Ethical Issues in the Practice of Midwifery

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Outline

• Context & Definitions

• Exploring ethical documents: philosophies and codes of Midwifery (global and contextual)

• Bioethical Frameworks for Midwifery Care

• Clinical Case

• Panel members

• Discussion
Background

- Regulation of Midwifery in Ontario in 1994
- Self regulated and governed by the College of Midwives of Ontario
- Although the ‘title’ of midwife is protected within the legislation, the legislation recognized that Aboriginal Midwives can still practice autonomously and are accountable to their communities and not the CMO.
International Confederation of Midwives (ICM)

« A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Global Standards of Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and the title ‘midwife’; and who demonstrates competency in the practice of midwifery. »

Definition con’t: scope of practice

- Responsible and accountable professional working in partnership with women supporting providing care and advice during pregnancy, labour and the postpartum period

- Conduct births on the midwife’s own responsibility and to provide care for the newborn infant
Providing Care is defined as including:

- Preventative measures
- Promotion of normal birth
- Detection of complications in mother and child
- Access to medical care and appropriate assistance
- Carrying out emergency measures
Relevant Documents guiding Midwifery practice

- Philosophy
- Models/standards
- Code of Ethics
Philosophy of Midwifery Care: Universal Description (ICM)

- Pregnancy and childbearing are usually normal physiological processes
- Promotes, protects and supports women’s human, reproductive and sexual health rights, and respects ethnic and cultural diversity. It is based on the ethical principles of justice, equity, and respect for human dignity
Midwifery care takes place in partnership with women, recognizing the right to self-determination, and is respectful, personalized, continuous and non-authoritarian.

Ethical and competent midwifery care is informed and guided by format and continuous education, scientific research and application of evidence.

Model of Care: relevant points

- Midwives promote and protect women’s and newborns’ health rights.
- Midwives promote women with appropriate information and advice in a way that promotes participation and enhances informed decision making.
Midwifery in Ontario

Informed Choice

- Midwives recognize the client as the primary decision-maker and facilitate the collaborative process of informed decision-making by:

  - Fostering a relationship of trust and respect between midwife and client.

  - Providing relevant information in a collaborative and non-authoritarian manner.

  - Considering the experience, feelings, beliefs, values and preferences of the woman.

  - Making a best effort to ensure the client fully understands all relevant information prior to making a decision.

  - Allowing adequate time for decision-making by the client.

  - Supporting the client’s decision.
Professional Codes of Ethics

- Codes are used to characterized a practice as a profession and to guide us in applying our philosophies and standards of care
- Usually based on consensus of experienced individuals
ICM Code of Ethics

« Midwives develop a partnership with individual women in which they share relevant information that leads to informed decision-making, consent to an evolving plan of care, and acceptance of responsibility for the outcomes of their choices. 

CMO Code of Ethics

- Always act in such a way as to promote and safeguard the well-being of clients, advocating their interests
- Respect a clients’ right to informed choice
- Attempt to provide the best possible care under any circumstance. A midwife may not refuse to attend a client in the course of labour

Codes con’t

- Just one way of resolving ethical conflict (prescriptive)
- At micro levels: do codes always help us navigate moral dilemmas?
- How do we can we translate our guiding documents into Midwifery practice (acting in an ethical manner)?
Using Midwifery Philosophy, Models and Code we can summarize a general formulaic approach to midwifery ethics

- Protection of rights (mainly reproductive/sexual)
- Promotion of decision-making
- Non-authoritarian
- Informed choice
- Supporting and accepting the consequences of women’s decisions
Normative Ethics

Principalism:

- Autonomy
- Beneficence
- Nonmaleficence
- Justice

Practicality?

- At first glance Midwifery ethical rhetoric prioritizes autonomy
- Is this a practical and realistic approach?
- What happens when beneficence from the midwives perspective differs from that of the woman?
VM Woodward describes two situations in which tensions arise between respect for autonomy.

When the midwife perceives a client's decision as potentially harmful.

When the woman refuses the care the midwife advocates.

*Remember: Midwives have to accept their client’s choice and are still clinically accountable.*

Case in Point: vaginal birth after caesarean section (VBAC) and homebirth

- Generally standard in Canada to provide VBAC in an in-hospital setting due to a slightly elevated risk of rupture along the uterine scar.

- However, safety of VBAC at home (within 30 minutes of surgical setting) has not been researched and currently VBAC homebirth must be offered to midwifery clients in Ontario.

- Moral dilemma can ensue if the risk of homebirth VBAC is perceived as too high by the midwife if her client chooses this option.
Barriers to Autonomy

- Principle of autonomy and midwifery led informed decision-making must take into account the diversity of women seeking care
- However, Ebert L et al identified that socially disadvantaged women did not feel safe to fully participate in autonomous decision-making with their midwives
Ebert et al con’t

Found that socially disadvantaged women felt like « outsiders to the maternity care culture and decision-making processes. Consequently, they delegated responsibility for maternity care choices to those who do belong: midwives »

Ebert L, Bellchambers H, Ferguson A & Browne J. Socially disadvantaged women’s views of barriers to feeling safe to engage in decision-making in maternity care. Women and Birth (27) 2014; 132-137.
Principalism: conclusions

While autonomy is a prioritized ethical principle for midwifery care, it has limitations if women not seen as having equal access to the informed decision-making process and as autonomous individuals.

Furthermore, from the midwife’s perspective tensions between autonomy and beneficence create moral dilemmas for the midwife, inter-professional conflict, and can put her in medico-legally compromising situations.
Modified Principalism?

