"I'm sure we talked about it": Midwives experiences of ethics education and ethical dilemmas, a qualitative study

Michele Megregian[a], Lisa Kane Low[b], Cathy Emeis[c], Raymond de Vries[d,e], Marianne Nieuwenhuijze[f]

[a] *Nurse-Midwifery, School of Nursing, Oregon Health & Science University, United States*

[b] *School of Nursing and Department of Women's Studies and Department of Obstetrics and Gynecology, University of Michigan, 400 North Ingalls Suite 3160, Ann Arbor Michigan, 48103, United States*

[c] *Director of the Nurse-Midwifery Program, School of Nursing, Oregon Health & Science University, 3455 US Veterans Hospital Rd, Portland, OR, 97239, United States*

[d] *School of Public Health and Primary Care Maastricht, University Maastricht, Maastricht, Universiteitssingel 60, 622ER Maastricht, The Netherlands*

[e] *Center for Bioethics and Social Sciences in Medicine, University of Michigan Medical School, 2800 Plymouth Rd Ann Arbor, MI, 48109, United States*

[f] *Professor of Midwifery, Research Centre for Midwifery Science, Zuyd University, Maastricht, Universiteitssingel 60, 6229 ER Maastricht, The Netherlands*

Abstract

Aim:
Midwives are expected to identify and help resolve ethics problems that arise in practice, skills that are presumed to be taught in midwifery educational programs. In this study, we explore how midwives recognize ethical dilemmas in clinical practice and examine the sources of their ethics education.

Methods:
We conducted semi-structured, individual interviews with midwives from throughout the United States (U.S.) (n = 15). Transcripts of the interviews were analysed using an iterative process to identify themes and subthemes.

Findings:
Midwives described a range of professional ethical dilemmas, including challenges related to negotiating strained interprofessional relationships and protecting or promoting autonomy for women. Ethical dilemmas were identified by the theme of *unease,* a sense of distress that was expressed in three subthemes: *uncertainty of action, compromise in action,* and *reflecting on action.* Learning about ethics and ethical dilemmas occurred, for the most part, outside of the classroom, with the majority of participants reporting that their midwifery program did not confer the skills to identify and resolve ethical challenges.

Conclusion:

Midwives in this study reported a range of ethical challenges and minimal classroom education related to ethics. Midwifery educators should consider the purposeful and explicit inclusion of midwifery-specific ethics content in their curricula and in interprofessional ethics education. Reflection and self-awareness of bias were identified as key components of understanding ethical frameworks. As clinical preceptors were identified as a key source of ethics learning, midwifery educators should consider ways to support preceptors in building their skills as role models and ethics educators.

Keywords:
Midwifery, Midwifery education, Ethics, Ethical dilemmas

Statement of significance

Problem
Ethics curricula in midwifery programs may not adequately prepare midwives to recognize and negotiate common ethical dilemmas.

What is already known
Ethics education in midwifery programs in the United States is currently lacking in standardization regarding ethics content, methods of teaching and evaluation, and expected outcomes.

What this paper adds
Midwives recognize ethical dilemmas through a sense of unease. They report little ethics education from their midwifery programs, and rely upon clinical preceptors, not classroom content, for ethics learning.

Implications for practice
Midwifery education programs should consider purposeful inclusion of ethics content. Improved understanding of the function of clinical preceptors as role models of ethics is needed.

Introduction

Perinatal health care brings particularly complex ethical questions. Midwives and the women they care for are confronted with ethical dilemmas on a regular basis. Midwives are expected to possess a sensitivity to ethics and the skill to guide ethical, shared decision-making [1]. However, there is no consensus regarding the specific skills that are needed to achieve competency in the recognition and negotiation of ethical situations and dilemmas, including the challenges associated with informed choice [1,2]. There are few studies that explore the impact of providers' ethics education in undergraduate or graduate nursing, midwifery, or medical programs on their confidence to cope with ethical dilemmas or ethics decision-making [3–6]. Oelhafen and colleagues looked at moral problems and moral distress experienced by midwives with the aim of developing a list of moral competencies that may be foundational to midwifery care and that should be included in midwifery education [7]. Their results showed that interprofessional conflict resulting from constraints on a midwife's autonomy was identified as the most relevant ethical issue. A literature search revealed no published studies that specifically target the experiences of midwives from the U.S in recognizing, negotiating, or coping with ethical dilemmas.

Aim

This study had two aims: to explore the experiences of U.S. midwives with regard to ethical dilemmas in clinical practice and to identify key sources of their ethics learning. Our prior survey of program directors of U.S. midwifery programs showed a lack of standardization of ethics content in the curricula [8]. We hypothesized that the effect of this lack of standardization would have an impact on practicing midwives through their experiences of recognizing, negotiating, and coping with ethical dilemmas in midwifery practice. Through interviews we sought to discover how midwives recognized situations of ethical conflict or concern, as well as how they reflected upon those situations in the context of their midwifery practice. In addition, we asked midwives to identify the key sources of ethics education and learning, and how those sources influenced their recognition and understanding of ethical dilemmas. We were particularly interested in their experience of ethics learning during their midwifery education, and all participants were asked to provide details as able.

