MATERNAL911®








Ethics and Substance Use Disorder

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The buttons on the upper right from left to right are:

- Table of Contents
- Home
- Help
- References
- Close

Course Description:

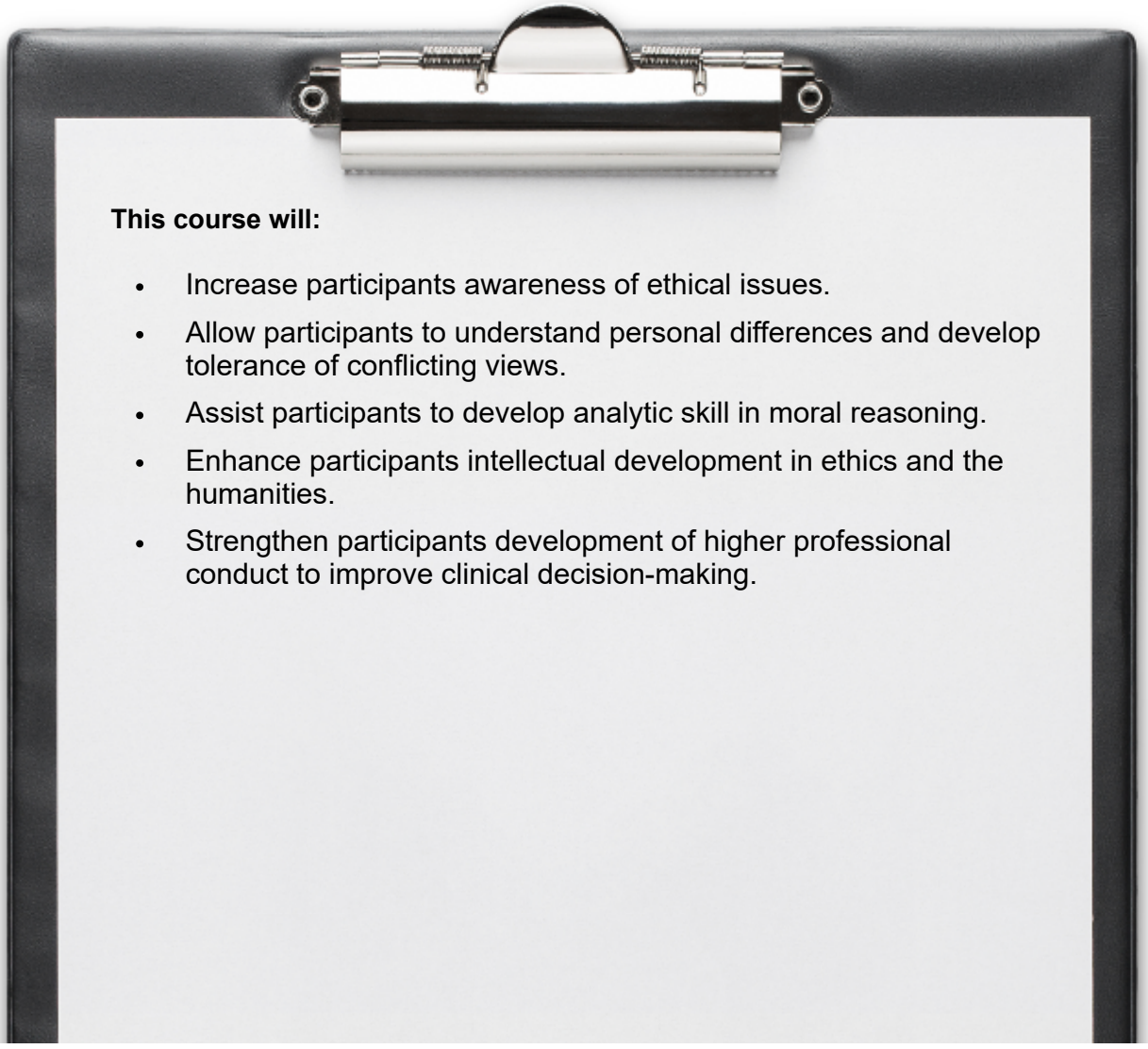
- This course on ethics in pregnancy will evaluate situations that require the midwife to place personal values and beliefs aside and come to an understanding of what the patient desires.
- Disagreements between the midwife and the patient, on the choice of therapy, can be a tremendous challenge in medical practice and cause tension in the patient and midwife relationship.
- This course will help the provider work through situations when the patient does not accept the recommended treatment or requests treatment that is deemed unsafe for her and/or her unborn fetus.

Approximate Time to Complete: 60 minutes

Click here to download a print version of this course.



Introduction



This course will:

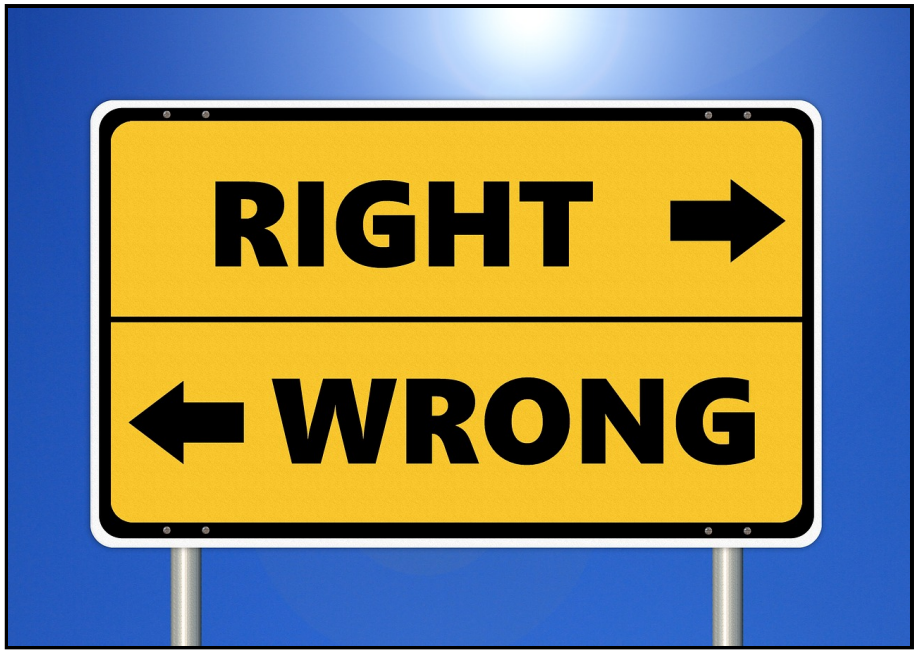
- Increase participants awareness of ethical issues.
- Allow participants to understand personal differences and develop tolerance of conflicting views.
- Assist participants to develop analytic skill in moral reasoning.
- Enhance participants intellectual development in ethics and the humanities.
- Strengthen participants development of higher professional conduct to improve clinical decision-making.

- Ethics
- Healthcare Ethics
- Obstetric Ethical Challenges
- Principles of Bioethics
- Conflicts of Value, Beneficence and Non-Maleficence
- Medical Futility
- Just Culture
- Decision Making
- Medical Decision Making
- Surrogate
- Acting as a Surrogate
- Decision Hierarchy During Pregnancy
- Preventive Ethics
- Preventive Ethics Examples
- Obstetric Ethical Issues
- Summary
- Summary Cont'd
- Summary Cont'd
- Summary Cont'd



Definition of Ethics

Ethics is a discipline of systematizing, defending and recommending concepts of right and wrong behavior.



Bioethics

Bioethics -- also known as medical ethics -- applies the core principles of autonomy, beneficence, non-maleficence and justice, to medical and health care decisions. It is a multidisciplinary lens through which to view complex issues and make recommendations regarding a course of action.

Ethical concerns arise frequently in all health care settings, but there can be particular challenges when a woman is pregnant.



Obstetric Ethical Challenges

Obstetrical complications are difficult to predict and can quickly threaten the life of the patient and her unborn baby.

- If there is no assigned medical decision maker and an emergent situation arises, medical decision making defaults to next of kin and subsequently follows a specified hierarchy.
- Difficulties arise if there is disagreement regarding medical decisions among family members.



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Principles of Bioethics

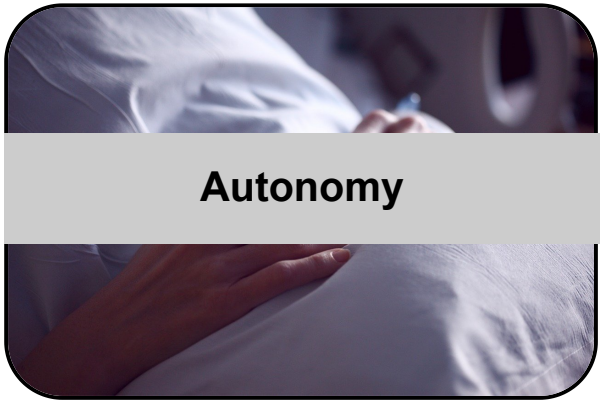


- Autonomy
- Justice
- Beneficence
- Non-maleficence

Principles of Bioethics







Click each picture for more information.

[Click for a video on the Basics of Ethical Principles from the School of Professional Studies at Columbia University]

Beneficence

- Patients should be treated in an ethical manner by respecting their decisions and protecting them from harm
- Midwives also have a duty to act for the benefit of the patient and to promote their welfare

Non-maleficence

- The obligation of a midwife to do no harm

Autonomy

- The right for patients to make decisions regarding their healthcare, even when decisions contradict the recommendations of the healthcare team

Medical Futility

Two reasons to address futility:

- To conserve resources.
- To protect clinician integrity.
- Medical futility is the judged futility of medical care, used as a reason to limit care.

There are two types of futility:





Click each picture for more information.

Normative futility is a judgement that a treatment exists that has a physiologic effect, but is believed to have no benefit by the healthcare team.

- An example of normative futility would be to maintain life in a patient who is in a permanent vegetative state - the treatment sustains life, but does not improve the quality of life for the patient

Physiologic futility is a judgement that a proposed treatment cannot physiologically achieve a desired effect

- An example of physiologic futility is taking an antibiotic for an uncomplicated viral infection

Just Culture

- A **just culture** recognizes that many individuals represent predictable interactions between human operators and the system in which they work.
- A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.

Click the picture for more information.



Just Culture

- It's a culture that holds organizations, including birth centers, accountable for the systems they design and for how they respond to staff behaviors fairly and justly. The premise is instead of facilities punishing people for making mistakes, they should concentrate on fixing the systemic problems causing mistakes to be made.
- Just culture requires a change in focus from individual errors and outcomes to system-wide design and management of the individual behavioral choices of all employees [1].

