2023

**Woman-centred ethics: A feminist participatory action research**

Katherine A. Buchanan  
*Edith Cowan University*

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Woman-centred ethics: A feminist participatory action research

Katherine Agnes Buchanan

Submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy (Integrated)
School of Nursing and Midwifery
Edith Cowan University
2022
Abstract

Background: The maternity system has a complexity of everyday ethical issues. The bioethical principles: non maleficence, beneficence justice and autonomy, that govern health care practice have been criticised as abstract, patriarchal and even rhetorical in maternity care practice (MacLellan, 2014) and consequently may be insufficient in guiding care of childbearing women. Midwifery-led care is guided by the International Confederation of Midwives International Code of Ethics, which considers more than the bioethical principles, such as the importance of relationship. Care ethics is a relational based feminist ethics first described by Gilligan (1983) and has been theorised as an alternate paradigm for midwifery (Newnham & Kirkham, 2019). A paper was published in Nursing Ethics as a result of the literature review; Care ethics framework for midwifery practice: A scoping review and it was determined that care ethics is demonstrated in practice with four domains; Relationship, Context, Caring Practices and Attention to power. In addition, there is limited empirical evidence as to women’s experiences of care from an ethical perspective, and importantly what women describe as ethical, revealing a gap in the literature that has yet to be explored.

Objective: The aim of the study reported in this thesis was to investigate women’s experience of maternity care from an ethical perspective and to determine whether a care ethics paradigm would better suit midwifery.

Methods: The transformative research was undertaken using Feminist Participatory Action Research (FPAR). FPAR is a feminist and transformative research design, which includes participants as central to research design. Purposive sampling was used to recruit women who had experienced midwifery-led care. Nine women formed the Community action research group (CARG), they worked with me over three years, guided the research and planned action. The CARG participated in five focus groups, for data collection and organising action toward the changes they wished to see. Their involvement in the research included: defining the research problem, creating a priori codes for analysis, reviewing analysis, disseminating findings and provided recommendations for policy change. A paper was published in Woman and Birth: Navigating midwifery solidarity: A feminist participatory action research framework, describing some of the finer points of FPAR including a framework for novice researchers. In phase two a further ten women who had had midwifery-led care were involved in this study and interviewed about their experiences of ethical maternity care. Data were collected from September 2019 to April 2022 via five focus group interviews and ten one-on-one semi-structured interviews. The interviews were recorded, and transcribed, and template and Reflexive thematic analysis was applied (Braun & Clark, 2021).

Findings: The findings in this study were presented in two parts. The first phase of the study revealed midwifery-led care demonstrated care ethics in practice. The Community Action Research
Abstract

Group (CARG) created a priori codes and a template analysis determined that midwifery models of care demonstrate care ethics. A paper of these findings was published in Nursing Ethics; Does midwifery-led care demonstrate care ethics? A template analysis.

In the second phase of the study, the data corpus was analysed using reflexive thematic analysis and the primary theme, Radical desires: Individuals’ values and context, captures the woman at the centre of the care, her values and context, as central to understanding ethics. The quality of the relationship, the knowledge that was shared, and the manner of the care given were deemed important elements of ethical care. I assigned categories Woman-centred ethics or Authoritarian ethics to describe these elements of ethical or unethical aspects of care. Woman-centred ethics contains the subcategories of: harmonised relationship, transparent wisdom, and midwifery solidarity. The category Authoritarian ethics contains the subcategories of: uneasy alliance, opaque information, and saving women from themselves. How the woman experienced these categories affected the liminality and sense of self, and are described in subthemes, Claiming power and Surrendered power.

Discussion: The themes were explained, discussed, and contrasted against the extant literature in the discussion. Pregnancy and birth as a transformative rite of passage was valued by the women in this study and they perceived care as more ethical when the care providers respected this. Authoritarian ethics, when viewed with a feminist and care ethics lens highlighted continued female oppression from the maternity system structures and culture. A conceptual model, Woman-centred ethics, was developed based on midwifery philosophy and feminist care ethics, which may help midwives embody a different kind of ethics and provides a way to enhanced ethical practice. A paper was published that shared the conceptual model in Midwifery Journal: Woman-centred ethics: A feminist participatory action research.

Conclusion: This study has contributed to the body of knowledge that describes how women perceive ethics in maternity, and honours women’s voices as central to ethical care. The study advances midwifery philosophy through exploring midwifery ethics and offers a conceptual model to guide practice. The woman-centred ethics model describes an embodied way of practicing ethical care and may provide a starting point for moving the field forward in ethical discussion. The CARG group involvement in the research and action together were an important feature of this project. Several recommendations arose from this study for practice, organisational, and educational processes.
Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

i. incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education.

ii. contain any material previously published or written by another person except where due reference is made in the text of this thesis; or

iii. contain any defamatory material.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement (2018) on Ethical Conduct in Human Research (2018) The proposed research study received human research ethics approval from Edith Cowan University REM Buchanan 2019-2019-00296 and REM Buchanan 2020-01707.

Sign

Date: 30th Nov 2022
Acknowledgements

I acknowledge the traditional owners of Noongar Whadjuk country, on which I work and live, pay my respects to elders past, present, and emerging, and thank them for their wisdom, beauty, and resilience.

To the women who shared their pregnancy and birth experiences, I am honoured to hold your birth stories in my head and heart; I knew each of your words and who had said them by the time I finished writing. Your lived experiences bring the research alive. Thank you to the incredible group of women who formed the CARG and the work we did together toward transformative action — precious CARGo indeed.

An enormous thank you to my excellent supervisors past and present. Sara Bayes who opened the door to the PhD world and supervised me to Candidature, Clare Davison whose feminist passion inspired me, Deb Ireson for the warm encouragement, Sadie Geraghty for being an exemplary leader, Lisa Whitehead for the clear path to submission, and finally to Liz Newnham who supervised the whole PhD journey, who embodies care ethics in everything she does. Thank you all, for your wise and generous supervision.

Thank you to James, my accidental feminist, who got our teenagers hooked on cycle racing, which freed up hours and hours of a quiet house. Thank you to my son Stirling, a fellow early riser, who sat on my lap while I ‘PhDed’, and surprising me with ‘midwifery speak’ whenever I need encouragement (Use your birth breathing mum!).
Dedication

To my red thread:

To Mum: You instilled in me a social justice heart. You took me to my first protest when I was just two, you wore a solidarity badge to church, you filled my childhood with glorious stories of injustice and overcoming.

You make me laugh harder than anyone else I know.

You have been a midwife to my whole life’s journey.

To my daughters: Holly and Karri – My joy and delight, you are the why xx.

To all birthing people: May you have known a midwife through pregnancy and birth.
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Glossary and Abbreviations

Birth Centre, Family Birth Centre: Birth centres are midwifery-led, home-like birth environments; they can be freestanding or on the grounds of a hospital. In Perth there are two birth centres, which are on grounds of two tertiary hospitals.

Caesarean: The surgical delivery of a baby via the mother’s abdomen. Also referred to as a c-section, caesarean section, and Caesar.

Cardiotocograph (CTG): A machine used for monitoring the foetal heart rate and maternal contractions. It provides a graphic representation of the correlation between foetal heart rate patterns and uterine contractions during labour and birth.

CARG: Community Action Research Group

Community Midwifery Program (CMP): The CMP is a WA government-funded, midwifery-led model for low-risk (but subject to overarching polices of the tertiary hospital it’s attached to) women choosing homebirth. The midwives are employed by the health department.

Continuity of care (COC): The care provided by one midwife over the course of the pregnancy and birth

Endorsed Midwife: a midwife endorsed with the Nursing and Midwifery Board of Australia competent to provide pregnancy, labour, birth and postnatal care to women and their infants; and is qualified to provide the associated services and order diagnostic. They often privately practising.

Eligible Midwife: Term interchangeable with the above

ICM: International Confederation of Midwives

Midwife: ICM definition (2014). The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the new born and the infant.

Midwifery-led care: Primary care led by a midwife (interchanges with term below)

Midwifery model of care: Primary care led by a midwife

Medical model of care: Primary care led by medical professional.

Nursing and Midwifery Board of Australia (NMBA): The regulatory board for Nurses and Midwives in Australia.

OECD: Organisation for Economic Co-operation and Development (low OECD or high OECD countries)
Glossary and abbreviations

**Obstetric-led care:** lead carer by an obstetrician

**Oxytocin:** The natural hormone that initiates contractions of the uterus during labour.

**Physiological birth:** normal bodily function, where the birthing person labours and births the baby in a healthy uncomplicated way without intervention.

**Privately Practising Midwives (PPM):** Midwives who are self-employed. They are not employed by a health service but employed directly by the woman. Most PPMs provide continuity of care across the full scope of midwifery practice and provide homebirth services.

**Vaginal birth after caesarean (VBAC):** When a baby is born vaginally after the mother has had at least one previous caesarean section.

**Vaginal Examination (VE):** A digital examination attended by a midwife or doctor to determine cervical dilatation and descent of the presenting part of a foetus.
Language and terminology use

Over the four years of this PhD, a movement toward more inclusive language has developed. I was initially guided by my feminist position, which acknowledges the gendered nature of childbirth and the historical struggle for power and agency in this space, and which therefore seeks to advocate for women. However, from an intersectional feminist perspective, the inclusion of people who do not identify as female or who are non-binary, is an important point of solidarity against oppression. Therefore, I use the term birthing person where the term woman wasn’t a necessary description, and interchange between these terms. I will use the term woman when referring to a participant who identifies as cis woman, where I refer to other research which has used the term woman, or when following the ICM definition and scope of woman-centred care. Elsewhere, I will use the more inclusive term of birthing person.
Research Outputs

This thesis is presented in a ‘with publication’ format. Four manuscripts were prepared for publication. In chapter two, I present ‘Care ethics framework for midwifery practice: A scoping review,’ published in Nursing Ethics. In chapter three, I present ‘Navigating midwifery solidarity: A feminist participatory action research framework,’ published in Women and Birth. In chapter five, I present ‘Does midwifery-led care demonstrate care ethics? A template analysis,’ published in Nursing Ethics. In chapter six, I present ‘Woman-Centred ethics: A feminist participatory action research,’ in review with Midwifery journal.

Published


Book Chapter in review

Research outputs

Presentations


Accepted to present at the *International Confederation of Midwives Conference* June 2023. Bali, Indonesia (15 min).
Chapter 1. The beautiful lie: Medicalised birth

Humanizing birth means understanding that the woman giving birth is a human being, not a machine and not just a container for making babies. Showing women — half of all people — that they are inferior and inadequate by taking away their power to give birth is a tragedy for all society. On the other hand, respecting the woman as an important and valuable human being and making certain that the woman’s experience while giving birth is fulfilling and empowering is not just a nice extra, it is absolutely essential as it makes the woman strong and therefore makes society strong.


Chapter overview

Chapter one introduces the study and explains the feminist standpoint which underpins the study. The Australian maternity system context sets out the complexities and issues and provides insight into the rational for the research. Midwifery philosophy is described as juxtaposed to systems based standardised care. The research problem, including a consumer definition of the research problem is offered, and the research concept; maternity ethics is presented. The research aim and objectives are outlined. The chapter ends with a description of how the thesis is organised.

Research motivation

The motivation for my study was to contribute in a small way to a kinder and more peaceful world. I am also exited by fields of philosophy and wanted to explore midwifery theoretical underpinnings which are intrinsically feminist and emancipatory. Ethics is one aspect of philosophy that underpins midwifery care and this study set out to explore ethics and midwifery in the hope of advancing midwifery philosophy.

Ethical standards and codes are fundamental to guiding good practice for health care professionals. Philosophical rationales and moral values undergird ethical codes and guidelines. Health professionals’ ethical practice is underpinned by the principles of biomedical ethics (bioethics), first published in 1979, which includes four prima facie principles: non-maleficence, beneficence, justice, and autonomy (Beauchamp & Childress, 2019). Bioethical principles are designed to be logically rigorous in order to be practically applicable (McKeown, 2015). However, the increased reporting of harm, mistreatment, and disrespect toward women during pregnancy and childbirth (Bohren et al., 2016), there
may be a need to explore ethical underpinnings and that an ethics of care (care ethics) may align better with midwifery practice (Newnham & Kirkham, 2019; MacLellan, 2014).

There is little empirical evidence that demonstrates the bioethical principles in maternity care practice. Wangmo and colleagues (2018) collated 1000 articles that provided empirical research of bioethics, of the 25 topics, none of which addressed maternity care. I found no empirical research related to bioethical principles in maternity care practice, which demonstrates a gap in the literature. Whilst there are discussion papers challenging bioethics as insufficient for maternity care and proposes the care ethics approach, they are interpretations of what women value (Newnham & Kirkham, 2019; MacLellan, 2014;). Critically no voices of the women at the centre of maternity care and what they said was ethical have been explored.

Context: contemporary maternity systems

Models of care
The Australian contemporary maternity system frames and gives context to the study. There exist 5 broad categories of maternity ‘models of care’ in Australia in 2022, standard public care, shared care, public midwifery continuity care, private obstetric care and private midwifery-led care with 900 variations of these (Australian Institute of Health and Welfare [AIHW], 2022; Donnelley et al., 2016, Talukdar et al., 2021). Models of care are used in the maternity system to classify care, which assists in the practical and organisational care delivery and identifies the discipline, carer, location and funding of care (Donnolley et al., 2016; Miller et al, 2022), less visible are the values philosophy, culture and attitudes of the model in classification systems (Eri et al., 2020).

