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Does midwifery-led care demonstrate care ethics: A template analysis

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Does midwifery-led care demonstrate care ethics? A template analysis

Abstract

Background: Ethical care in maternity is fundamental to providing care that both prevents harm and does good and yet, there is growing acknowledgment that disrespect and abuse routinely occurs in this context, which indicates that current ethical frameworks are not adequate. Care ethics offers an alternative to the traditional biomedical ethical principles.

Research aim: The aim of the study was to determine whether a correlation exists between midwifery-led care (MLC) and care ethics as an important first step in an action research project.

Research design: Template analysis (TA) was chosen for this part of the action research. TA is a design which tests theory against empirical data, which requires pre-set codes.

Participants and context: A priori codes that represent midwifery-led care were generated by a stakeholder consultative group of nine childbearing women using nominal group technique, collected in Perth, Western Australia. The a priori codes were applied to a predesigned template with four domains of care ethics.

Ethical considerations: Ethics approval was granted by the Edith Cowan University research ethics committee REMS no. 2019-00296-Buchanan.

Findings: The participants generated eight a priori codes representing ethical midwifery care, these were: 1.1 Relationship with Midwife 1.2 Woman-centred care 2.1 Trust women's bodies and abilities 2.2. Protect normal physiological birth 3.1. Information provision 3.2. Respect autonomy 4.1. Birth culture of fear (MLC counter cultural) 4.2. Recognition of rite of passage. The a priori codes were mapped to the care ethics template. The template analysis found that midwifery-led care does indeed demonstrate care ethics.

Discussion: Care ethics takes into consideration what principle-based bioethics have previously overlooked: relationship, context, and power.

Conclusion: Midwifery- led care has been determined in this study to demonstrate care ethics, which suggest that further research is defensible with the view that it could be incorporated into the ethical codes and conduct for the midwifery profession.

Key words: care ethics, ethics, feminism, midwifery-led care, relationship, code of ethics

Introduction

Ethical principles that govern maternity care practice are central to the care of childbearing women. However, there is growing perception and acknowledgment that many women are not receiving ethical care. There is limited evidence related to ethical perspectives in maternity care and a paucity of empirical evidence in addressing the ethical needs of childbearing women. This paper first situates the research topic in the background of global concern about increasing reports of disrespect and abuse in childbearing women, with a concerning lack of ethical input. An overview of the feminist ethic of care, referred to as care ethics, and its relationship with midwifery is then presented as a possible solution (1,2).

Childbearing over the last one hundred years has become increasingly medicalised and technocratic; with the move of childbirth from home to hospital, the medical model has become the dominant model of care (3). Maternity care medicalisation is a multidimensional dynamic, that pathologizes normal birth processes, increases intervention and standardizes care of the woman within a culture of fear and risk reduction (4). A resulting factor of medicalisation is women having less power and control over their birth experiences, which have detrimental effects on women's psychological, emotional, and physical health (3,4,5). Further, the literature describes obstetric violence, physical abuse, verbal abuse, and

disrespect within the maternity system as a global systemic issue (6, 7). It has been suggested that ethical care is sometimes rhetorical or even disregarded in the medicalisation of birth (2).

While researchers have been addressing the pervasiveness and epidemiology of disrespect and abuse in childbirth, one perspective that has not been widely explored in countering injustices and oppression of women in maternity care is that of ethics (1,2). There is limited evidence about how ethical principles are used and understood in maternity care, and yet ethical issues arise in almost every aspect of pregnancy, labour, birth and the puerperium (1,2). There is contemporary literature that describes maternity care decision making and ethical dilemmas after the fact, but ethical care is more than these, it is how the whole notion of care is approached and the impact this has on women (1,2,7,8).

Ethical behavior for midwifery care is guided by the International Code of Ethics for Midwives (8). The code has four domains which point to the expectation of respectful, humanised practice. The Code of Ethics four domains are: midwifery relationships; the practice of midwifery; professional responsibility of the midwife; and advancement of midwifery knowledge. These mandates detail how midwives prioritize relationships, how they practice upholding professional responsibilities and how they ensure integrity of the midwifery profession. The four bioethical principals; Non-maleficence, beneficence, justice, and autonomy, are implicit in the international Code of Ethics for midwives, which additionally acknowledges the human rights of women, seeks justice for all women, and is based on respectful relationships.

The four bioethical principles may suit the standardized medical model of maternity care but may not necessarily suit the woman being cared for. Where bioethical principles perceive principles, norms, and specific rules, they do not recognize the complexity or context of the human experience that includes; the influence of relationships; the context of decision making as part of a greater story: the responsibility of care as forming part of the complex matrix of a woman's life and the role of emotions in

decision making (2). Whilst bioethical principles are important, in the conventional model of maternity care, these are determined by those who hold the balance of power, and therefore may tend to support institution-centred care rather than woman-centred care (2).

