Continuing Education Module

A Fine Line: Ethical Issues Facing Childbirth Educators Negotiating Evidence, Beliefs, and Experience

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ABSTRACT

The trend toward evidence-based information in childbirth education has been ongoing for some time. Lamaze educators are encouraged to present evidence for the Six Care Practices That Support Normal Birth to pregnant women in their childbirth classes. In a previous article published in *The Journal of Perinatal Education*, my colleague and I provided an overview of the dilemmas facing American childbirth educators. Childbirth education is a domain in which many types of authoritative knowledge are used: evidence, beliefs, and experience. In our study, educators told us their goal is to provide class participants with unbiased information that allows women to choose what is best for them. In this article, I further analyze educators' dilemmas and challenges in presenting unbiased information, and I discuss some ethical considerations in educators' practices.

Journal of Perinatal Education, *18*(1), 25–31, doi: 10.1624/105812409X396200

Keywords: childbirth education, ethnographic research, ethical considerations, evidence-based research, authoritative knowledge

The trend toward evidence-based information in childbirth education has been ongoing for some time. Lamaze educators are encouraged to present evidence for the Six Care Practices That Support Normal Birth to pregnant women in their childbirth classes (see Lamaze International, 2007). In a previous article, my colleague and I provided an overview of the dilemmas facing childbirth educators (Morton & Hsu, 2007). Childbirth education is a domain in which many types of authoritative knowledge are used: evidence, beliefs, and experience. In our study, educators told us their goal is to provide class participants with ''unbiased information so that women could choose what is best for them'' (Morton & Hsu, 2007, p. 32). In the present article, I further analyze educators' dilemmas and challenges in presenting unbiased information. I also discuss some ethical considerations in educators' practices.

I argue that educators solve the dilemma of how to present unbiased information through various strategies. One is by presenting options using a ''menu-based'' approach. That is, educators lay

Lamaze International has created a continuing education home study based on this article. Please visit the Lamaze Web site (www.lamaze.org) for detailed instructions regarding completion and submission of this home study module for Lamaze contact hours.

To view the Six Care Practices That Support Normal Birth, log on to the Lamaze Web site (www.lamaze.org), click ``About Lamaze,'' then click on the link for the Lamaze Institute for Normal Birth.

out a menu of possibilities in a neutral manner, implying that all options are equal. To use a restaurant analogy, educators acknowledge that salads (normal birth) are healthier, with a brief reference to medical science. However, most restaurants offer cheeseburgers (standard maternity care), and the statistics clearly show that most women have cheeseburgers (standard maternity care). Then, the topic quickly shifts in class to whether one will eat inside or on the patio. In the end, the decision for a salad (normal birth) or a cheeseburger (standard maternity care) is left as an individual choice for the consumer. I conclude with possible ways to broaden the context (many different restaurants). I also suggest educators consider using a rights-based framework when presenting quality care practices, health-care options, and consumer rights and consider lessening the emphasis on choice.

METHODS

Several data collection methods were employed in the original study, including participant observation of childbirth classes; in-depth interviews with childbirth educators, birthing women, and key informants; a review of printed materials; and an information sources survey (Morton & Hsu, 2007). However, in this article, I draw on data from interviews with childbirth educators and key informants and from classroom observations.

Morton and Hsu's (2007) previously published article, ``Contemporary Dilemmas in American Childbirth Education,'' is available for free download at JPE's site on IngentaConnect (www.ingentaconnect.com/content/lamaze/jpe).

Two institutional review boards reviewed and approved study protocols and materials. All individuals who participated in observed childbirth classes provided consent for the researcher to be present. Separate consent was obtained for in-depth interviews and completion of the information sources survey.

