Beyond autonomy: Care ethics for midwifery and the humanization of birth

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Abstract

The bioethical principle of respect for a person's bodily autonomy is central to biomedical and health care ethics. In this article, we argue that this concept of autonomy is often annulled in the maternity field, due to the maternal two-in-one body (and the obstetric focus on the fetus over the woman) and the history of medical paternalism in western medicine and obstetrics. Respect for autonomy has therefore become largely rhetorical yet can hide all manner of unethical practice. We propose that large institutions that prioritize a midwife-institution relationship over a midwife-woman relationship are in themselves unethical and inimical to the midwifery philosophy of care. We suggest that a focus on care ethics has the potential to remedy these problems, by making power relationships visible and by prioritizing the relationship above abstract ethical principles.

Introduction

The issue of women's autonomy in health care has been on feminist and midwifery agendas for decades, and came to general public attention with both the natural childbirth and women's health movements in the mid-twentieth century. These movements brought welcome changes, including ideas of women's self-determination over their bodies, and the adoption from the early 1980s of a principled approach to medical bioethics supported these changes—at least in theory. However, a disquieting ethical quandary has come to light over the last decade or so, concerning the bioethical principle of respect for autonomy and the apparent lack of adherence to this principle in practice in midwifery and in maternity care services more broadly. In this article, we argue that bioethical principles as they are used in the maternity care setting fail to safeguard ethical care due to a hollowed-out practice of autonomy that we refer to as 'rhetorical autonomy'. What we mean by 'rhetorical autonomy' is this: the terms 'autonomy' and 'informed consent' are regularly referred to in maternity care, and underpin ethically sound maternity care practice, yet many women are denied both. Women who adhere to medical advice and guidelines may be seen to have 'autonomy' to the extent that they agree to their care, but it becomes obvious when women decline recommended care that 'autonomy' is at best lip-service as the full force of medical power is displayed—in persuasion, coercion, threats and withdrawal of care. We also propose that institutionalized birth as it is currently organised is inherently unethical; midwives and doctors are expected to place allegiance to hospital policy or cultural practices over respect for the wishes and needs of women. Cases of not only disrespect and abuse, but failure to acknowledge women's autonomy or gain consent for procedures are well-documented by childbirth rights advocacy groups such as Human Rights in Childbirth[1] and Birthrights[2].[i]

Maternity care providers, and those with a broader interest in pregnancy and childbirth, therefore need to consider how the ideal of 'woman-centred care' is to be maintained under current models. Engaging with 'ethics of care' theory, MacLellan[3] proposed that moving beyond an atomistic, principles-based ethics which is often swayed to support institution-centred care, to an ethics based on relationship and responsibility is better aligned with midwifery practice. We advance this argument for drawing on ethics of care as a way of overcoming these inherent ethical problems. Care ethics supports the primacy of the midwife-woman relationship already present within midwifery philosophy and can provide an alternative to this ethical dilemma of rhetorical autonomy. If the midwife-woman

relationship, which can be disrupted by the requirements of the institution, is given central importance from a moral perspective, it follows that attentive, relational and humanized birthing practices will increase as they become embedded into ethical decision-making.

Background

These ideas stem from our previous work in various areas of maternity care. My (EN) ethnography of hospital labour ward practice aimed to investigate the personal, social, cultural and institutional influences on women in deciding whether or not to use epidural analgesia in labour. What I found was an institutional paradox that framed risky practices, such as epidural analgesia or induction of labour, as safe because they fit within medical parameters, and framed practices that support physiological birth (and decreased medical intervention) such as water immersion, as risky. Dominant medical definitions of risk versus safety were therefore heavily skewed towards the safety of medical procedures and the risk of non-medicalized choices. These conditions culminated in priorities and cultural practices that were based in the symbolism of medical safety (and fitting within the 'flow' of the institution) rather than being what could be considered objectively as particularly safe practices. The discourses surrounding these practices, framed by the unconscious bias of 'medical safety'[4], were reproduced in hospital policy documents, and therefore, in the information that was provided to women by midwives[5].

My (MK) work on informed choice[6] showed the prevalence of an institutional "right way" of doing things and the pressure on midwives and mothers to "go with the flow" of normative institutional practise. More recent work[7, 8] has outlined the contradictions between the values of midwifery, which prioritize relationships, confidence building and the strengthening of mothers and those of the modern NHS, which are business-centred emphasising economy and speed of throughput, together with the predominant modern value which places trust in technology and thereby reduces the role of mothers and midwives to the relatively passive one of consumers.

