Analysis of the ethical issues in the breastfeeding and bedsharing debate

ABSTRACT
Recommendations advising against mothers and their infants sharing a bed during sleep (bedsharing) have sparked heated debate in recent years, the effects of which are that bedsharing is now most often only considered in the polarised contexts of being either 'the norm' or 'inherently unsafe'. This has resulted in significant tensions between supporters of bedsharing and public health bodies who seek to eliminate the risks associated with SIDS. This paper considers the issues surrounding this debate by examining the evidence associated with bedsharing, SIDS and breastfeeding. This is undertaken using Baum's six-step framework for analysing potential ethical tensions in public health policy, which includes the principles of utility, evidence base and effectiveness of action, fairness, accountability, costs and burdens, and community acceptance. This framework has allowed us to examine the competing principles involved in the bedsharing and breastfeeding debate, and arrive at a position constructed using ethical considerations.

Keywords: co-sleeping, bedsharing, breastfeeding, SIDS, ethics framework

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INTRODUCTION
Considerable debate in both the academic literature and the media has occurred in recent years regarding the increasing trend for government and professional bodies to publish recommendations advising against an adult (usually the mother) and her infant sharing a bed for sleep (bedsharing) (Ball et al 2012; Gettler & McKenna 2010; Vennemann et al 2012). This debate arises from varied interpretations of the evidence, in addition to the potential effects such recommendations are believed to have on successful breastfeeding and responsive parenting.

A major issue surrounding the bedsharing debate is the lack of standardised typology regarding the characteristics used to define both co-sleeping, which includes bedsharing, and sudden infant death syndrome (SIDS). The confusion in regard to SIDS definitions is related to the various components within the definition that have undergone several changes over the last three decades. These include the absence or inclusion of components such as medical history, death scene investigation, autopsy, sleep association and stratification of risk. Readers who are interested in the commentary on the need for international consensus, and the implications and challenges presented by changes in definitions over time, are referred to reviews by Hauck and Tanabe (2008) and Krous (2010), where these issues have been discussed in detail.

Adding to concerns surrounding the diagnostic definitions of SIDS, the term co-sleeping has also been subject to different interpretations and has been variously used in the literature to refer to mothers either room sharing or sharing the same sleep surface with their infant. This contributes to the lack of clarity around the combined issues of SIDS and co-sleeping. This has also been an issue in relation to the term ‘bedsharing’. For example Mitchell et al (2011, p. 3) in their position paper summarising the evidence underpinning Australia’s SIDS and Kids Safe Sleeping Program refer to bedsharing as ‘being the mother (it is usually the mother, but can include fathers or other adults) sleeping with the infant on the same sleeping
surface (usually a mattress). However, anthropological, breastfeeding and epidemiological literature (Ball et al 2012; Blair & Ball 2004; Blair, Heron & Flemming 2010; Gettler & McKenna 2010) refer to bedsharing as when an adult (usually the mother) and her infant sleep together in the same adult bed. Bedsharing then becomes a subset of co-sleeping, where co-sleeping involves the infant sleeping within sensory exchange of an adult who is usually the mother (McKenna, Ball & Gettler 2007). Using this definition, co-sleeping may refer to either sharing a bed, or other sleep surfaces such as sofas and armchairs, where risk factors may not be comparable. It also may include same room cot sleeping and side-crib sleeping.

Clarity in any discussion related to the bedsharing and breastfeeding debate is dependent on unambiguous definitions. Therefore, in preference to the umbrella term co-sleeping, we will refer to specific situations involving the baby sleeping with their adult carer (usually the mother, but may be the father) as they arise. These terms include:

- **same surface co-sleeping**: an adult carer sharing any sleep surface with their baby
- **bedsharing**: an adult carer (usually the mother) and their infant sleeping together in the same adult bed
- **sofa sleeping**: an adult carer sharing a sofa, couch or armchair with their baby during sleep
- **sidecar crib sleeping**: baby sleeps in a cot or crib attached to the parental or hospital bed
- **same room cot sleeping**: baby sleeps in a cot in the same room.