Methods

Design

This is a qualitative descriptive thematic study, exploring midwives' experiences with ethical dilemmas in clinical practice, as well as key sources of learning about ethics [9]. In-depth interviews with individual midwives in the U.S. were conducted between April and June 2018. We asked midwives to tell us about their experiences with identifying and negotiating ethical dilemmas and to describe how they learned about ethics, specifically regarding ethics content in their midwifery education and the degree to which they felt prepared to identify and respond to ethical problems.

Participants

Midwives were eligible if they were or had been in clinical practice and had graduated from an accredited midwifery program in the U.S. Email invitations were sent out to all active members of the American College of Nurse-Midwives (ACNM), asking them to reply with interest in participating in one-on-one interviews. Midwives were enrolled in the order of response to the initial email invitation. Participants were de-identified at the time of enrolment and assigned a number in the order they were interviewed (CNM1, CNM2, etc) in order to maintain confidentiality.

Data collection

All midwives who responded to the initial invitation with an interest in participating were sent information sheets and invitation dates for interviews, which were subsequently scheduled for a time and method (for example, by telephone) most convenient for the participant. Interview questions were developed by the study team, based on current literature and the project aim [6,10–12]. The semi-structured interview guide was comprised of six questions aimed at encouraging participants to use stories to illustrate their experiences with ethical dilemmas, ethical decision-making, and ethics education. (Table 1). Probes were used to encourage participants to reflect on their own stories, creating the opportunity to reveal the how they learned about ethics and how to negotiate ethical dilemmas.

Participants were asked to describe the ethical dilemmas they experienced in everyday practice and the impact of those experiences on the way they practiced. We then asked them to reflect upon how they learned about ethics and clinical ethical dilemmas, the influence of that education on their practice in general and with regard to events they had previously revealed. To help us assess midwives' perception of ethics learning during their midwifery program, we specifically asked participants to describe any ethics education they had received during their graduate education.

All interviews were conducted by telephone by the first author (MM), a midwife from the U.S with experience in midwifery practice, midwifery education, and ethics. Participants were asked for limited demographic information, including the number of years in practice, current type of practice (for example, midwife-owned independent practice or hospital-owned practice with midwives, obstetrician-gynecologists, or other providers) and the name of the educational institution that conferred their midwifery degree. Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy by the study team. Interview length ranged from 30-60 min.

Table 1. Interview Questions

- What do you consider to be ethical dilemmas that you face in clinical practice?
- Tell me about an ethical problem that was particularly impactful for you.
- To whom do/did you look for support when negotiating this challenge?
- Tell me how you came to the decision that you did, or to take action as you did.
- How did you learn to negotiate or cope with the ethical challenges you have experienced (or are experiencing)?
- Tell me about, to the best of your ability, the ethics training that you received during your midwifery program.

Data analysis

Transcribed interviews were uploaded into Dedoose, a qualitative data analysis software program [13]. The transcripts were checked against the audio recordings to confirm accuracy, then read several times to facilitate familiarity with the data, and from this memos were created outlining potential code and ideas. We used thematic analysis to examine midwives' experiences with identifying and negotiating ethical dilemmas. We developed an initial coding scheme informed by the interview process, which was then adjusted via iterative analysis of the transcripts and discussions among study team members (MM, MN) [14]. The final coding scheme yielded themes that were merged, split, reviewed, and then checked and rechecked by the study team members to confirm relation to the data and findings. We used thematic mapping to provide a visual representation of the coding scheme and to confirm the relationships between themes and subthemes [15]. For data regarding sources of ethics learning, we reviewed the transcripts and performed content analysis of the data. Themes and subthemes regarding sources of ethics learning emerged from the data, which were then refined and reviewed for consistency and fidelity to the data by the study team. The themes and subthemes were discussed in order to obtain consensus and to reflect on the analytic process, drawing on the qualitative research expertise of the study team members. The standards for reporting qualitative research (SRQR) was used as a guide for the writing process [16].

Ethics

This project was granted approval by the institutional review board of Oregon Health and Science University, Portland, OR. At the beginning of each interview, the participants were informed of the goals of the project. Information sheets explaining that participation was voluntary and that all data would be securely kept and confidential were emailed to each participant prior to the actual interview and reviewed at the start of each interview. Participants were compensated for their time with a ten dollar gift card.

Findings

After receiving responses from 50 midwives expressing a willingness to participate, recruitment was closed. Those 50 respondents were sent email invitations with interview dates and ultimately 20 interviews were scheduled. The remaining thirty midwives either failed to respond to further invitations (N = 18) or declined to participate for other reasons (lack of time N = 11, declined to be interviewed N = 1). Of the 20 midwives who scheduled interviews, five cancelled due to unexpected scheduling conflicts and declined to reschedule, resulting in 15 completed interviews (Fig. 1). Saturation was achieved after 13 interviews; analysis of the remaining interviews generated no new findings [17]. The 15 participating midwives represented a diverse group of midwives, providing clinical care in home and hospital practices, private and academic practices, and independent and collaborative practices. Time in practice ranged from one to forty years, with seven midwives in practice for less than 10 years. Participants attended midwifery programs from across the United States, including in-person and online programs. (Table 2)

