Ethics on-the-run

By Joanne Kinnane

Midwives work as specialized professionals in a fast moving and challenging work environment where they interact with a variety of people every day. They often face situations where multiple demands are made of them and their time simultaneously, or where there are many different pathways that could be taken. Their days are full of circumstances and events that almost always involve an ‘other’. Each of these comprises an ethical encounter (Thompson and Thompson, 1996) and offers opportunities for good or bad decisions to be made. As ethics is embedded within every encounter a midwife has, it is essential that all midwives have an awareness and understanding of their own value systems, professional ethical codes and ethical principles that can act as guides when they have to make choices in these situations, which are frequently challenging.

Abstract
Midwives are involved in a very dynamic profession. As they face their everyday tasks they encounter many different situations and a variety of people which results in a vast number of interactions. This narrative research project sought to identify some of the ‘ordinary’ encounters and interactions that midwives working in a hospital environment experience in their daily work and explore them from an ethical perspective. It found that many ethical decisions have to be made ‘on-the-run’, with no time to contemplate or decide what the best course of action might be. As ethics is embedded within every encounter a midwife has, it is essential that all midwives have an awareness and understanding of their own value systems, professional ethical codes and ethical principles that can act as guides when they have to make choices in these situations, which are frequently challenging.

Midwives value respect and kindness for self and others which has many implications including:
‘valuing the moral worth and dignity of oneself and others.’

As respectful consideration of every word and action and their implications can seem to be an impossible task, ethical acumen is beneficial for midwives.

How a midwife acts and prioritises her work can have far-reaching effects. Magill-Cuerden (2007: 534) sums this up succinctly, telling a story of a mother who said that:
‘you never forget the midwives and how they were towards you. That remains with you and affects you forever’.

Some assert that whatever happens during a birth will be remembered by the mother and can lay down either good or bad memories (Eliasson et al, 2008). This brings into focus how crucial it is that midwives treat their clients the ‘right’ way. This is, however, a complex matter.

Over recent years there has been an increasing interest in these aspects of midwifery which are broadly known and understood as midwifery ethics. Frith (1996), Frith and Draper (2003), Jones (2000) and Thompson (2004) have each written or edited books discussing many important aspects of ethics within midwifery practice, and a number of research papers exploring ethical issues in midwifery can now be accessed. A notable recent example is Eliasson and colleagues’ (2008) article ‘Uncaring Midwives’ in which the authors report that almost half of their participants (new mothers) found their midwives displayed uncaring behaviours during their labour and birth. An interesting feature of midwifery ethics that does not seem to be addressed in the literature to date, however, was evident in the narratives shared in this project. Midwives often find themselves doing ethics ‘on-the-run’. This is frequently not a simple task and can, at times, be emotionally demanding. There is no time to stop and think—only time to do. A participant, summed it up precisely saying:
‘like [it’s] not that you can go and sit down and discuss it beforehand’. (Henrietta)

Often midwives need to think, decide and act simultaneously, so their ethics becomes blended with their practice in a seamless way. Yet ethics cannot and must not be relegated to an instinctive realm.
Box 1. Henrietta’s story

‘I always remember one of my first deliveries as a midwife… an unknown IUFD… obviously stressful for everyone… this woman had arrived just at handover time… we examined her to put on a fetal scalp electrode… and got no response… and by this stage she wanted to push. So I think the stressful part was the mother just not knowing what we know – at this stage she was pretty much unaware that the baby was dead, so the question in the back of my mind and the other midwife that was with me, was, what do we do? And without sort of conferring much at all we both seemed to agree that we would go through the process of having the baby… So we delivered the baby, head came, once the head was delivered, we started to give her some information… and once baby was out we clamped and cut the cord and baby went straight to the resuscitare which was right beside the family and then we started feeding back more information to her… you have to read what you think is sort of the right ethical position to take, whether you say before this lady’s bad baby that you think the baby’s dead, or do we let her have her baby and find out that it is dead… like [it’s] not that you can go and sit down and discuss it beforehand but [you have] to make a decision sort of fairly quickly… I think the reassuring part of the whole incident is probably that the other midwife, who was very experienced, without us even conferring, you both, you know, presumed that that’s what we would do.

