG]. (2008). ACOG committee opinion no. 395: Surgery and patient choice. *Obstetrics & Gynecology*, 111, 243–247.
- Anspach, R. R. (1993). *Deciding who lives: Fateful choices in the intensive-care nursery*. Berkeley, CA: University of California Press.
- Armson, B. A. (2005). Umbilical cord blood banking: Implications for perinatal care providers. *Journal of Obstetrics and Gynaecology Canada*, 27(3), 263–290.
- Armstrong, D. (2007). Embodiment and ethics. In R. De Vries, C. Bosk, L. Turner, & K. Orfali (Eds.), *The view from here: Social science and bioethics* (pp. 194–208). London: Blackwell.
- Asch, A. (1999). Prenatal diagnosis and selective abortion: A challenge to practice and policy. *American Journal of Public Health*, 89(11), 1649–1657.
- Atkins, C. G. K. (2008). The choice of two mothers: Disability, gender, sexuality, and prenatal testing. *Cultural Studies - Critical Methodologies*, 8(1), 106–129.
- Baker, S. R., Choi, P. Y. L., Henshaw, C. A., & Tree, J. (2005). "I felt as though I'd been in jail": Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology*, 15(3), 315–342.
- Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.
- Benatar, M., & Benatar, D. (2003). Between prophylaxis and child abuse: The ethics of neonatal male circumcision. *The American Journal of Bioethics*, 3(2), 35–48.
- Bergeron, V. (2007). The ethics of cesarean section on maternal request: A feminist critique of the American College of Obstetricians and Gynecologists' position on patient-choice surgery. *Bioethics*, 21(9), 478–487.
- Blum, L. M. (1999). *At the breast: Ideologies of breastfeeding and motherhood in the contemporary United States*. Boston: Beacon Press.
- Bosk, C. (1992). *All God's mistakes: Genetic counseling in a pediatric hospital*. Chicago: University of Chicago Press.
- Boyle, R. J., & Savulescu, J. (2003). Prenatal diagnosis for "minor" genetic abnormalities is ethical. *The American Journal of Bioethics*, 3(1), W60–W65.
- Brooks, H., & Sullivan, W. J. (2002). The importance of patient autonomy at birth. *International Journal of Obstetric Anesthesia*, 11(3), 196–203.
- Bryant, L. D., Green, J. M., & Hewison, J. (2006). Understandings of Down's syndrome: A Q methodological investigation. *Social Science & Medicine*, 63(5), 1188–1200.
- Callahan, D. (2003). *Setting limits: Medical goals in an aging society*. Washington, DC: Georgetown University Press.
- Caniano, D. A. (2004). Ethical issues in the management of neonatal surgical anomalies. *Seminars in Perinatology*, 28(3), 240–245.
- Carlton, T., Callister, L. C., & Stoneman, E. (2005). Decision making in laboring women: Ethical issues for perinatal nurses. *The Journal of Perinatal & Neonatal Nursing*, 19(2), 145–154.
- Chachkin, C. J. (2007). What potent blood: Non-invasive prenatal genetic diagnosis and the transformation of modern prenatal care. *American Journal of Law & Medicine*, 33(1), 9–53.
- Christilaw, J. E. (2006). Cesarean section by choice: Constructing a reproductive rights framework for the debate. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics*, 94(3), 262–268.
- Cruz, R., Glick, L. B., & Travis, J. W. (2003). Circumcision as human-rights violation: Assessing Benatar and Benatar. *The American Journal of Bioethics*, 3(2), W19–W20.
- D'Alton, M. E., Aronson, M. P., Birnbach, D. J., Bracken, M. B., Dawood, M. Y., Henderson, W. G., et al. (2006). National Institutes of Health state-of-the-science conference statement: Cesarean delivery on maternal request March 27–29, 2006. *Obstetrics and Gynecology*, 107(6), 1386–1397.
- Declercq, E. R., Sakala, C., Corry, M. P., & Appelbaum, S. (2006). *Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences*. New York: Childbirth Connection.