The majority of women gave birth in hospital 96%, with the standard public hospital maternity care model making up the majority of this portion at 40%. Only a small number of women gave birth in public midwifery continuity of care (15%). Most research in Australia often compare just two models Standard Public care and Public Midwifery Continuity Care when determining the outcomes of models of care (Tracey et al., 2013, McLachlan et al., 2016; Wong et al., 2015; Talkudar et al 2021). When Public Midwifery Continuity Care was compared to Standard Public Care, midwifery continuity models demonstrated shorter
hospital stays, higher rates of unassisted vaginal births and spontaneous onset of labour, and lower rates of caesarean births, epidurals, and episiotomies (Miller et al., 2022). However, the public midwifery continuity of care model is still positioned under the medical speciality of obstetrics (Eri, 2020) and governed by hospital systems, policies, philosophies and values. Thus, the care given may appear structurally as a midwifery model but philosophically remains medical-led. The different models of care are underpinned by different birth philosophies (ontology, ethics, perception) which are expressed in the practice and care provided. Eris et al., (2020) recent review of midwifery models of care detailed the importance of knowing the philosophical underpinning of a model of care in order to implement evidence-based and normalcy-facilitating care (Eri et al., 2020).

**Funding**

The funding mechanism for maternity care in Australia, is two-tiered; the national funding of Medicare, a universal health care system, along with voluntary health insurance (AIHW, 2022). Birth people can access free public funded care or care in the private system subsided by private health insurance. Government incentivised private health insurance increased the percentage of birthing people choosing private hospital care (Fox, et al., 2019). With the move to private models of care, and no government regulation of fees, a free-market economy exists where families out of pockets expense increased 1035% between 1992/3 and 2016/17 and more specifically the out-of-pocket expense for in-hospital obstetrics intervention increased by 77% (Callander & Fox, 2018). Interestingly, the public still funds a significant portion of private hospital births which cost Medicare about twice the amount as public births in public hospitals over the first 1000 days (Callander et al., 2021).

The free-for-service model, which determines funding and privatisation of maternity systems, has turned health care services into a commodity (neoliberal consumerist health system) which has been linked to the decline of health care quality (Ratna, 2020) and subsequent medicalisation of birth (Fox et al., 2019; Rothman, 1979) and limited access to midwifery-led care (Fox, et al., 2019). Medicalisation is a multidimensional dynamic, which pathologises and standardises normal birth processes, and is rooted in risk reduction and associated with increased intervention (Benyamini et al., 2017; Cleese et al., 2018; Preis et al., 2018). With the demand for technology and intervention, midwifery models of care have become limited and less readily available to women globally (Bull et al., 2022; Nove
et al., 2021). In Australia in 2022, only 0.4% of the population engage a Private Midwife (Endorsed, privately practising midwife).

Over the past decade there has been a steady rise in caesarean section births from 37% in 2010 to 42% in 2020, and the induction rates have increased to 41% for first-time mothers and vaginal birth has dropped to 51% (Australian Institute of Health and Welfare (AIHW), 2022). Increased technological advances and intervention use in the context of preventing and treating risk is rationalised as a moral obligation to prevent complications and to protect women and babies (Cole et al., 2021; Downe et al., 2019). However, excessive intervention such as fetal monitoring, induction, and augmentation has resulted in nominal improvement in fetal and maternal mortality rates (Dahlen et al., 2013; Peters et al., 2018; Watson et al., 2021). Other authors have noted that the over-medicalised approach fails to meet evidence-based standards, with women having less power and control over their birth experiences, resulting negative psychological, emotional, and physical well-being (Byrne et al., 2017; Davis-Floyd, 1994; White Ribbon Alliance, 2011). Obstetric violence, a concept which describes the abusive and disrespectful behaviour by maternity health care providers toward childbearing women, continues to rise on an individual and structural level (Perez, 2010; Philbin & Schiller, 2021; Pickles & Herring, 2020; van der Waal & van Nistelrooij, 2022).

Worldwide health authorities and maternity consumer activists are advocating for change to reflect the need for respectful, woman-centred maternity care based on Human Rights principles (United Nations High Commissioner for Human Rights, 2019; World Health Organization [WHO], 2014). The emphasis being on quality interactions that includes respect for women’s feelings, dignity, choices, and the provision of quality information within a woman-centred model of care (Jolivet et al., 2021; Moridi et al., 2020; Morton and Simpkin, 2019).

**Midwifery model and philosophy**

Midwifery philosophy is rooted in feminist emancipatory values (International Confederation of Midwives [ICM], 2014). Midwifery, as an autonomous profession, supports and promotes normal physiology, women’s rights, and the profound experience of pregnancy and birth (ICM, 2017). A midwifery model of care is based on a social, holistic model of birth that is woman-centred and relational (Maclellan, 2014). Pregnancy and birth
are viewed as more than a biological event, encompassing social, emotional, and spiritual aspects that have long-lasting impacts on woman, baby, and family (Cook & Loomis, 2012; Davis-Floyd, 2022; ICM, 2014; Rai & Squire, 2017). The liminality or the transition between life stages, with pregnancy and birth recognised as transformative experiences (Davis-Floyd, 1994; Rich, 1986).

Eri’s (2020) recent review detailed midwifery philosophy as evident in midwifery-led models of care as; midwifery-woman relationship, feminist theory, childbirth as a normal process, empowerment and a rejection of medical model of care. Other reviews describe Woman-centred care as integral to midwifery philosophy, and woman-centeredness was demonstrated by continuity, choice of carer and control (Sandall, et al., 2016).

In this study I wished to explore care that was given by a midwifery model that most closely aligned with the International Confederation of Midwives (ICM) definition of midwifery model of care, where a midwife is autonomous and practising to the full scope and guided by a midwifery philosophy and ethics (ICM, 2014). In Australia this mode is only accessed by 4% of the Australian birthing people (AIHW, 2022). The rationale for choosing a very limited population is to better understand midwifery ethics, contribute to midwifery understandings and advance midwifery philosophy. I therefore use the terms medical model of care and midwifery-led care (MLC) through this study.

Next, I introduce a feminist lens to describe how medicalisation impacts pregnancy and birth experiences and midwifery scope.

**A Feminist critique of medicalisation**

There remains a need for feminist critique of contemporary maternity systems whilst there is disrespect and mistreatment toward women during pregnancy and childbirth. Medicalisation, neoliberal consumerism, and colonist, racist systems (van der Waal, et al., 2022) along with patriarchal philosophies that determines the female body and birth as pathological and requiring medical intervention (Davis-Floyd, 1994). Maternity systems are rooted in deeply held views of women and birth and does not seem to demonstrate the underlying values or support for promoting normal physiology (Reed, 2021).

Feminist analysis creates an opportunity to explore how the underlying structures of the maternity system and highlights issues of power imbalance between midwives, women,
doctors, and systems in the contemporary (Cahill, 2001; Davis-Floyd, 2001; Johnston & MacDougall, 2021). Figure 1, adapted from one originally presented by Rai and Squire (2017), likens the maternity system to a traditional family unit (See Figure 1.). Rai and Squire describe obstetrics as being male gendered, scientific, technological, and active in the patriarchy. Power is held by the doctor in the maternity system, with the woman obliged to obey the doctor because they have power, social influence, and superiority. The midwife is likened to a wife, necessary and useful, kind and caring, but inferior and therefore passive to the patriarchy. The woman in this analogy is represented as the child; if she is good, she will give birth in the hospital and make use of the interventions offered (Rai & Squire, 2017). Thus, the figure highlights how the oppression of women and midwifery in the maternity system is rooted in patriarchy, with power held by men and medicine (Donnison, 1978). This feminist critique of the underlying structures and paradigms within the maternity systems helps frame the ethical issues discussed in this thesis.

**Problem identification**

There exist rising reports of obstetric violence, violation of human rights, and disrespect within the maternity system globally (Dhakal et al., 2021; Lokugamage & Pathberiya, 2017). This problem is due in part structure of the maternity system based on patriarchal
structures, consumerism, and medicalisation. But also, the inequities between the childbearing woman’s position and that of the system which leaves the birth person vulnerable to power imbalances, and importantly how the bioethical principles can conceal these power differences (Newnham & Kirkham, 2019).

The research topic, ethics, was chosen as one aspect that hasn’t been explored in addressing the inequities. Past research has not collated women’s experiences of care from an ethical perspective and sets up a gap in the body of knowledge around ethics. Thus, those most affected by the guiding bioethical principles, birthing people, have not been asked what they perceive as ethical. Presenting women’s voices regarding ethics could result in more ethical care toward women and help contribute understandings and insights into some of the contemporary issues with disrespectful care in the maternity system. To further direct the research, consumers recruited in this action research were asked how they saw the research topic from an ethical perspective; they defined the research problem as such:

**Consumer definition of the problem**

The contemporary maternity system is unethical for many reasons. The care provided is not woman-centred or individualised. Women don’t have access to information to make decisions about their own bodies and babies. The knowledge women are given is not evidenced-based nor current. There are structural barriers, policies and standardised care which is likened to financial companies — instead of marketing and adds they have policies and procedures. There is a sociocultural fear of normal physiological birth (Community Action Research Group [CARG], 2020).

**Research aims and objectives**

The aim of this research was to explore women’s experiences of maternity care from an ethical perspective and to determine whether a care ethics paradigm would better suit midwifery.

Achieving the following three objectives would enable this aim to be fulfilled

The first objective was to generate transformative research; to collaborate with a team of women to guide and conduct the research toward emancipatory action.

The second objective was to determine whether midwifery-led care demonstrates care
The third objective was to explore women’s experiences of pregnancy and birth from an ethical perspective.

Methodology

The research design chosen to accomplish the aim of the study was Feminist Participatory Action Research (FPAR). The design is underpinned by a transformative feminist theoretical framework which acknowledges the sociocultural hegemony that links power to the oppression of women (Maguire, 1987; Newnham & Rothman, 2022). Qualitative data collection with a feminist lens has the potential to excavate key voices and perspectives that have been kept silent, powerless, or subordinated (Hesse-Biber, 2012). Thus, collaboration with the participants toward action is a core feature of the design. This design will co-create knowledge with the CARG to capture their experiences, and another group of participants from one-on-one interviews, to help explain what ethical and unethical from their perspectives.

Scope of the study

Ethical understandings are nuanced and complex in the maternity system; everyday ethical issues may be overlooked due to medicalisation yet have significant moral impact on the woman. What this study sought to explore was the everyday care of pregnancy and birth from an ethical perspective. Thus, medical ethical dilemmas, ethical decision making, and ethical arguments associated with pregnancy and birth — such as second trimester termination, antenatal and newborn screening, as guided by the bioethical principles are not addressed in this study. These are beyond the scope of this study, as extreme ethical dilemmas are limited in use for navigating complexities in daily ethical practice (Liaschenko et al. 2006; Oelhafen et al., 2017). There exist guiding texts, ethical decision-making frameworks, interdisciplinary collaboration guidelines, standards, and policies based on bioethical principles that are useful for these.

Additionally, the scope of this study was limited to a small subset of women who had chosen midwifery-led care. Collecting data from birthing people from other models of care was beyond the scope, capacity, and purpose of this study, as my intention was not to explore medical ethics, ethical dilemmas, or ethical decision making. Rather, this study sought to gather the perspectives of women who choose midwifery-led care, as their
experiences, views, and perspectives may offer ethical insights for midwifery that women from other models may not have had.

**Researcher stance**

As a feminist, a homebirth mother, academic researcher, and practising midwife, I have a set of beliefs that influence how I approach this topic. This is evident in how the research question is framed, the methodology choice, the lens through which data is analysed, and the strong feminist language, with the aim to uncover structures that keep women in oppression and point out inequalities, injustices, and discrimination.

**Structure of thesis**

In this thesis, a research study that explores women’s perceptions of ethical care was reported and made meaning of. The primary aim of the research was to understand how women perceived their care from an ethical perceptive. The thesis consists of seven chapters. In the first chapter I present the context of the study and a contemporary snapshot of the maternity system. I present the aim, significance, and limitations of the study.

In chapter two, the background to the study is developed using an integrative literature review. Ethical theory and principles are described, including care ethics and a feminist relational ethic as an alternate to the bioethical principles. The bioethical principles are critiqued, using contemporary literature. The knowledge gap in literature, that women themselves haven’t been asked what is ethical, is highlighted. Finally, a published scoping review in *Nursing Ethics* is presented that demonstrates how other health professions successfully use care ethics to increase ethical sensitivity.

Chapter three sets out the theoretical underpinnings that provide rationale for the choice of methodology. The study was conducted using feminist participatory action research. The research design is a collaborative and transformative action research with a feminist lens. The methodology is published in *Woman and Birth* and provides evidence of meeting research objective one, feminist emancipation and collaboration with the community most affected by the research problem.

The methods are presented in chapter four. The participant recruitment, data collection methods, and how the analysis was conducted is discussed, including detailed processes of data collection and analysis. Ethical research and rigour are also discussed in
chapter four. The quality of the research was ensured through trustworthiness measures and reflexivity as a research practice.

In chapter five, the findings from the data are presented. I provide a template analysis which established a relationship between care ethics theory and midwifery practice and determined that midwifery-led care demonstrates care ethics. A published paper in *Nursing Ethics* describes in detail the methods, process, and results. The findings from the scoping review produced the a priori codes used for the template which was matched with a priori codes created by the CARG describing their care experiences from an ethical perspective. The template analysis provided foundational theory testing, strengthening the argument for care ethics in maternity care.

The latter part of the chapter offers findings from the reflexive thematic analysis. The central theme, **radical desires: individual’s values and context**, highlights the central position of the birthing person at the centre of the care in determining what is ethical. The central theme is supported by descriptions of the care experienced by the women. These were assigned categories: **woman-centred ethics** — made up of harmonised relationship, transparent knowledge, and midwifery solidarity — and **authoritarian ethics** — comprised of uneasy alliance, opaque information, and saving women from themselves. The outcomes of the care experiences were labelled in subthemes: **claiming power: embodied and strengthened** or **surrendered power: disembodied and diminished**, as the subsequent reordering of a woman’s sense of self and identity during pregnancy and birth. These findings provide evidence of meeting objective three, women’s experiences of care from an ethical perspective.