Midwifery and care ethics

MacLellan (1), and more recently, Newnham and Kirkham (2) have proposed the 'care ethics' approach as one solution to the many ethical problems associated with the medicalisation of childbirth and make the appeal for empirical research into care ethics.

Care ethics is an emerging normative ethical theory based on a feminist philosophical perspective that is also, referred to as ethics of care or relational ethics (9). Care ethics is defined by Held (10) as "compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility." (p.6). Care is a social practice that constitutes the care giver and the care receiver and is an ethical phenomenon in and of itself because care is identified as a universal human experience, with a moral responsibility attached to those relationships of care (11, 12). Care ethics proposes that the web of relationships - the context, power dynamics and individual preference - are as morally significant to consider as the principle based moral judgements of bioethics, in determining what is good. The care ethics paradigm would assist midwifery in drawing attention to the socio-political power imbalances embedded in the current medical dominated maternity system.

Contemporary care ethics comprises four broad aspects – relationship, the practice of care, attention to power and socio-cultural context (10-17). The practice of care has been further described as including the characteristics of responsiveness, attentiveness, responsibility, and competence (13). Relationship is the underpinning focus of care ethics that ensures power imbalances are made visible during care and recognizes the socio-cultural context in which caring is happening, thereby enhancing ethical sensitivity and the practice of good care (14). Attention to broader sociocultural contexts and power imbalances

extends ethical consciousness from a decision-making or moral dilemma focus to greater ethical attention in meeting the care needs of the individual (15).

Research is now needed to determine whether and how the care ethics approach might be more appropriate for midwifery. There is, to date, no published primary research in midwifery utilizing care ethics, although other fields are using this emergent paradigm (16, 17). Our study aims to fill this gap as the first study to examine care ethics in midwifery.

Research aim:

The aim of this study was to determine whether there is a correlation between midwifery-led care and care ethics using template analysis with a priori codes generated by participants.

Research design

This inquiry was grounded in the ontology of critical realism, which acknowledges the influence of power structures on observable reality. We therefore used the emancipatory methodology of participatory action research, with a feminist theoretical perspective (FPAR). Participatory action research was chosen to partner with women in the research process and the feminist critical lens was chosen to highlight the historical and sociocultural complexities of contemporary maternity care that lead to the disempowerment of women. Template analysis was chosen for this part of the action research, as the best method for testing the theoretical concept (care ethics) to practice (midwifery-led care). A key benefit of this study method is it enables direct questions to be asked of the data; in this case; does midwifery-led care demonstrate care ethics? This discursive approach confirmed with primary research the theoretical questions posed by the midwifery profession.

Designs which test theory against empirical data, requires pre-set codes (18) to aid data extraction. A data extraction template was created with four a priori codes that represent the main characteristics of

care ethics, synthesized from contemporary literature (9-17) as shown in Table 1. Next, a priori codes that represent midwifery- led care were generated by participants and were applied to the template as shown in Table 2. Then, evidence to support the a priori codes were populated into the template as shown in Table. 3.

Table 1. Data extraction template: Care ethics

A priori codes	Care ethics characteristics			
Care ethics codes	1.Relationship	2.Practice of care	3.Attention to Power	4.Sociocultural context
Midwifery-led care codes				
Evidence				

Participant and research context:

The study sample included women (n=9) who had experienced a midwifery-led model of maternity care. Participants were recruited through purposive sampling and self-selected from an electronic bulletin advertising the research in maternity consumer forums. A participant information sheet and consent form were provided and returned via email. Thirteen women returned the consent forms, four were not included in the study as they had not had a midwife as the primary care giver. A stakeholder advisory group of nine women called the ‘community action research group’ or (CARG) was formed.

Data was collected in Perth, Western Australia, September 2019. The purpose of this data collection was to generate a priori codes, that would be used to test theory, rather than rich, thick, qualitative data. Thus, nominal group technique (NGT), useful in groups that include stakeholders to discuss and rank hierarchy of importance, was chosen (19). A discussion topic guide was used which was informed by a literature review. The discussion questions included: Why did you choose midwifery-led care? What was good / beneficial about midwifery-led care? Can you share an experience that you felt was wrong, unethical or harmful?

The NGT process commenced as each participant was invited to discuss their views of the topic guide, often with group discussion ensuing. After each guiding discussion point was exhausted, the group summarized the views expressed into 5 – 8 key words. From this list each participant was then asked to prioritize, in hierarchy of importance, their top three key words that summarized the answer to the discussion, both privately and individually. These were collated after the focus group using enumeration, the process of quantifying data, which tally's the number of times the code was documented. The final eight a priori codes were member checked by participants. This process is a compelling example of FPAR design, co-collaborating with the women during the research process.

