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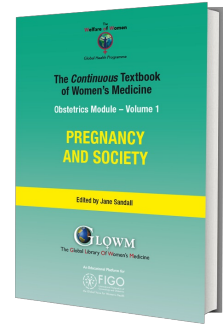
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### **PREGNANCY AND SOCIETY**

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## *Chapter*

# **Bioethics and Technology in Maternity Care**

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## **INTRODUCTION**

Supporting a woman at the birth of her child is one of the oldest forms of healthcare. Over the millennia, responsibility for this task has expanded from women who were close to the mother-to-be, to include traditional birth attendants, midwives, medical doctors, and obstetric specialists. These changes in the caregiver responsible for the health and well-being of women during pregnancy and birth are associated with changes in the technologies of birth. New technologies have been the entrée for new caregivers, altering how care at birth was delivered and who was present. It is important to note that not all new technologies improved the outcome of birth – measured in the health of mothers and babies, satisfaction, and costs – and not all new technologies were welcomed by caregivers.

When existing approaches to care are changed, ethical questions are bound to follow. This is especially true in maternity care, a branch of medicine where difficult questions about the boundaries of viable life are more common, and where care necessarily involves two individuals, the mother and the baby.

In this chapter, we look at the ever-changing technologies of birth, the effect of those changes on the way maternity care is delivered, the ethical questions those changes create, and varied strategies for identifying and resolving those ethical questions.

## **TECHNOLOGY**

In the fields of sociology and anthropology we speak of “material” and “nonmaterial” culture. Material culture refers to the things that we humans make, like pottery, books, and automobiles. Nonmaterial culture is made up of the ideas, beliefs, values, norms, and ways of thinking that are characteristic of a group of humans.<sup>1</sup> This distinction can be applied

to technology as well. The nonmaterial technologies of birth include the knowledge and practices of those who provide maternity care; the material technologies of birth include the devices – stethoscopes, doptones, catheters, vacuums, laboratory tests, scanners, and the like – used by those who care for pregnant and birthing women. These two types of technologies interact. For example, nonmaterial technologies – the ways care is given – affect the acceptance of the devices in birth care and how they are used, and new material technologies will change the practices of caregivers.

The history of maternity care is marked by this interaction between nonmaterial and material technologies.<sup>2,3</sup> Traditional birth attendants – both trained and untrained – used a variety of material and nonmaterial technologies to assist birth, including herbs, positioning during labor, and various tools for supporting women during labor, including ropes, poles, stools, and beds. With the increased value placed on new technologies – electric, electronic, and digital – in modern, high resource countries, birth attendants have turned to an array of devices – material technologies – and procedures – immaterial technologies – for monitoring and intervening in the birth process. Pinards, doptones, and CTG (cardiotocography, also referred to as EFM, electronic fetal monitoring) allowed surveillance of fetal heart tones and uterine contractions.

Forceps, vacuum, and steadily evolving surgical techniques allowed intervention to speed birth when it appeared the fetus was in trouble. These new technologies changed the way birth is attended and experienced. For example, the use of CTG requires that a woman remain in bed in a semi-supine position. The advent of telemetry has allowed women to move about, but not all women have access to telemetric CTG. Different sets of values among different types of birth attendants have encouraged or discouraged use of these new devices and procedures. In general, modern practitioners find little value in traditional ways of assisting at birth, while traditional practitioners are wary of the new tools and techniques being introduced to obstetrics.

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## ETHICS/BIOETHICS IN HEALTHCARE

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Dealing as it does with life, health, and death, medical care generates many and varied ethical questions. When does life begin? Does the human embryo have all the rights given to an adult? When are parents allowed to make life and death decisions for their children? How much information is needed before an individual can give fully informed consent for a medical procedure? When is it acceptable to use a human as a research subject? When is someone "dead enough" to allow the harvesting of organs that may save the lives of others? Should there be an upper age limit for *in vitro* fertilization (IVF)? Should the use of IVF be contingent on an assessment of the quality of a couple's relationship? When, if ever, is it acceptable for a caregiver to overrule the wishes of the patient? When healthcare resources are scarce, how do we decide who gets access to what?