As we and others have been writing about these problems, other issues in maternity care were being challenged and brought to light. The humanized birth movement was building[9, 10] and the Human Rights in Childbirth[11] group was formed, holding its inaugural conference in the Hague in 2012. They indicate the need for such a group on their website:

> Examinations, interventions and procedures that pose risks to both mothers and their babies are routinely performed without informed consent, or through coerced compliance via threats or fear. When women come out of childbirth with post-partum PTSD from disrespect, abuse, or obstetric violence, the goal of a "healthy mother and healthy baby" has not been met[11].

In the meantime, throughout the world, independent midwives were being subjected to vexatious professional reporting for providing homebirth services in an increasingly difficult climate that appeared to be closing in on birth options for women. From these events, it appeared that the principle of autonomy—so central to western biomedical ethics, and to the midwifery philosophy of woman-centred care—does not actually apply to pregnant women. When the principle of autonomy is taken to its end-point, when a childbearing woman is making decisions about her body and her baby's wellbeing that are outside of medically recommended guidelines—or without the medical symbols of safety—they are exposed to 'escalating intrusion', an intensifying series of behaviors designed to obtain compliance that range from manipulation to assault.[12] Those midwives and obstetricians who try to facilitate

true autonomy, especially when providing care outside of medical parameters, place themselves in professional jeopardy.

It is for this reason that we have termed the notion of autonomy in maternity settings 'rhetorical autonomy'[ii] and submit that the related practice of gaining 'informed consent' is also then, in practice, rhetorical[13] (p. 266). That is, informed consent practices are still highly geared towards the gaining of consent rather than giving full and unbiased information in order for the person to either consent to or refuse the proposed treatment or intervention.[14] Even when women are not contesting medical advice, whether or not the ethical principle of autonomy is ever really upheld is arguable, given that the information upon which the decision to consent is made is biased towards medical and institutional norms.[5] Hospital culture, its policy and practices are all set to the rhythm of 'institutional momentum'—the machinations of hospital culture that propel women through (and therefore out of) the system to keep them 'safe'.[15] This makes it far easier to consent to a medical procedure (so often associated with expediting labour and birth) than a non-medical one (which involves the patience of watching and waiting for birth to unfold in its own time). Therefore, women make choices that align with hospital policies and practitioner preferences,[13] 'going with the flow' of the institution rather than their birthing bodies. Women are unlikely to request options that have not first been presented to them, meaning a great deal of power rests both with practitioners, but ultimately, with institutional policies, which dictate which options are available and therefore how these birth options are presented.[5, 13, 16]

The politics and power relations of birth are most often visible only when someone resists them. Rhetorical autonomy is only called out in some instances, and for the most part, goes unchecked. Social media platforms are awash with stories of first-time mothers who are devastated because they didn't know the power relations of birth; that they believed in the symbolism of medical safety, that information would be unbiased, that safe practices would be promoted, that they would be informed, that their birthing bodies would be supported, rather than undermined. This is not to say that medical intervention is not safe, useful or necessary in some circumstances, or welcomed by some women. The symbolism of safety to which we refer is the promise that medical settings and procedures are always safer for birth than non-institutional settings and physiology-supporting practices. This is the main claim of obstetric birth discourse, however as more and more research is showing, Many routine medical practices, historically based in a lack of trust in women's bodies to birth,[17] do undermine birth physiology[18, 19] and women are not necessarily informed of this.[14]

What is most concerning is that due to the abstract nature of biomedical ethics, maternity care practitioners can essentially claim to be providing ethical care—maintaining an adherence to the biomedical principle of autonomy and practice of 'informed consent'— even when they are actively manipulating or coercing women into a decision. In most areas of biomedicine, the 'right to be left alone' (and decline surgery or treatment even if it is life-saving) is upheld both ethically and by common law (p. 304).[20] However, obstetric biomedicine has been complicated by the two-in-one body and the aligning of medical with fetal interests over the mother/baby connection. Mahowald (p. 38) discusses the incongruity of separating this dyad, saying:

> The…consideration of the fetus as if it is separable from the pregnant women is another illustration of the fallacy of abstraction. Neither conceptually nor practically is it true that fetuses as such are separable from pregnant women. Embryos are occasionally separate from women (e.g., when they are formed through in vitro

> fertilization or flushed from the woman's body after in vivo fertilization), but fetuses, once separated from women, are no longer fetuses but newborns or arbortuses or stillborns.[21]