Sample and Recruitment

Data were collected from observations of 11 childbirth class series, eight of which were offered by large organizations and three of which were offered by independent educators. Class series included in the study were purposely selected to represent a range of formats (weekend mornings, weekday evenings, and weekend workshops), philosophical perspectives, and institutional affiliations. Seventeen ethnographic interviews with childbirth educators and/or key decision makers (i.e., program administrators, public health officials, and trainers) were conducted. Interviews were semistructured and explored experiences teaching childbirth education, personal philosophies regarding birth, and thoughts about current trends in childbirth education.

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Setting

The study was conducted in a large U.S. metropolitan area with a highly educated population. Of the eight hospitals in the state's county, three contracted childbirth education programs and five hired childbirth educators directly into their programs. Home birth, birth center birth, and midwifery care were available and covered by private and public health insurance. Public health programs covered childbirth education costs for women enrolled in the state's maternity support services program.

Data Collection

Overall, 11 childbirth education class series were observed. Within the series, only classes on labor and birth were attended, as well as nine class reunions. A total of 160 hours of observation were logged. Altogether, the data set included observations of 65 individual class sessions. The number of class sessions per series ranged from 2 to 10 sessions. These data were supplemented by ethnographic observations of two childbirth education trainings, photos of classrooms and teaching tools, hospital tours, review of printed and online program materials, and immersion into the childbirth education scene at conferences, community events, and social gatherings.

Data Analysis

Observations were recorded with handwritten field notes, which were then transcribed by the observing investigator. Interviews were audiotaped and transcribed verbatim by a professional transcriptionist. During the data collection phase, the investigators met regularly to share insights and debrief findings. Both investigators read through the interview transcripts and typed field notes. These data were entered into qualitative data analysis software (ATLAS.ti) and coded for key content and themes. The identified themes were examined for patterns across types of educators and organizational settings.

FINDINGS

In the summary of findings below, block text presented in italics indicates the actual words used by educators. Some editing has been done for clarity and readability. Codes are used to identify the following:

- Type of data: class observations (Field notes) and interviews (INT).
- Type of participant: childbirth educator (CBE), pregnant woman (PW), and key informant (KI).
- Type of childbirth education class: organizational (ORG) and independent (IND).

Interviews: What Childbirth Educators Say

In our interviews, childbirth educators cited evidence-based information as an authoritative source for determining and evaluating maternity care practices on the population level as well as the starting point for their own personal beliefs and choices. Educators told us their goal is to provide class participants with "unbiased information so that women could choose what is best for them" (Morton & Hsu, 2007, p. 32). Educators revealed a strong sense of responsibility toward this goal. Educators who taught classes that included a significant variation among students' goals and expectations explicitly framed their role as one that does not question, challenge, or judge women's choices regarding caregiver, birth setting, and/or pain-relief methods. These educators were highly sensitive to the possibility of inducing guilt or doubt in women. For example, an education program administrator who was responsible for hiring and managing childbirth educators articulated a philosophy we heard many times from other study participants:

> *In a class, part of our role is to help women feel safe wherever they're birthing and whomever they're birthing with. And there are some things we might want to do in the early pregnancy to get them to choose the kind of caregiver we'd like. But when they're 4 weeks away from their due date is not a time to be criticizing their caregivers. It is a time to be supportive and be sure to give them the tools. . .to know how would you find out if that was the right thing, and how would you go about having more informed choice, but always continuing to imply that everyone involved in this birth has the best interests of you and your baby at heart.* (INT: KI: ORG)

Educators in the present study talked about supporting pregnant women's choices and expressed a genuine concern for women's autonomy and ability to make the best choices for themselves. Educators also acknowledged the context in which these choices are made and lamented that they do not have influence over information women use to make their choices in the early weeks of pregnancy. According to the study's findings and to the previously stated analogy regarding salads, cheeseburgers, and restaurant choices, educators are ambivalent about their role in preparing women who are about to go to a steakhouse (a hospital with standard maternity care practices) with preparation on how to make an informed decision about choosing a salad (normal birth). But when faced with a classroom of women with divergent attitudes and expectations and with different caregivers and birth places, educators could not assume shared views regarding medical interventions or methods of pain relief. One educator noted her approach to this situation:

> *My classes are almost always 50/50—half are wanting less intervention, less. . .pharmacologic pain relief, and the other half are, "I don't mind intervention so much, I think my doctor probably knows it's best for me, and I'm pretty darn sure, I'm going to have an epidural." . . .I want both groups to talk to each other. The natural-birth group, "Good luck to you, I think that is awesome and I want to hear about all your plans to get there," and the other group, "Great, you know exactly what you want, I want to hear about your plans to get there," and then we should talk together about that, 'cause there's going to be tons of crossover.* (INT: CBE: ORG)

This educator accepted on face value the validity of the choices women had already made, prior to encountering the information in her class. Her desire and enthusiasm for getting the two groups talking presumed a crossover, but she did not elaborate whether the crossover would be from circumstances or from conscious choice.

In summary, educators told us their role is to support women and their partners and help them feel safe with the choices they have already made, whether salad (normal birth) or cheeseburgers (standard maternity care). They described their role as giving women support and information in order to prepare for their labor and birth experiences. In most classes, the type of information presented was from a standard curriculum, whether in lecture or video format. Sometimes, though, educators judged circumstances within the class dynamics to guide what information is presented. The same educator quoted above remembered a class in which nearly one third of the women were in their 40s, mixed in with Generation Y (early 20s) types. In response

to the interviewer's question about whether the educator taught differently or noticed topics in this particular class that had not come up in others, the educator reflected:

> *Well, I think the older group was a little higher anxiety. . .but they were sensitive, and . . . if you're going to make good choices, you've got to know what you're looking at. And so. . .you know, I gave them flat out the C-section rate by age group. And so. . .over 45, that's a 53% C-section rate. That's what we see in the hospitals. I don't do that for all groups, I did that for that group. 'Cause I think it would be unfair, for them not to have that information.* (INT: CBE: ORG)

Here, we see the educator selecting how to present information based on the characteristics of the students in the classroom, judging that it would be unfair not to let them know of their greater risk for cesarean due to their age.

Observations: What Childbirth Educators Do

I next provide ethnographic observations of classroom presentations as they occurred in real time and place. Education is a dynamic phenomenon. Pedagogy and curricula are foundations, but the provision of education is, above all, a performance. It is interactive, undertaken in the moment, with many factors such as emotions, histories, desires, and situations potentially affecting what the educator says and how she says it. In my analysis, I acknowledge the contingent and constructed nature of these social actions in the classroom. At the same time, I highlight the values and moral judgments inherent in these examples of childbirth education, as performed in real time.

Menu-based approaches. In class presentations, educators operationalized unbiased information in various ways. In a typical menu-based approach, educators invoked equal measures of science (clinical research evidence), beliefs (individual preference and cultural practices), and experience (everyone is different). Research findings were presented in class, but they were introduced alongside an example of a local practice and individual experience. The following presentation of what happens when babies are born is an example of this approach:

> *Once the head is out, they typically put the baby on mom, dry it off fast, and put nude baby skin to skin with mom, which is fun. Most physicians cut the umbilical cord right away. I've always been on the fence about that. The Lamaze folks looked at the research, and there is some advantage in letting the cord pulsate a bit. They clamp it in two spots, dads usually cut it—it's tough—and there is a symbolism there. You are there at the beginning.* (Field notes: ORG)

In this short presentation of the cord-cutting procedure, the educator drew on many sources of information: her knowledge of typical practice (most physicians cut right away); her own position (unsure); research findings (let cord pulsate); and, again, practice (they clamp and dads cut).