Click for a video on Just Culture from Securite Industrielle

Decision Making

The principle of autonomy holds that patients have the right to accept or reject health care recommendations made by health care providers [2]:

- This does not mean the patient has the right to demand interventions which are not medically indicated.

Decision Making

The principle of autonomy holds that patients have the right to accept or reject health care recommendations made by health care providers [2]:

- Good decision-making and patient-centered care is knowing what is important to the patient and their families [3]. Knowing what is important will assist in avoiding disagreements between the health care provider, patient and family members [4].

Medical Decision Making

Decision making requires suggestions or recommendations by the midwife and/or allowing a family member to verbalize what would be in the patient's best interest.

Criteria frequently used to determine a patient's best interests include:



Click each checkbox for more information.

- Considering what the patient's description of acceptable care would be.
- Evaluating the benefits and risks of each reasonable intervention as well as short and long term outcomes.
- Determining what the patient's description of acceptable or stable quality of life was, or what the patient would described as sufficient decrease in quality of life if affected by the decisions that are made.
- Defining the risk and degree of pain and/or suffering associated with an intervention, plus the midwife's ability to decrease any suffering encountered.
- Explaining the expected outcome and/or prognosis with or without treatment in terms of survival and long term consequences.

Acting as a Surrogate

If there is no assigned medical decision maker and an emergent situation arises, medical decision making defaults to next of kin and subsequently follows a specified hierarchy

- The hierarchy typically follows:
  - Legal guardian or durable power of attorney
  - Spouse
  - Adult child
  - Parent
  - Sibling [7-9]

Stressors associated with a surrogate decision maker :

- Unawareness of what the patient's preferences would be
- Uncertain prognosis
- Communication difficulties with the health care providers
- Time frame allowed to make a decision
- Conflict between midwife and family
- Logistics of the process of decision making
- Feelings of uncertainty or guilt over the decisions

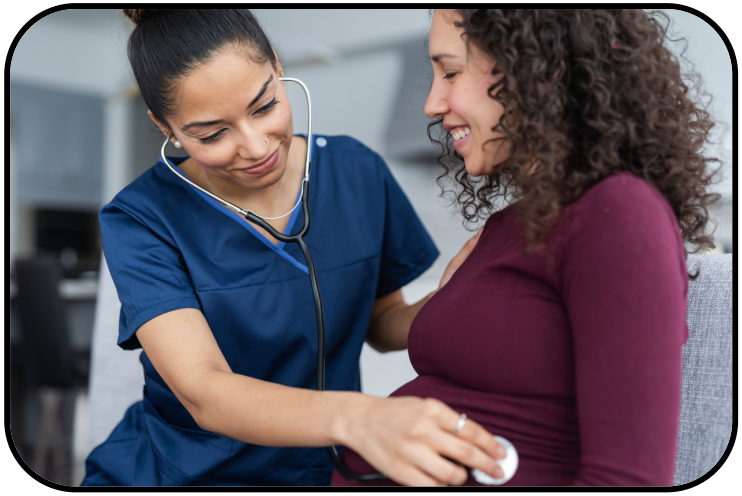
Decision Hierarchy During Pregnancy

Members who may be involved in the hierarchy are:

In obstetrics, if the woman is not able to verbalize her decision, hierarchy will be implemented for decisions in health care. This can become complicated if she is not married, not in a relationship, or if her unmarried partner and family disagree on medical decisions. This can occur any time from conception through postpartum.



Preventive Ethics

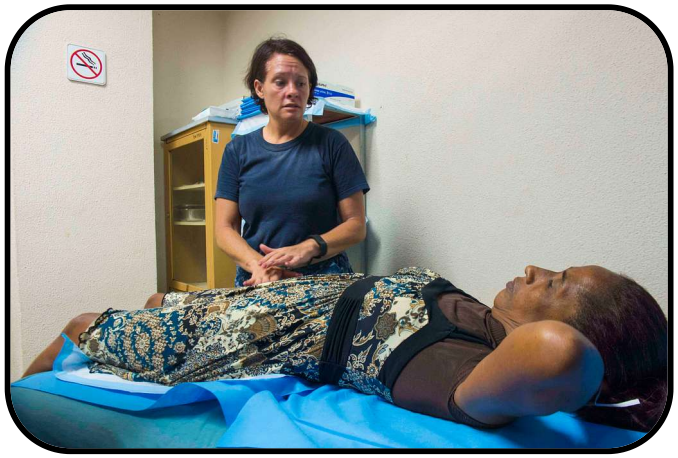


Click the picture for more information.

There is an advantage in obstetrics as the woman who is receiving prenatal care can receive informed consent prior to the time when a decision needs to be made. This situation:

- Promotes an understanding of the issue and opportunity for discussion.
- Reduces the risk of miscommunication.
- Allows time to resolve disagreements between the midwife and patient [10].

Preventive Ethics



Intrapartum decision making can be difficult due to unanticipated complications and emergent issues [10].

Examples of Preventive Ethics





Click the pictures for more information.

Women with underlying health conditions need to be educated regarding management of the condition during pregnancy; including typical course, medication management and potential impact on the pregnancy. This can include many preexisting conditions, including but not limited to hypertension, diabetes, mood disorder and cancer treatment.

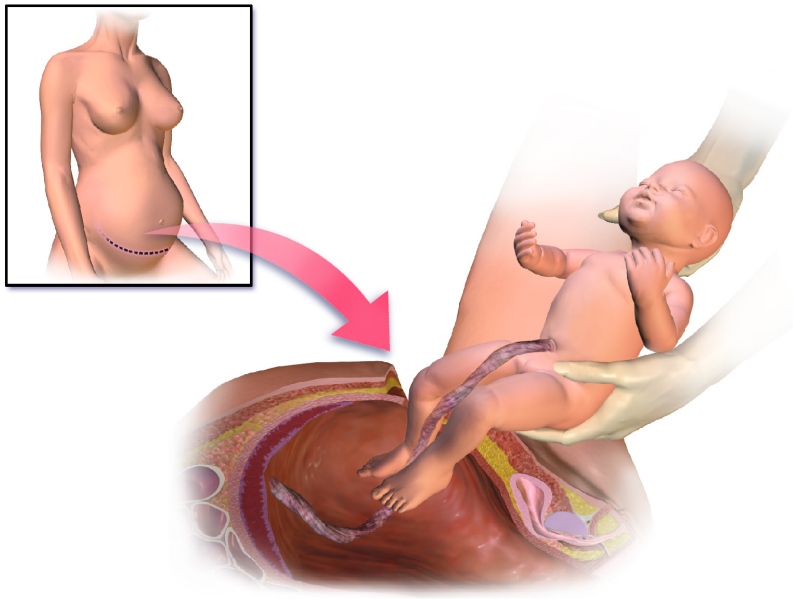
During preconception counseling or the first antenatal appointment, pregnant women should receive education, including the understanding that 2 to 3% of all pregnancies are affected by fetal anomalies [11].

- The woman needs to understand an anomaly can occur with no fault of her or the midwife.
- When an anomaly occurs, the midwife needs to discuss options for risk assessment, diagnosis and management of fetal anomalies.

The next slides will cover several obstetric ethical issues:

- Maternal request for Cesarean delivery
- Maternal request for inappropriate management
- Maternal refusal of blood
- Maternal emergency care
- Pregnancy and those without shelter
- Intimate partner violence
- Maternal mood disorders

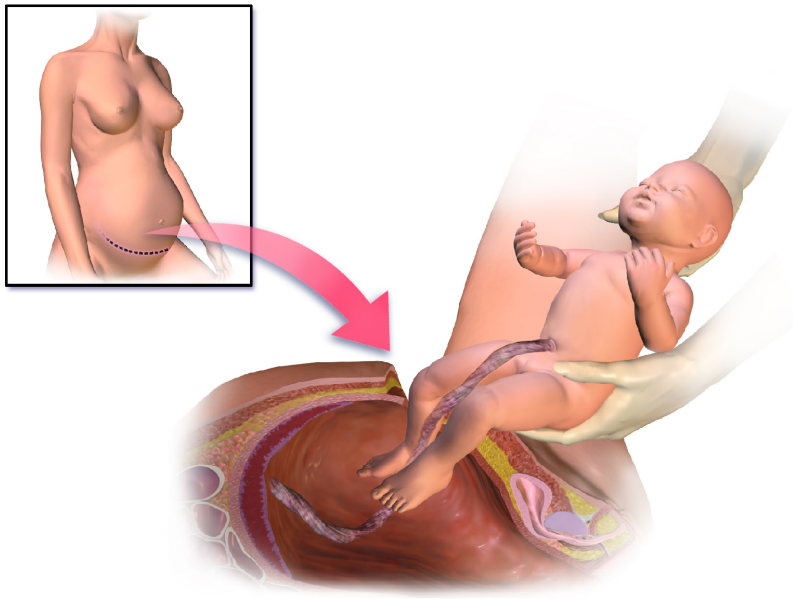
Maternal Request for Cesarean Delivery



When asked about cesarean delivery on maternal request, the midwife should determine the reasons for the woman's request:

- Evaluate her values and emotional and social needs.
- Discuss her concerns about labor and vaginal birth and any misinformation contributing to those concerns.
- Over a number of clinic visits, involve her and her support person(s) in a discussion about the risks and benefits [13].

Maternal Request for Cesarean Delivery



- The American College of Obstetricians and Gynecologists (ACOG) committee opinion states that — in the absence of maternal or fetal indications for cesarean delivery — vaginal delivery is safe and appropriate, and should be recommended [14,15].

Maternal Request for Inappropriate Management

Inappropriate requests may be defined as requests for clinical management that are not medically reasonable, because they are incompatible with evidence-based clinical judgment.

Examples include:

- Request for vaginal delivery in the setting of a complete placenta previa.
- Request for vaginal delivery in the setting of Category III fetal heart tones remote from delivery.

Maternal Request for Inappropriate Management

When situations such as this arise, it is the midwife's responsibility to review risks and benefits of management options and how each choice could affect both the patient and her baby.

- It is important to thoroughly document these conversations, but, due to patient autonomy, the decision for management is ultimately up to the patient.
- If the patient continues to contradict medical advice, the conversations should continue throughout the course of prenatal care and delivery [12].

Maternal Request for Inappropriate Management

It is important to start discussions early in pregnancy, provide risks and benefits to care selected, and educate patients on the standard of care

Maternal Refusal of Blood

- One of the most common obstetric complications is hemorrhage. For this reason, it is important to discuss willingness to accept blood products during the course of prenatal care.
  - Women who identify as Jehovah's Witnesses commonly will not accept blood transfusions, even in life threatening situations
  - This group of patients has been identified as having 44-130x higher risk of maternal mortality from hemorrhage than women who are accepting of blood products [26].
- Not all Jehovah's Witnesses are the same in what blood products they will and will not accept. It is important to develop a checklist and review all blood products during the prenatal course.