These questions, and others like them, were once left to the discretion of physicians and other caregivers, but over the past half-century a new profession – bioethics – has emerged to help healthcare professionals reason through these difficult issues.<sup>4</sup> Why have health professionals turned to bioethics? New material and nonmaterial technologies – think of the ability to do fetal surgery, which requires both types of technology – have created complicated moral questions that go beyond the training typically given to healthcare workers. At the same time, growing skepticism about healthcare professionals has decreased public trust in the ability of physicians to make decisions in the best interest of their patients.<sup>5,6</sup> Bioethics, a multidisciplinary field, moved into the space created by these technological and social changes, using insights from philosophy, theology, social work, law, medicine, and the social sciences to speak to these new and complex question.<sup>7</sup>

The task of bioethics is made difficult, not just by the complexity of the questions the field is asked to consider, but also by the cultural variation between and within societies. Because different societies and different groups within a society call on different moral resources – e.g., sacred texts, oral traditions, socialization – to answer bioethical questions, the dilemmas bioethicists are asked to resolve often have more than one "right" answer. Jewish, Islamic, and Christian traditions, for example, disagree on when life begins, and hence, on the moral status of an embryo, resulting in different conclusions on the moral acceptability of using embryos in research.

Even those who associate with the same moral tradition may disagree on the proper resolution to a moral quandary. Consider for a moment, the classic case of the "trolley problem". Imagine that you are standing at a railway switch when you see a trolley with no driver headed directly toward five workers on the track. They are unaware of the trolley speeding their way and if you do nothing, they all will be killed. You can avert this tragedy by throwing the switch in

front of you and sending the trolley down a sidetrack where one workman is busy and unaware of the pending danger. What would you do? If you are committed to a rule-based ethic (e.g., "thou shalt not kill") you may choose to simply let the trolley roll to avoid actively killing the single worker by throwing the switch. If you are a "consequentialist" (acts are right or wrong based on the consequences of those acts) you would likely throw the switch because one death is less tragic than five. Faced with this dilemma, devout followers of the same religious or humanistic tradition will disagree about the proper course of action.

How, in the face of this pluralism, can a bioethicist offer moral advice? In any given hospital or research institute, several moral traditions will coexist. In response to the problem of moral pluralism, bioethics has developed a "middle" way to approach ethical problems. Rather than calling on "first principles" – precepts found in sacred texts and/or fundamental beliefs about the nature of human beings and morality (e.g., rule based vs. consequentialist reasoning) – the dilemmas arising in medicine and the life sciences are addressed by appealing to four "mid-range" principles that are described as being widely accepted in most moral traditions.<sup>8</sup>

1. *Respect for autonomy*: All persons have the right to retain control over their bodies. They must be allowed to make their own decisions independently and according to their values and beliefs – whether or not the healthcare provider believes these choices are in that person's best interests.
2. *Beneficence*: Do good. Healthcare providers must do all they can to benefit those in their care. All procedures and treatments recommended must be with the intention to do the most good for the patient. This requires developing and maintaining a high level of skill and knowledge and use of the best medical practices.
3. *Non-Maleficence*: Do no harm. Based on the Hippocratic principle, 'primum non nocere' (first do no harm) caregivers must avoid practices that harm those in their care. This may mean doing nothing, if an intervention does more harm than good.
4. *Justice*: Be fair. Caregivers must ensure that the costs and benefits of care are fairly distributed, with equal distribution of healthcare resources.

These principles have proven to be a useful and practical guide for identifying and resolving complex ethical questions, but not all agree that they offer the best framework for ethical decision-making. The 'principlist' approach has been criticized on several grounds.<sup>9</sup> First, it is not clear what should be done when two principles come into conflict. When respecting a person's autonomy results in harm to that person, how should one proceed? Which principle takes precedence?

Principlism has also been faulted for overlooking the fact that it has emerged from the Western philosophical tradition and is not applicable in societies with other histories and systems of moral reasoning. Principlism, although it seeks to accommodate pluralism by finding a 'middle ground' for ethical decision making, nevertheless relies on the existence of a "common morality:" "a set of norms shared by all persons committed to morality ... applicable to all persons in all places".<sup>8</sup> The notion that the principles are universal prevents the appreciation and use of the rich diversity of the world's moral traditions. As Tosam points out:

*"It would be an error to assume that only one of [the] diverse medical and moral traditions is the most valid. Because the global ethical space is diverse and variegated, we owe each other a moral duty to encourage, not stifle, these ethical traditions. To do this, it will require sensitivity and openness especially towards marginalized bioethical traditions. Recognizing different moral views will promote moral progress, as this will permit us to learn or beg and borrow from each other."*<sup>10</sup>