The a priori codes were then mapped to the predesigned care ethics template. The template was finalized with examples from the participants under each category, thus retaining women's voices in the research process.

Ethical considerations

Ethics approval was granted by the Edith Cowan University Research Ethics Committee REMS no. 2019-00296- Buchanan. Consent to the study was voluntary, the participants contacted the research team from an electronic bulletin advertising the research. The participants signed the participant information document detailing the research and verbal consent was gained prior to the interviews. Pseudonyms were assigned at transcription to ensure anonymity and confidentiality.

Trustworthiness measures

Trustworthiness was ensured through methods choice, reflexivity and an audit trail recording decision making rationale. Despite having a small data set for this part of the project, the methods were true to aim in testing theory against practice. Dependability was ensured through correct method choice of template analysis and NGT that could be repeatable. Participant generated a priori codes ensured credibility and confirmability was ensured through retention of raw data in the examples within the final template.

Findings

The participants generated eight a priori codes that represent ethical midwifery-led care. These findings were then applied to the care ethics template as shown in Table 2.

Table 2. Care ethics data extraction template populated with midwifery-led care codes

A priori codes	Care ethics characteristics			
Care ethics codes	1. Relationship	2. Practice of care	3. Attention to power	4. Socio-cultural context
Midwifery-led care codes	1.1 Relationship with Midwife 1.2 Woman-centred care	2.1 Trust women's bodies and abilities 2.2. Protect normal physiological birth	3.1. Information provision 3.2. Respect autonomy	4.1. Birth culture of fear (MLC counter cultural) 4.2. Recognition of rite of passage

The final template was populated with evidence of women's experiences of midwifery-led care from an ethical perspective as shown in Table. 3.

Table. 3 Final Care ethics template with populated evidence of midwifery-led care

Care ethics codes	1. Relationship		2. Practice of care		3. Attention to Power		4. Socio-cultural context	
Midwifery-led care codes	1.1 Relationship with Midwife	1.2 Woman centred care	2.1 Trust women bodies	2.2 Protecting normal birth	3.1. Information provision	3.2 Respect autonomy	4.1 Birth culture of fear (MLC counter cultural)	4.2 Recognition of birth as rite of passage
Evidence	<p><i>“There was an exchange – it didn’t feel like she was up there, and I was down here, and they are really joyful, even this time when she feels a kick, she gets excited. It’s a joyful, close transparent relationship”</i></p> <p><i>“the biggest thing for me was having relationship in having a consistent care provider ...</i></p>	<p><i>“I felt like my midwife looked at everything, from a holistic point of view, it wasn’t just physical, it was mental, emotional, even spiritual and took to understanding who I am.”</i></p> <p><i>“a holistic approach, Midwives look at the whole picture, she will look at the body language and is led by how she knows the woman.”</i></p>	<p><i>“MLC would respect that you’re the expert of your body. “</i></p> <p><i>“empowerment through knowledge of what the body can do.”</i></p> <p><i>“it’s because we are trying to follow physiological birth and the midwife ensures that “</i></p> <p><i>“and if someone had gone by</i></p>	<p><i>“If I hadn’t had a homebirth midwife there was no way I would have been able to have a physiological birth, I would have ended up with the medicalised cascade of intervention and probably a c/section at the end”</i></p> <p><i>“the midwife said we don’t call them (DR) till later, the</i></p>	<p><i>“Open presentation of research ; so I had amniotic leak in one of my pregnancies and my midwife said this is the research and she got the most up to date stuff and we looked through everything and she said what’s your decision , it was never, I drove all the decisions, she helped me with the research and we would</i></p>	<p><i>“Discussing information before the birth so women can make informed choices”</i></p> <p><i>“Talking through the policies and procedures”</i></p> <p><i>“telling the midwife, you decline all screening, and she doesn’t even blink”</i></p> <p><i>“I wanted to have my choices respected and I</i></p>	<p><i>“There is an underlying mistrust in our bodies, our ability to give birth”</i></p> <p><i>“You can’t talk about your positive birth story”</i></p> <p><i>“Other women saying they would have died if they had had a homebirth.”</i></p> <p><i>“Drs have no confidence in women’s bodies, that we can’t do it without help</i></p>	<p><i>“midwives’ acknowledgment of the significance of pregnancy and birth”</i></p> <p><i>“so, I think it’s got to be given some significance, the rite of passage, this is a momentous event, some women only do it once in their lifetime and so that has to be given some significance”</i></p>