Click for more information

Maternal Refusal of Blood

- Educating women about the possibility of antepartum, intrapartum and postpartum hemorrhage is an important discussion during prenatal care so she has knowledge that refusal could result in her and/or the fetus' death.
  - Risks of refusal should be clearly communicated and documented.
- For women who plan to refuse blood products, it is important to be proactive regarding management of antepartum anemia.
- At the time of delivery, it is important to consider hemodilution techniques and to be proactive with management of hemorrhage including administration of medication and surgical techniques.

Click for information on why Jehovah's Witnesses don't accept blood transfusions?

https://www.jw.org/en/jehovahs-witnesses/faq/jehovahs-witnesses-why-no-blood-transfusions

Maternal Care Emergency

- As previously mentioned, all pregnant women should be informed that obstetric complications can arise quickly and can be unpredictable [10].
- Midwives have a legal and ethical responsibility to provide the woman with information that they can process and use to make decisions.
- Examples include:
  - Discussing risks and benefits of vaginal birth after cesarean section versus repeat cesarean section in women with a prior cesarean section
  - Discussing risk factors for hemorrhage at the time of delivery

Click the next arrow above for more information.

Maternal Care Emergency

Educating the pregnant woman on situations that could possibly happen at any time antenatal, intrapartum or postpartum may create a trusting relationship, allow the opportunity for questions and ensure her understanding.

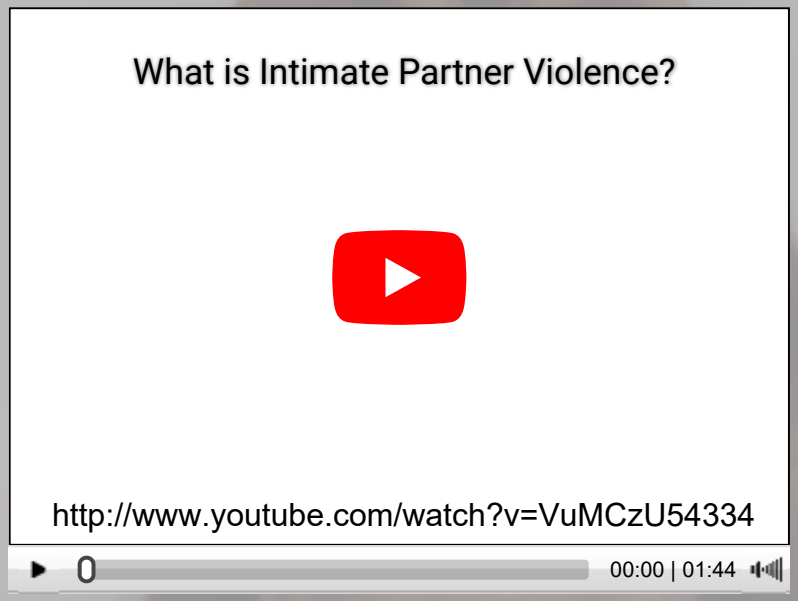
Click this button for a list of high-acuity, low occuring events

- Preterm labor (PTL)
- Premature preterm rupture of membranes (PPROM)
- Hypertension in pregnancy
- Gestational diabetes
- Umbilical cord prolapse (UCP)
- Shoulder dystocia (SD)(SD)
- Intrahepatic cholestasis of pregnancy (ICP)
- Amniotic Fluid Embolism (AFE)
- Imminent birth
- Induction of Labor (IOL)
- Operative vaginal birth
- Postpartum hemorrhage (PPH)
- Intrapartum hemorrhage
- Venous thromboembolism (VTE)
- Sepsis in pregnancy
- Cardiomyopathy

Many of these topics are included in the other Maternal 911 modules.

Intimate Partner Violence

Centers for Disease Control and Prevention Video - What is Intimate Partner Violence



Click the next arrows to read more information.

Intimate Partner Violence

- Intimate partner violence (IPV) affects over 32 million Americans [37].
- In countries around the world, 10 to 69% of women report physical assault by an intimate partner at some time in their life [38].
  - IPV is an actual or threatened harmful event which can be:
    - Psychological
    - Physical
    - Sexual
    - Experienced by a current or former partner or spouse
- IPV can occur among people with any sexual orientation or gender identity, and does not require sexual intimacy.



Click the next arrows to read more information.

Intimate Partner Violence

- IPV screening should be a routine part of prenatal care.
- ACOG recommends screening at the first prenatal visit, at least once per trimester and at the postpartum visit [39].
  - Women may be asked to complete a questionnaire detailing their psychosocial, medical, obstetric and family history.
  - Women for whom IPV is suspected but not acknowledged should be asked again at subsequent visits.

Click the next arrows to read more information.

Intimate Partner Violence

- Midwives should be aware that domestic violence often begins or increases during pregnancy and the postpartum period [40-42].
- Women with an unintended pregnancy have a 3 times greater risk of physical abuse compared with those whose pregnancy was planned [43].
- Pregnant women who are abused have a 3 times higher risk of being victims of attempted or completed homicide than non-abused people with similar demographic characteristics [44].

Click the next arrows to read more information.

Intimate Partner Violence

- Intermittent screening throughout pregnancy increases the detection of IPV
- When violence is identified, the following steps are important [45]:

Click this button for more information



Click the next arrows to read more information.

- Non-judgmental and compassionate health care professionals
- Confidentiality maintenance
- Understand the complexities of violence and the difficulty of a quick resolution
- Not ‘medicalizing’ the issue
- Communication that is neither rushed nor hurried
- Affirmation that the violence is undeserved
- Supportive listening and feedback
- Allowing her to progress at her own pace
- Not pressuring her to disclose, leave the relationship or press legal charges
- Shared decision-making
- Respect for her decisions

Intimate Partner Violence

- The immediate expression of empathy, acknowledgement and continued ability to support and assist the woman are the most important components of care after a patient has disclosed abuse.
- The midwife must remain ethical in assisting her with decision-making and not allow personal values into the discussion.
- If IPV is recognized, the midwife should offer continued support, and review with her available prevention and referral options.
  - Availability may vary across the nation.
  - Learning of available programs in your community is key for her health and well being.
- If the woman declines services at an appointment, she should be offered these services at subsequent appointments and told she can contact the clinic at any time.

Maternal Mood Disorders



All pregnant women should be screened for mood disorders during the pregnancy and postpartum period.

- Antenatal depression is associated with an increased risk of poor obstetrical outcomes, including spontaneous abortion, bleeding, operative deliveries and preterm birth [46,47].
- Mood disorders can also affect a woman's ability to understand information provided to her and make health care decisions.

Maternal Mood Disorders



Depressive disorders:

- Major depression is common in pregnant women and is a condition which often goes untreated [48].
- Untreated mental health conditions increase the risk for [49, 50]:

Click this button for more information

Maternal Mood Disorders

- Poor nutrition
- Substance use disorders
- Minimal prenatal care
- Increased risk of postpartum depression
- Impaired family relationships
- Increased risk of suicide

Maternal Mood Disorders



Patients with psychotic or schizoaffective disorders, bipolar mood episodes with psychotic features and unipolar major depression with psychotic features, may be at risk for impaired capacity.

There are four generally accepted decision-making abilities that constitute capacity:

- Understanding
- Expressing a choice
- Appreciation
- Reasoning

Decision making capacity is determined by formal neurocognitive testing.

Maternal Mood Disorders

Maternal Mood Disorders



Anxiety Disorders

- Anxiety is common in pregnancy due to the uncertainty regarding the prenatal course and the potential for unforeseen complications
  - Anxiety disorders are also common in pregnancy
  - Anxiety disorders increase the risk of pregnancy complications and increase the risk for postpartum depression

Click to learn more about treatment for mood disorders

Maternal Mood Disorders



When a mood disorder is identified, for treatment should be considered. This can include counseling, cognitive behavioral therapy (CBT) and psychopharmacology therapy.

Maternal Mood Disorders



Mood disorders during pregnancy are usually treated by primary care clinicians (PCP) in collaboration with perinatal or general psychiatrists [49, 51-53].

Referral may be needed if this is not the health care provider's expertise; however, the obstetrician should continue to address the mood disorder at all prenatal visits.

Maternal Mood Disorders



Barriers to treatment during pregnancy may include:

- Cost
- Maternal fear of exposing the fetus to antidepressant medication
- Refusal of psychotherapy
- Psychotherapy is unavailable
- Stigma associated with mental health disorders [49,50].
- Health care providers who lack expertise in prescribing medication to pregnant women [54].

Click for more on barriers to treatment

Maternal Mood Disorders



- In cases of mild depression, the patient should be recommended to seek counseling and consideration should be given for initiation of medical treatment
- The patient should be asked if she has ever been on pharmacologic treatment for depression or anxiety in the past and the perceived efficacy of prior medication should be reviewed
  - If safe in pregnancy, consider resumption of prior therapy
  - In pregnancy, therapy with SSRIs, including Zoloft, Prozac, Lexapro and Celexa, is considered safe

Maternal Mood Disorders



Treatment for Severe Depression

- Mental health treatment is provided in an appropriate setting for her condition [56-57].
  - Inpatient hospitalization may be needed to maintain her safety and stabilize her, especially when suicidal ideation with a plan or intent is in place.
  - Perinatal psychiatric inpatient units are preferable, however, these facilities are typically not available [58].
  - Partial hospitalization, also known as day therapy, may be implemented when she has moderate symptoms — such as when suicidal ideations are nebulous or no plan exists and she is deemed not at imminent risk.
  - Outpatient therapy may be implemented when there is no acute threat present. She may have thoughts, such as that her family would be better off if she were dead, but has no plan or preoccupied thoughts to commit suicide.

Click for more on barriers to treatment

Maternal Mood Disorders

Maternal Mood Disorders



- If she is unwilling or does not recognize the need for either pharmacologic and/or therapy, the hierarchy of decision making may be needed to keep her safe.
- At times court ordered treatment may be necessary to ensure her safety and the safety of her unborn child.
- Ongoing monitoring and therapy will be needed through the pregnancy, the postpartum period and beyond by her health care team of PCP, Psychiatrist, Counselor, and Obstetrician.
- Considering various issues involved in psychiatric disorders and research, ethics plays a crucial role in protecting the rights of individuals with mental illness and simultaneously safeguarding them.

