Ethical Framework for Decision-Making for Midwives during the COVID-19 Pandemic

Identify the problem and potential solutions

What is the situation or the problem? [Describe problem]

Our practice group has completely run out of protective equipment. The only place in the community that has any PPE left is the hospital and they are rationing it (2 masks/ shift per caregiver). Some of the practice wants to do only hospital births, others feel that homebirths may be safer in the case of asymptomatic women as they will only be exposed to their clients (and not every nurse, MD, orderly, anesthetist, security guard, etc.) and that they don't want to take away women's choices of birthplace for a healthy person. And if we are seeing people without PPE prenatally and postpartum do we not still have the same risk of transmitting or receiving the COVID virus?

What is the ethical issue? What part of this situation or problem is causing moral distress? [Identify ethical issue]

The ethical issue is that because of shortage of PPE, we are faced with potentially dangerous work conditions and that one of the potential solutions limits client's individual autonomy by limiting choice of birth place.

What are potential solutions to the problem? [List possible options/solutions]

- Provide care only in hospital
- Continue to offer choice of birthplace
- Other options?

For every proposed solution, work through the table below.

OPTION 1: [insert possible solution here]: Provide care only in hospital

Stakeholders	Who does the decision impact and how? (e.g. individual midwives, practice group, hospital, clients, larger community)

	[insert stakeholders] Clients, individual midwives, practice, community (other MPGs, hospital, public, etc.)
Values that support this solution	[insert values to support solution] -Beneficence (midwife): access to PPE will protect MWs caring for those with suspected or confirmed COVID-19, has potential to protect midwives for those clients with asymptomatic COVID-19. Likelihood of transmission of COVID-19 to care providers higher in the intrapartum period. -Stewardship: using resources for encounter most likely to transmit infection. -Solidarity: amongst MWs – most conservative approach, may protect or make some MWs feel safer (?), and thus more likely to continue to provide care.
Values against this solution	[insert values that are against this solution] -Stewardship – in asymptomatic people, lower risk of COVID contamination (although blood borne illness risk always present), saves masks for other HCPs caring for those who have confirmed or suspected COVID-19. -Beneficence: should attempt to maintain Professional Standards if possible.
Expected benefits	[list expected benefits] -Access to PPE for MWs during births may help to reduce community transmission and keep MWs and their household safer.
Expected harm	[list expected harms] -Decrease pregnant people's choices (autonomy). -Work outside of CMO Professional Standards. -Does not deal with issue of antenatal and pp care and risk of COVID transmission. -Is there nosocomial transmission from being in hospital? May we contaminate a healthy person?

	-What do we do for pregnant people in precipitous labour? Not attend?
Harm mitigation that may be implemented	[list harm mitigation solutions for possible solution] -Institute other measures available (MW and possibly client to wear homemade masks, rigid hand hygiene, social distancing as far as possible at all visits for both MW and client) -Is there a way to continue to offer choice of birthplace? (e.g. in large practice home team and hospital team but potentially giving up continuity of care?)
Evidence for	[list what evidence is available to support this solution] -Evidence emerging and unclear. -Recommendations for taking care of persons with co-morbidities and symptomatic or diagnosed in hospital.
Evidence against	[list what evidence is available that does not support this solution] -Generally pregnant people with suspected or confirmed COVID-19 have had good outcomes, based on limited number of cases to date, interpret with caution. -The majority of pregnant persons who are asymptomatic likely do not have COVID-19. -It is midwives' responsibility to adhere to Professional Standards.
Emotions this solution elicits[1]	[list emotions that arise] -For clients: loss of autonomy, choice, and control, ?fear of hospital and of infection. -For midwives: anger to have to make these decisions, fear for their own and their loved ones health. -Grief over loss of "regular life".

[1] Ethical decision-making requires identification and acknowledgement of our emotions, including fear. Being aware of emotions permits a more rational, critical analysis of the issues at hand and may also give us insight on the values that are most important (to us personally) regarding the issue at hand.