Chapter six presents my interpretation of the findings, which are discussed in relation to the existing literature, highlighting the unique contribution of this study. A published paper in *Midwifery* journal, ‘Woman-centred ethics: A feminist participatory action research,’ is presented, which features some of the findings and contributes the conceptual model for practice. The model provides an alternate ethical paradigm for midwifery toward the advancement of midwifery philosophy.

The thesis concludes with chapter seven, in which the limitations, recommendations, and conclusions of this study are presented.
Chapter 1. The beautiful lie — medicalised birth

Chapter summary

In this chapter, the context, concepts, and research problem were outlined. The research argument was presented, within the context of a medicalised maternity system, and in discord with midwifery philosophy. The aims and objectives of this feminist participatory action research study of women’s perceptions of ethical care was presented. The scope of the research and my stance were addressed. Finally, an overview of the thesis was provided in chapter descriptions. In chapter two, the background to the research problem is addressed, wherein ethical theory is described and the bioethical principles are critiqued. A feminist relational ethic — care ethics — is presented as an alternate ethical model and a published scoping review of how care ethics is utilised among other health professions closes that chapter.
Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

Birth matters. It matters because it is the way we all begin our lives of our source, our mother’s bodies. It’s the means through which we enter and feel our first impression of the wider world. For each mother, it is an event that shakes and shapes her to her innermost core. Women’s perceptions about their bodies and the bodies capabilities will be deeply influenced by the care they receive around the time of their birth.

Ina May Gaskin (2011, p.1)

Chapter overview

Chapter one contextualised and presented the reason for the study, outlining the research aim and objectives. This chapter presents the foundation and frame of the research, exploring ethical underpinnings in maternity care and more specifically midwifery. First, an overview of ethical theories, bioethical principles, and alternate relational care ethics are presented. Next, a metaethical critique, further develops the background and research problem. The four bioethical principles that guide health care practice — non-maleficence, beneficence, justice, and respect for autonomy — are critiqued by mapping literature to each of the principles to determine whether care demonstrates these principles.

Care ethics is offered as an alternative ethical theory and described in detail. Finally, a published scoping literature review in Nursing Ethics is presented to demonstrate care ethics being used in other health fields and to explore how this relates to midwifery care. Through this literature review, it is identified that minimal attention has been paid to woman’s perspective of care from an ethical perspective, and it is this knowledge gap that this study will address.

Ethical theory and principles

Ethics, from the Greek ethos, meaning values and practices, is at its core about morality and determining what is right and wrong (Leavy et al., 2018). The term ethics, like midwifery, is both a noun and verb, through the action and doing of the skill, the noun achieved (Foster et al., 2011). Ethics is broadly viewed in health as the study of ethical systems and the examination and justification for behaviour (Beauchamp & Childress, 2019). Ethics may be delineated to two branches, normative and non-normative, with practical ethics the attempt to apply these norms (Beauchamp & Childress, 2019).
Normative ethics (how people ought to act) are the codes, guidelines, and rules dictated to guide, evaluate, and conduct behaviour. Non-normative ethics are investigations into people’s behaviour and are categorised as either descriptive or metaethics. Descriptive ethics is the actual behaviour described, with no judgement as to good or bad, just what is or has been accepted as moral conduct. Metaethics investigates the underlying philosophy, presuppositions, concepts, and reasonings that underpin ethical behaviour (Beauchamp & Childress, 2019).

In the context of health, ethics is the analytical and methodological foundation for how moral judgments are and should be made (Kerridge et al., 2013). Bioethics is the accepted normative theory guiding and informing actions in health care. Bioethics is described as the discipline of the ethical implications of biological research, health and medicine. Beauchamp and Childress (2019) eruditely detail a cluster of equally important prima facie principles that provide the framework for biomedical ethics, namely, non-maleficence, beneficence, justice, and autonomy.

Ethics are grounded in background beliefs, and are a complex mix of philosophies, disciplines, theories, discourses, and organisations concerned with legal, ethical, and social questions. The bioethical principles are underpinned by deontology, utilitarianism, Kantian, and virtue ethics (Beauchamp & Childress, 2019). Codes of practice based on bioethical
Theories provide the moral framework for healthcare practitioners, helping to guide ethical conduct and decision making and to fulfil a professional duty of care (Kerridge et al., 2013). Principles of virtue ethics such as truthfulness, confidentiality, compassion, and kindness are accepted as inherent within the bioethical principles (Beauchamp & Childress, 2019). A brief definition and philosophical underpinning of the four bioethical principles are next discussed.

The bioethical principle *non-maleficence* is a maxim to avoid causation of harm. Attributed partly to the Hippocratic oath (AD 245), ‘primum non nocera’ (above all do no harm), the maxim was developed further by Immanuel Kant (1724–1804); Kantian theory is a key element of deontology. Deontology proposes that duty and obligation to do what is right are of prime importance and morality is grounded in rules by which to abstain from doing harm (Beauchamp & Childress, 2019).

The bioethical principle *beneficence* encompasses a group of norms that lessen harm and provide benefit, interpreted as ‘to do good’ or the moral obligation to act for the benefit of others. Beneficence is more than just preventing harm and is instead focused on increasing the ‘happiness’ or ‘utility’ of others. Theorised by David Hume in the mid-1700s, it was later developed as utilitarianism by Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873). Utilitarian ethics is concerned with legal and social utility, the idea that behaviour must prioritise the greater good for the greatest number (Varkey, 2021). Beneficence is made up of three tenets: to prevent evil or harm; to remove harm; and to promote good (Beauchamp & Childress, 2019).

The bioethical principle *justice* describes a group of norms for fairly distributing resources toward equity, which encompasses both fair treatment of others and toward a social justice (Beauchamp & Childress, 2019). The bioethical principle of justice has roots in Aristotelian philosophy, where the care for the other is seen as a moral virtue: ‘giving to each which is his due’ (350 BC). Justice theory was further developed by John Rawls (1971), who articulated the idea of the ‘social (and natural) lottery,’ where individual’s starting positions in life are considered in terms of luck rather than merit and argues for the sharing of resources to help overcome disadvantage. Justice also has roots in utilitarianism, which is underpinned by consequentialism. Consequentialist ethical theories judge right and wrong action according to their consequence for the greater good, thus individual human rights and justice may be superseded (Beauchamp & Childress, 2019; Birchley, 2021).
Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

The bioethical principle *respect for autonomy* is the norm of respecting and supporting the ability to govern the self, free of controlling influence (Beauchamp & Childress, 2019; Foster, 2011). Autonomy is based on the idea of self-governance, from the Greek word *autos*, meaning self, and *nomos*, meaning rule, and asserts that the individual is free to make choices and exercise agency. It includes the tenet respect for person, influenced by Immanuel Kant and John Mill (Beauchamp & Childress, 2019). Two conditions are required for autonomy—independence from coercion and the capacity to exercise agency (Beauchamp & Childress, 2019). Respect for autonomy is the basis for informed consent, decision making, truth telling, and confidentiality (Varkey, 2021).

Despite bioethics being the accepted ethical foundation to guide health care practice, there are criticisms and complexities with the bioethical principles. Beauchamp and Childress (2019) themselves warn that different persons and groups will offer conflicting ethical views, potentially creating multiple partial moralities, but balance this by stating that all should be committed to common morality. Bioethics in maternity care has been criticised as medical paternalism, that the principles fail to recognise relationships, and because the principles are abstract, may limit their use in practice (MacLellan, 2014; Newnham & Kirkham, 2019; Oelhafen et al., 2017). Bioethical principles may also be rhetorical in the care of childbearing women, because there is an absence of childbearing people’s values and thought on what is ethical (Newnham & Kirkham, 2019; Varkey, 2021). Although midwifery is one of the oldest professions, modern professional midwifery is young in its alignment with the medical model, and with that the bioethical principles are helpful but may also hinder, given the complexity of pregnancy and birth in balancing the demands of each principle (Foster, et al., 2011). The four bioethical principles are implicit in the ICM Code of Ethics (2014), though the codes consider much more than the principles, being based on midwifery philosophy and woman-centredness.

The ICM Code of Ethics (2014) is an example of normative ethics, a guide for midwifery behaviour and practice. Ethical behaviour for midwifery practice in Australia is directed by this code which reflects midwifery philosophy and midwifery models of care. The codes consist of four domains: midwifery relationships; the practise of midwifery; professional responsibility of the midwife; and advancement of midwifery knowledge. The codes are based on respectful relationship between the midwife and woman, acknowledges the basic human rights of all women and seeks justice for all women. These mandates detail midwives give priority to relationship, while upholding professional responsibilities, and to
ensure the integrity of the profession of midwifery. However, due to the move from home to hospital and the dominance of medicalisation, midwives’ daily hospital work remains aligned with the system a concept termed ‘institutional paradox’ and the practice of bioethical principles (Newnham, et al., 2018).

The bioethical principles have been criticised for their narrow perspective of human existence, which fails to acknowledge intersectionality of race, gender, and class (Crenshaw, 1989; Harding, 2013). Others describe a lack of empirical evidence and research around bioethical principles, due to the competing perspectives of the four bioethical principles, and differing paradigm underpinnings and philosophical reasoning (McKeown, 2015; Wangmo & Provoost, 2017). Some have described problems with applying the four principles to practice due to the disparate and sometimes conflicting stance and thus bioethics are reduced to abstract theorising (Engelhardt, 1995; van Reenen & van Nistelrooij, 2019; Varkey, 2021). Taking Induction of labour, for example, the practitioner may deem an induction necessary for a large baby (beneficence in the practitioner’s view), but the woman may refuse this induction (exercising autonomy) due to honouring normal physiology (beneficence in the mother’s view), at which point the practitioner may discuss the risks to the baby (non-maleficence, beneficence), but this doesn’t acknowledge the risk to the mother (justice). Here the bioethical principles become complex and subjective.

Bioethics is a problem-solving approach, where rules are followed, checklists utilised, and information provision often stated in terms of risk and benefit, rooted in medicalisation (McLellan, 2014; Newnham & Kirkham, 2019). Some modern ethicists have described biomedical ethics as moral imperialism because they overlook power in relationships, diversity and context of the lived experience, and what is meaningful to the individual (de Panfilis et al., 2019; de Vries & Leget, 2012). Bioethical principles, with patriarchal underpinnings, utilise a top-down approach where what is ethically ‘good’ is medically defined, decided by experts (Held, 2006; Newnham & Kirkham, 2019; Tronto, 1993). Biomedical ethics has been said to therefore support institution-centred, rather than woman-centred, care (Newnham & Kirkham, 2019).

Although the bioethical principles should protect against basic ethical infringements, they fail to consider the complexity of the human experience and the role of emotion, intuition, autonomy, and personal contexts in decision making (Schutcher & Heller, 2018; de Panfilis et al., 2019; Osuji, 2018). Feminist theorists challenge the concept of autonomy
because it denies the importance of relationship and the responsibilities that come with relationships (Gilligan, 1982). In the context of maternity care, intuition, emotion, respect for women’s ways of knowing, holistic understandings of women, and birth as a rite of passage are overlooked in preference of a biomedical view (Davison et al, 2015).

There is limited evidence analysing maternity care from the ethical perspective yet caring for childbearing women is full of ethical issues. Everyday ethical issues in maternity practice are complex; relationships, practitioners as moral agents, culture, and differing values, all influence the nuance of ethics in practice. There is also limited literature that applies the bioethical principles in their entirety to the care the contemporary childbearing woman receives.

**Meta ethical critique of bioethical principles in the maternity system**

Metaethics is a descriptive and conceptual analysis of ethical principles or language, to find out what people are doing when they make moral judgments (Pradhan, 2015; Rudnick, 2001). I chose to do a metaethical critique to build a theoretical argument and body of work around evidence of bioethical principles use maternity care. Narrative reviews are a form of non-systematic review to critically analyse a topic and should use a logical frame, to organize, analyse and synthesise the literature (Ferrari, 2015). There is no acknowledged guidelines or methods; however, it is beneficial to provide information around dates of searches, keywords, and (Ferrari, 2015). This body of work was framed around the four bioethical principles: non maleficence, beneficence, justice and autonomy. The strength of narrative reviews are the logical thought and critical thinking which clearly set out the research topic and need for the study. The limitations of narrative review and metathetical critiques is the subjective nature and lens of the researcher (Ferrari, 2015). I applied a feminist lens to create an argument for the need for further research into ethical care of birthing people.

In September 2018, a preliminary search revealed limited evidence of empirical research on the research topic ethics. I used the bioethical principles as key terms to determine if the bioethical principles were evident in practice in the maternity system. This search was repeated in 2019 and again in 2022, papers retrieved from the databases MEDLINE, CINAHL Plus, ProQuest, PsychInfo, Cochrane Database of Systematic Reviews, and Scopus. Google Scholar was also used to locate additional articles that may not have
Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

emerged from the initial search. Literature from the last ten years, was sought and limited to English language and published in peer reviewed quality journals.

EBSCO search example for Autonomy: midwives OR midwifery OR nurse midw* OR maternity* OR pregnant* OR intrapartum OR antepartum OR postpartum OR birth OR Obstetric* AND ethic* bioethics* AND choice OR agency OR information OR choice OR ‘informed choice’ OR ‘decision making’ OR Informed choice OR Autonomy.

It was determined that to date, no study had organised evidence of bioethical principles as a group of maxims and their application in maternity care, revealing a gap in the literature.

Non-maleficence: First do no harm

Non-maleficence has been reported as absent in instances where women have described obstetric violence, dehumanisation, and trauma in maternity care (Perrotte et al., 2020; Watson et al., 2021). One consequence of medicalisation is the excessive, non-essential intervention which has resulted in increased complications, and even harm, without apparent improvement in outcomes for either mother or baby (Peters et al., 2018; Seijmonsbergen-Schermers et al., 2019). Both short- and long-term risks of intervention include haemorrhage, surgical injury, poor breastfeeding rates, postnatal depression, along with chronic morbidities (Chen et al., 2022; Liese et al., 2021).