Transfer to Hospital

Best Practice Guidelines
Transfer from Planned Home Birth to Hospital

"We believe that collaboration within an integrated maternity care system is essential/or optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits." [60]

Transfer to Hospital

EMTALA

- State-specific hospital regulations and the Emergency Medical Treatment and Labor Act (EMTALA) 35 establish the legal framework for requiring access to hospital care in the United States.
- The legal recognition of providers of maternity care services varies between states. However, each woman seeking care at any point during the maternity cycle has the right to optimal and respectful care regardless of her planned birth setting, the persons she selects to be part of the process, or state provider regulations.

[60]

Transfer to Hospital

EMTALA

- These guidelines are appropriate for births planned at home or in a freestanding birth center.
- Furthermore, we recognize not all providers of home birth or birth center services are midwives. However, we use the term midwife herein because the vast majority of providers of home birth or birth center services identify as midwives.

[60]

Transfer to Hospital

For the patient's best outcome

- Model practices for the **midwife** [60]
  - In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise.
  - The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.

Transfer to Hospital

For the patient's best outcome

- Model practices for the **midwife** [60]
  - The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.
  - The midwife continues to provide routine or urgent care en route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.

Transfer to Hospital

For the patient's best outcome

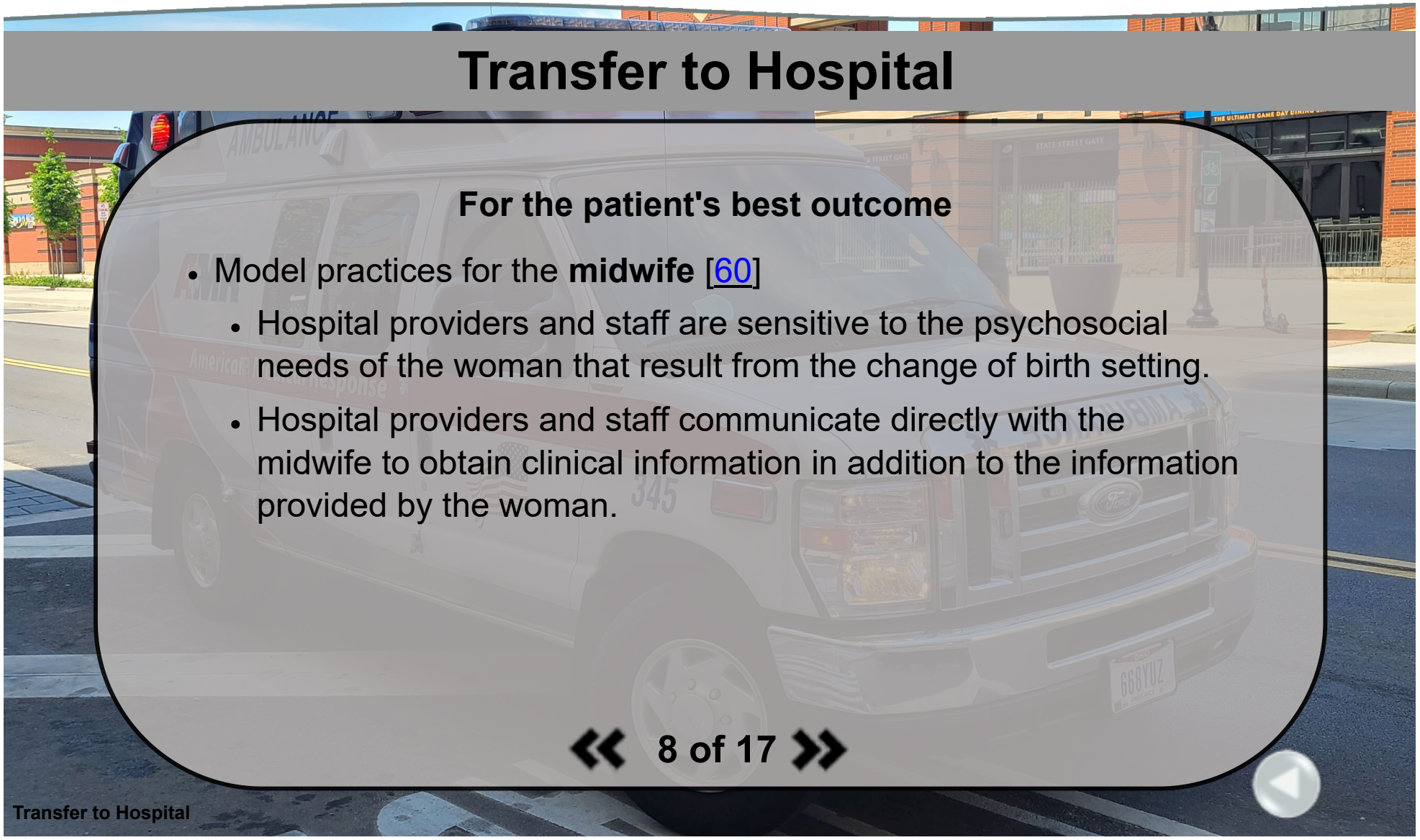
- Model practices for the **midwife** [60]
  - Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records.
  - The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider.

Transfer to Hospital

For the patient's best outcome

- Model practices for the **midwife** [60]
  - The midwife promotes good communication by ensuring that the woman understands the hospital provider's plan of care and the hospital provider understands the woman's need for information regarding care options.
  - If the woman chooses, the midwife may remain to provide continuity and support.

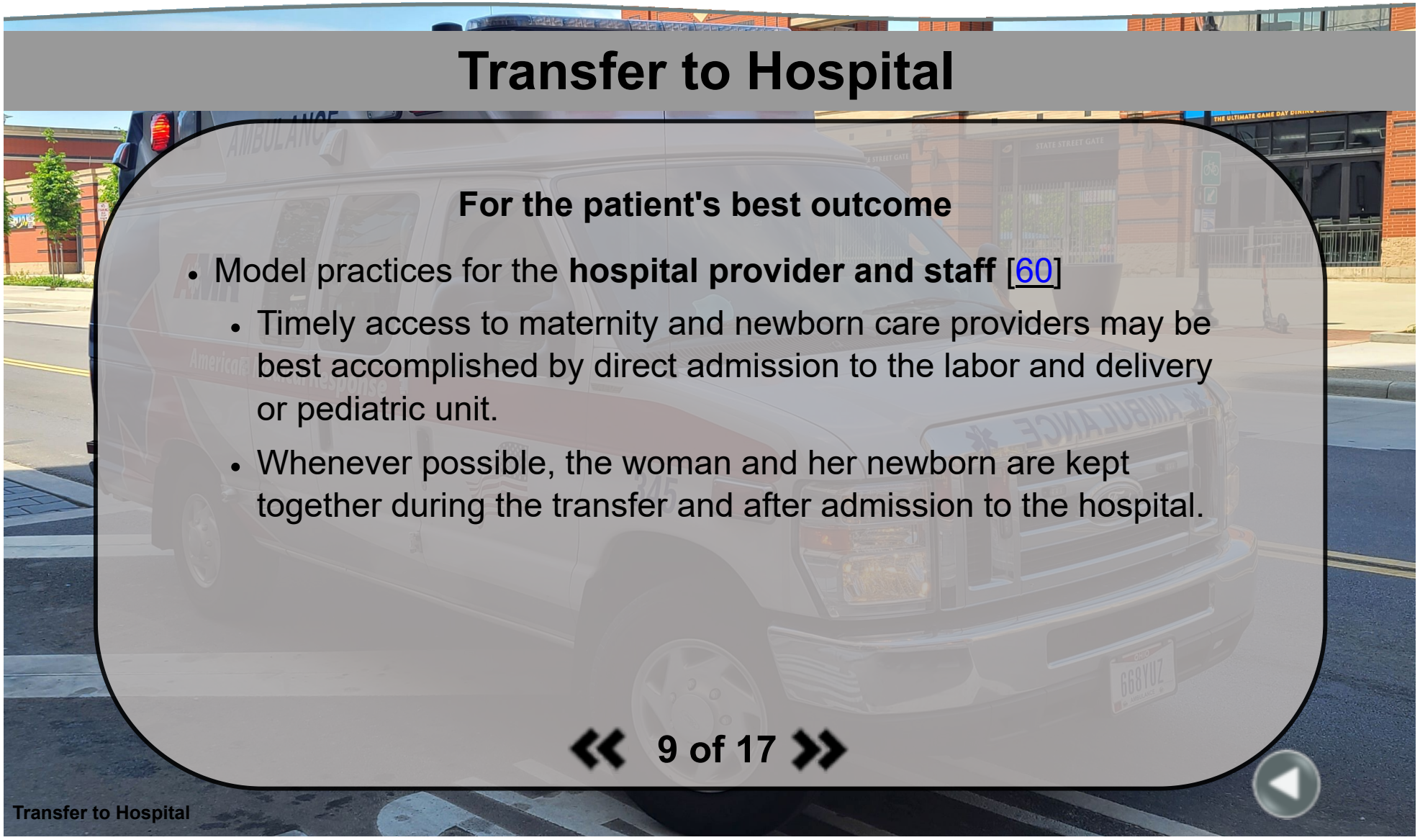
Transfer to Hospital



For the patient's best outcome

- Model practices for the **midwife** [60]
  - Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting.
  - Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.