<p>because if I had a 30-hour labour, I wanted the same midwife there the whole time, so that was really important”</p> <p>“Having one midwife that I would see each time”</p> <p>“the relationship with the midwife is an open relationship”</p> <p>“it’s a transparent relationship (with the midwife)”</p> <p>“Transparency was something I experienced too”</p> <p>“if I hadn’t had the relationship with my midwife and she hadn’t known</p>	<p>“also its quite an intimate process, considering conception is quite intimate, birth is intimate I think my previous births it was all done to me whereas this time (with IM) we were doing it together”</p> <p>“my midwife said when my placenta was still in – she said I wouldn’t have done this for everyone, but she knew it was the right decision for me – it’s the fact midwife can identify that because you’ve got that relationship, its tailored to me”</p> <p>“she’s (midwife) genuinely excited”</p> <p>“I felt nurtured by the midwife,</p>	<p>during the homebirth and said do you want and epidural? I would have gone out onto the street and grabbed them in and said yes but I didn’t want to be in that position so there was no way or opportunity at home. At the end my midwife said, “see you didn’t even ask for a Panadol” and I said – I could have had Panadol? (laughing)</p> <p>“(midwives) are listening to women”</p>	<p>earlier we call them the more they want to intervene. so, it was like this standard thing they don’t call them until basically the baby comes out.”</p> <p>“I was close to the weight limit cut off at FBC. We went on a Holiday to Serbia for the month and came back and she said I’m not going to write that weight down this week, and I did drop, 2 kg below the limit when I gave birth”</p> <p>“it was the perfect birth environment – the middle of the night, no one was there just my midwife and partner”</p>	<p>discuss it and go through her experience as a midwife and also what the literature said , and so I felt I was driving all the decisions.”</p> <p>“ways my midwife presented information was; these are your options if you do A) pros and cons) if you do b) these are the pros and cons if you do c) these are the pros and cons- so which one?”</p> <p>“even talking through the processes or policies– if this happens, these are the options, or this is what we need to talk about, so it was kind of already flagged before the event. Before when</p>	<p>felt that would happen in MLC”</p> <p>“and that’s where autonomy comes in – if you come into hospital and say I accept that is your policy, but I decline, then you shouldn’t then be coerced into doing it.”</p> <p>“Empowerment is choice.”</p> <p>“yes, in MLC you have true informed consent”</p>	<p>They have forgotten the fundamentals of women birthing”</p> <p>“Positive birth stories are shamed.”</p> <p>“because it makes other feel worse about their birth.my sister in-law arrived about half an hour after my birth and she asked how it was and I stated telling her it was amazing and she promptly said “stop ! you’re making me jealous” -because she had two electives. And now I have to stop telling my good birth story.”</p> <p>“I ran into acquaintances, both knew my husband works at the hospital and asked if I had had the baby there and I said no I had</p>	<p>“How impactful the birth experience is to bonding breastfeeding and mental health”</p> <p>“when a baby is born the mother is born”</p> <p>“so, we keep these stories inside of us, so really careful not to diminish anyone’s choices.”</p> <p>“and to what extent do we acknowledge that it’s an impactful event in this day and age, in other cultures and earlier in our culture that women gave birth and got on with it and it was normalized in the family”</p>
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	<p><i>what I went through with my first birth the I wouldn't have been able to get myself out of hospital. Like the first time I was begging them to let me go.</i></p> <p><i>"that's like my husband in the first month of pregnancy said "so when can we start the epidural" and by the end of the 9 months he said that he would never not have a private midwife. Relationship was a really big one"</i></p>	<p><i>"she (midwife) would sit next to me and fill in notes together"</i></p> <p><i>"My midwife debriefed my last birth, she debriefed a lot with me, the mental health aspect was really important. Any obstacle that would come up during my labour being a VBAC, we went through all that first, breaking things down and the emotional trauma of the last birth in hospital before this birth"</i></p>		<p><i>"I chose midwifery care to go without having the interventions"</i></p>	<p><i>you were talking about things as hidden but with the midwife it all felt very open like I kept my notes and had them with me all the time"</i></p> <p><i>"communication about what your options are, what those tests are, what the options are if you test positive. I declined GBS test, I declined it when presented with all the information. "</i></p>		<p><i>the baby at home actually and they turned and walked away, and I burst into tears."</i></p> <p><i>"As women who have had MLC, we're trying to tell all these positive birth stories, but other women say - don't tell me that."</i></p> <p><i>"I got abused because they confused HypnoBirthing with home birthing, and they said I can't believe you would put your children at risk."</i></p>	

The findings established that midwifery-led care demonstrated the four core domains of care ethics. The participants identified the importance of relationship as demonstrated by midwifery-led care, as significant for care to be deemed ethical, that midwives demonstrate the practice of care ethics, that midwifery-led care levels power, and that the sociocultural contexts of birth are significant.