However, there is frequent separation of the interests of maternal and fetal wellbeing. Even in countries such as Australia and the UK, where the fetus is not attributed rights of personhood until they are born, the threat of putting their baby's life at risk is made towards women who may well be trying to keep themselves and their baby safe; who are not subscribing to medical symbols of safety, but adhering to personal requirements of safety or evidence that supports non-intervention. There is no room within the medical model of childbirth to acknowledge that definitions of both risk and safety are variable, or to acknowledge that within the paradox of the institution, that which is purported to be safe may actually contribute to iatrogenic illness. Meanwhile, practices which are shown to support physiological birth with almost no risk are ignored, or worse, ridiculed or condemned, because they fall outside of medical symbols of safety.[22]

This has huge implications for women, including restricting birth options (or 'choice') to within narrow medical parameters, thereby reducing autonomy, but it also has implications for midwives, who often struggle to maintain their professional philosophy of supporting the process of physiological birth within institutions that are so skewed towards the medical model of birth that they cannot even identify that their own policies and practices might introduce risk. Such institutions, which often excel at emergency procedures, and perhaps their role should focus on this, are not actually set up to support the physiological process of birth. This struggle can lead to burnout and attrition in midwives and almost certainly contributes to the some of the 'demuhanized/ing' behaviours that are exhibited by both midwives and doctors.[7, 8]

The problem with abstract ethics

At the core of health care ethics are four bioethical principles, respect for autonomy, non-maleficence, beneficence and justice, as outlined by Beauchamp and Childress some decades ago.[23] Beauchamp (p. 4) says that

> respect for autonomy is rooted in the liberal moral and political tradition of the importance of individual freedom and choice. In moral philosophy personal autonomy refers to personal self-governance; personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice.[23]

This meaning of autonomy stems from a history of enlightenment moral philosophy that emphasized the individuality, equality and separateness of human beings. Abstract ethical theories often rely on general notions of individualism and agency and therefore have the potential to mask power relationships and structural inequalities. They are geared, in this sense, to uphold the status quo. Tronto questions whether any moral theory that fails to acknowledge inequality serves us best as a society.[24] And we pose the question whether a theory of biomedical ethics that fails to acknowledge the power imbalance between the woman and the institution (and is more supportive of institutional needs than those of women) serves us best in the maternity sector.

These arguments are also raised in the feminist ethical idea of relational autonomy which also recognizes the situatedness of the individual and the way in which relationships play a part

not only in decision-making but in the way that autonomy is either reinforced or compromised. It also questions the origin of the available options and indeed the information given about these, with medical research, practice and policy also revealing status and knowledge hierarchies as well as the power of social structures and norms. In this way, it also questions the legitimacy of the 'informed consent' argument, particularly for people within oppressed groups.[25]

Drawing on Sherwin's work, Thachuk describes how the midwifery relationship-based model of care, that honours 'the multiple dimensions of the lived, embodied experience' (p. 46) is already geared towards a relational autonomy approach and highlights the emphasis in this model of care on 'informed choice'—that recognizes the right to decline the recommended option of care—rather than 'informed consent'.[26]Edwards acknowledges even the rhetoric of 'choice' and calls for a different kind of ethics;[14] one that provides 'opportunities for decisions to be made and re-made where the focus is as much on dialogue as on the decisions made' (p. 23). What is required is an ethics that identifies power relationships, that contextualizes information, is based in practice, and in the provision of actual (rather than theoretical) alternatives. For this, we turn now to ethics of care.

Ethics of care

Ethics of care has developed over the last 40 years from diverse areas of study: feminism, education, psychology, political science, nursing and philosophy, drawn together by an interest in care as practice, and guiding concepts that include relationality, contextuality, vulnerability, embodiment and attention to power.[27]

Carol Gilligan in a critique of Kohlberg's theory of moral development,[28] which identified that boys were able to reach a higher level of moral development than girls, argued that rather than exhibiting a less developed moral outlook, the girls in the study instead solved ethical dilemmas with an eye to responsibility, relationships and individual circumstance (in other words, they used an 'ethic of care'), rather than relying on abstract rules or principles (which Gilligan came to call an 'ethic of justice').

Ethics of care has been, since then, an interdisciplinary and diffuse project, with underlying common criteria, in particular the primacy of relationship. And while the work of Gilligan[28] and Nel Noddings[29] has been criticized for equating care with 'feminine' traits, and therefore emphasizing the 'caring' role of women, Joan Tronto[24] took a step further and positioned care as central not just to particular relationships or to the private sphere, but as central to the ordering of the social world, and proposed an argument for a political ethic of care.