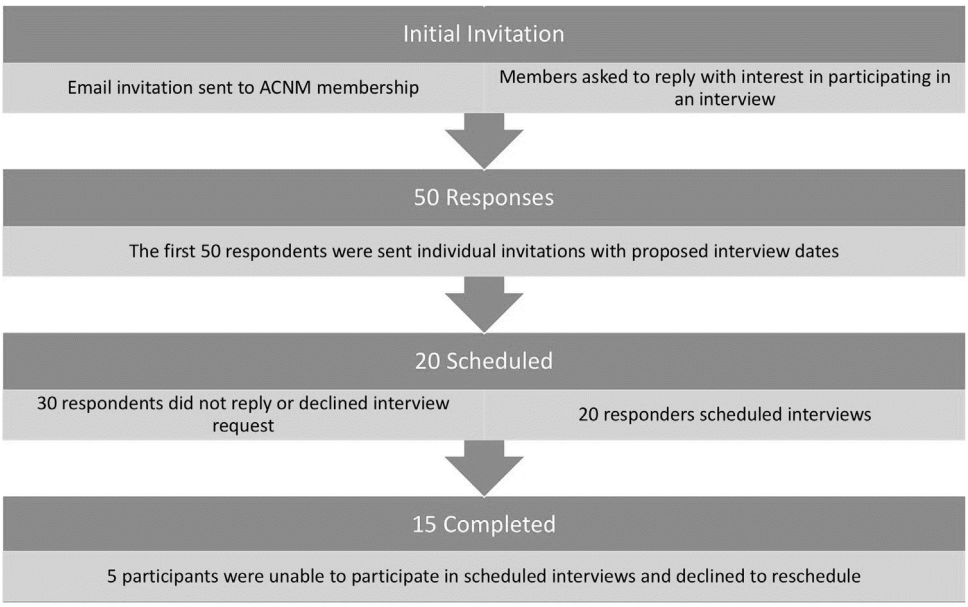

Fig. 1. Participant Recruitment

Table 2. Background details of participants

ID	Years in Practice	Type of Practice	Practice Location
CNM1	18	Private CNM	Hospital
CNM2	15	Private CNM	Hospital & Community
CNM3	14	Private, CNM & OB	Hospital
CNM4	6	Private OB	Hospital
CNM5	25	Hospital, CNM & OB	Hospital
CNM6	40	Retired	NA
CNM7	30	Private CNM	Community
CNM8	18	Private OB	Hospital
CNM9	10	Private CNM	Community
CNM10	8	Private OB	Hospital
CNM11	4	Private OB	Hospital
CNM12	6	Hospital, CNM	Hospital
CNM13	2	Hospital, CNM & OB	Hospital
CNM14	7	Hospital CNM	Hospital
CNM15	1	Hospital, CNM & OB	Hospital

Legend

Hospital CNM: Hospital-owned midwifery practice.

Hospital CNM & OB: Hospital-owned combined midwifery and obstetrician practice.

Private CNM: Midwife-owned independent practice.

Private OB: Obstetrician-owned independent practice with employed midwives.

Ethical dilemmas: problems in practice

The participating midwives recounted a wide range of experience with clinical and professional ethical dilemmas. Many of the midwives told stories about conflicts regarding abortion services, challenges in care for women with complex medical conditions and/or social circumstances, challenges to protecting or promoting autonomy and informed consent for women, and strained interprofessional relationships. One midwife described the difficult balancing act that she maintained in order to be recognized as a member of the obstetric team, particularly when policy decisions are made.

The midwives also discussed the difficulty women experienced in accessing appropriate care, particularly women in rural areas. These are women who may be seeking genetic screening or abortion care, who may require perinatal care outside of the midwife's scope of practice, or who may seek interventions that are contrary to the midwife's recommendation. They also recounted challenging situations involving potentially fraudulent business practices, situations involving state-level legislative or hospital-based restrictions that may curtail their scope of practice or ability to practice independently, and the difficulty of working in a healthcare system that does not reflect their midwifery philosophy.

Midwives also commented on the fatigue that they feel, not only from a physically demanding schedule and the difficulty in maintaining a work-life balance, but also the emotional toll experienced by coping with these daily ethical challenges. One midwife described it as an inability to be "fully present" (CNM10) with the women in her care.

Ethical dilemmas: themes

In our thematic analysis of how midwives identify and describe the nature of ethical dilemmas, we found one overarching theme – unease – and three associated subthemes. Ethical dilemmas were identified by a feeling of *unease,* a sense of distress felt either in the moment of an event or upon reflection of that event. This sense of *unease* was present in the three subthemes: *uncertainty of action, compromise in action,* and *reflecting on action.*

Defining ethical dilemmas: unease
Some of the midwives found it difficult to provide a definition or an example of an actual ethical dilemma, reflecting on the challenge of understanding when a difficult situation or conflict becomes an ethical dilemma per se. Most of the midwives reported a sense of unease with the situation they were in, and it was this sense that prompted them to think about ethics, or that they were in an ethical situation. They described this unease in three ways: unease related to uncertainty of action, unease related to a compromise in action, and unease in reflecting on action.