Additionally, when either the term co-sleeping or breastfeeding is referred to in relation to existing literature that employs these terms, we will seek to ensure its meaning, as used by the authors in the literature, is well described. To assist with this, the definitions currently used around infant death are also presented in Figure 1.

There are various examples within Australia and overseas where advice against bedsharing is recommended. The Public Health Association of Australia SIDS policy outlines five strategies as being ‘vital to the reduction of risk for both SUDI and SIDS’. The fifth strategy indirectly assumes a stance against a mother sharing a bed with her baby by recommending that parents ‘sleep baby in their own safe sleeping environment next to the parent’s bed for the first six to twelve months of life’ (PHAA 2009, p. 1). This is also highlighted by Australia’s recognised health promotion organisation in the area of sudden unexplained infant death, SIDS and Kids, whose Safe Sleeping 6-point message includes this recommendation (Young et al 2012). Similarly, in South Australia’s (SA) Safe Infant Sleep Standards (DoHSA 2011) room sharing is also recommended for the first 12 months and co-sleeping on any surface (including bedsharing) is ‘strongly discouraged’ (p. 9). However, the timeframe associated with advice against any bedsharing within Australia varies between states, as can be seen in the operational directive (OD) issued by the Western Australian (WA) Department of Health (DoHWA 2008), which ‘does not recommend bed-sharing/co-sleeping on discharge from a hospital or health service in the first three months of life’.

On the other hand, Queensland Health (2008) does not provide direct advice to parents not to share a bed with their baby but emphasises the risks that may be associated with any sleeping environment. This is achieved by promoting informed decision making through the provision of information regarding risk minimisation strategies that enhance a safe sleeping environment, including a mother sharing a bed with her baby. At the time of writing this paper, these guidelines and the parent brochures on safe sleeping, which include information for parents who may choose to share a sleep surface with their baby, were made available on the SIDS and Kids website. However, it was only on the page aimed at health professionals (SIDS and Kids 2012a).

Internationally, the American Academy of Pediatrics (AAP) Task Force on SIDS (2011, p. 1033) has also recommended in its policy statement that parents avoid...
‘bedsharing when the infant is younger than three months, regardless of whether the parents smoke or not. In the USA this has prompted significant debate, particularly in light of public health programs implementing the recommendation by using means such as the, now notorious, scare campaigns conducted in Milwaukee. Among other things, one campaign compared the parental bedhead to a tombstone in its advertisements (City of Milwaukee Health Department 2012). Despite this view, there are other countries that have adopted an alternative strategy that acknowledges sharing a bed with baby as a common occurrence amongst some sections of the community. This recognition has led these countries to adopt a risk minimisation approach, rather than the risk elimination approach where advice against any bedsharing is given. An example of a risk minimisation policy that is often cited is the UNICEF sample policy on bedsharing (UNICEF UK 2011), which only advises against those specific conditions that are known to be associated with placing infants at risk during sleep.

In our analysis of the issues surrounding this debate we will examine the evidence associated with SIDS, breastfeeding and an adult carer (usually the mother) and her infant sharing a bed for sleep (bedsharing). The emphasis of the discussion will be on the ethical implications related to the impact that same surface co-sleeping recommendations currently have for both health professionals and the community.

**Background to the issues**

Since the introduction of the ‘Back to Sleep’ campaign there has been a striking impact on the reduction in the incidence of SIDS. This campaign identified the prone and side-lying sleeping positions as a significant risk factor for SIDS, and its implementation has seen death rates in Australia drop from 0.17% of live births in 1991 (168.1 deaths/100,000 births) to 0.06% (63.2 death/100,000 births) in 2002 (Australian Institute of Health and Welfare (AIHW) 2005). This dramatic fall in SIDS rates has been observed in the UK in both solitary sleeping infants (in cots) and in infants who share a bed with their carer. However, the Avon Longitudinal Study, which incorporated 300 SIDS deaths from 1984 to 2003, showed that bedsharing deaths had not fallen to the same degree as solitary sleeping deaths (Blair et al 2006). Also of note are findings from a case-control study by the same authors, in which the number of sofa sharing deaths was shown to have actually increased (Blair et al 2009).