In this work, Tronto (p. 103) defines care as:

> a species activity that includes everything we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web.[24]

In placing care as central to all human activity and endeavour, Tronto troubles the idea of autonomy, and posits that all human beings at some point or other will require care. Central to Tronto's political ethics of care thesis is the idea of care as a practice (rather than a virtue, or a principle). It is also contextual, situated and can only be evaluated by those receiving the care. Tronto's ethics of care consists of four primary elements: attentiveness, responsibility,

competence and responsiveness.[24] Attentiveness refers to being able to recognize the needs of those around us. Requiring first that one's own needs are met, that one is in a position to be attentive and not 'over-attentive' (putting others needs first) attentiveness is in itself a 'moral achievement' (p. 127). Responsibility is central to care ethics and is not perceived in terms of predestined social contracts or obligations. Human beings have responsibility to care for each other and this is at government (eg social care) and individual (eg humanitarian, family concern) levels.

The element of competence is aligned to moral consequentialism and creates an onus on those intending to provide care to do so adequately and competently. Finally, responsiveness relates to the experience of the care-receiver. To receive care is to be, at some level, vulnerable—the care-receiver/care-provider power balance is unequal. For care to be assessed then, it must be done by the receiver of care. Responsiveness refers to whether or not the care-receiver feels they experienced 'care' or perhaps 'good care'. Critical to Tronto's argument is that care ethics does not replace abstract or universal notions of justice, but is a vital adjunct if humanity is to realize stated goals of equality and egalitarianism, because 'care becomes a tool for critical political analysis when we use this concept to reveal relationships of power' (p. 172).[24]

Also coming from an ethics of care perspective, Elisabeth Conradi questions the centrality of 'autonomy',[30] a legacy of Kantian moral philosophy which identified autonomy, symmetry and reciprocity as the three principals of respect for human dignity. However, to have respect tied to these three principals is problematic, she argues, because in identifying these principals as fundamental to human dignity, it limits respect for dignity to them, bringing under question the right to respect for those who do not have decision-making capacity. Conradi goes on to explain how care is also neither symmetrical (due to differences in power—in fact, it is explicit in ethics of care discourse that to need care is to be vulnerable), nor reciprocal—it is not a contract, but a gift, independent of any expected return from the care receiver.

From the perspective of giving and receiving care, instead of a focus on respect for autonomy Conradi proposes that the first element of care ethics—attentiveness—as something that arises between people rather than being located in one person or the other (as autonomy is seen to be present within the receiver of care).[30] Fundamental to this turn is the idea—central to care ethics—of human interdependency. One person is not dependent on another in a fixed way, rather human beings are dependent on each other, dependent on age and circumstance. Therefore, all human beings are entitled to respect (whether or not they also have autonomy) and attentiveness.

The practice of care, viewed in this way, introduces a critical perspective, capable of transforming society by changing the way people interact at an individual and institutional level.[30] If care is placed central to a social and moral order it reflects and interrogates the way that society is organized. Tronto (p. 124) argues that:

> Because care forces us to think concretely about people's real needs, and about evaluating how these needs will be met, it introduces questions about what we value into everyday life. Should society be organized in a way that helps to maintain some forms of privilege before the more basic needs of others are met? Those kinds of questions, posed in stark form, help us get closer to resolving fundamental questions of justice more than continued abstract discussions about the meaning of justice.[24]

Thus, care ethics can reveal and redefine power relationships and help to imagine a more equal environment. An important aspect of care ethics is its grounding in studies of the real world—emphasizing the contextual nature of care ethics, and the need to study ethics as it occurs in practice, rather than from abstract principles.[31] Leget and colleagues describe care ethics as necessarily interdisciplinary, although shaped by one's field of study, and with a theoretical framework assembled around the social and political practice of care.[27] They also emphasize the empirical nature of care ethics and suggest an ongoing dialectic between theoretical framework and empirical data. These authors suggest a focus on one or more of the following for research into care ethics: lived experience, practices of care, and social and political organization.

Care ethics in midwifery

In 2014 Jennifer MacLellan wrote a call to midwifery about turning to ethics of care to attend to some of the issues we have just discussed.[3] However, to our knowledge, this call has not been taken up in further midwifery research, practice or literature.