Transfer to Hospital



For the patient's best outcome

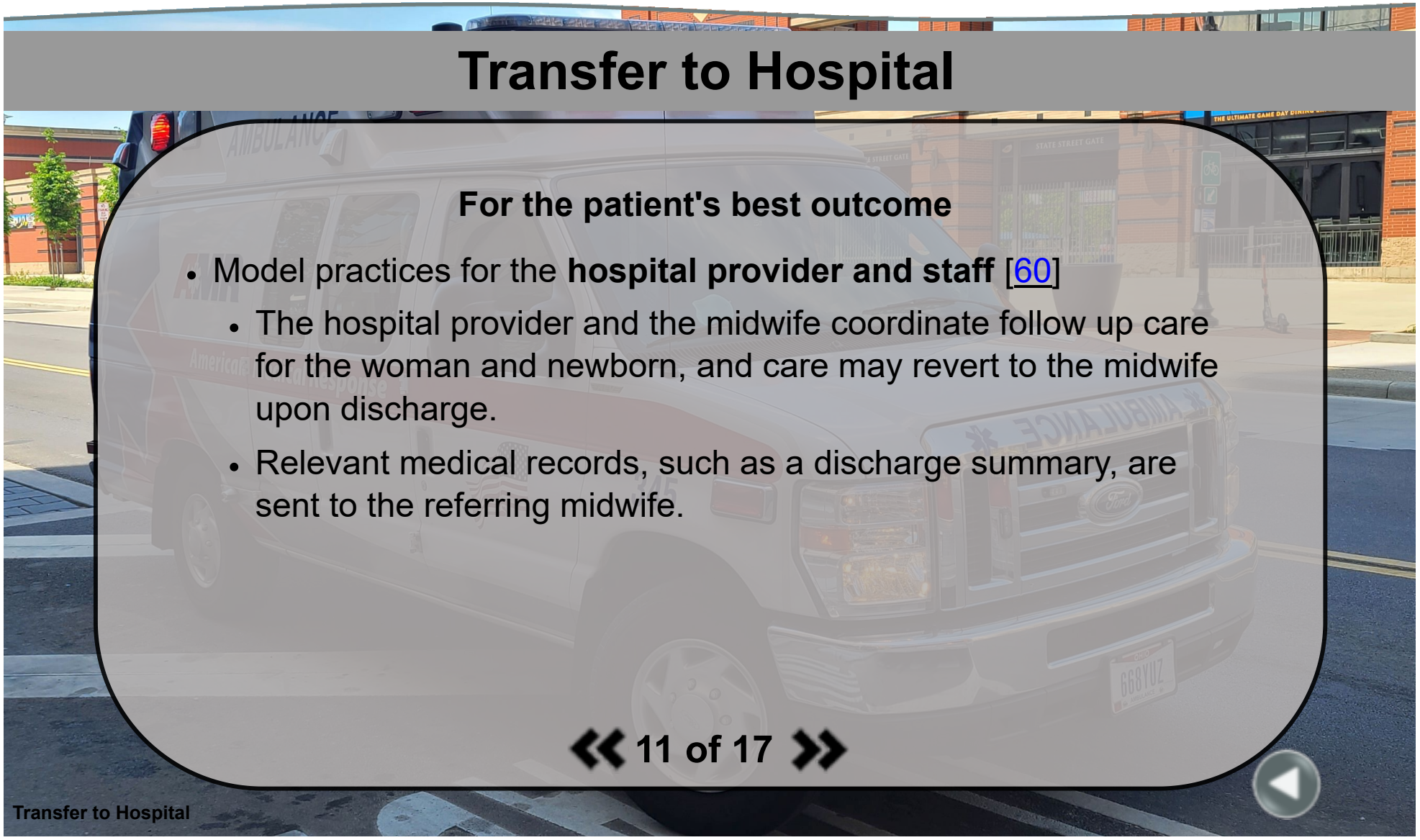
- Model practices for the **hospital provider and staff** [60]
  - Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.
  - Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.

Transfer to Hospital

For the patient's best outcome

- Model practices for the **hospital provider and staff** [60]
  - Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.
  - If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman's primary support person during assessments and procedures.

Transfer to Hospital



For the patient's best outcome

- Model practices for the **hospital provider and staff** [60]
  - The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.
  - Relevant medical records, such as a discharge summary, are sent to the referring midwife.

Transfer to Hospital

Quality Improvement [60]

- Quality improvement and policy development All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process.
- Policies and quality improvement processes should incorporate the model practices above and delineate at a minimum the following information:

Transfer to Hospital

Quality Improvement [60]

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the woman prior to hospital discharge.

Transfer to Hospital

Quality Improvement [60]

- Documentation of the woman's perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery.
- Opportunities for education regarding home birth practice, shared continuing medical education, and relationship building that are incorporated into medical, midwifery and nursing education programs.
- Multi-disciplinary sessions to address system issues may enhance relationship building and the work culture.

Transfer to Hospital

Quality Improvement [60]

Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital. [60]

Three Broad Goals [61]:

1. Develop mutual understanding of provider roles and client needs during childbirth and perinatal transfers
2. Improve effective communication and collaboration between providers during perinatal transfers
3. Increase safety, well-being, and care experiences for families during childbirth

Transfer to Hospital

Benefits versus Barriers [61]

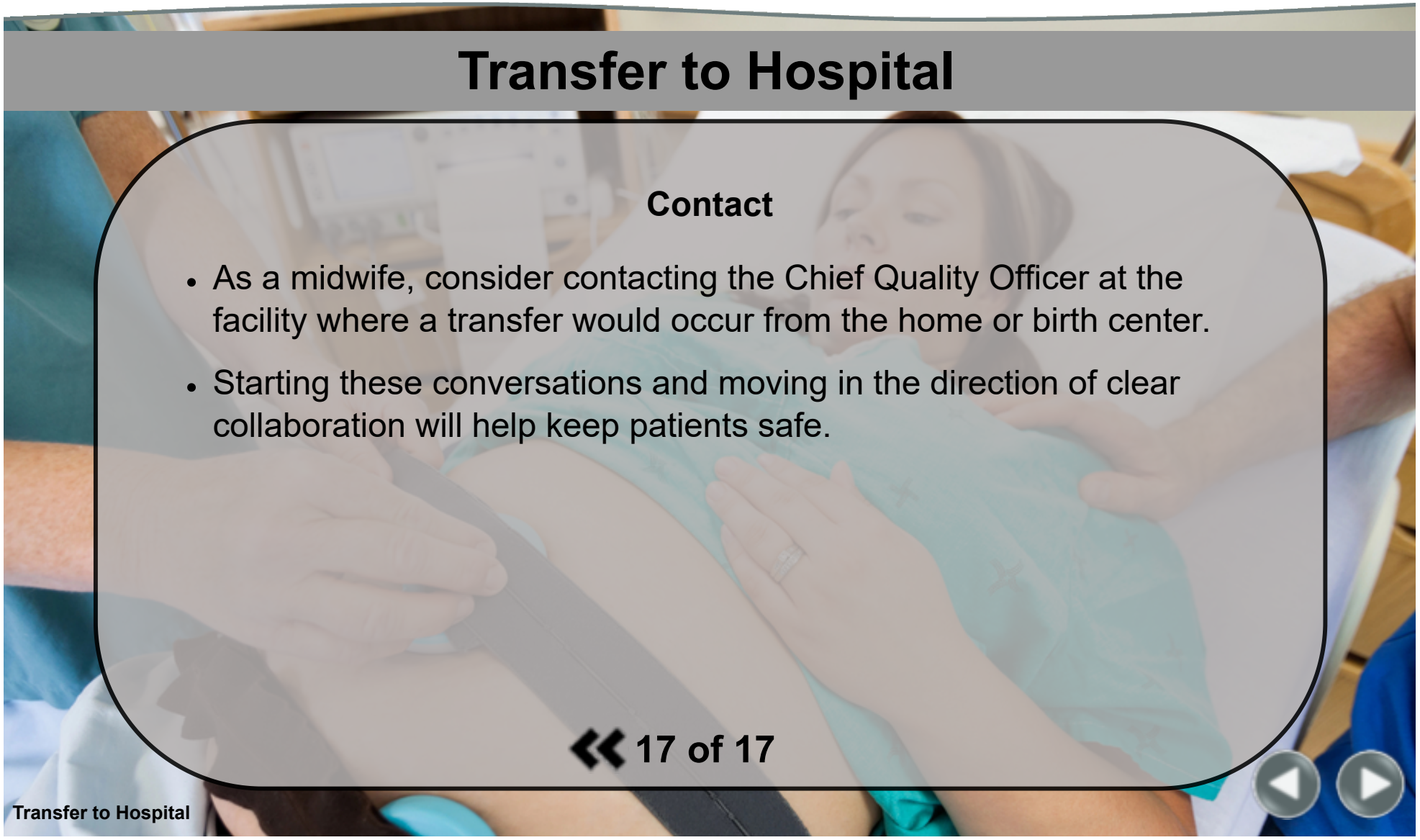
BARRIERS

- Unequal power dynamics
- Liability and insurance issues
- Poor communication
- Lack of clarity in understanding role/responsibilities
- Conflicts in care models
- Delays in treatment and options

BENEFITS

- Positive impact for care experience of patient/client
- Increased efficiency in care
- Increased cost savings
- Improved health outcomes
- Enhanced provider satisfaction
- Greater integration into health care systems

Transfer to Hospital



Contact

- As a midwife, consider contacting the Chief Quality Officer at the facility where a transfer would occur from the home or birth center.
- Starting these conversations and moving in the direction of clear collaboration will help keep patients safe.

Belligerent Spouse

- Handling a belligerent and aggressive partner during childbirth can be challenging, but maintaining a calm and professional demeanor is essential for the well-being of both the mother and the healthcare team.
- Following are some strategies for managing a difficult partner during the delivery process.

Belligerent Spouse

Educate in Advance:

- Provide education to both partners before the delivery about what to expect during the birthing process.
- Discuss the importance of emotional support and cooperation.

Belligerent Spouse

Maintain Calmness and Composure:

- As midwives, we are astute to keeping our calm, but we all have limitations.
- Keep your own emotions in check. Responding with calmness and composure can help diffuse tension.
- Avoid escalating the situation by remaining focused on the needs of the mother.

Belligerent Spouse

Effective Communication:

- Clearly communicate the importance of a calm and supportive environment for the well-being of the mother and the baby.
- Use a calm and reassuring tone to convey information and instructions.

Belligerent Spouse

Establish Boundaries:

- Politely but firmly set boundaries for behavior in the delivery room.
- Clearly communicate the expectations for respectful and cooperative behavior.

Belligerent Spouse

Involve Support Staff:

- If necessary, call for assistance from support staff.
- Ensure that there is a plan in place for managing disruptive behavior.

Belligerent Spouse

Empower the Mother:

- Encourage the mother to express her feelings and preferences.
- Empower her to communicate with her partner about the need for a supportive and respectful environment

Belligerent Spouse

Reassure and Involve the Partner:

- Reassure the partner that their presence is valued, but their behavior needs to be supportive.
- Involve them in positive aspects of the birthing process, such as encouraging them to support the mother during contractions.