Box 2. Lucy’s story

‘I can remember one night;… The agency midwife had a [twenty-something] wecker lady who was in, supposedly, early labour… [She] said to me about six o’ clock in the morning, “oh, my lady’s back from labour ward, but she’s saying she wants to push”. … The lady who was sharing the room with this [twenty-something] wecker came… and says “I think you’d better come in. This lady’s making a noise”. Now I didn’t know anything about this woman really, except that I wasn’t looking after her, … I get there and this lady says, “I want an epidural”. And I said, “Oh, really”. Anyway, I felt her tummy. She was contracting big time, she said she was [twenty-something] weeks and she’d just been to birth suite and had pethidine. She was starting to push. I could tell she was pushing. I said, “Right. Let me just have a look down here”, took off her undies, vertex, that much… Anyway, I said to the lady next door, I tried to keep my calm about it, “Well, darling what was your name?” “Oh [Wendy],” she says. … I said to this … lady, “What’s your name?” She told me. “I’m [Lucy].” I said, “You’re going to have this baby right here, right now.” The emergency button’s going off; by the time everyone gets here this baby’s in my hands. The baby, [twenty-something] wecker cried, spontaneously, beautifully, … I had sent this girl who was sharing the room… to get me a hot bundle, you know blankets… She was getting all the stuff, because there was no-one else around, I was on my own. I was on my own. … Everything worked out well in the end, you know, but, maybe it couldn’t have. You know what I mean?’

Method

Recruitment and consent

Midwives from three hospitals in south-east Queensland, Australia, were invited to participate in the project. Recruitment methods included individual invitation and advertising at an institutional level. The recruitment method varied due to the requirements of different hospital administrations and ethics committees. Appropriate ethical clearance or exemption was sought and granted from all institutions.

Fifteen midwives who indicated a willingness to participate in the study were able to be actively involved. All interested persons were provided with written information about the research project. This information clearly indicated that the area of interest in the research was ethics. An opportunity to ask questions was offered before both verbal and written consent was sought and obtained.

Collection of narratives

Individual, unstructured interviews were conducted at a time and place suitable to the participant. The following open-ended question was used to commence the interview

‘Could you please share with me some of your experiences as a midwife? These might include situations that you have found rewarding, and others that were challenging or even disturbing. You might like to share why it is that you remember these encounters, what your part in the situation was, or how you feel about the outcome.’

This invited stories of the participants’ experiences as midwives. The interviews, which were conversational in nature, varied in length from approximately one to two hours. They were tape recorded to facilitate an accurate record of the conversation and later transcribed.

Interpretation

The researcher aimed to engage with the narrative material from the interviews drawing on understandings based on Bruner’s (1991) ten features of narratives. This was achieved through multiple listenings and readings. Passages from the interviews were also coded thematically which aided the researcher in identifying recurring topics and ethical concepts within and across interviews.

Ethics on-the-run

Many of the midwives in this project found themselves having to make decisions very quickly indeed. Henrietta, Lucy and Olga (names have been changed for confidentiality) share their stories and it is possible to identify some of the ethical complexities of these situations.

Henrietta (Box 1) was in a very awkward situation as she
was unable to even vocalise her thoughts, concerns or ideas. She had to somehow make her decisions, the right decisions, and convey them to her colleague almost silently in the midst of a birth occurring.