The four elements of care ethics—attentiveness, responsibility, competence and responsiveness—are perhaps familiar ideas in midwifery. The emphasis within midwifery philosophies on politics, power and emancipation, the links between midwifery and feminism and the centrality of the relationship to midwifery care means that there has always been attention to these elements to various degrees.[32] It is also evident that while the principle of autonomy assumes a level playing field, the reason it can be so easily overturned in maternity care is because women do not have equal power within the institutions of medicine and the hospital—although this imbalance is hidden by the 'political myth of independence and autonomy that is embodied by the institution' (p. 806).[3] Medicine not only has the power to decide which knowledge is valid, what counts as safe and which options are provided, health professionals also hold professional power over women in individual clinical circumstances.[33-36] They have the power of the institution and their professional knowledge and status behind them, while women, as the recipients of care, are more vulnerable. The reality of women choosing from within these confines is remote from the ethical principal and meaning of autonomy, as if woman (care-receiver) and clinician (care-giver) are two independent, atomistic individuals with equal access to power.

The other issue is the growing number of women experiencing (or disclosing) dehumanizing birth experiences perpetuated by doctors and midwives. We know that the institution comes between the midwife and the woman in ways that we have described above.[37] If midwives have to adhere to strict institutional policies that conflict with the needs of the woman, they cannot also be attentive to the woman's individualized needs which may then be disregarded or ignored. There exists a double bind in that institutional policies may not be based on robust evidence, yet midwives are contractually obliged to follow them. In addition, these are located within what is deemed accepted cultural practice within a risk-averse, technorationalist society. Examples include: not 'allowing' a woman to eat in labour although it has long been acknowledged as beneficial or denying a woman access to water in labour despite it being the woman's choice because she is one point over the body mass index (BMI) cut-off of 35. These kinds of behaviours show a lack of adherence to midwifery philosophy of individualised 'woman-centred' care and commitment to supporting birth physiology and women's determination of their own bodily autonomy. And although midwives often rebel against such policies—turning the back while the woman eats, altering cervical dilatation scores to allow women more time in labour, dropping scissors to put off an 'unnecessary'

episiotomy, perhaps changing the woman's BMI by 1 point or claiming she is not yet in labour so she can get in the bath, what this does is to uphold rather than challenge existing restrictive policy and potentially put both the midwife and the woman at risk: the midwife professionally and the women physically.[37-39]

Midwives in hospitals also self-regulate according to sense of being observed – for example conducting vaginal examinations, artificial rupture of membranes or continuous cardiotocograph (CTG) monitoring because 'they' (the institution, the policy-writers, the obstetricians) would want it done rather than because they thought it would be clinically necessary. There is a full and writhing can of ethical worms beneath clinical decision-making in maternity care, influenced a great deal by the power relationships about which Tronto writes, and highlighting in particular the creation and adherence to particular knowledge claims.[35] The cultural 'story'[40] privileges obstetric knowledge, technological beneficence and institutional control whether or not it is actually rational or beneficial.[22]

Midwives overturn their responsibility to woman-centred care to attend to the requirements of the institution not necessarily because they feel a moral duty, but because following policy is their professional safeguard. If there is an emergency or a bad outcome, and the midwife has followed policy, her actions are covered by vicarious liability. If she has not followed policy, she leaves herself open to professional reporting, and possible deregistration. She is in the position of having to put herself and the hospital before the woman. This not only leads to disruption of the care relationship, but can also lead to burnout, attrition and lack of professional fulfilment. So, following Maclellan[3] who argues that this tension results in dehumanized care, we would like to pose the question whether moving away from biomedical principlism as the first ethical construct of midwifery and moving towards an ethic of care can help to alleviate this.

Within the pressures of the institution, midwives and mothers experience the contradictions resulting from the market values on which modern health care systems (such as the NHS) are based. Care takes time. Attentiveness and responsiveness require a continuing relationship which is very different from the rapid recording of clinical data which protects the institution and can now be equated with care.[41] Pressures towards efficiency result in the limiting of resources and the main midwifery resource is staff time. Indeed, it has been argued that true relational care sees time very differently from the linear, measured and limited time of the cost-cutting conveyor-belt, with its emphasis on pushing women through overcrowded maternity care institutions.[42] An ethic of care approach would highlight this issue and the harm it does to mothers and midwives, whereas the current economic approach serves to conceal care for both people and planet.[43]