Care ethics category - Relationship

'Relationship' and 'woman-centred care' were major findings of this study. Women described the relationship with the midwife as 'continuous' and 'woman-centred' based on equality and transparency. All women wanted continuity of care with the same caregiver throughout pregnancy and beyond. The priority for the woman was that the midwife shared the same philosophy of birth, respected her agency, and would aim to strengthen her capabilities. All participants confirmed that continuity with the midwife was extremely important in what they described as ethical care.

Georgia – “the biggest thing for me was having relationship in having a consistent care provider ... because if I had a 30-hour labour, I wanted the same midwife there the whole time, so that was really important”.

Most women in this study chose midwifery-led care following as previous birth in the medical model. Women shared their experience of relationship with the midwife as an intimate knowing from a holistic perspective.

Annie – “I felt like my midwife looked at everything, from a holistic point of view, it wasn't just physical, it was mental, emotional, even spiritual and took to understanding who I am.”.

This was echoed by Ava who said that midwives take -

“a holistic approach, Midwives look at the whole picture, she will look at the body language and is led by how she knows the woman.”

The relationship with the midwife was individualized and went beyond meeting physical needs, also meeting psychosocial and emotional needs. The woman-centredness is described by Ava as *“the relationship is tailored”*. The relationship was a conduit to achieving the experience the woman wanted, in line with her own beliefs about her body’s ability to birth.

The relationships with the midwife was also described as open. All the women confirmed transparency as being a key component of ethical care. Ava - *“it’s a transparent relationship”* confirmed by another Kara- *“Transparency was something I experienced too”*. Elisa explaining - *“also its quite an intimate process, considering conception is quite intimate, birth is intimate I think my previous births it was all done to me whereas this time (with MLC) we were doing it together... (midwives) are listening to women”*

The women’s descriptions demonstrating a leveling of the power in the relationship, based on transparency. Equality in the relationship was defined as a building of trust over time and respect between a woman and her midwife.

Lucy – “There was an exchange – it didn’t feel like she was up there, and I was down here, and they are really joyful, every time she feels a kick, she gets excited. It’s a joyful, close transparent relationship ...in the appointments the midwives are transparent, she would sit next to me with the notes on the desk and we would fill in notes together”

Practice of care

This category, the practice of care, as set out in care ethics includes responsibility and competence. This was matched to the a priori codes ‘trusting women’s bodies’ and ‘protecting physiological birth’.

Trusting women’s bodies to birth was an important theme for the women in describing good care. They felt it was important that the care provider share the same beliefs about normal physiological birth and

trust in women's bodies and abilities. Lucy said - *"Midwifery- led care would respect that you're the expert of your body "*. Annie explained - *"empowerment is through knowledge of what the body can do"*. The women felt empowered, and their capabilities strengthened through the trust midwives had in birth and women.

The women identified responsible and competent ethical care as prevention of intervention and facilitating normal physiological birth. When sharing their experiences of midwifery care, each woman consistently referred to how the care empowered her toward achieving a normal physiological birth. The women concurred that it was midwifery-led care that facilitated normal physiological birth through intervention prevention.

Harriet said - *"If I hadn't had a homebirth midwife there was no way I would have been able to have a physiological birth, I would have ended up with the medicalised cascade of intervention and probably a c/section at the end"*.

Clare described specifically this trust in the normal physiological process and preventing intervention specifically.

Clare shared - *"my midwife said to me – when my placenta was still in (physiological third stage) –"I wouldn't have done this for everyone", but she knew it was the right decision for me – it's the fact midwife can identify that because you've got that relationship, its tailored."*

The relationship allows for transparent discussion of intervention when deemed necessary, while still trusting and supporting her decision, and upholding physiology around the intervention.

Attention to power

This category was represented by the subcategories' 'information provision' and 'respect autonomy'.

The women identified that the balance of power within the relationship influenced how ethical the care

was. Their collective experience led to the recognition that the midwife builds relationship by working to equalize the power between the woman and midwife, whereas in the medical model, the care provider often retains their power and authority in the relationship. Kara - *“Yes it’s all about the relationship – some women would prefer to hand over all the consent (to the Dr.)”*

Women described the relationship with the midwife as based on open provision of information and respecting autonomy. The women felt this established a sense of mutual trust on which the foundation of decision making could occur. They described that in the midwifery model of care, information was presented in a transparent manner, which enhanced ethical care. They felt fully informed, empowered with knowledge, and could exercise their autonomy and be responsible for decisions.