Unease in uncertainty of action
Unease related to uncertainty of action was described by midwives in circumstances where there was no clear choice of the right action to be taken. This type of unease was expressed as uncertainty associated with situations with no right or wrong answer, or when there were multiple ways to approach and solve a particular problem. This ambiguity, or lack of a clear dichotomy of right or wrong was regarded as the essence of an ethical dilemma, and the uncertainty of action and the lack of a clear path forward was a potential cause of distress.

I don't know that there's a right and wrong answer for a lot of ethical questions too. It's really a matter of deepening our understanding and being able to know which are our highest priorities and how do we sort out who's rights are more important than others' rights.(CNM9)
I guess I feel like there's a lot of grey area, and so I'm not sure if I even know clearly myself like what would constitute an ethical issue in my clinical practice.(CNM15)

Unease in compromise in action
Unease related to compromise in action occurred when there was incongruity between the midwife's ideas of the right action to be taken and her ability to implement that action. These situations were described as those where right and wrong were clearly defined and the decision-making path was obvious, but the midwife was prevented from implementing it. Midwives reported having a clear understanding of the action she *should* take, but, because of institutional pressures, they were unable to take that action. The midwife's ability to pursue right action was compromised by the context of her situation. This usually involved a conflict between the midwife's perception of what should be done in the best interests of the woman or in line with promoting physiologic birth and midwifery care, and what the midwife was allowed to do in that situation as dictated by a particular hospital system, community standard, or regulatory statute. One midwife (CNM4) emphasized the importance of having a clear understanding of right and wrong in this context and having the courage to challenge the authority responsible for constraining their action.

I would just say you have to know right from wrong . . . You have to know right from wrong and know what your scope of practice is. And if someone higher up from you says it's okay you have to know if it's really okay or not okay. (CNM4)
I would describe an ethical dilemma as something that you feel as though is right in your heart, but you know that people around you or the institution may not want you to do that. (CNM2)

Unease in reflecting on action
Unease related to reflecting on action describes circumstances where the midwife understood herself to be in an ethical dilemma only upon reflection after the event. Midwives used reflection upon their actions and residual feelings of unease, not just to describe the impact of an ethical dilemma, but to categorize the event as an ethical dilemma in the first place. The idea of "*can you sleep at night*" was a touchstone, used to identify when an ethical dilemma was occurring and as a measure of moral distress associated with that conflict.

There's a way to find it within yourself so that you can sleep at night and feel like you were making the right decision even when things went wrong. Because you know things are always going to go wrong. So that was, you know, that's always the test. (CNM7)
I try to present it [genetic screening] in that manner, so that they can figure out exactly where they're at. But in this area I struggle. And you know, I don't wake up at night about it. But still . . . I think it is an issue. And I always wonder if I'm adequately educating my client to make a really informed decision. (CNM8)

Learning about ethics

Participating midwives were asked about how they learned about ethics and how to be aware of ethical dilemmas, including any past experiences of learning, discussing, or thinking about ethics and ethical dilemmas. If they did not initially discuss their midwifery education, they were prompted to reflect upon any ethics education that they may have received during their midwifery program, and what impact it may have had upon their ability to recognize and negotiate ethical dilemmas. Descriptive analysis of their responses – how midwives learned to identify and negotiate ethical dilemmas – yielded three themes: learning from individuals *outside* of the classroom, such as mentors, colleagues, or clinical preceptors; using their own experiences to inform and guide their ethics decision making; and the contribution of their educational programs to their ability to recognize and negotiate ethical dilemmas.

Learning ethics from others
Many of the midwives reported that they learned about ethics *outside* of any classroom or dedicated didactic program time, instead learning about ethics from key people in their lives, such as mentors, role models, or clinical preceptors. Mentors included undergraduate professors and nursing and midwifery colleagues. They assisted the midwife in developing critical thinking skills to analyse an ethical dilemma and to reflect upon their own actions, values, and biases.

Midwives identified their mentors as role-models and key support people who helped them think through dilemmas and mitigate emotional distress. Clinical preceptors, in both nursing and midwifery, provided opportunities to observe positive ethical behaviors in action. While they looked to their clinical preceptors as role-models for demonstrating critical behaviors in difficult situations, discussions specific to ethics (for example, ethics principles or decision making) did not seem to be a part of their interaction. Observing the clinical preceptor in action allowed student midwives to reflect upon their own behavior and to imagine what they would do in a similar situation, actions that provided some motivation to learn that behavior.
For some, an understanding that the interactions that they observed were ethical interactions and examples of ethical behavior was gained in retrospect, rather than at the time of observation. The midwives were not necessarily aware that they were learning ethics in the moment.

You know I don't think that much of that really came from what happened in a classroom setting at school. But I do remember watching preceptors and seeing like, that's a conversation that went well. I want to be able to do that. (CNM11)
I went to her[undergraduate professor and ethicist] because I was so conflicted about what was the right answer in this situation, and what . . . are the issues that I couldn't even sort any of that out myself at the time . . . and she really framed it for me in an ethical perspective . . . I remember that being a really formative experience for me of thinking through things in that way, that logical way. And I have sought advice from ethicists since then. (CNM9)

Learning ethics from the past: using one's own experience
Midwives also relied upon past experiences to provide them with the skills needed to recognize and cope with ethical dilemmas. Prior involvement in ethically fraught situations, as a student, nurse or midwife, no matter how central or peripheral their role, was key to providing opportunities for improved self-reflection and insight into their own values and biases. These prior experiences also provided a greater understanding of contextual factors and values involved in ethics decision making. One midwife (CNM 10) related that her ongoing experience participating in difficult conversations provided her with an enhanced sense of nuance and allowed her to promote autonomy in a deeper way. Since she had seen the outcomes of many divergent choices, she felt she could better interpret the evidence, balance risk perception, and improve shared decision making. Her experience increased her awareness of the ethical challenges involved in these discussions.