Belligerent Spouse

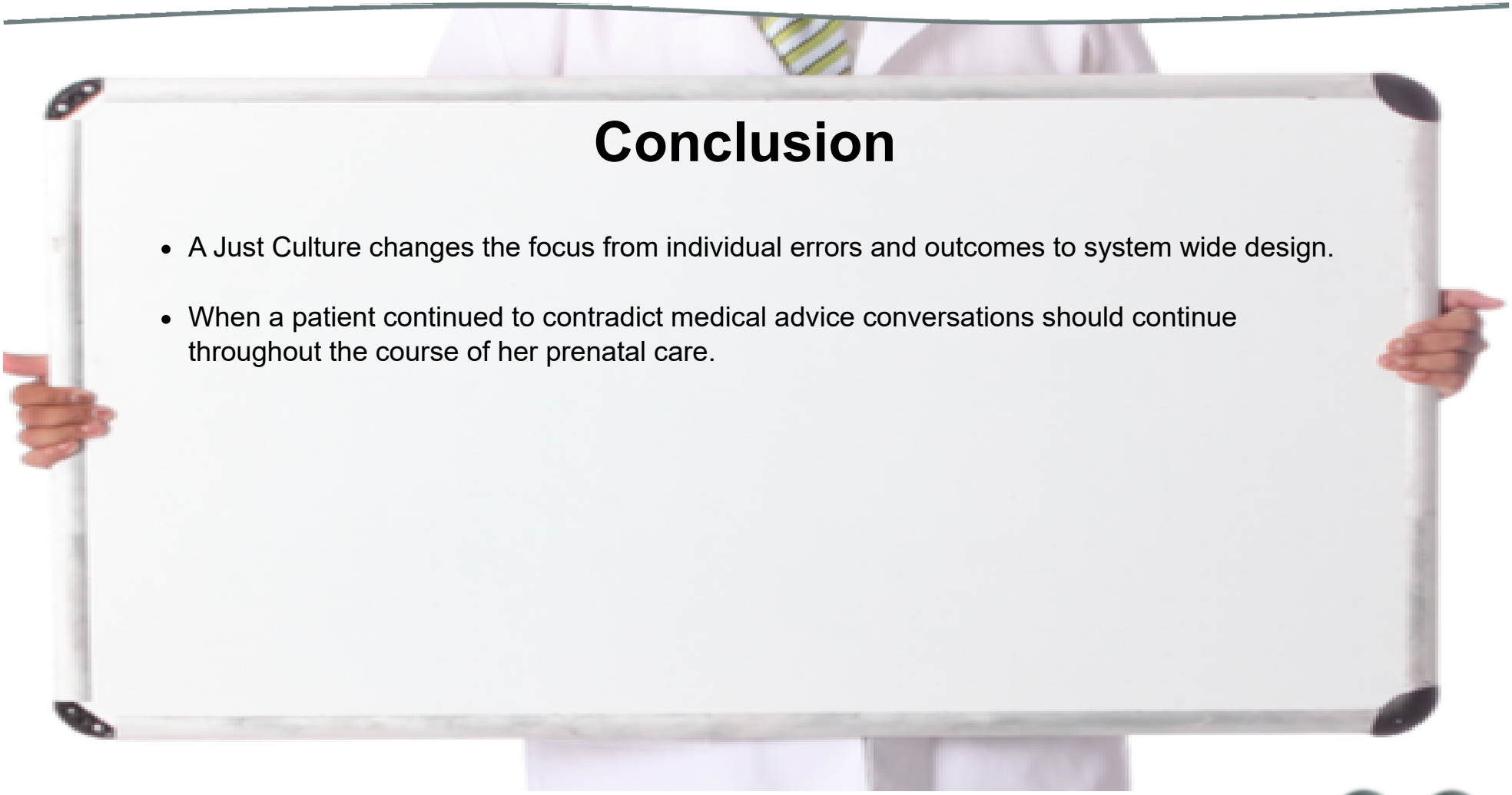
Staff Debriefing:

- After the delivery, hold a debriefing session with the healthcare team to discuss the incident and identify areas for improvement in managing similar situations in the future.

Belligerent Spouse

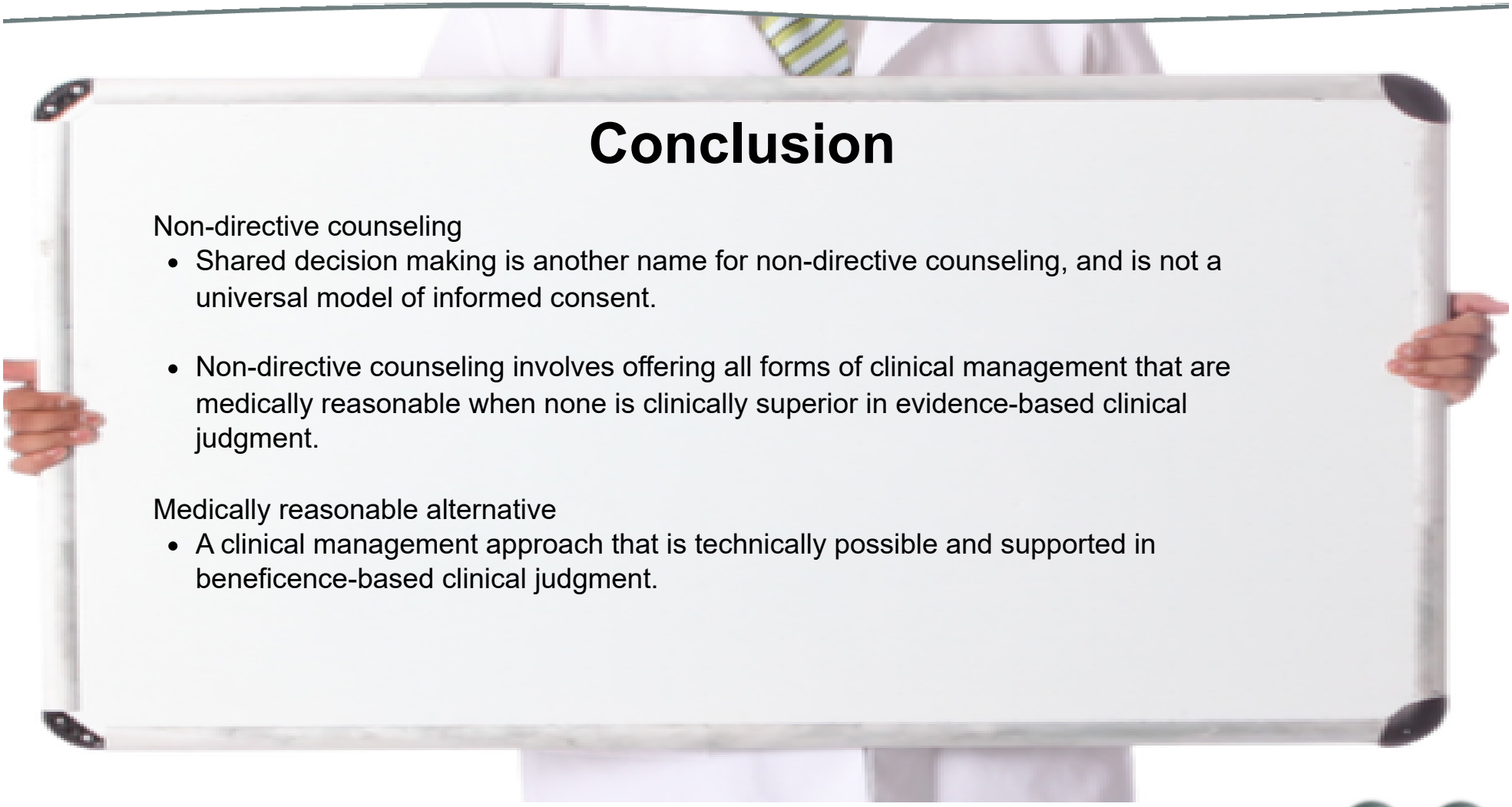
De-escalation Tactics:

- Remain calm
- Actively listen and show genuine interest in understanding their perspective
  - Eye contact, nodding
- Empathize with statements like “I understand this is difficult for you”.
- Use open body language by not crossing arms and being at eye level
- Avoid confrontation by not arguing
- Set clear boundaries
- Use distraction techniques, send them after ice chips; change the topic of conversation
- Maintain personal safety
- Use a collaborative tone and use phrases such as “Let’s work together to find a solution” and this may encourage a sense of partnership
- Train by learning ongoing de-escalation techniques; role-play to practice and reinforce these skills



Conclusion

- A Just Culture changes the focus from individual errors and outcomes to system wide design.
- When a patient continued to contradict medical advice conversations should continue throughout the course of her prenatal care.



Conclusion

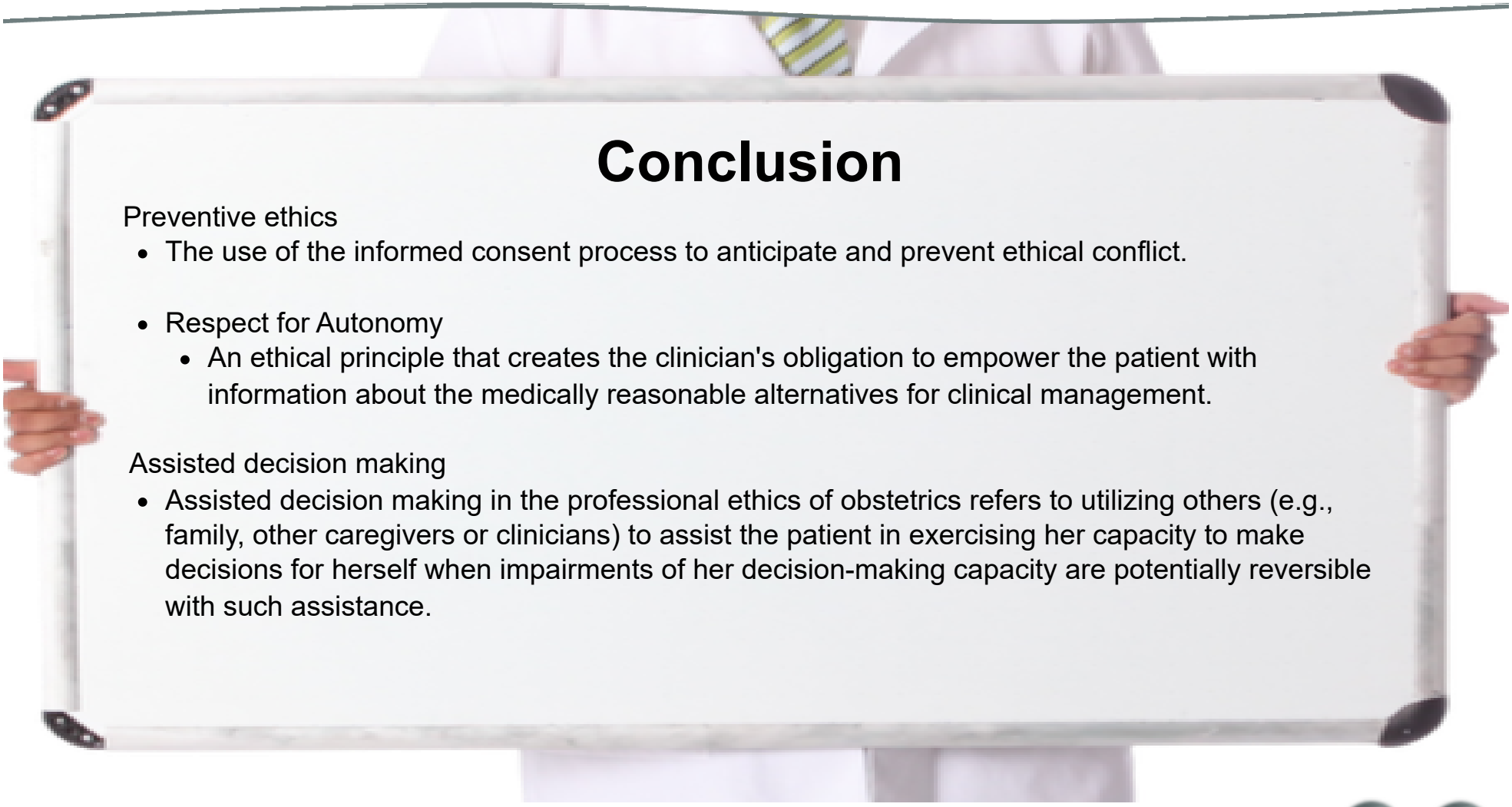
Non-directive counseling

- Shared decision making is another name for non-directive counseling, and is not a universal model of informed consent.