Georgia described – “(midwives) give open presentation of research; so I had amniotic leak in one of my pregnancies and my midwife said this is the research, and she got the most up to date stuff and we looked through everything and she said “what’s your decision?” ..., I drove all the decisions, she helped me with the research, and we would discuss it and go through her experience as a midwife and also what the literature said, and so I felt I was driving all the decisions.”.

The women all concurred that current research had been shared with them so that they could give informed consent, which in their view constituted ethical care.

Participants identified that this knowledge and information provision was necessary for true informed consent and enabled them to make decisions and hold responsibility for those decisions. Information was identified as either given transparently to women, to enhance their agency, or as withheld, which limited their autonomy. The women felt ethical care was demonstrated when they had the power to make decisions and to exercise agency.

Elisa said - *“They (midwives) talk through policies and processes and discuss options. If this happens these are the options or this is what we need to talk about, so it was kind of already flagged before the event. Before you were talking about when things are hidden but with the midwife it all felt very open”*

All the women agreed that when information was open and transparent it enhanced the women’s decision making and empowered her to be the director of her care.

Harriet described this process: *“the ways my midwife presented information was; these are your options if you do A) pros and cons) if you do b) these are the pros and cons if you do c) these are the pros and cons- and I made the decision”*. Elisa confirmed this – *“communication about what your options are, what those tests are, what the options are if you test positive. I declined GBS test, I declined it because when presented with all the information, I could make a decision.”*

The group were consistent in their understanding that ethical care was the provision of freely given information on which women can base decision making. They identified that midwives tend to respect women’s autonomy and trust a woman’s decision-making after the provision of all the information. Autonomy and self-determination were viewed as important in ethical care and were better upheld with detailed information provision. Kara said – *“I wanted to have my choices respected and I felt that would happen in midwifery-led care”* and Clare confirmed – *“telling the midwife you decline all screening and she doesn’t even blink”*.

Sociocultural contexts

This category was further enhanced through subcategories; ‘Birth culture of fear’ (MLC counter-cultural) and ‘Recognition of birth as a rite of passage’. The women identified as a group that the sociocultural

context of the maternity system was patriarchal and was underpinned by a fear approach to care, which they felt oppressed women. They agreed this culture is unethical in the care of women.

Ava said - "Doctors have no confidence in women's bodies, that they can't do it without help, they have forgotten the fundamentals of women birthing, there is an underlying mistrust in our bodies, our ability to give birth".

The women in this study sought out carers that held the same birth philosophies in trusting women's bodies and normal physiological birth processes, and they identified that this was not readily accepted by society. They identified the explicit role of the midwife in respecting that women are the experts of their bodies and in protecting normal physiological birth. The group discussed the role of the General Practitioner as gatekeeper and that women were mostly unaware of the importance of the choice of model of care in achieving a normal physiological birth.

Trinny described – "In that first appointment women are making a choice for physiological or pathological birth" but highlighted achieving a care provider that shared this philosophy was hard to find; Annie – "a homebirth midwife is really hard to find – I thought it would be as simple as Googling it."

Women reflected that the sociocultural context of fear and risk attached to birth limited them from sharing positive birth stories. The women in this study felt the lack of positive stories referring to normal physiological birth contributed to the sociocultural context of fear and risk thus contributing to the perpetuated myth that birth was risky and dangerous.

Annie said - "Positive birth stories are shamed ... because it makes other feel worse about their birth. My sister in-law arrived about half an hour after my birth and she asked how it was and I

stated telling her it was amazing and she promptly said “stop ! you’re making me jealous” - because she had two electives. And now I have to stop telling my good birth story.”

The women also described that the acknowledgement by the midwifery model of care of the impact of birth, as a rite of passage in their journey into motherhood was another important factor in their experience. Birth is a significant life event that impacts the mother, father, baby, breastfeeding and mental and emotional health. They identified that the birth experience is significant in either strengthening women’s capabilities or disempowering women.

Harriet explained - “And also acknowledgment of the significance of the pregnancy and birth so I think it’s got to be given some significance, the rite of passage , this is a momentous event , some women only do it once in their lifetime and so that has to be given some significance and I think that gets lost.”

Ava added -“And how impactful the birth experiences are and how they, generational trauma, all our experiences and anything that happens to us before our labour and afterwards, really does impact everything – the bond with our child , the breastfeeding, and all these things and the studies of increased perinatal anxiety and how it impacts our partner.”

The women felt ethical care was based on a trusting and levelled relationship, information provision to make decisions, respect for decisions which protected normal physiological birth and strengthened women’s abilities to birth, and the recognition of birth as a rite of passage into well motherhood.