- Relational model of decision-making (Noseworthy DA et al, 2013)
- Qualitative study suggests that ‘decision making for women and midwives is influenced by complex human, contextual and political factors’
This model moves away from the idea that autonomy is individualized and recognizes that there are "structural and personal limitations to power, responsibility and choice" that the normative idea of autonomy provides.

The midwife and client have a mutual philosophy and a "shared understanding of expectations". This model supports choice as dynamic and takes into account that if alternative decisions need to be made that clients could trust that the midwife would make the right decision.

Noseworthy DA et al. Toward a relational model of decision-making in midwifery care. Midwifery (29) 2013 e42-e48
Global context: human rights

- Recall the statements within the philosophy and code of ethics that emphasize rights, equality and justice?

- It is common knowledge within the medical community the link between health, gender and lack of basic human rights globally.
Human rights and health

It is a fundamental right to have access to health and health services and « midwives, together with women, work with policy and funding agencies to define women' needs for health services and to ensure that resources are fairly allocated considering priorities and availability »

Justice framework: examples of applicability

- **Globally:** Creates a platform for policies and funding to be fairly allocated to maternal-child health paying particular attention to building and supporting midwifery services (i.e.: UNFPA: millennium development goals)

- **Clinically:** by respecting each woman’s personhood, right to security and to be free from discrimination the midwife has strong ethical platforms from which to provide care to her clients in a fashion that aims to eliminate harm (i.e: violence)
ETHICAL COMPLEXITY IN MIDWIFERY
A CASE STUDY

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Objective

- brief history
- serious events during prenatal/birth/postpartum care
- actions taken by care providers
- ethical issues arising
History

- 31 y.o. pleasant, quiet
- administrative employment
- NW Ont First Nation Community
- first babe
- married
- husband American citizen (chiropractor)
- smoker, BMI 41, superficial skin condition, otherwise no clinical issues
Birth Plan

- extensive
- included many activities we execute routinely
- no vaginal examinations
- no medications for mother
- no tests for mother (GBS)
- no doppler and EFM
- physiological 3rd stage (extensive text disputing CT)
- no Vit K for babe
- no tests for babe, incl hearing test, NBS
- all issues were extensively discussed with the couple on numerous occasions
Prenatal

- pregnancy progressing normally
- evidently husband speaks for her
- difficult to stay in a conversation directed to the client due to husband’s interruptions
- high suspicion that the birth plan was written by husband and signed by client, only
Labour

- arrives @ 01:30 in L&D in labour
- midwife determines maternal well-being
- FHR normal, taken with fetoscope
- midwife re-iterates necessity for VE to determine the stage and/or progress of labour
- client consents verbally
- husband declines and disagrees
Labour - Husband’s Behaviour

- disagrees with VE
- aggravated by his perceived breach of “agreement” re VE’s
- increasingly became verbally firmer and louder
- threatening midwife with law suit re breach of “Consent To Treatment Act”
- threatening client with divorce and becoming verbally aggressive
Family

- arrives to attend labour and birth
- labour support
- states to husband, that client can make her own decisions
Labour - Professional Team Actions

- midwife asked nurses to attend the conversations for witness purposes
- midwife confirming consent for VE and obtaining written permission from client
- midwife confirming consent for fetal surveillance as appropriate as per standards of care and obtaining written consent from client
- midwife and RN’s removing husband from L&D with assistance from security personnel
- midwife includes family with course of care, including witnessing IC discussions
- midwife maintaining standard of care for normal labour (IA, positioning, bath, toilet)
- midwife citing birth plan when actions required differed from birth plan
- midwife obtaining permission and consent from client for every action taken
Birth

- client progressing rather precipitously
- baby boy, 3197g
- PPH requiring medication and surgical treatment
- OB and RN involvement for co-management
- low Hbg - blood transfusion offered and declined
- husband absent
Post Partum - Husband

- frequent calls to RN’s to acquire specific information on procedures and treatment of his wife
- RN’s decline release of information without client’s consent
- husband becoming threatening with law suits
- switch board involved to re-direct his phone calls
- wants to see his son
- states his position as advocate for his wife
Post Partum - Community

- very strong and supportive family
- client moved to her family resident
- Dilico involvement
- contact with family doctor
- husband was known to police
When a Client Chooses Care Outside Midwifery Standards of Practice

Midwifery clients may choose care that is outside midwifery standards of practice. For example, a client may decline care that the midwife considers essential for the provision of safe care, or the client may request care that the midwife is unable to safely manage.

It is important to respect the autonomy of those receiving health care and the rights of individuals to choose among alternative approaches, allowing them to weigh risk and benefits according to their needs and values.

Midwives are responsible for being clear about their scope of practice and limitations, giving recommendations for care if appropriate and for informing clients about risks, benefits and alternative approaches.
Ethical Issues Arising

- do no harm - (non)maleficence, beneficence
- care provider’s responsibility to exercise respect within a suspected abuse (control issues) situation
- follow specific instructions of a plan a birth plan, when it is signed by the client and likely not written by her
- right to see babe and/or acquire access to information of child
- privacy issues within a marriage
- justice - facts/rights/emotions when interacting with client, baby and husband, documenting and sharing information with stakeholders
Ethical Issues Arising

- Medical legal and ethical cross roads
- Treatment of staff by the institution after the written complaint
Ethics Ongoing

- let the conversation continue
References

- Ebert L, Bellchambers H, Ferguson A & Browne J. Socially disadvantaged women’s views of barriers to feeling safe to engage in decision-making in maternity care. Women and Birth (27) 2014; 132-137.
- When a Client Chooses Care Outside Midwifery Standards of Practice (January 2014). Available at http://www.cmo.on.ca/?page_id=73
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Noseworthy DA et al. Toward a relational model of decision-making in midwifery care. Midwifery (29) 2013 e42-e48