Finally, principlism has been criticized for overlooking important relational aspects of ethical problems, opting for a juridical approach based on the objective application of rules. "Care ethics" has been offered as an alternative method for identifying and addressing the moral problems of medicine.<sup>11</sup> The groundwork for care ethics was created by Carol Gilligan<sup>12</sup> and Joan Tronto.<sup>13</sup>

Gilligan was a student of Lawrence Kohlberg, a psychologist who developed a theory of moral development that suggested that boys used more sophisticated moral reasoning than girls.<sup>14</sup> Doubting that conclusion, Gilligan did her own research, which led her to conclude that girls were not morally inferior to boys, they simply had another way of solving ethical dilemmas. Where boys focused on rules to resolve moral problems, girls focused on responsibilities,

relationships and individual circumstances. Gilligan's research points to the value of an 'ethic of care' that calls on the moral value of nurturing and caring, rather than on abstract juridical rules.

Tronto extended Gilligan's work by adding a political dimension, asserting an 'ethics of care' is fundamental for the creation of a 'good' society. She identified four elements that comprise 'good' care: (1) **attentiveness** – recognizing and responding to the needs of others; (2) **responsibility** – seeing care as a gift and not an obligation; (3) **competence** – ensuring that care is adequate and safe; (4) **responsiveness** – meeting the needs of the vulnerable without taking over. An ethic of care sees autonomy – a core element in the principlist approach – not as the assertion of individual rights, but as "relational". Autonomy is always realized in a social context, in the relation of a person with others.<sup>15</sup>

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## THE ETHICS OF MATERNITY CARE

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These approaches to bioethics provide the context for thinking about the ethical problems that arise in maternity care. As suggested above the technologies of maternity care – be they traditional or modern, nonmaterial or material – have ethical implications, and the ethical questions that arise in maternity care are unique in that they often involve two persons: the mother and the baby. The presence of an additional person in the care relationship complicates ethical decision-making.

Efforts to resolve the ethical problems of pregnancy and childbirth have often relied upon the principlist approach, and, focusing on the "two person problem" stressed the conflict between the *autonomy* of the mother and provision of *beneficent* care for the fetus. As a result, many of the moral problems in maternity care were framed as conflicts between mother and fetus.<sup>16</sup> The American College of Obstetricians and Gynecologists (ACOG) reified this way of thinking in their 1987 opinion, *Patient choice: Maternal- fetal conflict*.<sup>17</sup> Twelve years later, the committee replaced the term maternal-fetal conflict with "maternal-fetal relationship," but this way of thinking about mothers and their babies continues to influence what happens in maternity units.<sup>18,19</sup>

In the principlist algorithm, autonomy must be weighed against beneficence. Called upon to balance the desires of the mother and the perceived needs of the baby, autonomy is most often discarded and beneficence carries the day.<sup>20,21</sup> Van Nistelrooij and van der Waal explain: "In healthcare and ethics attention for pregnancy and birth is often focused upon the child. Less attention is paid to the mother's perspective. Within ethics an individualistic approach of mother and fetus dominates, resulting in a separation of their interests and a subsequent undervaluation of the mother's interest". They go on to suggest: "An alternative relational ethical approach could offer a counterbalance, to increase philosophical insights into pregnancy and to improve care practices concerning pregnancy and birth".<sup>22</sup>

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## CASE STUDIES: USING THE ETHICAL APPROACHES

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A useful way to understand the relationships between ethics and the technologies of maternity care is to examine particular case studies where the delivery of care, technology, ethics, culture, and the organization of society meet. We consider several examples of instances where technology – material and nonmaterial – generates ethical questions and consider varied responses to those questions.

### Cesarean delivery on maternal request

Cesarean delivery involves major abdominal surgery, requiring an incision through a woman's abdomen and uterus. In some cases, a cesarean is an intervention that is essential to protect the health and life of a mother and/or her baby. But, because it is associated with complications immediately after birth and in future pregnancies, it is not an intervention to be taken lightly. Compared with a vaginal delivery, delivery by cesarean section results in more overall pain afterward, more use of antibiotics, longer hospital stays, and longer recovery time. If done too early in the gestational period, a cesarean can result in problems for the baby. Cesarean birth can also lead to complications in future pregnancies including serious placental problems.<sup>23,24,25</sup>

Given these facts, what should a caregiver do when approached by a healthy pregnant woman who wishes to schedule a cesarean even though there is no medical indication for the procedure? She may have justifiable reasons for such a request. Her work or family schedule may necessitate picking the day of her birth, or she may suffer from tokophobia

(the fear of labor). She may have other reasons for asking for a surgical birth, reasons that are real to her, but not supported by research: e.g., fear that a vaginal birth may make her less desirable to her partner or will cause incontinence.