Negative and harmful experiences of birth have been described in the literature as restraint, physical abuse, unnecessary procedures, verbal abuse, bullying, blaming, humiliation, procedures performed without informed consent, coercion, and bias (Freedman et al., 2018; Moridi et al., 2020; Shakibazadeh et al., 2018). The sequelae of a negative birth experience results in some women having long-term negative feelings of failure, humiliation, and shame. Some women also describe post-trauma symptoms such as feeling angry, destructive, and traumatised (Simpson & Catling, 2016; Thomson & Downe, 2016). The adverse physical and psychological effects stemming from obstetric violence, harm, disrespect, and abuse contribute to the picture that the bioethical principle non-maleficence is not being met.
Autonomy: Women’s agency

Autonomy, a woman’s freedom to make decisions about her own body without coercion, has been countered by evidence which indicates that choice and control are limited by the medicalisation of birth (Deherder et al., 2022; Peters et al., 2022). In exercising their agency in their reproductive rights, childbearing women have the right to informed choice and also the right to refuse treatment (Bohren et al., 2020; Kotaska, 2017). Informed consent requires the health professional to offer information on the risks, benefits, and alternatives to assist the unbiased decision-making process (Bringedal & Aune, 2019). Medicalisation aligns with standardised care where information may be presented to childbearing women in accordance with hospital or institution policy and guidelines rather than with current evidence-based practices. In this scenario the concept of informed consent may be nominally fulfilled, and yet true informed consent and autonomy may not have been achieved, discussed previously as ‘rhetorical autonomy’ (Newnham et al., 2017).

Ethical problems arise in maternity care where there is a lack of adequate consent and understanding about birth-related procedures (Huschke, 2022). Women expressed that birth intervention was not clearly explained, nor informed consent gained, and often not free from coercion, which leads to women feeling a lack of control during the birth experience (Simpson & Catling, 2016). One example of this, non-consensual episiotomies, are a violation of human rights and women’s agency (Powell, 2014; Zaami et al., 2019).

Autonomy and decision making for childbearing women occurs within a relationship (O’Brien et al., 2021) Women need relational and holistic support to make decisions and give informed consent (Bringedal & Aune, 2019; Keedle et al., 2022). Standardised care that doesn’t consider the individualised, holistic, and relational aspect of care contributes to the disrespect and disempowerment of childbearing women (Bohren et al., 2020).

Justice: Power differentials

Justice, fairness, and equity is described in the maternity literature as not being met, where women describe power imbalance both from the medical system and from health care professionals (Huschke, 2022). Medicalisation creates an asymmetry that favours the medical profession over women and midwives, where the support is with the institution and standardised care over the needs of the individual woman (Fahy, 2007; Morris et al., 2021). The hierarchical structure of medicalisation situates the birthing mother in a place of inferiority and has led to the disempowerment of both women and midwives (Donnison,
Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

Medicalisation limits the social models of birth that prioritises woman-centred care (Hawke, 2021; Renfrew et al., 2019). Medical dominance is associated with the devaluing of midwifery-led care, which limits women’s options of birth choice (Naylor Smith et al., 2018). Midwives can therefore become ethically conflicted as they are caught between these two paradigms ‘institutional paradox’ (Newnham et al., 2018). This challenges midwives to disrupt the dominant biomedical discourse, proposing that it is unethical of the midwifery profession to uphold a solely medicalised, risk-focused philosophy of birth (Newnham et al., 2017).

Beneficence: Woman-centred care

The beneficence of midwifery models of care are well documented. A central tenet of midwifery continuity models is the relationship formed between the woman and the midwife. Relationship, advocacy, trust, choice, control, are all salutogenic elements offered through midwifery-led models of care (Perriman et al., 2018; Sandall et al., 2016). Women who experience midwifery continuity of care are more satisfied with their care compared to women who experienced other models of care (Cummins et al., 2019; Forster et al., 2016).

The women in midwifery-led care caseload models are more likely to have a physiological birth with less intervention, therefore leading to improved benefit to maternal and neonatal outcomes (Michel et al., 2021; Power et al., 2019) The midwifery model of care improves clinical outcomes and is as safe as other models in regards to maternal and neonatal morbidity and is also more cost effective than other models (Bagheri et al., 2021; Hutton et al., 2019; Sandall et al., 2016). The beneficence of midwifery- led continuity is limited due to structural design of the health system and socio-political changes which need to occur to improve outcomes for women and babies (Gamble et al., 2021; Renfrew, et al., 2019).

Beyond bioethics: Care ethics as a means to enhance ethical sensitivity

Despite the guiding bioethical principles in maternity care, it is apparent in the literature that care provision is at times unethical and requires further investigation. The literature around ethics in health care is largely after the fact, focusing either on ethical dilemmas or ethical decision making, rather than everyday practical ethics (Schuchter & Heller, 2018).
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The lack of empirical data on whether and how the bioethical principles are upheld by maternity care professionals, the patriarchal underpinnings of the bioethical principles, and the fact that women are describing maternity care as disrespectful and dehumanising, justifies further inquiry into how to best meet the ethical needs of childbearing women.

Recently, Newnham and Kirkham (2019) called for the ‘care ethics’ approach as one solution to the problem of bioethics disguising unethical behaviour. Duly, the need exists for research to explore care ethics within the context of maternity care, particularly the point that prioritising the relationship with women can enhance ethical care, and that is the broad focus of this research project.

Care ethics is a moral theory defined as “... compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility.” (Held, 2006, p.6). Care ethics is based on a feminist philosophical perspective is also referred to as feminist ethics or relational ethics. Care ethics emerged as an alternate approach to traditional ethical theories where rules, abstract principles, and rationalism guide ethics to a practice of moral care. The conceptual development of care ethics began with Carol Gilligan (1982), who shared a feminist ethic that focused on relationship and context versus impartial ethical principles. Gilligan’s work, *In a different voice*, described humans as interdependent rather than autonomous. She criticised Kohlberg’s theory of moral development, which had concluded that women were less able to reach full ethical attainment, arguing that females have a different, rather than under-developed, moral reasoning, and explored ethics from the perspective of gender, relationship, and context. Care ethics was further developed to include a socio-political perspective, and the identification of power dynamics within caring practices (Tronto, 1993; Leget et al., 2019). Tronto argued that every person cares or has been cared for at some stage in their life. She describes care as a practice rather than a female moral attribute; however, the practice of care does have a moral element. Good or ethical care is dependent on caring practice and the way care is given.

Tronto (1993, 2015) describes the practice of care as having five aspects: attentiveness, responsibility, competence, responsiveness, and, more recently, solidarity. Attentiveness describes the way that the care giver meets the needs of the care receiver, responsibility is carer taking responsibility to meet those needs, competence is the competence and skill with which the care is given, while responsiveness involves assessing whether the care given met the needs, and this can only be determined by the care receiver (Tronto, 1993).
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The fifth element, solidarity, requires relational care to be consistent with social justice, where there is a democratic commitment to justice, equality, and freedom for all (Tronto, 2015). The relational feminist care ethic called for a radical transformation of society, through the acceptance of the moral significance of the practice of caring. Care ethics recommends that relationships, power dynamics and the individual at the centre of care are morally significant in determining what is good (Noddin, 1995).

Contemporary care ethicists argue that care ethics is neither a set of values nor virtue ethics. Rather, care ethics is practical and relational, sensitive to power differentials and categories of oppression (MacLellan, 2014; Schuchter & Heller, 2018). Care ethics is practised beyond professional codes of conduct and rule- or principle-based behaviour (Abma et al., 2020). Care ethics promotes the practice of care as a whole, based on responsibility in relationship, with attention to power and context, which together determine what is good care, grounded in actual caring practices (Leget et al., 2019; Timmerman et al., 2019). Current care ethics emphasises the importance of consistent consideration of the views of the person at the centre of the care, thereby increasing moral sensitivity (Schuchter & Heller, 2018). Care ethics upholds that only the care receiver can validate what is good care and determine what is ethical (de Vries & Plaskota, 2017). This has been referred to as the ‘bottom up’ or ‘ground up’ approach, giving greater weight to the perspective of care receivers than to that of the care giver, who usually holds the power (de Vries, 2019; Schuchter & Heller, 2018).

Care ethics practices are socially embedded with feminist underpinnings, and yet supersede political, philosophical, or epistemological theory, so lend themselves to contemporary health care practices (Klaver et al., 2014; Newnham & Kirkham, 2019; Timmerman et al., 2019). Because of its potential to reshape current practices, care ethics has become popular in the practice of many disciplines, such as social work, education, and law. Care ethics resists its reduction to domains of society where care is the focus but argues for its applicability to all fields and institutions, including public policy and international relations (Leget et al., 2019). Table 2 offers a comparison between the bioethical principles and care ethics, highlighting key differences such as attention to relationship, power, context, and caring practices.
**Table 1. Comparison of bioethics and care ethics (adapted from van Reenen & van Nistelrooij, 2019)**

<table>
<thead>
<tr>
<th>Bioethics</th>
<th>Care ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert</td>
<td>Relational</td>
</tr>
<tr>
<td>Abstract</td>
<td>Care as a practice</td>
</tr>
<tr>
<td>Principalism — four principles</td>
<td>Elements, characteristics, or domains to care</td>
</tr>
<tr>
<td>Authoritarian</td>
<td>Attention to power</td>
</tr>
<tr>
<td>Common morality — good care determined by those who hold power</td>
<td>Individual morality — good care determined by receiver</td>
</tr>
<tr>
<td>Obligation</td>
<td>Responsibility</td>
</tr>
<tr>
<td>Top down — institution centred</td>
<td>Bottom up – person centred</td>
</tr>
</tbody>
</table>

**Care ethics and midwifery**

The inconsistency between women’s experiences of maternity care and the default bioethical principles may be improved with a care ethics paradigm. Care ethics aligns with the midwifery philosophy of feminism and the social model of birth (MacLellan, 2014; Newnham & Kirkham, 2019). Care ethics enables a focus on the importance of relationship which is central to the midwifery philosophy; the emphasis on care being woman-centred, holistic, and individualised aligns with care ethics (Brady et al., 2019).

The care ethics paradigm would also assist in balancing power between birth people and the hidden structures such as medicalisation and patriarchy. Medical hegemony dominates midwifery and childbearing women, and care ethics recognises the asymmetry of power in human relationships and safeguards the perspective and vulnerability of patients (de Vries & Leget, 2012). Care ethics may also draw attention to the disciplinary, philosophical, and ontological differences between midwifery continuity of care and the medical model and the respective care given to birthing women (MacLellan, 2014; Newnham & Kirkham, 2019).

Research is now needed to determine whether a care ethics approach may better align with midwifery than the existing bioethical principles. There is, as far as I understand, no primary research of care ethics use in midwifery, although other fields are exploring care ethics in health practice. This research proposes to fill this gap as the first study to examine care ethics in midwifery.
Care ethics use in other health professions

The purpose of this scoping review was to provide clear understanding of care ethics utilisation in the contemporary health system. The scoping review of the literature published in the last ten years (between 2009 and 2019) subsequently validated the need to explore care ethics as an ethical alternative for maternity care. A search of the databases produced no empirical data regarding care ethics utilisation and midwifery. There is an obvious and clear gap in the literature of ethical care utilisation in the contemporary maternity system.

To justify the use of care ethics as applicable for midwifery practice, it was prudent to investigate whether, and how, care ethics was being utilised in other health professions. A scoping literature review was undertaken. A scoping literature review was chosen as it is a useful method for identifying knowledge gaps and also clarifying key concepts in an emerging field (Tricco et al., 2016). The rationale for the use of the scoping review was to be able to report on evidence of care ethics use in practice to inform midwifery research (Peters et al., 2020).

Next, a published paper, ‘Care ethics framework for midwifery practice: A scoping review,’ is presented. Here, evidence of how care ethics are used in health care practice is presented. A working definition for care ethics is offered and a framework that highlights important elements of care ethics for health practitioners is provided (Buchanan et al., 2022).

Published paper. Care ethics framework for midwifery practice: A scoping review

Abstract

Background: As a normative theory, care ethics has become widely theorized and accepted. However, there remains a lack of clarity in relation to its use in practice, and a care ethics framework for practice. Maternity care is fraught with ethical issues and care ethics may provide an avenue to enhance ethical sensitivity.

Aim: The purpose of this scoping review is to determine how care ethics is used amongst health professions, and to collate the information in data charts to create a care ethics framework and definition for midwifery practice.

Method: The scoping review was conducted according to the Preferred Reporting Items for Scoping reviews (PRISMA-ScR) and Joanna Briggs Institute (JBI) recommendations. The search was applied to the databases CINAHL, MEDLINE, PschInfo and Pubmed which were searched in September 2019 and again in July 2021. The inclusion criteria were guided by the mnemonic for search terms: Participants, Concept, and Context (PCC) and included variations of health care professionals, care ethics and utilization. The search was limited to qualitative studies published in English between 2010 and 2021. A data extraction tool was used to extract and synthesize data into categories. The articles were screened for eligibility by title, abstract and full text review, by two independent reviewers.

Ethical Considerations: The scoping review was guided by ethical conduct respecting authorship and referencing sources.

Results: Twelve of the initially identified 129 studies were included in the scoping review. Data synthesis yielded four categories of care ethics use by health professionals: relationship, context, attention to power and caring practices. In combination, the evidence forms a framework for care ethics use in midwifery practice.

Conclusion: Care ethics use by health professionals enhances ethical sensitivity. A framework and definition for care ethics for midwifery practice is proposed. This review will be of interest to midwives and other health practitioners seeking to enhance ethical sensitivity.