- De Marco, M., Thorburn, S., & Zhao, W. (2008). Perceived discrimination during prenatal care, labor, and delivery: An examination of data from the Oregon pregnancy risk assessment monitoring system, 1998–1999, 2000, and 2001. *American Journal of Public Health, 98*(10), 1818–1822.
- De Vries, R., Kane Low, L., & Bogdan-Lovis, E. (2008). Choosing surgical birth: Desire and the nature of bioethical advice. In H. Lindemann, M. Verkerk, & M. U. Walker (Eds.), *Naturalized bioethics: Toward responsible knowing and practice* (pp. 42–64). New York: Cambridge University Press.
- Ekberg, M. (2007). Maximizing the benefits and minimizing the risks associated with prenatal genetic testing. *Health Risk & Society, 9*(1), 67–81.
- FIGO's Committee for the Ethical Aspects of Reproduction and Women's Health. (2006, November). *Ethical issues in obstetrics and gynecology*. Retrieved November 25, 2008, from <http://www.figo.org/docs/Ethics%20Guidelines%20-%20English%20version%202006%20-2009.pdf>
- Forbes, G. B., Adams-Curtis, L. E., Hamm, N. R., & White, K. B. (2003). Perceptions of the woman who breastfeeds: The role of erotophobia, sexism, and attitudinal variables. *Sex Roles, 49*(7–8), 379–388.
- Fox, R., & Swazey, J. (2008). *Observing bioethics*. New York: Oxford.
- Gates, E. A. (2004). Communicating risk in prenatal genetic testing. *Journal of Midwifery & Women's Health, 49*(3), 220–227.
- Goer, H. (1995). *Obstetric myths versus research realities: A guide to medical literature*. Westport, CT: Bergin & Garvey.
- Green, J. M. (1994). Serum screening for Down's syndrome: Experiences of obstetricians in England and Wales. *British Medical Journal, 309*(6957), 769–772.
- Gurman, T. A., & Becker, D. (2008). Factors affecting Latina immigrants' perceptions of maternal health care: Findings from a qualitative study. *Health Care for Women International, 29*(5), 507–526.
- Hamilton, B. E., Minino, A. M., Martin, J. A., Kochanek, K. D., Strobino, D. M., & Guyer, B. (2007). Annual summary of vital statistics: 2005. *Pediatrics, 119*(2), 345–360.
- Hampton, W. F. (2003). Nontherapeutic circumcision is ethically bankrupt. *The American Journal of Bioethics, 3*(2), W21–W22.
- Hartmann, K., Viswanathan, M., Palmieri, R., Gartlehner, G., Thorp, J., & Lohr, K. N. (2005). Outcomes of routine episiotomy: A systematic review. *Journal of the American Medical Association, 293*(17), 2141–2148.
- Hedgecoe, A. M. (2004). Critical bioethics: Beyond the social science critique of applied ethics. *Bioethics, 18*(2), 120–143.
- Hentschel, R., Lindner, K., Krueger, M., & Reiter-Theil, S. (2006). Restriction of ongoing intensive care in neonates: A prospective study. *Pediatrics, 118*(2), 563–569.
- Hill, G. (2003). Can anyone authorize the nontherapeutic permanent alteration of a child's body? *The American Journal of Bioethics, 3*(2), W16–W18.
- Howard, C., Howard, F., Lawrence, R., Andresen, E., DeBlicke, E., & Weitzman, M. (2000). Office prenatal formula advertising and its effect on breast-feeding patterns. *Obstetrics and Gynecology, 95*(2), 296–303.
- Hunt, L. M., de Voogd, K. B., & Castaneda, H. (2005). The routine and the traumatic in prenatal genetic diagnosis: Does clinical information inform patient decision-making? *Patient Education and Counseling, 56*(3), 302–312.
- Isle, S. (1995). Precious lives, painful choices: Helping parents who have abnormal prenatal test results. *Journal of Perinatal Education, 4*(4), 11–18.