This case is interesting because the ethics committees of both ACOG and FIGO (The International Federation of Gynecology and Obstetrics) were asked to provide an opinion about the ethics of honoring such a request. Looking at their differing responses offers insight into the way culture can influence ethical reasoning, even though, in this case, both ACOG and FIGO used a principlist approach in writing their opinions.

ACOG has issued more than one opinion on the question, but in their initial response – “Surgery and patient choice: The ethics of decision making” (2003) – the ethics committee prioritized autonomy (and beneficence), concluding:

*"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."*<sup>26</sup>

The most recent opinion from ACOG (2013) modifies this position somewhat, but continues to prioritize autonomy, concluding that: “Depending on the context, acceding to a request for a surgical option that is not traditionally recommended can be ethical”. The opinion adds:

*"Decisions should be based on strong support for patients' informed preferences and values; understood in the context of an interpretive conversation; and consistent with considerations of safety, cost-effectiveness, and attention to effects on the healthcare system of expanded choice."*<sup>27</sup>

The ethics committee of FIGO emphasizes a different set of principles – justice and non-maleficence – and came to a different conclusion. In 1999, FIGO's Committee for the Ethical Aspects of Reproduction and Women's Health published its position on nonmedically indicated surgical birth in a document titled *Ethical Aspects of Cesarean Delivery for Non-Medical Reasons*.<sup>28</sup> Its opinion, reaffirmed in 2012, was based on the principles of non-maleficence and justice. The committee starts with two observations: "Cesarean section is a surgical intervention with potential hazards for both mother and child"; and "[Cesarean section] uses more resources than normal vaginal delivery." Given that FIGO members "have a professional duty to do nothing that may harm their patients" and "an ethical duty to society to allocate healthcare resources wisely," the committee concludes:

*"At present, because hard evidence of net benefit does not exist, performing cesarean section for non-medical reasons is not justified."*<sup>29</sup>

Reflecting on these different conclusions, we see that even those who use the same approach to ethical decision-making can arrive at different resolutions to the dilemma. ACOG, an American organization, based in a culture with a strong emphasis on individualism, chooses to make autonomy “the first among equal” principles.<sup>30</sup> FIGO, an international organization, more sensitive to the costs associated with cesarean technology, called on the principle of justice to conclude that offering an expensive medical procedure when there was no medical need is unethical.

## Religious beliefs and level of care

Mrs A is pregnant with her second child. Her first child was born 2 years ago. The birth went well, although after the placenta was born there was some extensive bleeding (approx. 700 ml). This was managed by oxytocin; no blood transfusion was necessary, and she had no further complications. Mrs A is a Jehovah's Witness, she refuses all blood products and receiving a blood transfusion is not an option for her.<sup>31</sup>

During her check-ups, she indicates that this time she wants to give birth in the local hospital with her midwife. However, her midwife and obstetrician prefer her to give birth in a tertiary center 50 miles away, because of her previous hemorrhage and her rejection of all blood products. That center is better equipped with the technology required for dealing with severe hemorrhage, reducing the likelihood of a required blood transfusion. Mrs A is not convinced that this is necessary and is afraid that she will lose control when far away from her social environment. She provides an informed refusal.

Using the principlist approach, this dilemma presents a conflict between the principles of autonomy, beneficence and non-maleficence.<sup>8</sup> Should a caregiver accept the freedom of the woman to make her own choices even if that caregiver

is convinced this it is not in the woman's best interest? However, the caregiver might also ask if the woman is really making this choice from her own free will or as the result of pressure from others. Should the caregiver follow the principles of 'doing good' and 'no harm', keeping her children – who run the risk of being left without a mother – in mind?