Keywords: ethics, care ethics/ethics of care, scoping review, professional practice, midwifery, feminist ethics

Background

 Whilst ethical care in midwifery is guided by the International Confederation of Midwives (1) Code of Ethics, maternity systems are predominantly governed by obstetric medicine, which utilizes bioethical principles to guide care. Bioethical principles are the commonly accepted ethical framework for health care practitioners to guide conduct and analyze ethical issues in health care. Four enduring bioethical principles proposed by Beauchamp and Childress have underpinned the practice of health care since the 1960s (2) these are: non-maleficence (avoiding harm); autonomy (right to make decisions); justice (fairness and equality); and beneficence (doing good). However, despite having these principles behind health care practice, across the globe, women have described experiences of disrespect and abuse in pregnancy, labour and birth (3-5). The literature has described many examples of these four bioethical principles being unheeded. When women describe obstetric violence, dehumanization and trauma in maternity care, it demonstrates a lack of beneficence and non-maleficence (6-9). If mothers express that birth interventions either were not clearly explained or were not free from coercion, informed consent has not been demonstrated
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and thus autonomy has been disregarded (10, 11). If women describe instances of discrimination, both from institutional structures and relationally, which can occur due to power imbalances then justice has not been upheld (12-14). Or if women are unable to access midwifery continuity of care – endorsed by the World Health Organization (2018) as the gold standard for care the beneficence is limited (15-17). These examples indicate that current ethical frameworks may need to be reviewed for the contemporary maternity services.

Furthermore, such principles, codes and rules may not be adequate to guide midwifery practice, as they fail to consider the complexity of the human experience and the role of relationship and power (18-20). Midwifery (meaning “with-woman” in English) has a long history of women collectively supporting each other in childbirth and using and passing down empirical knowledge over millennia (21). It is therefore very different to the beginnings of medical practice, particularly the difference in power relationships between doctor and patient (22-24). Some ethicists have described bioethical principles as: imperialist, inapplicable, inconsistent, rhetorical and inadequate (20, 25, 26) Therefore, it is prudent to investigate what other models can offer maternity care professionals in this regard.

One model that could address the ethical inconsistencies of a default biomedical ethics for midwifery is care ethics. Care ethics is a normative ethical theory based on feminist philosophical perspectives concerning care as a central human practice with moral significance (26-29). Care ethics takes into consideration what is overlooked in principle-based bioethics, especially aspects of: relationship, context and power (18-20). Feminist ethics were developed in response to traditional ethical theories, where individualism, principalism and rationalism dominated, offering instead a relational perspective (25-27). Further, care ethics describes care not just as an act by and for and for only specific people (e.g., nurses or parents, infants or the ill) but as a universal human experience that acknowledges all humans as interconnected and mutually interdependent; thus, moral responsibility becomes attached to care and accordingly, care ethics has been proposed as a means of enhancing ethical sensitivity (30-33).

Care ethics has appeal for midwifery considering the human rights and ethical issues that many women experience in contemporary maternity systems (18, 34, 35) Whilst care ethics theory is well developed, there is little empirical evidence of its use in practice suggesting a gap in the knowledge currently available. This review therefore examines published articles that describe how care ethics was used by healthcare professionals in practice and to apply this knowledge to the context of midwifery, to produce a working definition of care ethics for midwifery practice.

Aim
The purpose of this scoping review is to determine how care ethics is used amongst health professions, and to collate the information in data charts to create a definition for midwifery practice that justifies the application of care ethics for midwifery practice.

Review question
How is care ethics used in practice by health care professionals?

Method
This scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews and the Preferred Reporting Items for Scoping reviews (PRISMA-ScR) (36-38). A preliminary search of databases produced no empirical data regarding care ethics utilization and midwifery. This features as a prominent gap in literature related to contemporary maternity systems. This prompted investigation as to whether and how care ethics are being utilised in other health professions.
Scoping reviews provide an overview of evidence and are utilised: to map key concepts that underpin an approach; to clarify a working definition of a concept; and to summarize the conceptual boundaries of a topic, where they are sometimes called mapping reviews (39, 40). A scoping literature review was chosen for this study as it is a useful method for clarifying key concepts in an emerging field and identifying knowledge gaps to understand and report on the body of literature that address and inform practice in a field (38).

**Search strategy and study selection**

The PCC mnemonic of: Participants (health professionals), Concepts (care ethics) and Context (practice, use, and application) was used to develop search terms for this review (38). A three-step approach informed by the JBI framework was used in this review. Firstly, a preliminary search of MEDLINE and CINAHL was undertaken to identify articles relating to the topic. Text words contained in titles and abstracts and key words of relevant articles, were used to develop a full search strategy (Appendix 1. Logic grid with key terms and Search Strategy). The second search included all identified keywords, which were entered into the databases CINAHL, MEDLINE, PUBMED and PsychInfo. Thirdly, the reference list of all included sources of evidence were screened for additional studies. We included studies published in English for feasibility. To capture contemporary practice and development in an emerging normative theory, we included studies published in the last ten years. We sourced only primary research papers as we wanted to collate empirical evidence from contemporary practice related to the review question – a description of how care ethics is used by health professionals, whilst allowing a broad scope of the literature.

All identified articles were uploaded into EndNote v9 and duplicates were removed, after which 129 articles remained. Studies were included if: the participants were health care professionals, where the concept was care ethics, and the context was care ethics use in practice. The sourced articles were all qualitative studies with designs covering phenomenology, grounded theory, case studies, qualitative descriptions, action research and feminist research. Studies were deemed ineligible if their concept was ‘health care (ethics)’ as opposed to ‘care ethics’. These were uploaded to RAYYAN © (41) and screened by title and abstract by two reviewers (KB, DI) resulting in 36 articles for full text review. Full text was assessed in detail by two reviewers (KB, DI) against the inclusion criteria. The literature retrieval resulted in the retention of 12 articles describing care ethics as used in practice by health professionals (30, 42-52). The results of the search and the study inclusion process are presented in a PRISMA-ScR flow diagram. Figure 1. Prisma flow diagram (Appendix 2. PRISMA-ScR flow diagram).

**Data charting**

Data charting, a systematic and descriptive data extraction process for scoping reviews, was used to collate the data according to JBI methodology for scoping reviews (38). The purpose of data charting is to identify, characterize, code and summarize research evidence in relation to a specific topic (38). This structured process optimizes reliability and enables the data to be presented in an organized way.

To implement this process, we developed a data extraction tool (data chart). The draft data extraction tool was piloted and modified during the process of extracting data. Each information source was screened for the review question: how is care ethics used in practice. To do this, we used a priori codes which we developed form a literature review on care ethics theory. Care ethics has been broadly described as including four broad concepts: relationship, caring practices, context and attention to power (18, 25, 26, 28, 29, 53). These concepts were decided upon by the research team using an iterative process and became the final four a priori codes. Each article was reviewed
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and screened for these a priori codes. The final data chart included the a priori codes and examples from the articles where this code was identified (Table 1. Results: Care ethics use in health practice).

The data chart also includes information about participants, study methods and key findings relevant to the care ethics review question. The health care professions that utilised care ethics within the captured articles included nursing, medicine, physiotherapy, and social work. A summary of the review findings is presented both as a final data chart and diagrammatically (Figure 2. Four categories that form a care ethics framework for use in practice). The findings are also discussed in the results section, with the categories are defined and described along with specific examples detailing care ethics use in health care practice.

Ethical Considerations
The scoping review was guided by ethical conduct referencing sources and respecting authorship.

Results
We identified from the empirical papers that care ethics was used in health care practice in four broad categories. These categories are; relationship, caring practices, context and attention to power, that together offer a framework for enhancing ethical sensitivity for practice. Figure 2. Four categories that form a care ethics framework for use in practice below illustrates the interrelationship between these categories as utilised in the ethics practice of health professionals. Next the four categories are developed in detail, with evidence and examples from the evidence sourced. Finally, the findings are synthesized in a definition of care ethics for health care practice.

Figure 1. Four categories that for a care ethics framework for use in practice (first author only)

Relationship
Ten of the reviewed papers identified the primacy of relationship, central to understanding the person at the center of the care, as a means for facilitating enhanced ethical care. These articles
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depict humans as social and relational beings, acknowledging that the carer and care receiver are interrelated and interconnected but often unequal in terms of power and resources. Therefore, ethical care must value the importance of relationships, and this is demonstrated through responsiveness, presence, trust, honesty, communication and respect (42-46, 30, 47-49, 51).

De Panfilis et al. (2019) interviewed sixteen nurses and doctors to explore how care ethics informs the way health practitioners manage ethical issues in palliative care. De Panfilis and colleagues established that the relationship between health professionals and patients assisted health professionals to understand what patients’ values are in decision making. The authors described the term relationship as personal involvement through emotional support and respecting patient dignity. They describe the practice of care ethics as involving care that centers on a patient’s views, emotions, thoughts and values. Juujari (2019) has similarly described how a focus on relationships enhances ethical reasoning in nursing practice with older patients. Their focus group study collected thirty-one nurse and physiotherapist views on ethical decision making using a care ethics lens. This study found that primary nurses developed deep ethical reasoning due to relationship and nuanced understanding of patients. These primary nurses had insights into each patient’s specific wishes and context, which aided in ethical decision making. Juujari and colleagues identified that nurses feel a moral responsibility because they have developed this relationship and feel answerable to patients whereas they proposed that physicians are more bound by legal responsibility.

A qualitative study by Barlow, Hargreaves and Gillibrand (2018) concurs that nurses were guided by governing bodies codes and standards (based on deontology and consequentialism) but further utilised care ethics in their practice to enhance ethical decision making. The authors interviewed 11 nurses and identified it was the patient centered relationship-based care that nurses formed with patients that contributed to the resolution of ethical dilemmas. Barlow and colleagues describe the nurse’s relationship with patients as accountable, seeking what is best for the patient, being collaborative and others focused, which also included other elements of care ethics such as acknowledging the role of emotions and power imbalance.

A socio-historic study by Barken and Davis (2020) set in the Indigenous communities of the Pentlatch people in Canada, describes care workers (including nurses) as utilizing the feminist care ethic in their approach to caring for the elderly. Relationship was described as based on meaningful connection. The authors highlighted that relational care includes the physical, social, and emotional needs of older persons in their homes. The authors argue the feminist care ethics approach as providing an alternative to guiding health policies as an ethical, relational moral practice.

From the articles screened it is evident that care ethics, with a central focus on relationship, has the potential to enhance ethical sensitivity. This relationship forged by the health professional was shown to be responsive, because the carer knew those they were caring for, they were actively present and more readily respectful to the needs and values of their patients.

Caring practices
Nine of the reviewed papers identified caring practices as the way the entire care experience was provided to a patient. The good or ethical emerges from how care is practiced. Care practices were described as an ethical endeavor in and of itself through the attitude and stance of the care giver. Care was often described by the authors using Tronto’s (1993) four aspects of care ethics: responsibility, responsiveness, attentiveness and competence. Current care ethics emphasize the importance of the views of the person at the center of the care as the expert of their own life and experiences. (30, 43, 45-47-51).

Schuchter and Heller (2018), in a pilot participatory study, demonstrated the use of care ethics
as part of an ethical consultation model ‘Care Dialogues’ in a nursing home setting. Using care ethics was described as enhanced consideration for patient feelings and emotions and resulted in better caring for the elderly. The authors describe how a bottom-up approach of care ethics practice, with ethics from the perspective of the one being cared for, generates greater understanding and empathetic involvement regarding a patient’s day to day care. Schutcher and Heller (2018) suggest care ethics be used in practice through consistent participation of the people concerned to ensure their insights contribute to their care. They suggest that ethical consideration of care be toward understanding and learning rather than a focus on decision-making and that ethical reflection is situated in everyday practice.

Kuis and Goossensen (2017) have conducted a qualitative pilot study of 31 nurses to evaluate good care from a care ethics perspective. They created a three step care ethics evaluation of care model. Central to their evaluation of good care was the caring practices described by Toronto’s (1993), where they explained that experienced nurses were responsive in that they saw what was important to patient, beyond their diseases/illness. The authors described that nurses were more attentive by searching for who the patient was, rather than relying on general insights or first impressions. It was concluded that the care ethics method was patient-centered, enabling nurses to identify important issues from patient perspectives, suggesting this is ultimately what humanizes care. De Vries and Leget (2012) and Ward (2012) have also discussed the practice of care as set out by Tronto (1993), namely attentiveness and responsiveness, are important in identifying what is meaningful to patients. Juujari (2019) confirms care ethics practice is both an attitude and a mode to care.

Lachman (2012) has also utilised Toronto’s practice of care ethics to analyze a case study of diabetic alcoholic man who declines treatment, describe how nurses can use attentiveness to first identify the needs of the patient – beyond medical diagnosis. Responsibility and competence were demonstrated in the case study as care that combines activities, attitudes and knowledge of the situation. Attentiveness was demonstrated in the case study as detecting the needs of the patient. Finally, responsiveness was demonstrated where the nurse verified with the patient that the care given met the patient’s needs. Lachman summarizes good care as a commitment to attending to a patient’s needs physical, psychological, cultural, and spiritual needs of the patient and family.

Vanlaere, Coucke and Gastmans (2010) study of a care ethics lab in Belgium is an example of how care ethics can be used in practice to enhance empathy among nursing students in an e-simulation lab. The lab was designed to teach nursing students ethical care with the aim to generate empathy through reflection. In this qualitative study, it was described that ethical reflection and sensitivity were enhanced via generating an understanding of patient’s needs. The students cared for an individual in the care ethics e-lab and then through guided discussion answered questions related to what helped most in providing good care. The authors describe “Good care includes everything that care providers undertake in order to respond to the vulnerability of other... this means being attentive to the person and providing more than minimal needs” (p. 325).

The articles captured particular caring practices that enhance ethical sensitivity. Ethical caring practices were often described as using Tronto’s (1993) seminal conceptualization of care ethics as responsibility, responsiveness, attentiveness and competence. Understanding that caring practices are in and of themselves what is good about the care.