In addition to sofa sharing, other key risk factors associated with our modern lifestyles have now also been identified as being implicated in same surface sleeping deaths. These risk factors include smoking, alcohol and substance use and abuse, overheating, and infants sleeping on either soft surfaces or surfaces other than beds, such as either sofas or armchairs, and infants sharing a bed with pets or siblings (AAP 2011). Identification of these risks has, as illustrated earlier, led countries such as the USA, and some state health authorities in Australia, to warn against all forms of same surface co-sleeping, including bedsharing where a mother shares her bed with her infant during sleep.

The action in Western Australia to include advice against bedsharing for the first 3 months was prompted, in part, when same surface co-sleeping was described as one of the three key risk factors for perinatal and infant mortality for the 3-year period from 2005–2007 (Perinatal and Infant Mortality Committee of Western Australia (PIMCWA) 2010). During this time, 29 (66%) of the 44 cases of SIDS were found to have occurred in association with same surface co-sleeping, which was noted as an increase from the 2002–2004 period, when 13 (56%) of the 23 SIDS deaths occurred (PIMCWA 2010). Similar reports of increases in same surface co-sleeping deaths in other states in Australia have also occurred, such as those reported in NSW (NSW Child Death Review Team 2010) and in Victoria, where the latter reported an increase in same surface co-sleeping deaths from 7 to 15 for the 3-year period from 2008 to 2010 (Bugeja, Dwyer, & McIntyre 2011). However, these increases are not reported within the context of data from either the population under consideration or any comparison group, so their significance is difficult to interpret.

In addition to the concerns associated with the increased number of reported same surface co-sleeping deaths in state department reports, advocates of the advice against any bedsharing quote findings from the literature to support their stance. They specifically cite studies where it has been found that there is an increase in the risk for SIDS in the first 12 weeks, independently of the mother’s smoking status (Carpenter et al 2004; McGarvey 2006; Tappin, Ecob, & Brooke 2005; Venne mann et al 2009). However, such recommendations then give the appearance to the community of an assumption that any SIDS death that occurs in a parental bed may be directly attributable to the act of bedsharing, rather than other risk factors that may also be present. This is of concern as the studies that identified an increased risk for bedsharing, independent of smoking, did not also examine other potential risk factors such as either alcohol or substance use, and sofa or armchair sharing during sleep. Yet, in a population-based case-control study in the UK, which adjusted for these variables, only 6% of deaths occurred while bedsharing compared to 10% of controls (Blair et al 2009). This suggests there is no increased risk amongst infants of this age group in regard to bedsharing. Furthermore, the authors also found ‘the sociological and educational characteristics of families that are most likely to share beds in the first few months place them at very low risk of SIDS’ (Blair, Heron & Fleming 2010). These findings were also supported by an Alaskan study (Blabey & Gessner 2009) that found that in 99% of bedsharing deaths either
maternal smoking or sleeping with someone affected by substances was involved.

The lack of studies examining other potential risk factors is highlighted in a recent meta-analysis of 11 case-control studies (Vennemann et al 2012). Although the analysis showed that the greatest risk for SIDS associated with bedsharing was firstly amongst those infants whose parents smoke and secondly, in infants less than 12 weeks of age regardless of smoking status, the authors acknowledged a lack of clarity surrounding the findings. This was related to the potential interactions between bedsharing and other risk factors such as alcohol and drugs, which were not accounted for in most of the studies analysed. Also, earlier studies included in the meta-analysis did not have data that differentiated infants sleeping in the parental bed from those sleeping on other surfaces such as sofas. Subsequently, the authors felt ‘it was not clear whether public health strategies should advise against bedsharing in general or just particular hazardous circumstances in which bedsharing occurs’ (Vennemann et al 2012). This view is taken further by Blair (2010, p. 69) who states ‘that bed-sharing both for infants and mothers results in complex interactions which are completely different to isolated sleeping and which need to be understood in detail before applying crude labels such as “safe” or “unsafe” (Blair 2010 p. 69).