I think it's just been a culmination of all of my different experiences that have colored how I practice. (CNM10)
And I went into it kind of with my own experience. I mean I was 34 years old when I was going into midwifery. So I have some life experience around me, but I can't remember at [midwifery program] having those conversations about OB [obstetric]-related issues in particular. (CNM14)

Learning about ethics from educational programs
Midwives were divided about the influence that any formal education (non-nursing, nursing or midwifery) had on their sense of preparation when encountering ethical dilemmas in the "real world". Only a few of the midwives specifically remembered learning ethics content during their midwifery curricula.

I know we had an ethics course. I certainly had one in my registered nursing training some years back and . . . then when I transferred over to [X], and that was for midwifery, they also had a portion of ethics. So I had ethics all along the way . . . I think it really reinforced why we do what we do anyway. And to know that we are not only making a difference in each person's outcome that we come across when we are aware of not only just what is ethical in general but that that changes depending upon what that patient wants, needs, the whole package of evidence based practice and individualized care. And then the providers themselves, how we treat our colleagues. It's a systematic and systemic approach rather than how we feel about an issue or a topic or perspective. (CNM12)

They also credit the ethics content, in particular the emphasis placed on reflection and awareness of bias, with providing ethical frameworks that emphasized the woman's autonomy and self-awareness. Reflective discourse was viewed as a critical tool and skill for students to acquire in order to become competent in ethics decision-making.

If you don't feel that you can be nonjudgmental in your care and provide complete and accurate information to your patients, because you may be the only person who is honest with them, you've got to know where you're at yourself. And I'm not sure that you can do that solely on a self-study, I think it's involved in discussions, it's involved in reflection, in hearing other people's experiences. (CNM8)
I need to assess myself, where am I coming from. Do I have personal views that are feeding into this, and that each person involved in a patient's care, can do the same thing and take an objective approach at what should be done and how things should be handled. (CNM12)

Most of the other midwives remembered receiving ethics content during their graduate education, but they were critical of the classes as being unclear in their intention, poorly constructed, or not midwifery-specific in content. They remembered content that addressed issues of professionalism but did not distinguish between ethics and professionalism as distinct subjects. Some midwives had vague recollections of class discussions of paradigmatic cases or assigned readings, but again did not identify that as ethics content per se. As one participant stated, "*I'm sure we talked about it*" *(CNM10)*

[the program was] good at legal aspects of your license, women's healthcare and teen's rights. But as far as ethics though there wasn't anything. There wasn't really discussion or classwork about that. (CNM1)
We did have a class on it; I don't think it was particularly well taught. Um, we talked about some different ethical models and different lenses to look at things through. It wasn't specific to midwifery. It was for the whole nurse practitioner program. (CNM13)

The midwives also offered suggestions for midwifery programs regarding how best to provide ethics education for students. They emphasized the importance of including midwifery-specific content into any ethics discussion, particularly as a method of improving ethics awareness. Just as they identified interprofessional conflicts as an ethical dilemma, midwives identified improved interprofessional education as an important aspect of ethics education, including suggestions such as midwives teaching obstetric residents and medical students.

Discussion

These interviews with midwives offered insight into common ethical dilemmas and the challenges midwives experienced in defining them. An essential skill needed in clinical decision-making is ethical sensitivity or awareness [18, 19]. Some midwives had difficulty in articulating a precise definition of an ethical dilemma; for others ethical awareness was based on the perception of right and wrong framed as either polar opposites or as points along a continuum. Ethical awareness was also recognized in retrospect; a situation was considered an ethical dilemma only when later reflection triggered moral distress. For the midwives in this study, ethics learning occurred primarily through relationships with mentors or clinical preceptors. Few midwives could recall significant ethics learning from their midwifery program.

Identifying ethical dilemmas and moral distress

Ethical dilemmas have been defined as situations in which action must be taken when there are multiple and seemingly equal choices, and where each choice of action would promote or protect a particular value or ethical principle at the cost of another [6, 11]. Challenges may revolve around competing concerns, competing obligations, or competing interests held by different parties involved. The midwives in our study negotiated, for example, between the obligation to support a woman's choice to decline a particular medical intervention such as induction of labor, and the competing obligation to provide safe evidence-based care by recommending an induction of labor. Given that "advocacy for informed choice, shared decision-making, and the right to self-determination" is an ACNM Hallmark of Midwifery [20] (p.2) and a foundational concept of the Philosophy of Midwifery and Model of Care of the International Confederation of Midwives (ICM) [21], it is not surprising that midwives identified challenges to this core value as a common ethical dilemma. Midwives worked to find ways of supporting women when autonomy was constrained by institutional rules, by scope of practice, and by disagreements about medical interventions. Ethical dilemmas related to the limiting of both women's and providers' autonomy in decision-making is a common theme in midwifery and physician literature, and has been described as a significant source of moral distress [6,7,12]. Incorporating elements of care ethics, such as attentiveness and responsiveness, may be one way in which the deleterious effects of constraining autonomy may be mitigated [22].