Discussion

The present study examined women’s experiences of maternity care from a care ethics perspective to map midwifery practice against care ethics categories. The women clearly identified what was and what was not ethical to them. They generated the a priori codes, as subcategories, that could then be mapped

to care ethics, thereby demonstrating the correlation between the midwifery led care and care ethics. It was identified midwifery-led care reflects the categories of care ethics and could therefore be considered as more ethically sensitive, which is a new finding for the midwifery profession.

These findings of this study support the theoretical questions posed by MacLellan (1) and Newnham & Kirkham (2) who suggest that care ethics should be further explored as an alternative paradigm to the bioethical principles that currently guide maternity care in Australia and internationally. The findings are consistent with previous research into care ethics which demonstrates care ethics utilization as an ethical paradigm for enhancing ethical care (16, 17).

The a priori codes decided by the participants were mapped to the four domains of care ethics: relationship, practice of care, attention to power and sociocultural context.

Relationship The primary finding, the relationship between midwife and woman as beneficial, resonates with findings from previous studies on the midwife woman relationship (8, 20-22). The participants' accounts demonstrated that the relationship between the care provider and the woman affected whether women perceived their care as ethical. Indeed the 'care ethic' central principle of relationship resonates with midwifery's central tenet of being 'with woman' in relationship (8). For example, Bradfield et al (21) in their phenomenological study identified relationship, based on trust, as a key attribute that allows provision of woman-centred care, as central to midwifery care.

The practice of care was expressed by the women in the subcategories; midwives trust in their bodies ability to birth and protecting normal physiological birth. This has been confirmed in previous work Grigg's (23) study from eight focus groups of 37 women highlighted that a woman's choice of midwifery-led care was because of the woman and midwives' convergent beliefs about birth as a normal physiological process. This was confirmed by Dahlberg et al (24) when interviewing first time mothers who described the midwives as pivotal in their achieving normal physiological birth. More recently

Aannestad, Herstad, & Severinsson, (34) and Raipuria et al (25) literature reviews detailed the qualities of the midwife, all underpinned by a philosophy of care that regards birth as a normal life event. In our study it was these practices of care that strengthened women's own capabilities which to them demonstrated ethical care.

Attention to power – information provision and respect for autonomy were the subcategories identified by the women. The focus group concurred that in midwifery-led care there was an equalizing of the balance of power between the woman and the midwife. Attention to power as set out in care ethics, is relevant to childbearing women because they are vulnerable to power imbalance as the medicalisation of birth introduces hierarchy, standardizes care and reduces autonomy. This is supported by the work of Perriman, Davis, & Ferguson (26), whose literature review of 13 papers identified empowerment as a salient aspect of the midwife-woman relationship, with the women in that study also describing information provision that leads to decision making as representative of empowerment.

Power imbalances are subtle and the work by O'Brien et al (27) identified that informed choice is not the clear process as outlined in bioethics. Their study identified that midwives levelled power relations through information provision, and that women require support and relationship with their care provider for decision making. Autonomy is achieved through relational, cultural and emotional support to make decisions and give informed consent.

The sociocultural category circumstances within the maternity setting are complex. Understanding the woman's context of family and relationships within the greater socio-political contexts of power, patriarchy and feminist issues bring about deep ethical questions. The women in this study described a birth culture of risk and fear that controls women using the powerful and political dominance of the medical model. These women chose midwifery-led care, and felt it was unethical that more women did not have access to this model of care. Grigg, Tracy, Schmied, Daellenbach, & Kensington's (23) focus

group study confirmed what was expressed in this study - that midwifery-led models of care are still marginal and seen as counter-cultural to mainstream maternity, despite now having good evidence that it is the safest model of care.

Conclusion

These findings using participant generated a priori codes, demonstrated that midwifery led care exhibits the four domains of care ethics. The care ethics approach may, because of its consistency with feminist midwifery philosophy, values and priorities, yield better professional adherence to ethics and care of the childbearing woman. The apparent inconsistencies between contemporary maternity care and the default bioethical model can potentially be clarified when juxtaposed with the care ethics paradigm. Care ethics takes into consideration what principle-based bioethics have previously overlooked: relationship, context, and power.

This study is the first to demonstrate a relationship between a midwifery-led model of care and care ethics. It contributes to the existing body of knowledge by providing further insight and deeper understanding of the ethics of caring for childbearing women and provides valuable foundational information on which to explore further. Further work is required to ascertain whether care ethics would be a better fit for the midwifery model of care.

Disclosure statement

The authors declare they have no competing interests, financial interest or benefits arising from the research.