Despite the concern regarding these labels, the ‘unsafe’ tag has been frequently attributed to bedsharing, most notably in media headlines such as ‘Fear as babies die in their sleep’ (Crawford 2011 October 2) and ‘Warning on dangers of sleeping with baby’ (Rintoul 2011 November 29) where, in the latter, readers were told to avoid sleeping with their babies for the first 6 months. A ‘media watch’ blog (Murray 2011) reported that 31 media outlets had articles that made similar claims following the release of a report into same surface co-sleeping deaths by the Victorian Coroner’s Prevention Unit (Bugeja et al 2011). This was despite the report noting that:

The study was restricted to a case series of deaths, for which no comparison groups were available. Without being able to compare the proportion of co-sleeping among the fatal cases to the proportion of co-sleeping among non-fatal cases, it is not possible to provide an estimate of the increased risk of death attributable to co-sleeping. (Bugeja et al 2011 p. 18)

Bayer and Fairchild (2004, p.476) state that: ‘Epidemiology is the foundational science of public health’. Epidemiologists such as Vennemann and Blair have both published independent statements that the evidence around this issue is currently unclear. So, is the observed association between bedsharing and SIDS enough of an unreasonable risk to warrant the recommendation against bedsharing in the first 12 weeks of an infant’s life, on the grounds of protecting infant welfare? To answer this question we need to examine the literature around ethics and public health.

**Using an ethical framework to examine tensions in the bedsharing debate**

Public health involves ‘initiatives ... based on population-level data and typically involve measurement and surveillance, and development of evidence-based strategies to either prevent or overcome diseases’ (McMurray & Clendon 2011, p. 32). The decision to advise against same surface co-sleeping, which also encompasses bedsharing, can be considered in terms of a utilitarian approach that is commonly seen in public health. This approach sets out to achieve the best outcomes possible for the greatest number of people, as opposed to bioethics, which focuses more on the issues of the individual, such as autonomy (Petrini 2010).

In striving to achieve the common good, when using the utilitarian approach, there are inevitable tensions that develop between individual interests and that of public or social interests (Arah 2009). In the context of our discussion this can be seen in the current bedsharing/breastfeeding debate. Proponents of guidelines that advise against all same surface co-sleeping, including bedsharing, will argue that organisations are seeking to reduce the numbers of sudden unexpected deaths in infants (SUDI) by eliminating a perceived risk factor. On superficial examination, this elimination of risk may appear to be a laudable action that is justifiable to achieve a goal of reduced deaths. There is also another view amongst authors in the area of public health ethics that ‘the large scale altruism of public health has to be balanced with the value of individual autonomy’ (Mackenbach 2005, p. 823) and that this could be achieved by using a different approach than utilitarianism. Those readers who are interested in alternative ethical models are referred to a discussion by Petrini (2010), as we will only focus in this paper on an analysis of the ethics of the current approach, which includes advising against bedsharing.

The three main questions that we wish to address in the ethical analysis of this situation, have also been described by Petrini (2010, p.197). First is the question, ‘What is right and good?’ Secondly we should ask, ‘How do we justify our judgements about the right and the good?’ and lastly, ‘How ought we choose the good, and act rightly?’ Several frameworks have been proposed to assist policy makers in the ethical clarification required to answer these questions and consequently assist in establishing an appropriate path to follow. One such framework is that proposed by Baum et al (2007, p. 660) who contend that ‘ethical clarification helps practitioners identify the explicit ethical tradeoffs at stake, encourages consultation with others, and provides a framework for justifying the decision’. These
are all essential components of any health policy. Their framework has six components:

1. determine population-level utility of the proposed action
2. demonstrate evidence of need and effectiveness of actions
3. establish fairness of goals and proposed implementation strategies
4. demonstrate accountability
5. assess expected efficiencies and costs associated with the proposed action
6. consider political feasibility and community acceptance.

We have adopted this framework to examine the ethical questions related to the advice against bedsharing. We do this with the aim of providing an evidence base for a stance based on ethical considerations.