Similar to our findings, conflicts in interprofessional relationships, issues surrounding abortion care, and the impact of restrictive and hierarchical institutional regulations are reported in international studies of ethical dilemmas as experienced by midwives, nurses, and physicians [6,7,11,23,24]. Key sources of interprofessional conflict include poor communication skills, poor negotiation and resolution of disagreements, and real or perceived power or hierarchical differentials regarding decision-making [10,24]. Interprofessional education activities have shown positive changes in attitudes and learning among students, but it is unclear if those positive changes continue into practice and contribute to improved interprofessional communication and collaboration [25]. Further examination of the role of healthcare systems, including practice guidelines, legislation, and regulations addressing differing philosophies of perinatal care, midwifery licensure and scope of practice, and hospital medical staff by-laws, may contribute to better understanding of the underlying nature of interprofessional conflicts.

Experiencing an ethical dilemma or participating in complex ethical decision-making has the potential to produce moral distress in the individuals involved. The concept of moral distress has its origin in the nursing literature, and has been traditionally defined as emotional or psychological suffering experienced by individuals who are forced to participate in actions (or omissions of action) which they see as wrong or contrary to their individual values [26]. Constraint of right action diminishes the provider's agency, locus of control, and role in decision-making, thereby compromising their ability to provide appropriate care to individuals in a caring and compassionate manner [24]. However, sources of moral distress are not limited to experiences of power imbalance and inequity, but also include the need to make critical decisions when medical evidence is unclear or uncertain, the lack of objectivity in interpreting medical evidence, and the degree of medical acuity [27]. Moral distress may also be an indicator of compassion and empathy - that is, if a person did not possess and value compassion as a personal or professional attribute, then they would not feel moral distress when encountering its absence [27]. The midwives in our study identified ethical dilemmas that reflect the aspects of moral distress described here. Ethical dilemmas involving interprofessional conflicts and institutional or regulatory constraints engendered moral distress in the traditional sense of feeling disempowered and lacking in agency. This finding is similar to other studies of midwives' experiences of ethical dilemmas [7]. However, midwives in our study also identified ethical dilemmas as situations involving uncertainty of right action, characterized by the presence or absence of residual moral distress (the *can I sleep at night* touchstone). Ethical dilemmas involving a woman's autonomy often solidified the midwife's commitment to the ethical framework of supporting autonomy and promoting informed choice. Their additional awareness and acceptance of uncertainty, particularly as an aspect of risk perception and tolerance, allowed them to promote autonomy in a deeper and more nuanced manner.

Ethics education and preparation

An important aim of our study was to explore the sources of ethics knowledge and education for midwives, with specific reference to their experience in midwifery educational programs. An understanding of ethics content and the development of ethical awareness are considered to be critically important aspects of education for nurses and midwives [28,29]. In addition, familiarity with bioethics is a core competency of midwifery practice [20,30]. However, what constitutes familiarity is not clearly outlined, and ethics education in midwifery programs is currently lacking in standardization with regard to ethics content, methods of teaching, methods of evaluation, and expected outcomes [8, 31]. The integration of fundamental communication skills and understanding of ethical concepts into teaching ethics decision-making as a core competency in midwifery education has yet to be fully realized. That the midwives in this study relied upon sources outside of their didactic experiences for ethics learning, and the lack of awareness of ethics while involved in potential ethical dilemmas, indicates that midwifery programs should consider being purposeful in the inclusion of midwifery-specific ethics content in curricula.

The midwives in our study identified their experiences with clinical preceptors as critical to their ethics learning, for some more so than didactic learning. The role of the clinical preceptor must complement classroom learning and help to bridge the gap between theory and practice. Preceptors are called upon to create safe, effective learning environments for their students that allow students to hone their critical thinking skills in communication, risk awareness, informed choice, and clinical and ethical decision-making [32–34]. Midwifery students may actively look to clinical preceptors to be role models of ideal midwifery behavior [35]. The participants who identified their clinical preceptors as key to their ethics learning also acknowledged that their understanding and appreciation of learning ethics occurred in retrospect. They were not necessarily aware that they were observing an ethics dilemma at the time, or that their clinical preceptor was modeling ethical behavior or ethics decision making. Without explicit awareness of ethical dilemmas, the skills and behaviors demonstrated by preceptors in negotiating and resolving these dilemmas may be missed. Instead students may only receive only informal avenues of behavioral cues and cultural assimilation rather than through intentional instruction. The lack of purposeful ethics teaching may result in professional behaviors that conflict with the professional values discussed in academic programs. This informal education, or *hidden curriculum*, has been shown to promote systemic bias in the healthcare system and to have a negative influence on providers' empathy [36]. Midwifery-ethics specific post-graduate training for preceptors, as well as other avenues of support for clinical preceptors, should be considered.