Lucy’s situation (Box 2) is quite different to Henrietta’s but she is none-the-less faced with having to make some significant ethical decisions quickly. At first they might seem to be simply clinical decisions. There was a baby to be born and Lucy needed to assist the mother to birth. This lady was not Lucy’s responsibility though. Lucy could have told the agency midwife to attend to the lady when she had first mentioned her concern. When called to the room she could have chosen to go and get the midwife caring for the lady instead of entering the room. Then other ethical issues arise. Lucy introduces herself and asks the ladies’ names. The lady asks for pain relief. Lucy has to decide whether to address or ignore that concern. She thinks of the baby’s needs and the lady in the adjacent bed. Lucy felt alone, but chose to disregard that feeling, ‘keeping her calm about her’. All this was happening, with the emergency bell ringing, over probably no more than a five minute time span. Ethics ‘on-the-run’ in evidence.

Olga was just one of several midwives, and each of those was just one part of a large team of people who cared for this couple. Yet Olga also said: ‘I think I copped their anger and disappointment from the whole process’. She had cared for them for only a few hours throughout the entire process of their labour and birth and, during that time, had done everything within her power to address their needs.

During that time it had been evident to Olga that the partner was very angry. She was aware that his needs were not being fully addressed. However, she saw her first responsibility as being towards the woman, so concentrated on attending to her. Taking time out to deal with the partner would essentially prevent her from being with the woman. Olga did not realize, unfortunately, the magnitude of the partner’s anger which was immense. She said:

‘... in retrospect I probably should have gone out to one of my colleagues and said this guy’s got issues, can you help me deal with him? And [they] would’ve allocated someone else to come in and help … But I was doing it all myself and it didn’t occur to me.’

This is another example of ethics ‘on-the-run’ similar to those Henrietta and Lucy were involved in. Olga, however, by her own admission, missed some important cues. Many aspects of midwifery involve active roles, actually doing things, where midwives do not have time to stand back and think, let alone reflect upon the situation at hand. They are immersed in the moment, making decisions as best they can. If Olga had had the luxury of being able to stand back and reflect upon what had been happening in the room with the couple, she may have approached the situation differently. It may well have been possible to notice just how angry and distressed the partner was. Remedial action could have been taken at that point and perhaps prevented further problems from arising. However time for reflection and discussion prior to decision making was simply not a possibility. Olga was responsible for the woman’s care, who was in advanced labour and in need of constant attention. For Olga that meant caring for the woman and dealing with her partner concurrently. As it turned out, she was unable to do this successfully and bore the brunt of anger from both of them.

Negotiating ethics on-the-run

How did Henrietta and Lucy know what to do, and how can other midwives in similar situations make their decisions? How do we ‘do’ ethics ‘on-the-run’? Olga may have acted differently if she had known or should a similar situation occur again. She commented:

‘... that was a big learning curve for me. Like all things, bad things that happen are a learning curve for me. You go back and re-go over every single thing.’

When one is faced with having to do something quickly it is essential that the right equipment is at hand. Midwives need to be prepared so that they are able to make ethical decisions ‘on-the-run’. Possibly Henrietta and Lucy were just lucky that their situations worked out well, or, conversely, they were well equipped to deal with such situations.

There is no doubt that making good decisions at the right time and for the right reason — something which might constitute ethical practice—is not as simple as following a list of rules. Thompson (2007) says to be professional is to be ethical; Isaacs (1993), Massey (1998), May (2000) and Bayles (2003) agree that professionals seek to benefit the persons they exist to serve; and Beauchamp and Childress (1994), Fry and Johnstone (2002), Thompson (2004) and Begly (2008) have affirmed the benefits of virtues and the importance of acting from the right motivation.

Jolley (2008:12) says:

Box 2. Olga’s story

‘... she’d been in labour for ... like 16 hours ... [her partner] was very angry when I got there. It was something like my eighth or ninth shift and I was really tired, and I didn’t handle him the way I should have. Apparently she’d asked for an epidural during the night shift, and for some reason hadn’t been given an epidural. When I was there she wasn’t labouring well ... everything was really negative in the room, and I called doctors in to see her and they’d said continue, and they’d gone off ... [her partner] said, I want something done right now. And so I’d get the doctor in to see him and they’d have a few words to say to him ... But his anger had just built up over the time. ... eventually she had a caesar and bled profusely and all of it built up. Because [her partner] was angry all the way through, I don’t know whether he came in with issues in the beginning but that became very traumatic after the caesar ... and then with the postpartum haemorrhage bad blood transfusions, it was just a follow-on effect of all the bad things that could happen to her. And she had a very negative view, even though the baby was fine. ... the whole process was bad for them. So, a lot of their anger was directed towards me. [I was] the only one it was directed towards.
‘Principles are far more important than any set of rules’. Decision making is a complex and frequently very challenging task. There are, however, several ways in which midwives can enhance their ability to do ethics ‘on-the-run’ and thus increase their competence to practice ethically.