**Step 1: Determine population-level utility of the proposed action**

Public health decisions should be consistent with community needs. Clearly there is a need to reduce the rates of infant deaths associated with sleep. However, Baum et al (2007, p. 662) emphasise the importance of decision-makers having ‘a clear and accurate understanding of the expectations and values of members of the community’ in order for the decisions to have utility for that community. This would involve not only ensuring the community on which the decision impacts perceive this as appropriate to their needs, but also the health professional community charged with delivering the message. So we must ask ourselves the question, ‘Would the community accept advice preventing same surface co-sleeping, which also includes bedsharing, as justified in the hope that this action may prevent infant deaths?’

Evidence in relation to this question can be found in a study by Dodd (2012), who employed individual interviews and focus groups with WA parents and health professionals/workers in regional and metropolitan areas. Over half of the 34 women interviewed reported co-sleeping with their babies at least once, although the specific type of surface on which the co-sleeping took place was not outlined in the report. We have assumed this to be predominantly mother/infant bedsharing, although instances of other types of co-sleeping were mentioned, such as couch, non-parental beds and partner co-sleeping. Interestingly, mothers reported these practices after initially stating they had not co-slept with their babies. This report’s findings lead us to the conclusion that under-reporting occurred even in this sample, probably due to the nature of the inquiry also being related to their experiences of co-sleeping education. However, seven of these women were Indigenous and all described co-sleeping as culturally normal. All also disagreed with the advice given to them not to co-sleep.

The Dodd study also examined views of the health professionals working with parents of young infants and found that, by and large, the requirement for them to advise against same surface co-sleeping that included bedsharing during the first 3 months created in them feelings of personal conflict and moral tension. Nearly all the health professionals/workers interviewed described experiencing professional and ethical dilemmas surrounding the implementation of the WA operational directive. These are described as ranging from ‘their own misgivings about what they viewed as limited scientific evidence’ (Dodd 2012, p. 37) to concerns about alienating mothers by ‘insisting on a strict no co-sleeping stance’ that included bedsharing. They felt that such a directive would result in mothers just ‘shutting down’ and not disclosing important information regarding co-sleeping practices. This view was supported by information given by mothers who had made a conscious decision to co-sleep/bedshare despite what they described as ‘scare tactics’ used by midwives or child health nurses. As a result they had resolved to ‘keep quiet’ about the practice in their conversations with their child health nurses. A combination of all these factors led Dodd to conclude that the majority of the health professionals/workers interviewed for the study ‘were unlikely to follow the recommendations of the operational directive to the letter’ (Dodd 2012, p. 35).

A similar view was also seen in those working with women from indigenous and culturally and linguistically different (CALD) backgrounds who believed that the co-sleeping/bedsharing directive ‘did not reflect the reality of their workplaces and the client groups they worked with’. This was because the approach to working with such communities was more one of harm minimisation. In this context, Dodd reported them as describing the operational directive as ‘being less helpful and even irrelevant in responding to these women’ (Dodd 2012, p. 36). Overall this report gave a sense that health professionals found the component of the co-sleeping policy that advised against bedsharing did not allow them to accept and respond to the realities of people’s lives and negotiate low risk alternatives that were appropriate to their individual situations. Some also viewed the directive as not being reflective of current scientific evidence that supported co-sleeping.

Despite this negative reception from some portions of the community, including health professionals, there are many past cases of public health initiatives that have initially not been received favourably. Examples of these are fluoridation, vaccinations, wearing seatbelts and even laying babies down to sleep on their backs. However, in general, most people now accept these measures as necessary as the evidence has shown clear benefits for the majority of the population. This brings us to the next step in Baum's framework in relation to the importance of evidence-based practice.
Breastfeeding and sharing a sleep surface constitute an integrated care system which is mutually reinforcing ... that is, breastfeeding promotes shared sleep which increases breastfeeding frequency and extends duration of breastfeeding by months. (p.27)