- Non-directive counseling involves offering all forms of clinical management that are medically reasonable when none is clinically superior in evidence-based clinical judgment.

Medically reasonable alternative

- A clinical management approach that is technically possible and supported in beneficence-based clinical judgment.



Conclusion

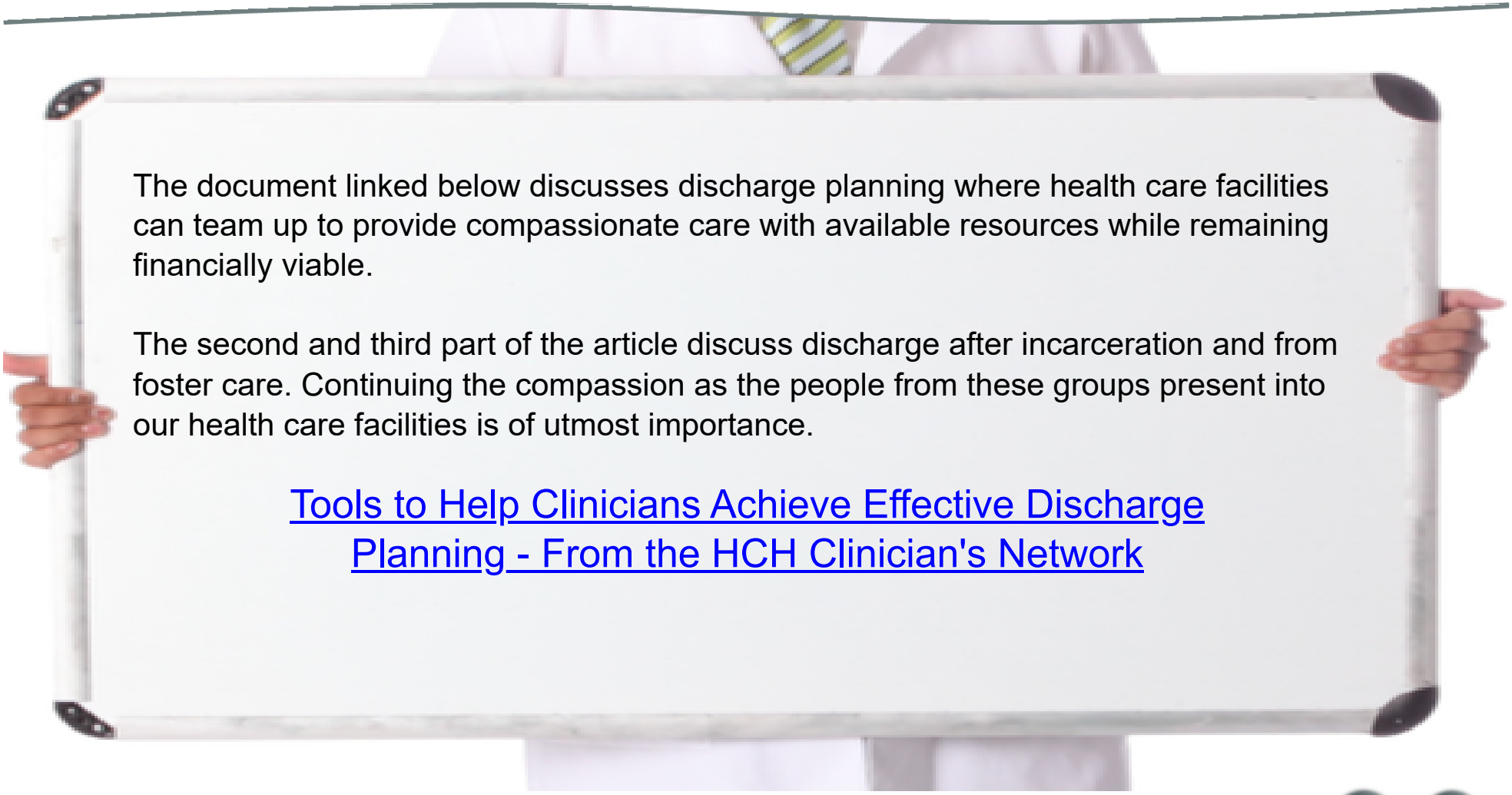
Preventive ethics

- The use of the informed consent process to anticipate and prevent ethical conflict.

- Respect for Autonomy
  - An ethical principle that creates the clinician's obligation to empower the patient with information about the medically reasonable alternatives for clinical management.

Assisted decision making

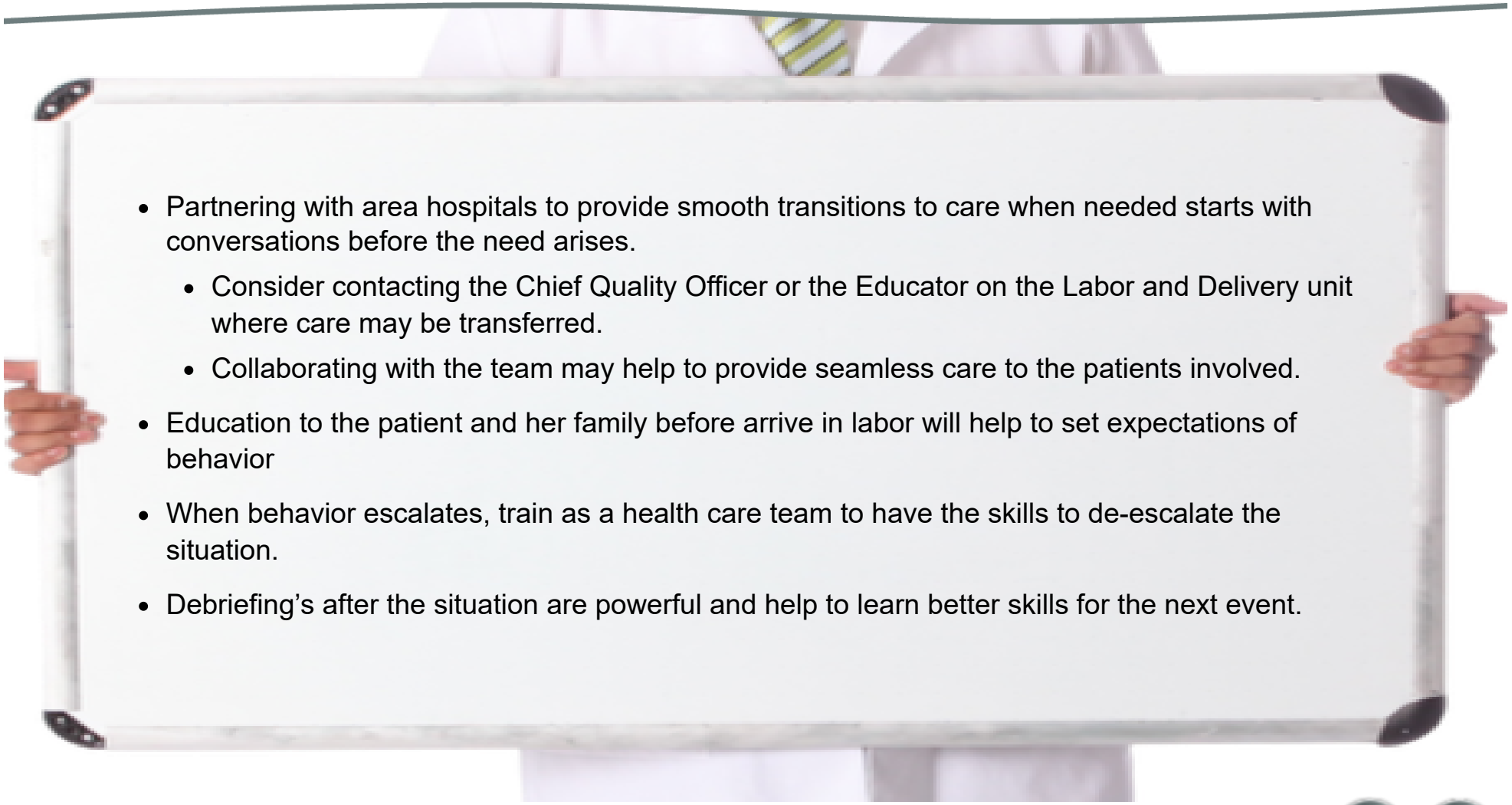
- Assisted decision making in the professional ethics of obstetrics refers to utilizing others (e.g., family, other caregivers or clinicians) to assist the patient in exercising her capacity to make decisions for herself when impairments of her decision-making capacity are potentially reversible with such assistance.



The document linked below discusses discharge planning where health care facilities can team up to provide compassionate care with available resources while remaining financially viable.

The second and third part of the article discuss discharge after incarceration and from foster care. Continuing the compassion as the people from these groups present into our health care facilities is of utmost importance.

[Tools to Help Clinicians Achieve Effective Discharge Planning - From the HCH Clinician's Network]



- Partnering with area hospitals to provide smooth transitions to care when needed starts with conversations before the need arises.
  - Consider contacting the Chief Quality Officer or the Educator on the Labor and Delivery unit where care may be transferred.
  - Collaborating with the team may help to provide seamless care to the patients involved.
- Education to the patient and her family before arrive in labor will help to set expectations of behavior
- When behavior escalates, train as a health care team to have the skills to de-escalate the situation.
- Debriefing's after the situation are powerful and help to learn better skills for the next event.