Other issues to consider	[list what else ought to be considered with this solution] -Should our approach be different for patients with confirmed or symptomatic for COVID-19 vs asymptomatic and no other identified risk factor? Possible exposure but asymptomatic? -Cannot extrapolate from the Long Term Care situation as they care for the sick, frail and elderly… but PSWs are also female HCWs that were left without protection in the community and this led to harm. This is making us uncomfortable.

Questions to ask about this solution:

Does this maximize overall benefit? Does it minimize harm? Is it equitable? What if everyone did this? Can we live with this decision? Is this our best option?

[Add notes from reflective questions about solution]

The answers to these questions will depend on the context and the balancing of risks and benefits based on the information at hand and consideration of values as well as the big picture context of the community and a public health emergency

OPTION 2: [insert possible solution here] Continue to offer choice of birthplace

Stakeholders	Who does the decision impact and how? (e.g. individual midwives, practice group, hospital, clients, larger community) [insert stakeholders] -Client, individual midwives, practice, community (other MPGs, hospital, public, etc.)
Values that support this solution	[insert values to support solution] -Beneficence – should provide standard of care whenever possible. -Stewardship and utility - recognizes that homebirth may reduce load on healthcare system. -Equity - recognizes complex needs of some clients best served at home or hospital. -Client autonomy.
Values against this solution	[insert values that are against this solution]

	-Beneficence - hospital and access to PPE particularly with symptomatic client is risk mitigation for MW. -Stewardship: access to PPE if client symptomatic is the current recommendation for care. -Solidarity: potential for disagreements among MPG members.
Expected benefits	[list expected benefits] -Helps ration masks and other PPE in hospital and saves hospital resources for those with suspected and confirmed COVID-19 (those who are ill) by decreasing # of hospital births and impact on strained hospital resources. -Preserves standard of care for healthy asymptomatic pregnant people. -Helps decrease barriers to accessing wanted care.
Expected harm	[list expected harms] -Lack of PPE means potentially higher risk of transmission for midwife, client and community. -Does not address PPE for antenatal and postpartum care.
Harm mitigation that may be implemented	[list harm mitigation solutions for possible solution] -Since clients are registered at hospital, could we advocate for 2 masks for their birth to be used for whole birth even in case of transfer? -Hospital vs home team or symptomatic/ risk factor or no risk factors/ no signs and symptoms team (is this something practice could accommodate) but may mean lack of continuity. -Use of cloth masks and other measures for home births, antenatal and postpartum care, other mitigation measures.
Evidence for	[list what evidence is available to support this solution] -Generally pregnant people have had normal outcomes, small case studies, evidence is emerging, interpret with caution. -It is midwives' responsibility to adhere to CMO Professional Standards.
Evidence against	[list what evidence is available that does not support this solution]

	-Evidence emerging, largely good outcomes from small case studies of pregnant people with COVID-19, interpret with caution. -Unclear risk of home vs hospital for increased transmission with or without masks.
Emotions this solution elicits[2]	[list emotions that arise] -May have midwives who do not feel comfortable with home birth without PPE finding themselves in difficult situations where they are forced to provide care that they feel endangers them causing anger and grief and the potential for these midwives to stop providing care. -Fear about unknown risks and grief for "regular life".
Other issues to consider	[list what else ought to be considered with this solution] -Should our approach be different for patients with confirmed or symptomatic for COVID-19? Possible exposure but asymptomatic? Other risk factors? Are there any other resources in our community that impact our thought process? What is our context and the needs of our community?

Questions to ask about this solution:

Does this maximize overall benefit? Does it minimize harm? Is it equitable? What if everyone did this? Can we live with this decision? Is this our best option?

[Add notes from reflective questions about solution]

The answers to these questions will depend on the context and the balancing of risks and benefits based on the information at hand and consideration of values as well as the big picture context of the community and a public health emergency

Review analysis for all proposed solutions, make a decision.

[2] Ethical decision-making requires identification and acknowledgement of our emotions, including fear. Being aware of emotions permits a more rational, critical analysis of the issues at hand and may also give us insight on the values that are most important (to us personally) regarding the issue at hand.