Limitations

This study has several limitations. While there was initial interest in participation via email response rate, ultimately only fifteen midwives were able to participate in interviews. The sample did, however, represent a diverse group of midwives in terms of practice type, practice location, and midwifery program attended. While the results are limited in the demographic representation of midwives in the United States, they do offer insight into processes used to understand and think about the ethical dilemmas of midwifery. This study also relied upon midwives' memories of learning ethics content, which may not reflect the actual content covered during their programs, and which may not reflect any evolution in the form of ethics education since the time they were students.

Conclusion

Using interviews with midwives, this study provides insight into commonethical dilemmas experienced by midwives, how midwives define ethical dilemmas, and their sources of ethics learning. Although only US midwives were included, their experience of challenging interprofessional conflicts, difficulties in ethical sensitivity and moral distress, and relianceupon clinicalpreceptors as role models for ethical decision-making are reflected in the literature of published studies about ethics and midwifery or health care professionals from other countries. A deeper understanding of ethical dilemmas and ethics learning as perceived by midwives in clinical practice can contribute to the development of midwifery-specific ethics education and offers an alternative to existing approaches to obstetric ethics [37]. In fact, the midwives in our studycalled for the purposeful inclusion of midwifery-specific ethics content in an integrated fashion throughout the curriculum and in a manner which complements other midwifery content. Reflection and self-awareness of bias were identified as key components of understanding ethical frameworks. Given that most of the midwives in this study relied upon clinical preceptors for ethics learning, midwifery educators should consider an exploration of preceptor skills, available post-graduate ethics training programs or workshops, and other ways to support preceptors. Current strategies for improving interprofessional relationships, particularly between midwives and obstetricians in the context of regulation-mandated oversight, may be inadequate, and new avenues, including interprofessional education, should be explored. In addition, more research is needed regarding the informal ways that midwives and midwifery students learn ethics, particularly in clinical situations and interprofessional interactions.

Conflict of interest

None.

Funding

None.

Ethical Statement

This project was granted approval by the institutional review board of Oregon Health and Science University, Portland, OR. The approval number is STUDY00017655, and it was approved on October 26, 2017.

CRediT authorship contribution statement

Michele Megregian: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Software, Validation, Writing - original draft, Writing - review & editing. Lisa Kane Low: Conceptualization, Formal analysis, Methodology, Supervision, Writing - review & editing. Cathy Emeis: Conceptualization, Formal analysis, Methodology, Supervision, Writing - review & editing. Raymond de Vries: Formal analysis, Methodology, Supervision, Writing - review & editing. Marianne Nieuwenhuijze: Conceptualization, Formal analysis, Methodology, Supervision, Validation, Writing - original draft, Writing - review & editing.

References

[1] F. Légaré, N. Moumjid-Ferdjaoui, R. Drolet, et al., Core competencies for shared decision making training programs: insights from an international, interdisciplinary working group, J. Contin. Educ. Health Prof. (2013), doi:http://dx.doi.org/10.1002/chp.21197.

[2] J.A. Carrese, J. Malek, K. Watson, et al., The essential role of medical ethics education in achieving professionalism: the romanell report, Acad. Med. 90 (2015) 744–752.

[3] H.A. Monroe, Nurses' professional values: influences of experience and ethics education, J. Clin. Nurs. (2019), doi:http://dx.doi.org/10.1111/jocn.14806.

[4] J.C. Kesselheim, J. Johnson, S. Joffe, Pediatricians' reports of their education in ethics, Arch. Pediatr. Adolesc. Med. 162 (2008) 368–373.

[5] M. Buxton, J.C. Phillippi, M.R. Collins, Simulation: a new approach to teaching ethics, J Midwifery Women's Heal 60 (2015) 70–74.

[6] G. DuVal, B. Clarridge, G. Gensler, M. Danis, A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation, J. Gen. Intern. Med. 19 (2004) 251–258.

[7] S. Oelhafen, S. Monteverde, E. Cignacco, Exploring moral problems and moral competences in midwifery: a qualitative study, Nurs. Ethics (2018), doi:http://dx.doi.org/10.1177/0969733018761174.

[8] Ethics education in midwifery education programs in the United States, J Midwifery Women's Heal 61 (2016) 586–592.

[9] Creswell JW, Qualitative Inquiry & Research Design, (2007), doi:http://dx.doi. org/10.1111/1467-9299.00177.

[10] J. Rainer, J.K. Schneider, R.A. Lorenz, Ethical dilemmas in nursing: an integrative review, J. Clin. Nurs. (2018), doi:http://dx.doi.org/10.1111/jocn.14542.

[11] B. Bringedal, Isaksson Rø, Magelssen K, F.ørde M, Aasland R, OG. Between professional values, social regulations and patient preferences: medical doctors' perceptions of ethical dilemmas, J. Med. Ethics 44 (2018) 239–243.

[12] S.A. Hurst, S.C. Hull, G. DuVal, M. Danis, How physicians face ethical difficulties: a qualitative analysis, J. Med. Ethics 31 (2005) 7–14.

[13] Dedoose Version, 8.2.14, Web Application for Managing, Analyzing, and Presenting Qualitative and Mixed Method Research Data, (2019) .

[14] L. Spencer, J. Ritchie, W. O'Connor, G. Morrell, R. Ormston, Analysis inpractice eds, in: J. Ritchie, J. Lewis, Nicholls C. McNaughton, R. Ormston (Eds.), Qualitative Research Practice, 2nd editio, Sage Publications, London, 2014, pp. 295–346.