Adopting a care ethics approach<sup>15</sup> will create a different set of questions. What are the needs and motives that are leading this woman to her choice (attentiveness)? Does the caregiver freely offer options for care, or is there an element of safeguarding her/himself (responsibility)? How might it be possible to make sure that the woman's needs are met in this situation, while still giving her control (responsiveness)? If an individual is always in relation with others and autonomy is realized in a social context (relational autonomy), should others be involved in the decision-making? If so, how can that be accomplished? Who has the ultimate say in the matter?

By contrasting the different sets of questions created by the two approaches, we see that using the principles often results in a search for the *right* answer, while using care ethics leads to the search for a *good* answer.

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## IMPLICATIONS FOR MATERNITY CARE IN COUNTRIES WITH DIFFERENT LEVELS OF RESOURCES AND DIFFERENT MORAL TRADITIONS

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Differing levels of resources – material and nonmaterial – will affect the recognition, framing, and resolution of ethical problems. In the example of different ethical approaches to the problem of cesarean delivery on maternal request, we have demonstrated how social contexts – including the availability of surgical resources *and* the cultural ordering of the four principles – can lead to different conclusions about the right thing to do.

The principles "fit" with Western moral traditions emanating from the Jewish and Christian scriptures, Greek philosophy, and the Enlightenment. But the principlist mode of ethical reasoning does not fit in other social and cultural settings. Differences in material resources and different ways of thinking about moral questions and solutions lead to different ways of processing and resolving ethical dilemmas. For example, in recent years, and in response to perceived moral imperialism of the West, there has been renewed attention to the Ubuntu philosophy of certain African cultures and its application to bioethical questions.

According to Sambla *et al.*, Ubuntu ("I am because we are") represents "a core value of African ontologies: respect for all humans, human dignity, sharing, obedience, humility, solidarity, caring, hospitality, interdependence, and communalism". At its core, "Ubuntu philosophy is the notion of collective solidarity, whereby the self is perceived primarily in relation to others. That is, persons are perceived less as independent but rather as interdependent"<sup>32</sup>. When foreign moral principles, coming from an individualistic society, are used a culture with a collectivist tradition, confusion is bound to result. Chattopadhyay and De Vries describe what can happen:

*"Insistence on individualistic notions of autonomy results in the ritualistic use of written consent forms in illiterate communities. "Autonomy" is thus honored and upheld and the researchers have a written record of their compliance with research ethics committee regulations. But the subject of the research has no idea about what she agreed to. We have heard stories of people in illiterate communities showing up at hospitals with years-old consent forms believing that the form was some kind of admission ticket to medical care. The regulations were followed, "universal" principles honored, and the subjects were exploited."*<sup>33</sup>

The problems created by the collision of moral traditions are not easily solved. The way forward requires mutual respect for the traditions of the other. Myser, in her collection of articles about ethics in a variety of societies and cultures, offers descriptions of successful and less successful interactions between moral traditions, suggesting models for those seeking to accommodate different ethical practices.<sup>34</sup>

Ideally, the intersection of moral traditions can inspire ethical advances as cultures learn from each other. This has, to a certain extent, occurred with revisions to principlism. Faced with critiques of its strong support for individualistic notions of autonomy – from care ethics with its notion of 'relational autonomy' and from those working in more collectivist cultures – some principlists have broadened their notions of autonomy to include cases where interdependent persons decide together.



## PRACTICE RECOMMENDATIONS

Maternity care is a team effort with caregivers from different professional backgrounds offering care collaboratively, occasionally facing technologies that have a huge impact on their personal and professional moral standpoints.

Understanding each other's points of view and reaching mutually acceptable agreements about how to share responsibility for care are essential to guarantee optimal continuity of care and to keep caregivers healthy and motivated to give their best. This means that there must be room for exchange and debate when confronted with new ethical dilemmas or moral questions.

"Moral case deliberation" – a process developed by ethicists in The Netherlands – offers an effective strategy for dealing with different views on complex issues.<sup>35</sup> It is a structured conversation method moderated by a facilitator, often an ethicist. In a collaborative meeting, caregivers come together to discuss a real-life moral question and jointly reflect on all aspects concerning this question. During the deliberation, caregivers have the opportunity to freely articulate and share their stories, experiences, opinions and perspectives. Moral case deliberation can facilitate changes in practice, mostly for caregivers in multi-professional context. It helps caregivers to feel related to other caregivers, gives them an understanding of the perspectives of colleagues, and an understanding of their own perspective.

### CONFLICTS OF INTEREST

*The authors of this chapter declare that they have no interests that conflict with the contents of the chapter.*

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