This statement is supported to some extent by findings that ‘babies who bedshared in the first 13 weeks were twice as likely than non-sharers to breastfeed to 6 months’ (Ball et al 2012) and breastfeeding prevalence was higher in every month to 15 months in those mothers who either bedshared in the first 3 months or bedshared constantly to 15 months (Blair et al 2010). However, the researchers do caution that a directional relationship cannot be concluded from these results. What this means is that it is not clear from the data whether the bedsharing had a causal relationship in regard to length of breastfeeding or whether mothers who breastfeed were simply more likely to bedshare because of their approach to mothering. However, multivariate models of a longitudinal study by Blair and colleagues (2010) found a complex interdependence between bedsharing and breastfeeding. This, combined with the advantages involved in the protection of breastfeeding against SIDS, is a basis for concern, as in eliminating bedsharing we may be negating the benefits of breastfeeding in protection against SIDS (Gettler & McKenna 2010).

We accept that there is evidence demonstrating a need for preventative strategies in relation to sleep-related infant deaths. However, from the breastfeeding evidence discussed it would appear that the decision to advise against a mother bedsharing with her baby during sleep does not fit the ‘effectiveness of action’ component of this framework in regard to breastfeeding mothers in low risk groups. Subsequently the authors believe there is currently no ethical or practical advantage to...
be gained in including breastfeeding mothers in low risk groups in any recommendation that advises against bedsharing.

**Step 3: Establish fairness of goals and proposed implementation strategies**

This step involves examining public health decisions in relation to what the intervention hopes to accomplish and whether ‘the expected benefits and burdens are likely to be distributed equitably in the community’ (Baum et al 2007, p. 662). In other words, are any sections of the community disadvantaged by advice against bedsharing? We know that in certain cultures bedsharing is considered normal infant care practice. The risk for SIDS is very variable amongst these different cultures depending on the presence of other risk factors. Some of these communities have, comparatively, a very low risk for SIDS. One such example is the South Asian community surveyed in the Bradford Infant Care Study (Ball et al 2012). This study found that infants of Pakistani mothers were significantly more likely to sleep in the parental bed and to have either ever breastfed or to have breastfed for more than 8 weeks compared to their white British counterparts, whose SIDS rates were four times that of the Pakistani community. Other groups that may also be disadvantaged by advice against any bedsharing are those that are pro attachment parenting and those groups that make up the breastfeeding community, which crosses many cultural boundaries and ethnic groupings. Both have been very vocal in their opposition to the advice against bedsharing. The focus of these objections has been previously outlined in Step 2 of Baum’s framework and revolves around the potential impact this advice will have on breastfeeding success and responsive parenting. In this regard, the fairness of such recommendations do not appear to extend to sections of the community such as those whose risk for SIDS is low and where bedsharing is a normal infant care practice.

**Step 4: Demonstrate accountability**

Accountability is related to transparency and making clear to the public the justification associated with the intervention. Health professionals/workers on the front line who are charged with delivering the no co-sleeping/bedsharing message have expressed difficulty with this aspect. There are those on both sides of the debate who have reflected this in their comments to Dodd (2012) during her study. One child health nurse, who was described as the exception to the general view, was supportive of the no co-sleeping/bedsharing stance in the DoHWA operational directive. However, despite this, the nurse found it difficult to dissuade women who intended to co-sleep/bedshare, as not enough evidence had been provided to assist her in supporting the recommendation. Clear public health messages are those that have clear supportive evidence that enable health professionals to be accountable for their advice.

**Step 5: Assess expected efficiencies and cost associated with the proposed action**

On superficial examination there is a utilitarian argument that advice against same surface co-sleeping that includes bedsharing, is a simple low cost efficient message that could have positive effects on reducing same sleep surface infant deaths. However, is there an unacceptable cost involved to the community? If we accept the premise that the relationship observed between breastfeeding and bedsharing influences duration of breastfeeding then the answer to this is: yes. A cost analysis performed in the USA (Bartick & Reinhold 2010) found that if 90% of babies were exclusively breastfed to 6 months $13 billion would be saved in health costs and 911 deaths would be prevented, nearly all of which would be infants. In the same vein, an Australian study conducted 10 years ago (Smith, Thompson & Ellwood 2002) calculated that annual hospitalisation costs associated with early weaning in the Australian Capital Territory were between $1–2 million when considering five common infant and childhood illnesses.

