POSITION STATEMENT

Conscientious Refusal and the Profession of Midwifery

Midwives who care for women and families may encounter situations in which opposing moral and/or ethical beliefs create conflicting views regarding health care decisions. The American College of Nurse-Midwives (ACNM) endorses the ethical principles delineated by the American College of Obstetricians and Gynecologists[1] and the Association of Women's Health, Obstetric and Neonatal Nurses[2] and those outlined in the ACNM Code of Ethics.[3] Further, ACNM respects the federal and state laws that govern the rights of women and health care workers.

ACNM maintains the following:

- Midwives have an ethical, moral, and legal obligation to "respect the human rights and the dignity of all persons."[3]
- Midwives have the right as individuals to live and practice with moral integrity in accordance with ethical, moral, or religious beliefs. However, in emergency situations in which referral is not an option, midwives have an ethical, moral, and legal obligation to provide appropriate, quality care regardless of personal bias and beliefs.
- Midwives have an ethical, moral, and legal obligation to create a non-judgmental atmosphere of shared decision making based on mutual respect, adequate information and freedom from bias and discrimination for the women and families in their care.
- Midwives, as employers, educators, and colleagues, have an ethical and sometimes legal obligation to make reasonable accommodations when appropriate to meet the needs of the individual midwife to maintain moral integrity.
- Midwives who have ethical, moral, or religious limitations to scope of practice have an obligation to notify potential employers and clients of those limitations and to ensure that mechanisms are in place for referral.

Background

Conscientious refusal or objection has been defined as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."[4] The beliefs in question may not be merely preferences; they must be deeply held moral convictions that are intrinsic to the individual's daily existence.[1] The term *conscientious refusal*

originated in reference to pacifists who objected to service during wartime and were often imprisoned for their beliefs.[5] Legislated protection for conscientious refusal was originally limited to physicians who refused to perform abortions.[5] Some states have expanded this legal protection to any paraprofessional who objects to any involvement in the care under contention.[6]

The right to live in concert with one's religious, moral, and ethical beliefs has long been recognized in Western culture.[7] Researchers have repeatedly described the detrimental effects of moral distress when health care providers are faced with clinical cases that create a conflict with deeply held beliefs.[8,9] The practice of midwifery may place the midwife in situations in which beliefs regarding birth practices, futility of care, end of life issues, and reproductive rights are challenged. The ACNM Code of Ethics calls for respect for self and others in order to provide an atmosphere of tolerance and respect that leads to shared decision making rooted in the ethical principle of autonomy, the right of self-determination in health care decision making.[3] Respect for autonomy is at the heart of the legal and ethical concepts that underpin the informed consent process in midwifery care.

The nature of the relationship between the midwife and the woman who requests care creates legal and ethical obligations on both sides. The midwife is obligated to provide care that meets the legal and ethical standards of the profession, including some subordination of personal needs for the public good. Consider, for example, the historical obligation to care for the suffering during periods of epidemic even at great personal risk. The woman seeking care is obligated to provide the information needed to establish a plan of care and to act responsibly as a partner in that care. There is a natural imbalance of power in the relationship between the midwife and woman: the midwife has greater power, responsibility, and obligation consistent with the greater knowledge and experience inherent in midwifery practice. This power imbalance further reinforces the legal and ethical obligation to protect a woman's rights without compromising the basic rights of the midwife. It also forms the basis of the limits of conscientious refusal.

Conflicts arise when care is requested by a woman, and the midwife has serious moral or ethical objections to the plan of care. Such disputes create the need for a balanced analysis of legal and ethical rights and obligations to inform negotiation and ideally to reach consensus. The factors weighed in the analysis include the importance of protecting the moral integrity of the midwife, the importance of the woman's right to autonomy/self-determination in health care decision making, the legal rights and obligations of the parties involved, any applicable social justice concerns, and the options available.

Notice and referral for care are 2 of the most commonly used mechanisms to manage situations in which conflict occurs. The midwife has an ethical and a legal obligation to notify a woman if the midwife cannot participate in care that is within the scope of midwifery practice. The midwife is further obligated to refer the woman to a provider who can render the requested care. The act of referral may be viewed as complicity; however, if referral is not provided, health care may be delayed. If the midwife believes referral in certain situations is untenable, then the midwife should avoid situations likely to raise conflicts. For example, if a midwife holds strong

beliefs against the use of contraception, employment at a clinic known to offer contraceptive health care services should be avoided. Maintaining personal integrity is best achieved by structuring a professional practice that is synchronous with one's moral and ethical beliefs and offering notice to potential clients and employers if these beliefs limit services offered.

Conflict may also occur during midwifery education. For example, a student may have a moral objection to providing contraceptive care. However, students who have moral, religious, or philosophical objections to certain practices must be prepared to participate in classroom learning and clinical preparation in all core competencies of midwifery. Educators may be able to make reasonable accommodations by demonstrating clinical skills in simulation settings rather than with actual clients in clinical settings. However, such accommodations should balance the needs of the student with the obligation of the education program to assure the competency of the student before entering clinical practice.

In the future, advances in science and technology will most likely add to the complexity of the health care decisions women and families face. The ACNM Code of Ethics and carefully structured practice guidelines will help guide midwives in client interactions to meet the needs of midwives and the women they serve.

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Note: Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC).

Source: ACNM Board of Directors
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