In another example, when a class participant suggested perineal tears heal better than an episiotomy based on what she had read in the class book and heard from a friend, the educator responded:

> *It's a matter of philosophy. For a number of persons, though, that is a theory. But research does show we do okay to minimize it. Remember, if you do have one—I disagree with the book—it doesn't have to be severe. I did tear and I did have to be stitched up. It was moderate. Depends on what degree you had to get. And a woman with episiotomy didn't know she got it. You couldn't feel you got it.* (Field notes: ORG)

Again, this educator draws upon many sources of authoritative knowledge in her answer. She first evokes philosophy, suggesting it is a matter of opinion or an individual position. She refers to research but includes her personal experience, because it is the basis for her disagreement with the class text. In this, as in many similar cases, one mention constitutes the entire presentation of this topic.

Selective approach. Another approach is one in which the educator provides selective data that illustrate variation in practice but stops short of making connections between practice variations and making decisions about birth places. Similar to the educator above who said she provided C-section rates by age for her class with older women, another educator was observed citing C-section rates by hospital. Just before this exchange, she was talking about breastfeeding and cesareans and the difficulties of recovering from the surgery. A pregnant woman in the class then asked where to seek breastfeeding consultation, and the following exchange was noted:

CBE: Your birth place. I want to send you away with, "It can be okay."

PW: What are the rates [for cesareans]?

CBE: The [local health maintenance organization] is 16%, the [local university hospital] is 30%, and the [local private hospital] is a bit unwilling to share.

PW: Why would they not want to share their numbers?

CBE: Your hospital culture has a great deal to do with how you will deliver.

PW: What is the time between when you get the cesarean and when you can hold the baby?

CBE: Pretty soon. [She then talks about the fact that they take the baby away to check various things; within a couple minutes, the class goes on break. The topic of hospital culture is not further elaborated.] (Field notes: ORG)

Avoiding the issue altogether. In some cases, topics such as induction were not discussed but were introduced and taught via a film (e.g., *Induction and Augmentation*). In one class, the educator started the video and then left the room. The ethnographer's field notes show the types of information presented and the class reactions:

Video: Reasons for inducing: postdates, water breaks, baby or mom not doing well.

Narrator: Inductions should only be done when medically necessary. Not to have the baby on a certain day or to meet the schedule of a visiting relative [class laughs].

Methods for inducing: prostaglandins, pitocin, breaking bag of waters [narrator states this is painless].

Narrator: Keep in mind, the contractions you have when induced with pitocin are often stronger and closer together than natural contractions. . . these stronger contractions may put stress on the baby. [CBE has been out of the room, but now returns.]

Video: Risks: infections, prolapsed cord. Monitoring is standard procedure, done every 5–20 minutes. Discusses the external and internal fetal monitor. May be given IV fluids. . .Reasons: maintain blood pressure, deliver pitocin, and treat dehydration.

[CBE turns on lights and turns down the sound on the video. She points to little pieces of paper she had distributed and asks class members to put a rating on the paper. "On a scale of 1–5, with 1 being you learned nothing/not helpful/waste of time and 5 being learned a lot or was more than I thought I would learn." Students fill out their pieces of paper and slowly pack up their things to go.] (Field notes: ORG)

DISCUSSION

Presenting information that is balanced, accurate, complete, and contextualized is challenging. Presenting unbiased information to expectant couples to make decisions about their labor and birth is perhaps impossible. Without bias, whether in favor of scientific information, experiential knowledge, or optimal health, all options effectively become value-neutral. The educators in our study wrestled with the "best" way to present contested information, such as epidurals, for the couples in their classes. In our prior analysis, this was referred to as a dilemma, noting that educators struggle to balance what is optimal on a population level (evidence-based research); what women are likely to expect (organizational level); and the unique, unpredictable variation in childbirth experience (individual level). When an issue is presented in class, these levels are not typically differentiated, as we saw earlier. Educators are reluctant to point out the gaps between what evidence says is safest for mothers and babies and common practices found within standard maternity care, for fear of "criticizing their caregivers," as one educator put it.