References

1. MacLellan J. Claiming an Ethic of Care for midwifery. *Nursing Ethics*. 2014;21(7):803-11. <https://doi.org/10.1177/0969733014534878>
2. Newnham E, Kirkham M. Beyond autonomy: Care ethics for midwifery and the humanization of birth. *Nursing Ethics*. vol. 26, no. 7-8, 2019, pp. 2147–2157., doi:10.1177/0969733018819119.
3. Clesse C, Lighezzolo-Alnot J, de Lavergne S, Hamlin S, Scheffler M. The evolution of birth medicalisation: A systematic review. *Midwifery*. 2018;66:161-7.
4. Benyamini Y, Molcho ML, Dan U, Gozlan M, Preis H. Women's attitudes towards the medicalization of childbirth and their associations with planned and actual modes of birth. *Women and birth : journal of the Australian College of Midwives*. 2017;30(5):424-30.
5. Cole L, LeCouteur A, Feo R, Dahlen H. "Trying to give birth naturally was out of the question": Accounting for intervention in childbirth. *Women & Birth*. 2019;32(1):e95-e101.
6. Freedman LP, Kujawski SA, Mbuyita S, Kuwawenaruwa A, Kruk ME, Ramsey K, et al. Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth. *Reproductive Health Matters*. 2018;26(53):107-22.
7. World Health Organisation. The prevention and elimination of disrespect and abuse during facility-based childbirth. WHO. Geneva2014.
8. International Confederation of Midwives. International Code of Ethics for Midwives. Hague, Netherlands. 2014.
9. Gilligan, C. *In a different voice : psychological theory and women's development*. Cambridge, Mass.: Harvard University Press; 1982.
10. Held V. *The ethics of care : personal, political, and global*. Oxford; Oxford University Press; 2006. Available from: <http://site.ebrary.com/id/10211833>.
11. Klaver K, Elst Ev, Baart AJ. Demarcation of the ethics of care as a discipline. *Nursing ethics* 2014. vol. 21, no. 7, 2014, pp. 755–65., doi:10.1177/0969733013500162.
12. Leget C, van Nistelrooij I, Visse M. Beyond demarcation: Care ethics as an interdisciplinary field of inquiry. *Nursing Ethics*. 2019;26(1):17-25.
13. Tronto JC. *Moral boundaries : a political argument for an ethic of care*. New York: Routledge; 1993.
14. Vosman F, Niemeijer A. Rethinking critical reflection on care: late modern uncertainty and the implications for care ethics. *Medicine, Health Care, and Philosophy*. 2017;20(4):465-76.
15. Klaver K, Baart A. Attentiveness in care: Towards a theoretical framework. *Nursing Ethics*. 2011;18(5):686-93.
16. Osuji PI. Relational autonomy in informed consent (RAIC) as an ethics of care approach to the concept of informed consent. *Medicine, Health Care, and Philosophy*. 2018;21(1):101-11.
17. de Vries M, Leget CJ. Ethical dilemmas in elderly cancer patients: a perspective from the ethics of care. *Clinics in geriatric medicine*. 2012;28(1):93-104.
18. Brooks J, McCluskey S, Turley E, King N. The Utility of Template Analysis in Qualitative Psychology Research. *Qualitative Research in Psychology*. 2015;12(2):202-22.
19. Harvey N, Holmes CA. Nominal group technique: An effective method for obtaining group consensus. *International Journal of Nursing Practice*. 2012;18(2):188.
20. Borrelli SE, Spiby H, Walsh D. The kaleidoscopic midwife: A conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth. A grounded theory study. *Midwifery*. 2016;39:103-11.

21. Bradfield Z, Hauck Y, Kelly M, Duggan R. "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model. *BMC Pregnancy and Childbirth*. 2019;19(1):29.
22. Davison C, Hauck YL, Bayes SJ, Kuliukas LJ, Wood JG. The relationship is everything: Women's reasons for choosing a privately practising midwife in Western Australia. *Midwifery*. 2015;31(8):772-8.
23. Grigg CP, Tracy SK, Schmied V, Daellenbach R, Kensington M. Women's birthplace decision-making, the role of confidence: Part of the Evaluating Maternity Units study, New Zealand. *Midwifery*. 2015;31(6):597-605.
24. Dahlberg U, Persen J, Skogås A-K, Selboe S-T, Torvik HM, Aune I. How can midwives promote a normal birth and a positive birth experience? The experience of first-time Norwegian mothers. *Sexual & Reproductive HealthCare*. 2016;7:2-7.
25. Aannestad M, Herstad M, Severinsson E. A meta-ethnographic synthesis of qualitative research on women's experience of midwifery care. *Nursing & Health Sciences*. 2020;22(2):171-83.
26. Perriman N, Davis DL, Ferguson S. What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery*. 2018;62:220-9.
27. O'Brien D, Casey M, Butler MM. Women's experiences of exercising informed choices as expressed through their sense of self and relationships with others in Ireland: A participatory action research study. *Midwifery*. 2018;65:58-66.