**Context**
Eleven of the papers in this scoping review use care ethics to describe care that is sensitive to the uniqueness of a situation and to an individual’s social, emotional and existential context, as a means
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of identifying what is meaningful to a patient. Care ethics as an ethical model, thus allows for the acknowledgment of tacit, embodied and experiential knowledge, as important and integral to ethical care. Accordingly, good care is individualized, holistic and receptive to context, partnering with the person at the center of the care to determine what is ethical (30, 42 – 50, 52).

In the reviewed studies, acknowledging individual context was a key element towards achieving ethical care. De Vries and Leget (2019) compared two case studies of elderly cancer patients and identified that care ethics approaches highlighted the variety of patient contexts, what is meaningful to patients and thus what is morally relevant. Describing the first case study, choosing end-of-life chemotherapy; the authors acknowledged the bioethical principals helped decision-making to a point, however, when including a care ethics interpretation that includes the context of: physical vulnerability, mental decline, social stressors and existential (facing dying), the decision to undergo treatment or not was better understood. The second case study highlighted that care givers may believe themselves to be doing the right thing when overriding a patient’s decision, and yet care cannot in fact be deemed good care unless it is embedded in the patient’s sociocultural context and values. De Vries and Leget (2019) argue that bioethical principles neglect this context and recommend that the patient’s position should guide any ethical approach.

Kuis and Goossensen (2017) research findings also preface the importance of a patient’s context and perspective. This study interviewed 31 participants to create a care ethics evaluation of a care model and conducted focus groups with health professionals to determine the value of the model. The authors demonstrated that an insider perspective, where the values of patients are followed, both enhanced ethical care and contributed to humanizing care. Context was also highlighted in the study by Jujarvi (2019), where nurses’ understanding of a patient’s context supported them to address sociocultural needs, and where the care ethics approach helped to meet these ethical deliberations.

Baur, Nistelrooij, Vanlaere, and van Nistelrooij (2017) have also detailed that, emotions are a valuable source of knowledge, serving as a vehicle for ethical care. The authors developed a care ethics reflective tool to use with emotionally turbulent practices (moral dilemmas) as a way of thinking/doing ethics, rather than principle-based ethics. The study concluded that since caring is an emotional and political practice, moral space and attention to these factors must be provided by health professionals for good care to occur. The authors also advocated for the necessity of institutions to be caring, where the role of emotions as set out in care ethics is incorporated into practice.

The reviewed articles all take into consideration that appreciation of a patient contexts enhances ethical sensitivity. Understanding and valuing what is important to the person at the center of care and considering the role of emotions and values as a source of knowledge, are proffered as important aspects in enhancing ethical care.

Attention to power

Eight of the 12 papers reviewed referred to attention to power in ethical care. In the reviewed studies, the application of care ethics, draw attention to potential power imbalances in the relationship between care givers and care receivers. In this sense, the one being cared for is sensitive to power imbalances, where the expert determines what is good, and thereby patients become vulnerable to this power difference, such as in the doctor/patient relationship. Some articles have highlighted that power difference may be the influence of structural forces such as standardized guidelines, institutions and policies. In this review, we therefore identify care ethics as a means of equalizing interpersonal or structural power differentials (30, 42, 44, 46, 48 – 50, 52).

In the action research conducted by Abma and Baur (2015), care ethics advocates are mindful
of broader structures of power that produce oppression and exclusion (Amba, 2020). Care ethics was used to prevent organizational processes from dominating, by reducing hierarchic power relations to a more equal relationship in an aged care resident meal program. The successful collaboration between health professionals and aged care residents was fostered through both mutual respect for both expert and embodied knowledge of residents and through the facilitator being mindful of the power position which together increased resident empowerment in long term care. Lachman (2102) also confirmed in their case study that a focus on meeting the care needs of a patient or family, ensures that paternalistic abuses of power do not occur.

Ward and Barnes (2016) has also explored power dynamics as elderly people navigated a new Care Act in the United Kingdom. The authors translated their findings from their two participatory studies between elderly residents and social workers, into resources using a care ethics lens. Ward (2015) identified that there was little acknowledgment within a policy framework for the complexities of elderly issues. It was through equal relationships with social workers that the elderly felt cared for when accessing support services. The authors detailed how using a care ethics framework in discussion with older people, moved the focus from being task orientated to being attentive to care receivers. Through care ethics, greater insights into caring practice were gained which helped shape both policy and practice. Similarly, Schuchter and Heller (2018) have confirmed in their care ethics study that the only way to equalize the patient / care giver asymmetry of power is to give voice to patients as experts of their own reality. They describe equalizing asymmetries through looking beyond social roles and giving priority to the values of the patients. Ethical deliberation was guided by patient narratives with democratization of opportunities to speak and thus the dominance of expert knowledge was annulled in favor of the patients.

The articles reviewed describe how care ethics was utilised to draw attention to potential power imbalances and equalize power in a relationship to achieve more ethical care. Power balance is attained though removing standardized care and structural dominance, respecting epistemological and embodied knowledge toward the person at the center of the care having a voice and becoming empowered.
Table 1. Data mapping Results: How care ethics is used by health professions (first author only)

<table>
<thead>
<tr>
<th>Author, year, Country</th>
<th>CONTEXT</th>
<th>PARTICIPANT</th>
<th>CONCEPT</th>
<th>Findings related to examples of care ethics in practice</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abma, 2015, Netherlands</strong></td>
<td>The aim of this project was to involve older people in a residential setting in decision-making processes concerning their life and well-being using a care ethics approach</td>
<td>Health professionals and 7 elderly women</td>
<td>Care ethics approach to patient involvement in long term elderly care</td>
<td>The care ethics led decision making led to patient empowerment and partly to an improved quality of life for elderly residents (p.2337) The findings demonstrate that care ethics allowed patient ownership to develop through relational empowerment (p.2338) Care ethics collaboration entails openness, mutual respect for both expert and experiential knowledge, and above all trust changing relationship, from a hierarchic power relation to a more equal relationship (p.230)</td>
<td><strong>Attention to power</strong> <strong>Relationship Context</strong></td>
</tr>
<tr>
<td><strong>Barken, 2020, Canada</strong></td>
<td>A community-engaged, socio-historical study to demonstrate policy structures and everyday caring practices</td>
<td>18 home support workers including nurses</td>
<td>The care workers used a feminist care ethic in their approach to caring for the elderly in the community</td>
<td>The relational ethics used by nurses reflect feminist perspectives on care (care ethics) (p.7). In their everyday practice, home support workers have provided care that extends beyond a narrow definition of health to address the physical, social, and emotional needs of older persons in their homes and in their communities (p.8)</td>
<td><strong>Relationship Context</strong> <strong>Care practices</strong></td>
</tr>
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### Barlow, 2018, UK

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<tr>
<th>Methodology</th>
<th>Participants</th>
<th>Data Collection</th>
<th>Findings</th>
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<tr>
<td>Qualitative interviews</td>
<td>11 nurses in acute care setting</td>
<td>A conceptual framework for managing ethical dilemmas included ethic of care – primarily relationship</td>
<td>Nurse demonstrated how, by developing and maintaining effective relationships with patients and other professionals, they were able to empower themselves to achieve a resolution of ethical dilemmas. Such relationships are recognized as central to morally correct culture and context and embrace the core aspects of moral agency, identities, relationships and responsibilities (p.239). Nurses used ethics of care which underpins the fundamental principle of seeking the best for each patient. In these instances, the nurses needed courage to challenge those in authority. In some cases, they chose to take a personal risk by working outside organizational policy if they believed that this would act in the best interests of the patient and secure a more favorable outcome (p.239).</td>
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Care—as a relationship premised on meaningful connections. Workers respected and appreciated the older people seeing them as whole persons rather than simply as care recipients. They had flexibility in how they spent their time...honored clients as people with complex identities and lives that transcend the care encounter (p.8).
Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

| **Baur, 2017, Netherlands** | To think with care ethical theory and looking through a care ethical lens at a practical case example, the authors discern reflective questions that shed light on a care ethical approach toward the role of emotions in care practices | One psychiatric patient  
One nurse  
Case study | Care ethics approach to create a care ethics reflective tool to deal with emotionally turbulent care practices. | Care ethics is a way of thinking / doing ethics – not an applied principle after the fact, through the use of reflection in practice (p.486).  
Authors conclude emotions can be a source for moral action. Care ethics considers emotions as a valuable source of knowledge for good care (p.492)  

The discuss the importance of moral case deliberation: paying attention to embodiment (embodied knowledge), choosing a deeply relational approach, and accessing different forms of knowledge (p.491).  
For care institutions to be caring institutions, where moral space that allows and acknowledges emotions (p.492). |
| **De Panfil’s, 2019, Italy** | How care ethics informs the way health professionals make sense of ethical issues in palliative care | 16 nurses and doctors  
Qualitative study semi-structured interviews | Care ethics utilised to review ethical dilemma | Care ethics allows the values of both the patients and professionals to come to light through the relationship of care.  
Ethical care was the whole care received, relational and related to individual context (p.7).  
Five themes identified: morality is providing global care; morality is knowing how to have a relationship |

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<th>Care practices</th>
<th>Context</th>
<th>Relationship</th>
<th>Power</th>
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Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

| De Vries, 2012, Netherlands | To increase ethical sensitivity care ethics is explored as an alternate ethical framework | 2 elderly cancer patients Case studies | Care ethics approach applied to two case studies and analyzed from two perspectives: care ethics and bioethics | Good care extends ethical awareness from decision making to care ethics that focuses on relationship, attentiveness and responsiveness to the patient (p.102)

*Case 1:* Using care ethics perspective, it is acknowledged that the elder patient is socially, emotionally, and existentially embedded in the context of family. Only within this context can the decision to undergo another treatment or not be judged as ethically good or not (p.99).

*Case 2:* the ethics of care perspective focus on the caregiver’s attentiveness, responsibility, competence and responsiveness. Caregivers may believe themselves to be responsible and competent when overriding a patient’s decision, but it cannot be deemed good care without attentiveness and responsiveness. Ultimately it is the care receivers’

| Relationship | Context | Care practices | Power |
| **Juujarvi, 2019, Finland** | To examine nurses’ ethical decision-making in the context of primary nursing using an ethic of care | 7 nurses, one physio, plus results included a focus group of 22 nurses | Moral conflict resolved using care ethics and justice considerations | Care-based ethical reasoning is deeply grounded in primary nursing practice with older patients. The nurse develops a trusting relationship with her patient and takes responsibility for planning and caring for patient (p. 193) 
Nurses employ empathetic understanding and thinking when building relationship with patients in turn, it is based on particularistic thinking that recognizes patients’ subtle needs beyond symptoms and overt behavior (p.189) 
Care ethics is not derived from rules, norms, or principles but from idiosyncratic care situations bound by patients’ particular identities, time, and place, and therefore it cannot be replaced by the ethic of justice (p. 193) | Relationship Context Care practices |

| **Kuis, 2017, Scandinavia** | The aim is to investigate how care ethics can be operationalized in an assessment method and evaluate | 31 participants – aged care residents 
Member checked with hospital staff | Emotional touchpoint interview method to assess patients’ perceptions of quality of care | The touchpoint method (care ethics) distinguishes itself because no pre-defined categories are used but the values of patients are followed, which is an essential issue from a care ethical perspective (p.569). | Context Care practices Power |
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| Lachman, 2012, USA | To utilize a case study to illustrate Toronto’s four elements of care to help nurses to determine if they are applying this theory effectively to their practice. | An elderly alcoholic requesting pain medications creating conflict between physician and nurse | Case study | Tronto’s (1993) four elements of care ethics utilized to analyze the ethical conflict: 1. attentiveness 2. responsibility 3. competence 4. responsiveness of the care receiver | Good care was summarized using Toronto’s (1993) four element of care.  
Care is a reciprocal practice, occurring within a framework of a relationship between the nurse (caregiver) and patient (care receiver) The reciprocity consists of verifying that the care given actually met the needs of the patient (p. 112).  
Good care requires the competence to individualize care — to give care that is based on the physical, psychological, cultural, and spiritual needs of the patient and family. | Represents mentioned that the results form mirror information that enables (self-) reflection of professionals about humanization issues in the care they provide. The insider perspective of patients and thereby contributes to humanizing care (p. 576).  
The tool gives insight into the core care ethical principle of responsiveness. Professionals that are experts in acting responsive see what is important to the patient, beyond the disease, from the standpoint of the patient (p.578). |
### Chapter 2. The paradox of birth ethics in the maternity system: A metaethical critique

| Schuchter, 2018, Germany | To explore Care Dialogues in ethics consultation between health practitioners and patients and relatives. | 7 nursing homes, 20 Care Dialogues, 80 stories from nurses, relatives and volunteers. Participatory action research. | Care dialogues were utilised to analyze ethical care based on the care ethics framework called the “Ethics from the bottom up” (p.58). | The care ethics tool moved deliberation on ethical issues beyond moral dilemmas, encounter of persons with their stories, consistent participation of people concerned. Care dialogues used between Health professional and patients were found to
  a) socially connect  
  b) created joint understanding  
  c) Patients’ life experience knowledge and competence respected (p.57). Care Dialogs lay a major emphasis on the expression and interpretation of feelings...getting more deeply involved in other people’s history and therefore enlarging, changing and deepening perspectives (p.58). The only chance to equalize asymmetries and create understanding beyond social roles where the dominance of expert knowledge is annulled in favor of a democratization of the patient (p.59). | Context
Relationship
Care practices
Power |
### Chapter 2. The Paradox of Birth Ethics in the Maternity System: A Metaethical Critique

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<th>Reference</th>
<th>Purpose</th>
<th>Methodology</th>
<th>Findings</th>
<th>Conclusion</th>
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<td>Vanlaere, 2010, Belgium</td>
<td>To generate empathy in the care of vulnerable older persons requires care providers to reflect critically on their care practices in the care ethics e-stimulus lab</td>
<td>Nursing students Qualitative descriptive Focus group</td>
<td>Care ethics lab for students to create empathy</td>
<td>To generate empathy in the care of vulnerable older persons requires care providers to reflect critically on their care practices. The empathy session in the care-ethics lab is an example of experiential learning in ethic. These are compared and contrasted with what the participants experienced in the empathy session as relevant factors needed for providing good care. Through the group discussion, the participants examine what individual care providers can do to further enhance reflection in their care practice. In addition, the contrast experiences are an externalization of what can be called ‘ethical intuitions’, the intuitive feelings of what is ‘good’.</td>
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<td>Ward, 2016, UK</td>
<td>To consider relevance of care practices framed by care ethics to social work practice with older people</td>
<td>Nursing staff to 12 elderly Plus social workers Two participatory action projects using care ethics analysis of transcripts from</td>
<td>Care ethics was utilised as a framework to guide dialogue between social workers and elderly</td>
<td>The significance of care ethics is the relational perspectives, recognizing the way in which expertise can be generated through collaborative processes, and building relationships which unsettled initial assumptions about ‘who’s who’ (p.920) Involving older people in initiatives to shape policy and practice and research, demonstrate the importance of relational ethics.</td>
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<th>two studies in elderly people</th>
<th>This involved recognizing and acknowledging the value of what was being said in developing insight into the significance of issues, being attentive to the emotional nature of some issues.</th>
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Synthesis of findings
The scoping review met the literature review aim to map key concepts that underpin care ethics resulting in a framework for practice and to formulate a working definition of a care ethics. Thus, a definition for health care practice is presented.