I suggest this framing of the situation is not about criticizing health-care providers or raising issues of mistrust; rather, it offers ways to highlight and problematize organizational and systems-level contexts in which labor and birth occur and to highlight and problematize *practices* as opposed to specific persons or general roles. A rationale that incorporates some degree of protectionism raises ethical questions. On what grounds do childbirth educators decide to protect women from disturbing information because they think it *might* create more fear and/or anxiety? If the period of 34 or 35 weeks in pregnancy is not the right time to highlight practices most associated with negative health outcomes for women and babies, then when is the appropriate time? Is it ethical to withhold information about the institutional organization of obstetrics and, thus,

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not prepare expectant couples for considering what types of nonmedical factors affect their decision making?

One man I spoke with in the course of my fieldwork told me he wanted to be taken into a separate room and be told how he could best protect his wife. ''From what?'' I asked. He wanted to know how to assess and advocate for a competent anesthesiologist (if one was needed)—one who was not sleep-deprived or a resident. He wanted to know how he could be empowered as an advocate in a complex medical environment in which potentially multiple points of failure exist at many points along the line. The man was a high-level professional in a technical field, so he was well aware of systems factors that might impact individual experience. He was surprised, however, to learn about some organizational practices and associated outcomes with standard maternity care. Other partners may not have this sense of entitlement and authority, but they are no less concerned about the quality of care for their loved ones and how they can be most effective as advocates.

In very few instances did educators note that pregnant women enter a hospital system with its own sets of rules, logics, and practices. When such factors were mentioned, it was often pre-emptory and with little elaboration. These issues are also supported in evidence-based research: nursing staff with little to no knowledge or experience in supporting women who wish few or no interventions, especially pain medications, and nonmedical factors beyond the clinical and physical indications of the woman's labor. In no class did an educator discuss the expectations and consequences of women becoming ''patients'' upon admission to the hospital.

Are Lamaze educators acting in an unethical manner by not highlighting these factors? By laying out a menu of options in their concerns to not alienate or invoke guilt or anger in women, educators effectively construct outcomes as resulting from individual women's choices. If educators employ a ''rights-based'' framework, how would the rhetoric and substance of the curriculum change?

One way to develop a rights-based framework in childbirth education classes might be to provide participants with information about the rights of birthing women. Childbirth Connection's (2007) published statement, *The Rights of Childbearing Women*, is an excellent resource. In countries with universal health care, access to quality care is considered a ''right.'' In the United States, there are no quality measures for maternal health. The U.S. maternal and infant mortality rates are dismal for a developed country. By shifting attention to the practices employed in standard maternity care, educators may indeed stress to expectant couples that they have less choice than they may have thought. With a careful focus on institutional practices and nonclinical factors impacting standard maternity care, educators can give their students useful and valuable information for navigating a maternity care system that is not centered on normal birth.

Future Directions

In childbirth education classes, it is extremely challenging to teach about population-level research and make it meaningful and relevant to individuals who are about to experience one of the most transformative events of their lives. Social scientists have many resources and ideas for how to bridge this macro/micro divide, largely by highlighting practices within institutions and the cultural factors influencing those practices.

Childbirth educators who have developed methods of bridging this divide are encouraged to share their teaching experiences by posting live, online examples on YouTube or on the Lamaze Web site's ''Members Only'' link. With the advent of social media technologies (e.g., YouTube, wikis, blogs, podcasting), a plethora of opportunities are available for educators to learn from each other and collectively create alternative modes of presenting evidence-based information on nonmedically indicated inductions. These alternative modes would not be unbiased, because the point of view expressed would be biased toward evidence-based research and positive outcomes for women and infant health. However, I hope I have demonstrated that the goal of providing unbiased information so that women can make their own choices is a flawed and perhaps impossible goal for childbirth educators who want to teach normal birth.

ACKNOWLEDGMENTS

I am grateful to Lamaze International for funding this research and to Debra Bingham, Sylvia Star-Lack, and Judith Lothian for their helpful comments on previous drafts of this article.

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