Margaret Olivia Little: Bibliography of Online Articles in PubMed Central

The following citations are available in PubMed Central (http://www.pubmed.gov), an open access repository available at no charge to the public. While attending the IBC, you also have access to Georgetown's full-text institutional subscriptions. Please contact Martina Darragh in the Bioethics Research Library for assistance in accessing Georgetown's institutional resources (bioethics@georgetown.edu).

Lyerly, Anne Drapkin; Little, Margaret Olivia; Faden, Ruth R.; McCullough, Laurence B.; and Chervenak, Frank A. A Critique of the 'Fetus as Patient'. American Journal of Bioethics 2008 July; 8(7): 42-44; authors' reply W4-W6 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2553002/

Kukla, Rebecca; Kuppermann, Miriam; Little, Margaret; Lyerly, Anne Drapkin; Mitchell, Lisa M.; Armstrong, Elizabeth M.; and Harris, Lisa. Finding Autonomy in Birth. Bioethics 2009 January; 23(1): 1-8 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628951/

Abstract: Over the last several years, as cesarean deliveries have grown increasingly common, there has been a great deal of public and professional interest in the phenomenon of women 'choosing' to deliver by cesarean section in the absence of any specific medical indication. The issue has sparked intense conversation, as it raises questions about the nature of autonomy in birth. Whereas mainstream bioethical discourse is used to associating autonomy with having a large array of choices, this conception of autonomy does not seem adequate to capture concerns and intuitions that have a strong grip outside this discourse. An empirical and conceptual exploration of how delivery decisions ought to be negotiated must be guided by a rich understanding of women's agency and its placement within a complicated set of cultural meanings and pressures surrounding birth. It is too early to be 'for' or 'against' women's access to cesarean delivery in the absence of traditional medical indications--and indeed, a simple pro- or con- position is never going to do justice to the subtlety of the issue. The right question is not whether women ought to be allowed to choose their delivery approach but, rather, taking the value of women's autonomy in decision-making around birth as a given, what sorts of guidelines, practices, and social conditions will best promote and protect women's full inclusion in a safe and positive birth process.


Abstract: Deciding when and how to incorporate patient preferences regarding mode of delivery is challenging for both obstetric providers and policymakers. An analysis of current guidelines in four clinical scenarios (prior cesarean, twin delivery, breech presentation, and maternal request
for cesarean) indicates that some guidelines are highly prescriptive whereas others are more flexible, based on physicians' discretion or (less frequently) patient preferences, without consistency or explicit rationale for when such flexibility is permissible, advisable, or obligatory. Although patient-choice advocates have called for more patient-responsive guidelines, concerns have also been raised, especially in the context of discussions of cesarean delivery on maternal request, about the dangers of unfettered patient-preference-driven clinical decisions. In this article, we outline a framework for the responsible inclusion of patient preferences into decision making regarding approach to delivery. We conclude, using this framework, that more explicit incorporation of patient preferences is called for in the first three scenarios and indicate why expanding access to cesarean delivery on maternal request is more complicated and would require more data and further consideration.

Brown, Stephen D.; Lyerly, Anne D.; Little, Margaret O.; and Lantos, John D. Paediatrics-based Fetal Care: Unanswered Ethical Questions. Acta Paediatrica 2008 December; 97(12): 1617-1619
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2829752/

Lyerly, Anne Drapkin; Mitchell, Lisa M.; Armstrong, Elizabeth Mitchell; Harris, Lisa H.; Kukla, Rebecca; Kuppermann, Miriam; and Little, Margaret Olivia. Risk and the Pregnant Body. Hastings Center Report 2009 November-December; 39(6): 34-42
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3640505/

Abstract: Reasoning well about risk is most challenging when a woman is pregnant, for patient and doctor alike. During pregnancy, we tend to note the risks of medical interventions without adequately noting those of failing to intervene, yet when it's time to give birth, interventions are seldom questioned, even when they don't work. Meanwhile, outside the clinic, advice given to pregnant women on how to stay healthy in everyday life can seem capricious and overly cautious. This kind of reasoning reflects fear, not evidence.

Lyerly, Anne Drapkin; Little, Margaret Olivia; and Faden, Ruth. The Second Wave: Toward Responsible Inclusion of Pregnant Women in Research. International Journal of Feminist Approaches to Bioethics 2008 Fall; 1(2): 5-22
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2747530/

Lyerly, Anne Drapkin; and Little, Margaret Olivia. Toward an Ethically Responsible Approach to Vaginal Birth after Cesarean. Seminars in Perinatology 2010 Oct; 34(5): 337-44
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946940/

Abstract: Determining approach to delivery after a previous cesarean is among the most contentious areas of obstetrics. We present a framework for ethically responsible guidelines and practice regarding vaginal birth after cesarean. We describe ethical complexities of 3 key issues that mark the debate: the cesarean delivery rate, safety, and patient autonomy. We then describe a taxonomy of considerations that should inform a responsible framework for guideline development and highlight critical distinctions between types of guidelines that have been blurred in the past. We then forward 2 central claims. First, in otherwise uncomplicated birth after a single previous cesarean, both vaginal birth after cesarean and repeat cesarean should be
regarded as reasonable options; women, rather than policymakers, providers, insurance carriers, or hospitals, should determine delivery approach. Second, in complicated cases, providers and policymakers should carefully calibrate the strength of evidence to ensure differential risk and cost are adequate to justify directive guidelines given important variations in values women bring to childbirth.