If the cost of advising mothers against bedsharing is a reduction in breastfeeding duration, it can certainly be argued that this would be unacceptable from an economic and public health perspective. An excellent point has been made in relation to this by Blair (2010, p.69) who says that ‘advising parents to avoid co-sleeping may conceivably reduce the SIDS rates even further but not necessarily infant mortality in general’.

One could then logically conclude that to ensure breastfeeding rates are maximised, a risk minimisation strategy regarding bedsharing, rather than a risk elimination strategy, would be more appropriate. This would require policy makers to ensure that a safe sleeping message, in regard to known risk factors associated with co-sleeping, reaches all portions of the community. This would also require that health professionals are given the information and resources to assist mothers to breastfeed and bedshare safely, if that is their choice.

**Step 6: Consider political feasibility and community acceptance**

Political motivation to address sleep-related infant deaths is strong, especially with many of the Australian state coroners supporting the recommendation for advice against bedsharing (Bugeja et al 2011; The Advertiser 2011; Hope 2010) However, in acting in accordance with these recommendations there is no recognition of society’s ability to ignore advice they do not find acceptable. This non-adherence has been discussed previously in the findings reported from Dodd’s study (2012) and is also supported by other forms of positive affirmation for bedsharing that can be found in the media. Some allude to the biological imperative felt by mothers to keep their new babies close, such as in an article in a magazine where Miranda Kerr, a high profile Australian
supermodel who was also breastfeeding her new baby, was quoted as saying:

We spent every minute together for those weeks before I went back to work, he sleeps in our bed every night. I never want to let him go. (Marks 2011)

Another example of this attitude is illustrated in one of 45 comments posted in response to a media article in South Australia, advising mothers against sharing a bed with their baby (Schriever 2011):

When my first was born, babies were laid on their tummies to sleep. The one time she was on her back, she nearly died because she'd vomited when I stepped out of the room & I came back to her choking. By the time my second came along, we were told to put them on their sides. I still mainly used the stomach because of my previous experience. Then it was putting them on their back. But then mothers got told that caused a flat spot on the back of their heads. Then it was using sleeping bags instead of bed coverings. Now it's no co-sleeping. It's odd that co-sleeping was (& still is) used the world over for thousands of years, but that we shouldn't do it now because it will kill babies. What's next? Only have children raised by people who are trained in looking after babies? Posted at 12:42 PM October 12, 2011 Retrieved 5 February 2012.

This latter post conveys the frustration experienced by the writer in relation to the changing public health messages that have occurred in her time as a mother. It also implies that advice to mothers not to share a bed with their baby does not ‘ring true’ for many parents in the community. This type of response conveys to policy makers not only the importance of the message but also the method by which the message is conveyed. If parents do not perceive the message as relevant to their individual circumstances they are likely to ignore it anyway.

**Bedsharing and the Public Health Intervention Ladder**

There is no argument about whether infant death during sleep is a serious issue requiring public health strategies to minimise the occurrence. However, evidence to implement a strategy that eliminates choice for those at low risk and where breastfeeding and bedsharing maybe a cultural norm, requires significant justification. The Nuffield Council on Bioethics (2007) has proposed an eight-rung intervention ladder of possible government actions based on a stewardship model that incorporates seven public health goals. This model has a strong emphasis on community consultation and also aims at minimising intrusive measures that may conflict with important aspects of personal life. The ladder can be used as a tool to assist public health officials to consider how policies might affect people’s choices. In this way officials can judge whether the level of intrusion of a policy is justified by the risk it addresses. Interventions range from either simply monitoring the situation or informing and educating the public, at the bottom of the ladder; to strategies where choice is either eliminated or restricted, at the top of the ladder.