[15] V. Braun, V. Clarke, Using thematic analysis in psychology, Qual. Res. Psychol. (2006), doi:http://dx.doi.org/10.1191/1478088706qp063oa.

[16] B.C. O'Brien, I.B. Harris, T.J. Beckman, D.A. Reed, D.A. Cook, Standards for reporting qualitative research, Acad. Med. (2014), doi:http://dx.doi.org/ 10.1097/acm.0000000000000388.

[17] G. Guest, A. Bunce, Johnson l. How many interviews are enough?: an experiment with data saturation and variability, Field methods (2006), doi: http://dx.doi.org/10.1177/1525822X05279903.

[18] K. Weaver, Ethical sensitivity: state of knowledge and needs for further research, Nurs. Ethics (2007), doi:http://dx.doi.org/10.1177/0969733007073694.

[19] A. Milliken, Nurse ethical sensitivity: an integrative review, Nurs. Ethics (2018), doi:http://dx.doi.org/10.1177/0969733016646155.

[20] ACNM, Core competencies for basic midwifery practice, Am Coll Nurse Midwives Core Competencies (2012) 1–8.

[21] International Confederation of Midwives, Philosophy and Model of Midwifery Care, (2014) . https://www.internationalmidwiveshttps://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-philosophy-and-model-of-midwifery-care.pdf

[22] E. Newnham, M. Kirkham, Beyond autonomy: care ethics for midwifery and the humanization of birth, Nurs. Ethics (2019), doi:http://dx.doi.org/10.1177/ 0969733018819119.
[23] J. Sanders P dr, R. de Vries P dr, S. Besseling, P.D.M. Nieuwenhuijze, 'Such a waste' – conflicting communicative roles of Dutch midwifery students in childbirth decision making, Midwifery 64 (2018) 115–121.
[24] A. Haahr, A. Norlyk,B. Martinsen, P. Dreyer, Nurses experiences of ethical dilemmas: a review, Nurs. Ethics (2019), doi:http://dx.doi.org/10.1177/0969733019832941.
[25] L. Fox, R. Onders, C.J. Hermansen-Kobulnicky, et al., Teaching interprofessional teamwork skills to health professional students: a scoping review, J. Interprof. Care (2018), doi:http://dx.doi.org/10.1080/13561820.2017.1399868.
[26] J. McCarthy, C. Gastmans, Moral distress: a review of the argument-based nursing ethics literature, Nurs. Ethics (2015), doi:http://dx.doi.org/10.1177/ 0969733014557139.
[27] T.M. Prentice, L. Gillam, P.G. Davis, A. Janvier, The use and misuse of moral distress in neonatology, Semin. Fetal Neonatal Med. (2018), doi:http://dx.doi. org/10.1016/j.siny.2017.09.007.
[28] J. Burkemper, J. DuBois, M. Lavin, G. Meyer, M. McSweeney, Ethics education in MSN programs: a study of national trends, Nurs. Educ. Perspect. (2007), doi: http://dx.doi.org/10.1109/ISIE.2011.19.
[29] A.G. Peirce, J.A. Smith, The ethics curriculum for doctor of nursing practice programs, J. Prof. Nurs. 24 (2008) 270–274.
[30] International Confederation of Midwives, Essential Competencies for Midwifery Practice, (2019) . https://www.internationalmidwives.org/assets/files/ general-files/2019/02/icm-competencies_english_final_jan-2019-update_final-web_v1.0.pdf.
[31] S. Oelhafen, U. Hölzli, M. Häsänen, et al., Increasing midwives' ethical competence: a European educational and practice development project, Int J Ethics Educ (2017) 147–160.
[32] J. Lazarus, Precepting 101: teaching strategies and tips for success for preceptors, J. Midwifery Women's Heal. (2016), doi:http://dx.doi.org/10.1111/ jmwh.12520.
[33] D.S. Penney, Midwifing the student: creating an effective learning environment, J. Midwifery Women's Heal. (2016), doi:http://dx.doi.org/10.1111/ jmwh.12487.
[34] S.M. Thompson, M.J. Nieuwenhuijze, L.K. Low, R. De Vries, A powerful midwifery vision": dutch student midwives' educational needs as advocates of physiological childbirth, Women Birth (2019), doi:http://dx.doi.org/10.1016/j. wombi.2018.12.010.
[35] M. Nieuwenhuijze, S. Thompson, E.Y. Gudmundsdottir, H. Gottfreðsdóttir, Midwifery students' perspectives on how role models contribute to becoming a midwife: a qualitative study, Women Birth (2019), doi:http://dx.doi.org/ 10.1016/j.wombi.2019.08.009.
[36] L.S. Lehmann, L.S. Sulmasy, S. Desai, Hidden curricula, ethics, and professionalism: optimizing clinical learning environments in becoming and being a physician: a position paper of the American college of physicians, Ann. Intern. Med. (2018), doi:http://dx.doi.org/10.7326/M17-2058.
[37] R. De Vries, Obstetric Ethics and the Invisible Mother, Narrat. Inq. Bioeth. (2017), doi:http://dx.doi.org/10.1353/nib.2017.0068.