Summary Cont'd

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References

1. Boysen, Philip G. "Just Culture: a Foundation for Balanced Accountability and Patient Safety." The Ochsner Journal, vol. 13, no. 3, 2013, pp. 400-6.
2. Cerminara KL. The law and its interaction with medical ethics in end-of-life decision making. Chest. 2011 Sep;140(3):775-80.
3. IOM, Report Brief September 2014. http://www.iom.edu/~/media/Files/Report%20Files/2014/EOL/Report%20Brief.pdf. no abstract available.
4. Bernacki RE, Block SD. American College of Physicians High Value Care Task Force. Communication about serious illness care goals: a review and synthesis of best practices. JAMA Intern Med. 2014;174(12):1994.
5. Pope TM. Legal fundamentals of surrogate decision making. Chest. 2012 Apr;141(4):1074-81.
6. Scheunemann LP, Arnold RM, White DB. The facilitated values history: helping surrogates make authentic decisions for incapacitated patients with advanced illness. Am J Respir Crit Care Med. 2012 Sep;186(6):480-6. Epub 2012 Jul 19.
7. Pochard F, Azoulay E, Chevret S, Lemaire F, Hubert P, Canoui P, Grassin M, Zittoun R, le Gall JR, Dhainaut JF, Schlemmer B, French FAMIREA Group. Symptoms of anxiety and depression in family members of intensive care unit patients: ethical hypothesis regarding decision-making capacity. Crit Care Med. 2001;29(10):1893.
8. Wendler D, Rid A. Systematic review: the effect on surrogates of making treatment decisions for others. Ann Intern Med. 2011;154(5):336.
9. Braun UK, Beyth RJ, Ford ME, McCullough LB. Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making. J Gen Intern Med. 2008 Mar;23(3):267-74. Epub 2008 Jan 3.
10. Chervenak FA, McCullough LB. Preventive ethics for cesarean delivery: the time has come. Am J Obstet Gynecol. 2013;209(3):166. Epub 2013 Jun 4.
11. Chervenak FA, McCullough LB, Brent RL. The perils of the imperfect expectation of the perfect baby. Am J Obstet Gynecol. 2010;203(2):101.e1. Epub 2010 Mar 12.
12. Chervenak FA, McCullough LB. The Professional Responsibility Model of Perinatal Ethics, 1st ed, Walter de Gruyter, Berlin 2014.
13. Ecker J. Elective cesarean delivery on maternal request. JAMA. 2013 May;309(18):1930-6.
14. ACOG Committee Opinion No. 761: Cesarean Delivery on Maternal Request. Obstet Gynecol. 2019;133(1):e73.
15. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/01/cesarean-delivery-on-maternal-request.
16. Henderson J, Gray R, Brocklehurst P. Systematic review of effects of low-moderate prenatal alcohol exposure on pregnancy outcome. BJOG. 2007;114(3):243.
17. Chasnoff IJ, McGourty RF, Bailey GW, Hutchins E, Lightfoot SO, Pawson LL, Fahey C, May B, Brodie P, McCulley L, Campbell J. The 4P's Plus screen for substance use in pregnancy: clinical application and outcomes. J Perinatol. 2005;25(6):368.

18. Kitsantas P, Gaffney KF, Wu H, Kastello JC. Determinants of alcohol cessation, reduction and no reduction during pregnancy. Arch Gynecol Obstet. 2014 Apr;289(4):771-9. Epub 2013 Oct 23.

19. Denny CH, Acero CS, Naimi TS, Kim SY. Consumption of Alcohol Beverages and Binge Drinking Among Pregnant Women Aged 18-44 Years - United States, 2015-2017. MMWR Morb Mortal Wkly Rep. 2019;68(16):365. Epub 2019 Apr 26.

20. Sokol RJ, Martier SS, Ager JW. The T-ACE questions: practical prenatal detection of risk-drinking. Am J Obstet Gynecol. 1989;160(4):863.

21. Chan AW, Pristach EA, Welte JW, Russell M. Use of the TWEAK test in screening for alcoholism/heavy drinking in three populations. Alcohol Clin Exp Res. 1993;17(6):1188.

22. O'Connor MJ, Whaley SE. Alcohol use in pregnant low-income women. J Stud Alcohol. 2003;64(6):773.

23. Bradley KA, Boyd-Wickizer J, Powell SH, Burman ML. Alcohol screening questionnaires in women: a critical review. JAMA. 1998;280(2):166.

24. Chang G. Maternal substance use: consequences, identification, and intervention. Alcohol Res 2020.

25. El-Mohandes A, Herman AA, Nabil El-Khorazaty M, Katta PS, White D, Grylack L. Prenatal care reduces the impact of illicit drug use on perinatal outcomes. J Perinatol. 2003 Jul;23(5):354-60.

26. Rogers DM, Crookston KP. The approach to the patient who refuses blood transfusion. Transfusion. 2006;46(9):1471.

27. National Health Care for the Homeless Council. What is the official definition of homelessness? https://www.nhchc.org/faq/official-definition-homelessness/ (Accessed on November 16, 2017).

28. Bloom KC, Bednarzyk MS, Devitt DL, Renault RA, Teaman V, Van Loock DM. Barriers to prenatal care for homeless pregnant women. J Obstet Gynecol Neonatal Nurs. 2004;33(4):428.

29. Scappaticci A, Blay S. Homeless teen mothers: social and psychological aspects. J Public Health. 2009; 17:19.

30. American College of Obstetricians and Gynecologists. Committee on Health Care for Underserved Women. Committee opinion no. 454: Healthcare for homeless women. Obstet Gynecol. 2010;115(2 Pt 1):396.

31. Killion CM. Special health care needs of homeless pregnant women. ANS Adv Nurs Sci. 1995;18(2):44.

32. Feal AC, Redlener I. Enhancing perinatal outcome in homeless women: the challenge of providing comprehensive health care. Semin Perinatol 1995; 19:307.

33. Little M, Shah R, Vermeulen MJ, et al. Adverse perinatal outcomes associated with homelessness and substance use in pregnancy. CMAJ 2005; 173:615.

34. Stein JA, Lu MC, Gelberg L. Severity of homelessness and adverse birth outcomes. Health Psychol 2000; 19:524.

35. Paterson CM, Roderick P. Obstetric outcome in homeless women. BMJ 1990; 301:263.

36. Clark RE, Weinreb L, Flahive JM, Seifert RW. Homelessness contributes to pregnancy complications. Health Affairs 2018; 38:139.

37. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Publication No. NCJ-181867, US Department of Justice, Washington, DC 2000.

38. The World Health Organization. World report on violence and health. Chapter 4. Violence by intimate partners. http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap4.pdf (Accessed on August 07, 2011).

39. ACOG Committee Opinion No. 518: Intimate partner violence. Obstet Gynecol. 2012 Feb;119(2 Pt 1):412-7.

40. Hillard PJ. Physical abuse in pregnancy. Obstet Gynecol 1985: 66:185.

41. Stewart DE. Incidence of postpartum abuse in women with a history of abuse during pregnancy. CMAJ 1994; 151:1601.

42. Gazmararian JA, Lazorick S, Spitz AM, et al. Prevalence of violence against pregnant women. JAMA 1996; 275:1915.

43. Goodwin MM, Gazmararian JA, Johnson CH, et al. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. Matern Child Health J 2000; 4:85.

44. McFarlane J, Campbell JC, Sharps P, Watson K. Abuse during pregnancy and femicide: urgent implications for women's health. Obstet Gynecol 2002; 100:27.

45. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006 Jan;166(1):22-37.

46. Chaudron LH. Complex challenges in treating depression during pregnancy. Am J Psychiatry. 2013 Jan;170(1):12-20.

47. Lupattelli A, Spigset O, Koren G, Nordeng H. Risk of vaginal bleeding and postpartum hemorrhage after use of antidepressants in pregnancy: a study from the Norwegian Mother and Child Cohort Study. J Clin Psychopharmacol. 2014;34(1):143

48. Vigod SN, Wilson CA, Howard LM. Depression in pregnancy. BMJ. 2016;352:i1547. Epub 2016 Mar 24.

49. ACOG Committee on Practice Bulletins--Obstetrics. ACOG Practice Bulletin: Clinical management guidelines for obstetrician-gynecologists number 92, April 2008 (replaces practice bulletin number 87, November 2007). Use of psychiatric medications during pregnancy and lactation. Obstet Gynecol 2008;111(4):1001

50. Stewart DE. Clinical practice. Depression during pregnancy. N Engl J Med. 2011 Oct;365(17):1605-11.

51. Goodwin GM. Consensus Group of the British Association for Psychopharmacology. Evidence-based guidelines for treating bipolar disorder: revised second edition--

recommendations from the British Association for Psychopharmacology. J Psychopharmacol. 2009;23(4):346. Epub 2009 Mar 27.

52. Jones I, Craddock N. Bipolar disorder and childbirth: the importance of recognizing risk. Br J Psychiatry. 2005 Jun; 186:453-4.

53. Burt VK, Bernstein C, Rosenstein WS, Altshuler LL. Bipolar disorder and pregnancy: maintaining psychiatric stability in the real world of obstetric and psychiatric complications. Am J Psychiatry. 2010 Aug;167(8):892-7.

54. Shah N. Mood disorder in the perinatal period. OBMJ. 2012;344: e1209. Epub 2012 Mar 1.

55. Osborne LM, Hermann A, Burt V, Driscoll K, Fitelson E, Meltzer-Brody S, Barzilay EM, Yang SN, Miller L. Reproductive Psychiatry: The Gap Between Clinical Need and Education. National Task Force on Women's Reproductive Mental Health. Am J Psychiatry. 2015 Oct;172(10):946-8.

56. American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder (revision). Am J Psychiatry. 2002;159(4 Suppl):1.

57. Grunze H, Vieta E, Goodwin GM, Bowden C, Licht RW, Moller HJ, Kasper S. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of bipolar disorders: update 2009 on the treatment of acute mania. World J Biol Psychiatry. 2009;10(2):85.

58. Yatham LN, Kennedy SH, Schaffer A, Parikh SV, Beaulieu S, O'Donovan C, MacQueen G, McIntyre RS, Sharma V, Ravindran A, Young LT, Young AH, Alda M, Milev R, Vieta E, Calabrese JR, Berk M, Ha K, Kapczinski F. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2009. Bipolar Disord. 2009;11(3):225.

59. Kimmel MC, Lara-Cinisomo S, Melvin K, Di Florio A, Brandon A, Meltzer-Brody S. Treatment of severe perinatal mood disorders on a specialized perinatal psychiatry inpatient unit. Arch Womens Ment Health. 2016;19(4):645

60. https://calmidwives.org/wp-content/uploads/2022/01/CALM-Transitions-PPT_rmd-01-06-2022.pdf

61. https://www.birthplacelab.org/best-practice-guidelines-for-transfers-pdf/

62. https://www.homebirthsummit.org/best-practice-transfer-guidelines/