Definition of care ethics for health care practice:
Care ethics recognizes that care is a universal human experience. Care ethics is founded on relationship, based on presence, trust and respect, forged on knowing the person at the center of care. The practice of care is holistic, is attentive, responsive, responsible and competent. The richness and complexity of the individual socioemotional context is considered, and the caregiver equally values other ways of knowing. Care ethics recognizes the asymmetry of caring relationships and attention to this power imbalance is required. Only the person being cared for can determine what constitutes ethical care.

Discussion
There has been call for empirical research into care ethics to guide future health professionals practice (18, 28, 29, 53, 54). However, it has been acknowledged by ethicist researchers that there are difficulties in empirical research informing normative ethics (55). Ethical research is often interested in conceptual clarification and normative justification whereas empirical research is focused on definitives via description and analysis. Therefore, it is difficult to be precise about the relationship junction between the empirical data and ethical analyses, which may account for the limited research into the ethics guiding health professionals practice (56).

This scoping review endeavored to summarize how health professionals had used the normative theory care ethics in practice. Through the systematic analysis and synthesis of the literature, a framework was proposed to integrate the normative care ethics theory to guide future health care practice. From these findings we have established that care ethics is practiced using four central care ethics tenets; relationship, caring practices, context and attention to power. These four categories offer a framework for midwifery practice toward enhanced ethical sensitivity. The rise in mistreatment and abuse in the system is complex both at the systems level and interpersonal level (57). Care ethics addresses the interpersonal level through everyday reflective ethical practice.

Care ethicists argue one cannot introduce the good from the outside nor by applying top-down normative theory or ethical principles and codes but rather from insights gleaned from practice (53). There are many codes and guidelines to try and improve disrespect and abuse in the maternity system. The international Code of ethics for Midwives guides ethical behavior (1). Midwifery codes center the midwife-woman relationship as integral to ethical practice. Midwifery practice centers relationship with the childbearing woman as the very core of good practice (59, 60). The literature review highlighted relationship as a central and vital component to improved ethical conduct. Care ethics and midwifery align in prioritizing relationship as central to good care. Midwifery as a relational practice is one critical solution to improved care and reduction of abuse and disrespect in the maternity system and yet it remains underutilized (58).

The reviewed articles also captured particular caring practices that enhance ethical sensitivity. Ethical caring practices were often described as using Tronto’s (1993) description of care ethics as responsibility, responsiveness, attentiveness and competence. For midwifery, it is the caring practices a woman receives during labour and birth that either strengthen and empower or disempower and dehumanise women (61, 62). The reviewed articles demonstrated health professionals who considered a patient’s context, socioemotional and embodied knowledge demonstrated greater ethical sensitivity. Supported in feminist midwifery literature, midwives honor women’s ways of knowing and embodied knowledge, which in turn strengthen women’s
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capabilities (63, 64). Through relationship and knowing context the health provider is able to respond more individually in meeting care needs which is proffered as important to ethical care.

The articles reviewed also describe care ethics was utilised to draw attention to potential power imbalances and equalize power in a relationship to achieve more ethical care. Midwifery research points to drivers of disrespect and abuse in the maternity system due to disempowering experiences such as when informed consent isn’t fulfilled and the provider has decided the course of action for the woman (7, 10, 11). Power balance is attained though removing standardized care and structural dominance, respecting the one at the centre of the care to make decisions that is right for them, which in turn empowers citizens to develop their own ethical language (50, 65) which democratizes ethics itself.

Midwifery has been shown to demonstrate the practice of care ethics (18) where midwifery and care ethics correlate in their shared philosophies, epistemologies and normative approach to context and political aspects of care (18 -20). In highlighting care ethics in practice, new ways in which midwifery may be able to counter the disrespect and abuse that occurs in the contemporary maternity system were identified. The risks to good care involve negative aspects of patriarchy, power and politics, where these may be a contributing factor in the rise of abuse and obstetric violence toward women in the maternity system (18-20). Care ethics describe the importance of relationships, which corresponds to a component of midwifery philosophy which is based on relationship with woman. The strengths of care ethics would, therefore, likely be a valuable new addition to the midwifery professional ethos – caring for women in interdependency, reciprocity, and solidarity. The findings of this study suggest that care ethics could be further explored as a supplementary paradigm to the bioethical principles that currently guide maternity care in Australia and internationally.

Limitations
The limitations of this scoping review account for an element of subjectivity in deciding which papers to include, in addition to aspects of data extraction and categorization. Scoping reviews are limited by subjectivity of interpretation, where this review applied a feminist lens, this study recognizes that other lenses could also be applied. This was balanced by a dual member checking process, as described in the methods section. Further, some empirical care ethics papers may exist that we are not aware of through this process, and grey literature was not searched. The search was limited to the previous 10 years, however a common decision when gleaning understandings from contemporary practice.

Conclusion
In this scoping review, care ethics has been identified and successfully used empirically by health professionals. Through a review of the literature on care ethics practice, it has been demonstrated that relationships, caring practices, sociocultural contexts and attention to power, create a framework for practice and contributes to enhanced ethical sensitivity. A definition of care ethics for health care practice has been offered. Recommendations from the review have been presented. Together the strengths of care ethics would, therefore, likely be a valuable new addition to the midwifery professional ethos – caring for women in interdependency, reciprocity, and solidarity.

Implications of the findings for midwifery practice
In this paper we have categorized and defined care ethics practice for midwifery. This is an important first step and we recommend further research in applied care ethics to advance care ethics for health care practice.

We recommend the care ethics framework for everyday reflective ethical practice as a protective factor in reducing abuse and trauma in the maternity system.
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We suggest further research is required to understand ethics from the woman’s perspective and further testing of care ethics in midwifery practice to challenge the current dominance of medical ethics principalism, which is currently failing women in maternity care setting and to further develop a more feminist ethics for childbearing women to receive good ethical care.

This review of the literature may be of interest to other health professionals, academics and policy makers who are interested in fostering change toward more ethical care.

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Conflicts of interest
There is no conflict of interest in this project.

Appendices
Appendix I: Logic grid with key terms and Search Strategy
Appendix 2. PRISMA-ScR flow diagram
Appendix 3: Table 1. Results: Care ethics use in health professional’s practice
Appendix 4.: PRISMA ScR Checklist

References
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Chapter Summary

Maternity care is fraught with ethical issues. The metaethical critique of the bioethical principles revealed they were not effectively protective in preventing mistreatment and ensuring respectful maternity care. The integrated literature review revealed a gap in the literature and created an argument for the need to explore women’s perspectives of ethics and ethical care. Care ethics as a possible solution was presented and the scoping review demonstrated how care ethics can increase ethical sensitivity in health care clinical practice. Care ethics acknowledges caring as a human practice with moral significance, where the good or ethical arises from how the care is given. Relationship is central to caring practices and the person at the centre of the care is the one who determines what is ethical, as the authority of their own life and embodied experiences. Care ethics takes into consideration the complexity of a person’s context, the person’s values, emotions, thoughts, and views, which enhances decision making. Care ethics gives attention to power, through reflection and the democratisation of care. The scoping review provided a new and unique contribution to midwifery knowledge. A framework for care ethics was created, a definition of care ethics for midwifery practice was offered, and the findings provide a rationale to explore this theory of ethics for midwifery.

In the next chapter, I provide a rationale for the choice of methodology and detail how this study was conducted using feminist participatory action research.
Chapter 3. Midwives and women arise! Taking a feminist approach to participatory action research

To utilise a more feminist approach to PAR is not to use a set of techniques – it is broader than techniques. It is firmly situated within a larger paradigm approach to human enquiry that challenges the positivist research paradigm with its often-dehumanising assumptions, methods, and implicit messages. PAR is part of the emancipatory approach to human enquiry that encourages people to act unapologetically and boldly with, instead of for, the less powerful and voiceless.

Maguire (1987, p.74).

Chapter overview

The review of the literature presented in chapter two generated an understanding of the research gap and the justification for undertaking the study. This chapter presents the philosophical and theoretical underpinnings that resulted in the methodological choice. Feminist Participatory Action Research (FPAR) was chosen as the research design to meet the first research objective — to collaborate with a team of women to guide and conduct the research toward emancipatory action. Because FPAR has both an action arm and research arm, most of the action and evidence of collaboration with community members are presented in this chapter, with the remaining chapters left for the research arm. A published paper, ‘Navigating midwife solidarity – A feminist participatory action research framework,’ shows FPAR methodology and collaborative action with community members. A FPAR framework was developed using theory and practice and an exemplar is offered that details the action arm of FPAR.

Rationale for research design

A research framework is important to orientate the research design. Four elements are usually addressed in qualitative research: paradigm, theoretical lens, methodological approach, and methods. The paradigm is the researcher’s beliefs that guide action and is made up of one’s epistemology, ontology, and axiology (Lincoln et al., 2018). The theoretical lens is the theory drawn upon to conduct, organise, and frame the research. The methodology is the research design and the way in which the research was conducted (Denzin & Lincoln, 2018).

Firstly, I provide an overview of research paradigms to position my choice of feminist
participatory action research. Next, I discuss the philosophical underpinnings of the research and apply these to the research topic. Thirdly, I apply a feminist theoretical lens and explain the use of feminist theory in research. The remaining part of the chapter details the cyclical research process of feminist participatory action research.

Three drivers underpinned this research: to understand women’s experience, highlight feminist issues in the contemporary maternity system, and to work collaboratively with women toward change. Therefore, the methodology I was drawn to to develop and answer the research question and address the research problem was participatory action research. This methodology enabled me to explore the ethical issues in depth from the women’s perspective, include women as co-researchers, and to be emancipatory in driving change. A critical feminist lens allowed me to highlight the sociocultural complexities of contemporary maternity care that keep women oppressed.

This next section describes my philosophical assumptions — ontology, epistemology, and axiology — and the theoretical lens, which together explain the choice of methodology.

**Research paradigm**

Research is conducted within a philosophical worldview, or paradigm, through which the world is perceived, and therefore provides the foundation and orientation of the inquiry (Denzin & Lincoln, 2018). The researcher conducts their research from within the paradigm of their beliefs which guides thought and action. A paradigm is influenced by:

- **Ontology:** The nature of reality (for me, it was critical realism)
- **Epistemology:** How we know or understand the world (for this study, constructionist)
- **Axiology:** Values that guide decisions (for me, it was emancipatory)

The research paradigm tends to guide the approach to the construction of knowledge, broadly toward either quantitative or qualitative research (Denzin & Lincoln, 2018). Research paradigms are in a state of change, with older paradigms being reconfigured and post-interpretive paradigms being explored, due to enlightened ideas around ethics, social justice, and the politics of inquiry (Haigh et al., 2019; Poradzisz & Florczak, 2018). Two main paradigms are discussed in contemporary literature, with different fields tending to use primarily one or the other based on their philosophical foundation. The post-positivism paradigm is traditionally used in the medical sciences, while the naturalism paradigm is
commonly used in the social sciences (Denzin & Lincoln, 2018). However, the relationships between different fields and paradigms are nuanced and there exists a mix of paradigm positions in the given fields of study (Haigh, 2019).

The positivist or post-positivist paradigm is guided by a realist ontology — that reality is objective, observable, and neutral (Denzin & Lincoln, 2018). Knowledge is generated by an objectivist epistemology that includes determination, reductionism, empirical measurement, and theory verification (Creswell & Creswell, 2018). Research within the positivist paradigm is usually conducted using quantitative research methods of experiments, measurements, and statistical analysis (Denzin & Lincoln, 2018).

In contrast, the naturalistic paradigm is more usually associated with qualitative research and exploratory methods of scholarly inquiry (Denzin & Lincoln, 2018). Research conducted from this perspective is often undertaken in the natural setting and investigates the experience of humans within their context, which provides rich insight into human behaviour and explores the meanings individuals ascribe to their experience (Bennett, 2021). In qualitative research, a descriptive or explanatory theory is generated and either positioned at the end of the study or threaded throughout to explain the findings of the research (Denzin & Lincoln, 2018). Qualitative research broadly looks for meaning or experience and thus qualitative methods are appropriate for midwifery research due to the woman-centred underpinning of midwifery philosophy that honours women’s experiences of birth and maternity care (Jefford & Sundin, 2013).