- Jacknowitz, A. (2007). Increasing breastfeeding rates: Do changing demographics explain them? *Women's Health Issues, 17*(2), 84–92.
- Jonsen, A. (1998). *Birth of bioethics*. New York: Oxford.
- Kaplan, D. L., & Graff, K. M. (2008). Marketing breastfeeding—Reversing corporate influence on infant feeding practices. *Journal of Urban Health, 85*(4), 486–504.
- Keirns, C. C., Fetters, M., & De Vries, R. G. (in press). Bioethics and medical education: Lessons from the United States. In C. Brosnan & B. Turner (Eds.), *Handbook of the sociology of medical education*. London: Routledge.
- Kuppermann, M., & Norton, M. E. (2005). Prenatal testing guidelines: Time for a new approach? *Gynecologic and Obstetric Investigation, 60*(1), 6–10.
- Lamaze International. (2006). *Code of ethics for Lamaze Certified Childbirth Educators*. Retrieved October 5, 2008, from <http://www.lamaze.org/Default.aspx?tabid=561>
- Li, R., Darling, N., Maurice, E., Barker, L., & Grummer-Strawn, L. M. (2005). Breastfeeding rates in the United States by characteristics of the child, mother, or family: The 2002 national immunization survey. *Pediatrics, 115*(1), e31–e37.
- Lindemann, H., Verkerk, M., & Walker, M. U. (Eds.). (2008). *Naturalized bioethics: Toward responsible knowing and practice*. New York: Cambridge University Press.
- Lothian, J. (2006). Birth plans: The good, the bad, and the future. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 35*(2), 295–303.
- Lothian, J. A. (1997). Questions from our readers: The cost of “free.” *Journal of Perinatal Education, 6*(3), vii–ix.
- Lothian, J. A., & DeVries, C. (2005). *The official Lamaze guide: Giving birth with confidence*. Minneapolis, MN: Meadowbrook Press.
- Lowe, N. K. (2004). Context and process of informed consent for pharmacologic strategies in labor pain care. *Journal of Midwifery & Women's Health, 49*(3), 250–259.
- Marini, T., Sullivan, J., & Naem, R. (2002). Decisions about amniocentesis by advanced maternal age patients following maternal serum screening may not always correlate clinically with screening results: Need for improvement in informed consent process. *American Journal of Medical Genetics, 109*(3), 171–175.
- Marteau, T. M., & Dormandy, E. (2001). Facilitating informed choice in prenatal testing: How well are we doing? *American Journal of Medical Genetics, 106*(3), 185–190.

- Matthews, R., & Callister, L. C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33(4), 498–507.
- McFarlin, B. L. (2004). Elective cesarean birth: Issues and ethics of an informed decision. *Journal of Midwifery & Women's Health*, 49(5), 421–429.
- Miesnik, S. R., & Reale, B. J. (2007). A review of issues surrounding medically elective cesarean delivery. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 36(6), 605–615.
- Mitchell, L. M. (2004). Women's experiences of unexpected ultrasound findings. *Journal of Midwifery & Women's Health*, 49(3), 228–234.
- Morton, C., & Hsu, C. (2007). Contemporary dilemmas in American childbirth education: Findings from a comparative ethnographic study. *Journal of Perinatal Education*, 16(4), 25–37.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979, April 18). *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*. Retrieved November 25, 2008, from <http://ohsr.od.nih.gov/guidelines/belmont.html>
- National Institutes of Health. (2006, March 27–29). NIH State-of-the-Science conference statement on cesarean delivery on maternal request. *NIH Consensus and State-of-the-Science Statements*, 23(1), 1–29. Retrieved November 25, 2008, from http://consensus.nih.gov/2006/CesareanStatement_Final053106.pdf
- Orfali, K., & Gordon, E. J. (2004). Autonomy gone awry: A cross-cultural study of parents' experiences in neonatal intensive care units. *Theoretical Medicine and Bioethics*, 25(4), 329–365.