We believe any policy requiring health professionals/workers to advise all parents against bedsharing approaches the top half of the Nuffield Intervention Ladder in regard to the elimination of choice. It does not recognise that the evidence is still equivocal in regard to the role of bedsharing in SIDS in the absence of other risk factors. Nor does it recognise that breastfeeding is strongly protective of SIDS whilst being inexorably linked with bedsharing for some portions of the community. Consequently it does not allow women whose infants may be at low risk for SIDS (that is healthy term births, breastfed, not exposed to either parental smoking, alcohol and substance use or other risk factors such as soft bedding and overheating) to make the choice to bedshare or not.

Such a policy also imposes on health professionals a lack of choice when counselling mothers who wish to bedshare. This results in ethical tension in the health professional/worker and a reluctance to engage on behalf of the mother. A better alternative based on our analysis of the available evidence would to ‘enable choice’, which is the third rung from the bottom on the Nuffield ladder. This would help individuals change their high risk behaviours through education and enabling strategies.

**CONCLUSION**

When Baum’s framework to manage ethical challenges is applied to examine the issues surrounding the advice against bedsharing, it is evident that there are two significant public health issues that cannot be considered in isolation of one another. The first relates to the number of infant deaths associated with same surface co-sleeping, which includes bedsharing. The second is the important role that breastfeeding has in the prevention of disease and death in the population as a whole, including infants. There is strong political and community will to address both these issues. However, due to the strong association between breastfeeding and bedsharing, the bedsharing component of the co-sleeping advice has given rise to the debate that one message (safe sleeping) is being promoted to the potential detriment of the other (breastfeeding). Baum’s framework encourages us to look at these issues from several points of view, including evidence, utility, fairness, costs, accountability and community acceptance.

There is evidence that there are biological, sociological and practical reasons as to why parents take their babies into their beds and that the prevalence of this activity is high both here in Australia and in other countries. It is significant that breastfeeding duration has been found
to be associated with bedsharing. Although a directional relationship is yet to be elucidated, from biological, epidemiological and anthropological evidence, we know bedsharing’s relationship with breastfeeding success is likely to be a complex one. Superimposed on this is the evidence that there are significant risk factors in relation to bedsharing that are associated with our modern society, including smoking, alcohol and substance use, sofa sharing, soft bedding and overheating. However, given the strong protective effect breastfeeding has against SIDS, and the lack of evidence for a role for bedsharing in isolation of other known risk factors, we find that an unqualified public health approach that advises against bedsharing is currently not appropriate.

When considering the role of community acceptance we also find this is low amongst supporters and practitioners of either breastfeeding or attachment parenting. Health professionals also express moral and ethical conflict when being required to deliver this message, especially as their brief, here in Australia, is also to support breastfeeding in line with the Australian National Breastfeeding Strategy 2010–2015 (Australian Health Ministers’ Conference 2009). This has resulted in some health professionals ignoring directives that advise against bedsharing, which can only result in community confusion regarding the stance.

Similarly, examination of the justification of the costs involved to the community raises areas of concern. On one level it has been shown that mothers are less likely to participate in discussions concerning bedsharing with their health professional/worker due to fears associated with disclosure. On another, there is the potential that although the advice against any bedsharing may result in a reduction in bedsharing deaths, this will not necessarily translate into an overall reduction in infant mortality rates due to the possible impact it may have on breastfeeding success. Community acceptance is an essential component of the current trend towards building partnerships in public and community health. In regard to any government guidelines involving bedsharing and breastfeeding it is appropriate that parents, as well as community groups and health professionals/workers be seen as partners in the planning and care related to these practices. From this perspective, and in light of the importance of client centred care, the policy decisions related to bedsharing and the way they are implemented should be inclusive of community and personal preferences and choices.

Currently the confusion surrounding issues related to bedsharing is not serving the community well, either in regard to delivering a safe sleeping message or in promoting breastfeeding. In seeking to protect infants we have an ethical responsibility to ensure that evidence forms the basis for our advice to parents, and that steps taken by public health officials are undertaken in consultation and are ultimately acceptable to the community. As a result, we call for an approach where the needs of all community members are addressed in the interpretation of this evidence. This would involve families receiving messages tailored to their specific circumstances and risk factors, rather than a risk elimination approach that includes advice against any bedsharing.

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