Know your code

In Australia, as in many countries, nurses and midwives have Codes of Ethics which they are expected, or required, to follow. These codes provide valuable guidance for midwives who have to make difficult decisions every day. Carefully examined they can assist the midwife in identifying her own attitudes, beliefs and responsibilities, as well as helping her to understand the importance of individuality, accountability and tolerance. Although codes do not give specific instruction as to what to do in any given situation, they are valuable sources of information that can assist midwives to enhance their ethical awareness and prepare them for positive interactions with the people they meet in their everyday encounters.

Be aware of and understand ethical principles and their limitations

Principlism, a form of ethical reasoning drawn from medical ethics, has been very commonly taught to nurses and midwives. This is evidenced by its presence in many nursing ethics texts (for example, Johnstone, 1989; Davis, 2006; Fry and Veatch, 2006). It is based on the use of the following four principles:

- Respect for autonomy
- Beneficence (do good)
- Non-maleficence (do no harm)
- Justice (fairness).

Beauchamp and Childress (1994; 2001; 2008) have discussed these principles in detail and there is no doubt that they can be very helpful in assisting persons to make ethical decisions. However the principle-based approach to ethics has limitations.

One of the more obvious limitations is the fact that sometimes harm must be done in order to do good. For example when surgery is inflicted upon someone in order to birth a baby due to complications that have arisen during the course of labour. Caesarean section results in pain, causes injury to muscles and skin, interferes with normal bodily processes and has many associated risks. However it is performed, in this case, to maximize the safety of mother and baby thus the harm is necessary for the ultimate health and wellbeing of mother and child.

Another example where principles can confound matters is when a person’s autonomous decision, for reasons of insufficient information or unsound mind, might be harmful to themselves or others, so it would be unwise to respect their autonomy. An example of this could be found when a mother with puerperal psychosis wished to go home from hospital. Thus if her autonomous decision was to be respected, both mother and baby could be at risk. Despite their limitations, a sound knowledge of autonomy, non-maleficence, beneficence and justice would certainly benefit a midwife endeavouring to make a ‘good’ or ‘right’ decision.

Maximize positive relationships with colleagues and clients

The most significant finding of this study was that midwives are concerned with the relationships that they have on all levels. The quality of these relationships was of enormous significance, having the ability to make a bad situation ‘good’ or a good situation ‘bad’. Where everyone involved in a particular event or encounter communicated well, worked together harmoniously, showed mutual respect and a willingness to listen, positive relationships were evident. This enabled the midwives to negotiate their way through even challenging situations with the minimum of anxiety as they worked together towards common goals.

Felicity expressed the following: ‘the type of day that really I love working is where I have bonded with a particular person … and you felt that what you had said has made a difference, and the care that you have given is something … that’s a little bit more.’

Debbie expressed similar sentiments: ‘... it’s like being able to come home and feeling really great that you’ve, you’ve done something that not only reaffirmed who you are and what you believe in and what feels right, but you’ve also been able to do something that’s been constructive and positive to support a woman in labour.’

Many midwives experienced relationships that were not as pleasant. Natalie was very distressed by the encounter with a nurse manager:

‘... she’d yelled at me in front of a mother and I was very upset, I cried, which I don’t believe anyone has the right to make another person cry, deliberately. … then I went home and I cooled down a bit. I rang and made an appointment to come in and see her.’ (Natalie)

These midwives affirm that ethical practice is not only about caring for clients, it also involves caring for oneself. It is not only what the midwives do for the other, or what the other does for or to them that is significant in their encounters. How they respond, how they feel and opportunities for learning or growth are also important.