- Paris, J. J., Schreiber, M. D., & Moreland, M. P. (2007). Parental refusal of medical treatment for a newborn. *Theoretical Medicine and Bioethics*, 28(5), 427–441.
- Post, S. G. (2004). *Encyclopedia of bioethics*. New York: Macmillan Reference, USA: Thomson/Gale.
- Regan, M., & Liaschenko, J. (2007). In the mind of the beholder: Hypothesized effect of intrapartum nurses' cognitive frames of childbirth cesarean section rates. *Qualitative Health Research*, 17(5), 612–624.
- Robin, P. (1998). *When breastfeeding is not an option: A reassuring guide for loving parents*. Rocklin, CA: Prima Publishing.
- Rosenberg, K. D., Eastham, C. A., Kasehagen, L. J., & Sandoval, A. P. (2008). Marketing infant formula through hospitals: The impact of commercial hospital discharge packs on breastfeeding. *American Journal of Public Health*, 98(2), 290–295.
- Rosenthal, M. S. (2006). Socioethical issues in hospital birth: Troubling tales from a Canadian sample. *Sociological Perspectives*, 49(3), 369–390.
- Ross Products Division. (2003). *Mothers survey: Breast-feeding trends – 2003*. Columbus, OH: Abbott Laboratories.
- Rothman, B. K. (2001). Spoiling the pregnancy: Prenatal diagnosis in the Netherlands. In R. De Vries, C. Benoit, E. R. Van Teijlingen, & S. Wrede (Eds.), *Birth by design* (pp. 180–198). New York: Routledge.
- Ryan, A. S., & Pratt, W. F. (1991). A comparison of breast-feeding data from the national surveys of family growth and the Ross Laboratories mothers surveys. *American Journal of Public Health*, 81(8), 1049–1052.
- Scelfo, J. (2008, November 12). Baby, you're home. *The New York Times*. Retrieved November 25, 2008, from http://www.nytimes.com/2008/11/13/garden/13birth.html?_r=1
- Shaw, R. (2002). The ethics of the birth plan in childbirth management practices. *Feminist Theory*, 3(2), 131–149.
- Smith, C. (2003). Theorizing religious effects among American adolescents. *Journal for the Scientific Study of Religion*, 42(1), 17–30.
- Spidsberg, B. D. (2007). Vulnerable and strong—Lesbian women encountering maternity care. *Journal of Advanced Nursing*, 60(5), 478–486.
- Vehmas, S. (2002). Is it wrong to deliberately conceive or give birth to a child with mental retardation? *The Journal of Medicine and Philosophy*, 27(1), 47–63.
- Walker, M. (n.d.). *How to naturalize bioethics, and why: An opening for discussion*. Unpublished manuscript.
- Wall, L. L., & Brown, D. (2007). The high cost of free lunch. *Obstetrics and Gynecology*, 110(1), 169–173.
- Ward, L. M. (2002). Whose right to choose? The “new” genetics, prenatal testing and people with learning difficulties. *Critical Public Health*, 12(2), 187–200.
- Wax, J. R., Cartin, A., Pinette, M. G., & Blackstone, J. (2004). Patient choice cesarean: An evidence-based review. *Obstetrical & Gynecological Survey*, 59(8), 601–616.
- Wax, J. R., Cartin, A., Pinette, M. G., & Blackstone, J. (2005). Patient choice cesarean—The Maine experience. *Birth*, 32(3), 203–206.
- Wolpe, P. R. (1998). The triumph of autonomy in American bioethics: A sociological view. In R. De Vries & J. Subedi (Eds.), *Bioethics and society: Constructing the ethical enterprise*. Upper Saddle River, NJ: Prentice Hall.
- Wood, S. H. (2003). Should women be given a choice about fetal assessment in labor? *MCN. The American Journal of Maternal Child Nursing*, 28(5), 292–298; quiz 299–300.

JENNIFER TORRES is a doctoral student in the Sociology Department at the University of Michigan in Ann Arbor. RAYMOND DE VRIES is a member of the Bioethics Program and the Department of Obstetrics and Gynecology at the University of Michigan.