Many of these problems are not solvable by individual midwives or doctors, but are inherently structural.[13] MacLellan (p. 806) states that 'refocusing midwifery practice back to a foundation built on the ethic of care could alleviate and reverse this decline into dehumanized care, as the moral force of responsibility and relationship is stressed'.[3] We agree with this, holding that an emphasis on the moral primacy of the relationship would necessarily decrease the power of the institution, as midwives can first and foremost dedicate their attentiveness and responsibility to the women in their care. Midwives will often provide woman-centred care to the best of their ability—up to the point where they bump up against institutional requirements. Those in continuity models have a better chance fulfilling their professional responsibility and gaining more job satisfaction because of the emphasis on the one-to-one relationship, but an ethic of care would demand an emphasis on relationship in all

settings—and that is a radical transformation of care. Institution-led care introduces particular risk factors for women and midwives. Solutions need to encompass hospital settings as well as increasing access to birth at home and in midwifery-led units.

Conclusion

A care ethics approach would enable us to turn our perspective around and value relationships and caring first and foremost, highlight the unethical nature of regimented institutional birth and the damage caused by midwives' busyness and their requirement to push women through the system. What this may well do is reveal the underlying inequalities, toxic micro-cultures, bullying and maladjusted infrastructure, and effect change. A political ethic of care perspective 'would have us recognize the achievement of equality as a political goal. At present we presume that people are equal though we know that they are not' (p. 164).[24]

Given that 'story and storytelling are more central to us as creatures than rationality' and 'the dominant story is what controls everything else' (p. 21),[40] a care ethics approach would help to highlight the traditional midwifery story of relationship-based caring which incorporates Tronto's care ethics' elements: attentiveness, responsibility, competence and responsiveness. This is in stark contrast to the current dominant story of institutional throughput, obstetric knowledge claims and economic growth, all of which privilege technology-based care, the more expensive the better. (This also determines what is seen as evidence and what research is put into practice.) For midwives and mothers alike, this dominant story gives us a relatively passive role as consumers or operators of technology and concentrates on the short term. A care ethics approach could hold within it the seeds of a positive long-term vision, one that recognizes that trusted relationships—rather than abstract ethical principles or blanket policy—form the basis of equitable decision-making processes as well as 'good care' outcomes. It would also encourage recognition of the role of power in knowledge creation and policy-making and attention could be paid to the creation of inclusive policies that are reflexive to this.

In sum, a midwifery care ethics problematizes the primacy of autonomy and lays bare the often covert and unacknowledged power differentials. We suggest that the political be reinserted into midwifery theory and practice insofar as these power relationships are acknowledged, and that work to equalize power relationships continues. Care ethics, as an adjunct to biomedical ethical principlism, can provide a moral framework whereby the 'attentiveness' within a care relationship is placed higher than an ethical priority to adhere to institutional policy and hollow notions of informed consent. It has the capacity to identify and describe power relationships and their effects as they exist in maternity care. Attention to care ethics therefore provides potential for the move towards humanization of childbirth practices. We do not expect that this will lead to rapid change, given the entrenched attitudes, vested interests and fear of noncompliance which surround the present power structure. Yet new ways of looking can highlight what is taken for granted, its shortcomings and possible alternatives. We suggest that next steps include research into maternity services using a care ethical approach, to identify and describe current power relationships and their effects as they exist in maternity care, and what constitutes 'morally good'[27] practice from the care ethics perspective.

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[i] 'Consumer advocacy organizations, like Amici, have formed in response to such violations -- violations that are not uncommon in this country [the US]. For example, a 2013 survey reported that 25% of women who had experienced an induction of labor or a cesarean section felt pressured to accept those interventions. A 2014 study found that women who perceived pressure to have a Cesarean section were more than five times more

likely to have a one, more than six times more likely to have one with no medical basis, and nearly seven times more likely to have an unplanned cesarean. Moreover, 59% of women who received episiotomies did not give consent at all. Finally, 20-38% of women reported that the provider made the "final decision" about whether they would receive a planned cesarean surgery. These numbers can be fully understood only by listening to the women they represent. Their words convey how the birth of a child can be experienced as assault. Women ask advocacy organizations if they have a legal right to refuse labor induction and surgery. An abstract right is a weak shield if maternity care providers do not believe that informed consent is required as part of the care they provide' (Amicus Brief, p. 2).

[ii] rhetoric – language designed to have a persuasive or impressive effect, but which is often regarded as lacking in sincerity or meaningful content – Oxford living dictionary https://en.oxforddictionaries.com