Gastmans (1999: 214) provides an excellent proposition, saying that caring is a ‘morally virtuous attitude’ that can generally: ‘... be considered as a specific way of relating oneself to the other in a relational context, with attention given to the maintenance and development of the other (patient) and oneself (nurse).’

This fits very well with Isaacs’ (1998) concept of ethics as being ‘other-regarding’. In this view of ethics, all persons are valued, worthy of respect, acknowledgement, and having their interests taken into account—both the other and oneself. If midwives practise building good relationships with others, it will be easier for them to automatically make decisions which are respectful and, therefore, ethical.

Hunter and colleagues (2008) have described relationships as the essential binding element in midwifery. In order for midwives to communicate well with clients and colleagues, develop skills and trust and ultimately provide the best possible midwifery care, it is necessary for them to have positive relationships. They note however that despite the fundamen-
tal importance of sound relationships to maternity care there has been surprisingly little attention paid to this important aspect of the profession. Considering how frequently midwives have to make ‘on-the-run’ decisions, the importance of the quality of their relationships becomes paramount.

**Use stories for positive benefit: using the tea room**

In a mutually respectful and non-threatening environment, midwives are able to share and learn from their practice experiences through stories.

‘Mourning the devaluation of narratives as sources of knowledge, and emphasizing the moral force, healing power and emancipatory thrust of stories’ (Sandelowski, 1991:161, bold added), scholars have discovered our natural narrative inclinations. Our attention is drawn to the moral aspects of stories by Sandelowski. Stories can be useful for questioning, reflecting upon, teaching and, where appropriate, changing practice. We have to make the moral meanings of events fit together each time a story is told (Ochs and Capps, 2001). Thus, everyday storytelling can be used as a source of moral education. The regular, informal times that midwives gather in tearooms can be used as a source of moral education. This sharing and learning from the storyworlds can be used as a forum for interpersonal education.

Conclusion

Midwives are faced with frequent, varied and challenging situations that have an ethical component many times every day. In order to face these encounters with confidence and be able to respond in an ethically appropriate manner it is important that they be armed with the right knowledge and opportunities to share and learn. By being conversant with codes of ethics and practice and ethical principles midwives can be guided in their decision making when having to make ethical decisions ‘on-the-run’. Furthermore by developing positive relationships with colleagues and clients, it is probable that midwives will be more likely to make good decisions. Ethical awareness, understanding and practice can be further developed and enhanced by ‘using the tearoom’ as a forum for storytelling. If these measures are employed, midwives have a much better chance of being able to make the right decisions at the right time in the right place and for the right reasons.

Acknowledgements

David Massey, Visiting Fellow, Queensland University of Technology, Brisbane, Queensland, Australia. David Massey has indicated that he would be happy for me to be sole author of this paper. I would, however, like him to be acknowledged for the support and encouragement he has provided as supervisor and mentor throughout my studies and beyond.

Australian Nursing and Midwifery Council, Australian College of Midwives and Australian Nursing Federation (2008) Code of Ethics for Midwives in Australia, Canberra
Australian Nursing and Midwifery Council, Royal College of Nursing, Australia and Australian Nursing Federation (2008) Code of Ethics for Nurses in Australia, Canberra
Isaacs P (1993) Obligations of the Profession. In: Australian College of Midwives (Qld) Annual Conference. Queensland University of Technology, Brisbane

Key Points

- Ethics is embedded within midwifery practice.
- Midwives frequently have to make ethical decisions ‘on-the-run’, with no time to think through the best course of action.
- Midwives need to be prepared so that they are able to make ethical decisions.
- If midwives practise building good relationships with others, it will be easier for them to automatically make decisions which are respectful and, therefore, ethical.
- Mutually respectful, non-threatening environments enhance ethical awareness and behaviour.

BJM