**Ontology**

Ontological positions reveal the understanding of the nature of reality, which can be described as a continuum from ‘realism’ through ‘critical realism’ to ‘relativism’. At one end of the spectrum, realism sees the social and physical world as existing externally to human experience, whereas relativism views reality dependent on human interpretation, thereby many constructions of reality exist (Denzin & Lincoln, 2018).

This current inquiry is grounded in a critical realist ontology, which identifies that there are real structures existing in society that contribute to social inequity and has at its root an emancipatory (transformative) approach to human enquiry (Paradis-Gagné & Pariseau-Legault, 2022; Walsh & Evans, 2014). As an ontology, critical realism is theoretically linked with critical theory, which originally grew out of the post-Marxist philosophy of the
Frankfurt school in the 1930s as a response to positivist empiricism, to provide theoretical underpinnings to the social sciences (McKeown, 2015). Critical research, by its nature, challenges the status quo (Leavy et al., 2018).

Critical realist research examines the real whilst acknowledging that the real is also navigated and understood through power structures, or ruling entities, which may be hard to distinguish, such as theories, concepts, and institutions (Sturgiss & Clark, 2020; Walsh & Evans, 2014). Critical realist philosophical underpinnings are used when seeking to explore or uncover social issues that have to do with power and oppression (McKeown, 2015; Williams et al., 2017).

Critical realism is useful in midwifery research in identifying the underlying social structures that affect women’s agency (Walsh & Evans, 2014; Williams et al., 2017). In this study, the feminist standpoint acknowledges power imbalances between the birthing woman and the dominant medical system, which is shaped by social discourses and structures such as patriarchy, technology, and capitalism (MacLellan, 2014; Heckman, 1997). This research aimed to explore ethics, acknowledging the entities that oppress women and reduce their agency, as well as the ways they resist oppressive forces, and thus build deeper understandings of ethical care and women’s ethical needs in the contemporary maternity system.

Research developed from within this ontology often includes participants as active partners in the research and views the knowledge generated as a collaboration between participants and researcher (Mertens, 2017). Participants become not only the source of data collection but are involved in knowledge production, guiding the research, and actioning change, and through the research process become aware of the influencing power of sociocultural contexts (Cheyne et al., 2013; Poradzisz & Florczak, 2018).

**Epistemology**

Epistemology is the understanding of the nature of knowledge, the relationship between the researcher and knowledge, and the criteria for making claims about knowledge (Haig, 2019). This research utilises a constructionist epistemology. Knowledge is understood as personally and socially constructed, influenced by society and culture, and therefore human meanings and experience can only be understood within their context (Sarantakos, 2012).
Chapter 3. Midwives and women arise! Taking a feminist approach to participatory action research

The inclusion and emphasis of personal stories, through language and culture, and the exploration of sociocultural complexities makes constructionism relevant to this study. I embrace feminist standpoint epistemology that recognises women’s oppressed status in society, women’s understanding, and women’s ways of knowing (Mertens, 2019; Heckman, 1997). The constructionist epistemology underpins the methodology of this study, which emphasises working with childbearing women as co-researchers to explore ethical issues affecting women and together construct knowledge that affects change.

Axiology

The axiology or value system that underpins this research is emancipatory. The axiology in feminist research is often explicit and shapes decision making in the research process and guides the researcher’s approach to data collection, analysis, and interpretation (Hesse-Biber, 2014). The axiology highlights the research standpoint; in this research it was feminist standpoint theory (Harding, 2007). Emancipatory research values social justice and human rights, recognising the wider socio-political influences on policy change (Denzin & Lincoln, 2018; Mertens, 2010). The axiology of this research, as emancipatory, strives for change toward improved care of childbearing women. The axiology leads the research questions, influences how data is collected and how it is analysed (Hesse-Biber, 2014).

Theoretical perspective: Feminist standpoint theory

Feminist research takes an analytical perspective and critical stance toward oppression based on gender. “Feminism supplies the perspective, and the disciplines supply the method. The feminist researcher exists at their intersection” (Reinharz, 1992 p.243). Feminist methodologies rest in feminist theory, with concern for women’s experience and also women’s liberation and thus the principles of the ‘feminist struggle’ (Gustafson, 2000; Hesse-Biber, 2014). Feminist theory posits that all women share, by virtue of being, a common experience of oppression that it is a socially and politically constructed according to gender (Harding, 1991; Stanley, 2012).

There are many feminist theories from which to draw as a critical lens. In this research, a feminist standpoint approach is taken (Harding, 2007). Feminist standpoint theory asserts that it is women’s unique standpoint in society which enables feminists to develop valid knowledge that resists patriarchal structures and ideology. There are multiple women’s standpoints, thus women experience oppression based on the intersection of
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gender, race, class, sexual preference, disability, colonialism, and others (Crenshaw, 1991; Maguire, 1987). This feminist approach is contextual, inclusive, and experiential, and promotes social justice by exposing problems such as power, difference, silence, and oppression (Hesse-Biber, 2018; Sarantakos, 2012). The feminist standpoint lens is used to highlight the constructions that uphold women’s disempowerment and produce knowledge that improves women’s lives through social change and individual empowerment (Johnston & MacDougall, 2021; Leavy et al., 2018).

Feminist standpoint was first developed by Nancy Hartsock (1985) and coined by which categorizes epistemologies about knowledge generated by, for and with women. Rather than just a research perspective it is earned through the collective, political commitment and struggle against female oppression to improve and empower those most affected by the research (Harding, 1988). Feminist standpoint challenges traditional scientific epistemologies arguing knowledge and power are linked. Feminist standpoint includes four main elements: Strong Objectivity, Situated knowledge, Epistemic advantage and Power Relations (Gurung, 2020).

Harding (2004) suggests that all research is value laden, therefore Strong Objectivity amplifiers researcher bias, which can never be removed. The strength of Strong Objectivity is that knowledge generated from those who are marginalised reveal more objective accounts of the world (Harding, 2004). Reflexivity is used to balance the standpoint and to reflect on positionality and how this affects the research. My positionality in this research his acknowledged as a homebirth mother and midwife who desires to generate research that improves the position of women in the maternity system. Strong objectivity is evident in this research, in the language that is used, how the research problem is framed, the feminist and transformative methodology chosen and how the research is a analysed. The Strong Objectivity is balanced with reflexive journaling, supervisor review, community engagement and remaining open and aware of disconfirming data. Feminist accountability therefore acknowledges where complexities rather dichotomist solutions (Haraway, 1988). In this research the complexities of the contemporary ethical problems in the maternity system are acknowledged as grounded in neoliberal consumerism and medicalisation rather than a particular model of care, and the complexities are embraced in the participatory research journey.
Chapter 3. Midwives and women arise! Taking a feminist approach to participatory action research

Situated knowledge refers to the starting point of research that describes all knowledge as socially situate and that knowledge is partial influenced by culture and context. The knowledge generated from a particular situation or group, or context reveals insights and perspectives that may not have been uncovered in larger sampled research. Haraway (1988) explains the research generated is local knowledge rather than universal and research presents participants lives as complex even contradictory, but never simple nor universal. Situated knowledge embraces the particularities of the marginalised group in standpoint feminism toward other research methodises (Harding, 2004). Therefore, in this research rather than a unified or master theory a webbed account of experience will be presented.

Epistemic Advantage is described as the social oppression of being marginalised can generates epistemic benefit (Harstock, 1997). In this research the marginalised group is the small percentage of women who choose midwifery-led care and the experiences they describe generate a unique knowledge that would not otherwise be uncovered. Feminist standpoint challenges polarising dichotomies and provides rich and deep understating of particularities of the group being researched.

A feminist standpoint critiques the power of oppressive patriarchal structures as the reason for women's oppression, whilst recognising that power is also a source of resistance to oppression (Harding, 1991; Hesse-Biber, 2014; Johnston & MacDougall, 2021; Walsh et al., 2015). Sensitivity to power (Haraway, 1988) brings attention to how power influences knowledge production and through highlighting hierarchical social structures, which distorts knowledge, gain a more comprehensive understanding of the research (Gurung, 2020). In this study the background critiqued underlying structures such as neoliberal consumerism, patriarchal ethical principles and medicalisation as affecting marginalised women and midwifery practice.

**Feminist methodology**

There is no global, homogenous feminist methodology as feminist researchers draw from various paradigms that reflect differing contexts and agendas (Leavy et al., 2018; Sweet, 2020). Feminist research is varied because there are many feminist theories and epistemological positions and methodological principles. Maguire (1987) details how feminist research prefers to remain open without a descriptive process, as an antithesis to
positivist research. However, the foundations of feminist theory are those of critical theory, collaboration, and emancipation (Olsen, 2018).

Feminist research emerged from the women’s liberation movement of the 1960s, as female researchers recognised the absence of women as subjects and the lack of research into women’s issues (Maguire, 1987). Feminist researchers between the 1960s and 1980s were known as feminist empiricists because they argued for knowledge to be based on experience and began to deconstruct androcentrism in research (Harding, 1991). Feminist researchers took on more radical feminist epistemologies and methodologies challenging positivism, with feminists arguing that scientific objectivity is false as nothing can be value free (Hesse Biber, 2014). In the early 90s, following poststructuralism, feminist researchers identified that knowledge is influenced by power, and they argued for researchers to disclose their values and biases by engaging in reflexivity throughout the research process to improve research quality (Haraway, 1997; Harding, 1991). Feminist researchers highlight the importance of embodied experience, collaboration, and a critical lens in emancipatory research.

Ramazanoglu and Holland (2002) describe feminist research as having five characteristics: a feminist standpoint that explores the interaction of knowledge and power; the construction of feminist knowing; grounding in women’s experience; diversity among women; and acknowledgment that knowledge is partial. A feminist approach to research is also tied to the ‘feminist struggle’ in tackling research problems that expose power and oppression, dismantling those systems and seeking new ways of constructing knowledge (Johnston & MacDougall, 2021; Maguire, 1987). This approach contributes to the feminist goal of valuing women’s experiences and the commitment to end all forms of oppression through collaboration with women toward emancipation (Mutcherson, 2020; Rich, 1986).

Whilst feminist theoretical assumptions underpin much midwifery research, explicit feminist approaches are less obvious (Jenkinson et al., 2017). In this research, the rationale for the explicit feminist theoretical lens is driven by the research problem, to expose the hegemony of the medical system and the power imbalance between it and birthing women, and to understand the forces that sustain oppression of women in the maternity system. The feminist lens brings to the foreground the complex socio-political issues in the
maternity system obstructing midwifery and the imbalances of power, fear, and risk surrounding childbirth that contribute to the oppression of women.

Methodologies arising from critical theory are action research families that include participatory action research and community-based action research (Israel et al., 2012). The transformative philosophy and theory include social action and emancipation as important products of the research (Johnson & Flynn, 2021). Action research is recommended in the context of the midwifery profession, as it enables the desired outcomes for developing action-based interventions along with socio-political change (Walsh & Evans, 2014; Williams et al., 2017). Feminist scholarship remains relevant for health research to facilitate policy development and to continue to challenge women’s health injustices (Bennett, 2021; Olsen, 2018).

**Research design: Feminist Participatory Action Research**

The school of action research was conceptualised by Kurt Lewin (1890–1947) and has two purposes: new knowledge and solution to problems. Lewin described the research process beyond producing logico-empiricist works and argued that action should come from the research, through cyclical processes in mutual decision making (Bradbury, 2015; van Nistelrooij, 2018). Action research was further developed in the 1970s by Paolo Freire to include participatory research, where research was collaborative with participants (Bradbury, 2015; Coghlan & Brydon-Miller, 2014). Freire explains, “reflection without action is sheer verbalism or armchair revolution and action without reflection is pure activism, or action for action’s sake” (Freire, 1985, p.41).

Participatory action research, as a subset of action research, is defined as “a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview....[and bringing] together action and reflection, theory and practice, in participation with others in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and communities” (Reason & Bradbury, 2007, p.4). Collaboration with participants is conducted through the entire research process from defining the research problem through to disseminating the research (Israel et al., 2006). The research purpose of PAR is to both produce knowledge and drive action in relational collaboration and seeks to understand the world and improve the lived
Chapter 3. Midwives and women arise! Taking a feminist approach to participatory action research

experiences through action (Baum et al., 2006).

The process of participatory action research is reflective, repetitive, and cyclical, rather than linear in nature (Bradbury, 2015). As data is collected, it is analysed, with participants actively involved in each step of the research and the researcher practising reflexivity (Israel et al., 2012) (see Figure 3). However, the steps or phases within PAR are not well defined or reported (Chesney et al., 2019). It is generally understood that PAR follows self-reflective cycles of planning, action, reflection, and evaluation to bring about change (Bradbury, 2015). Figure 3 diagrammatically explains the repetitive cycles of PAR. Described by Denzin and Lincoln (2019), “The stages overlap as initial plans become obsolete in light of learning from experiences. In reality, the process is likely to become more fluid open and responsive “(p.595). Success in PAR is not that the steps were followed faithfully, but rather the researcher has authentic reflection and understanding of their research practices and participants were collaborative co-participants in the process.

![Figure 3. Repeated reflective cycles of Participatory Action Research](image)

The core principles of participatory research are to build participant ownership of the project, build collective inquiry, and focus on social justice toward change the group envisage through democratic decision making (Maguire, 1987). The benefit of employing this methodology lies in the grassroots approach where participants who are directly affected by the problem drive the research and determine the actions (Israel et al., 2012). A powerful result of PAR as a holistic and egalitarian methodology is that it produces results that are relevant, practical, and sustainable (De Chesnay, 2015). Participatory research is commonly used in nursing and midwifery due to its respectful collaboration with the
participants through the research process to create meaningful change (Cheyne et al., 2013; De Chesnay, 2015).

**Feminist participatory action research (FPAR)**

To accomplish the aim of the study, I am using a fusion of feminist theory with participatory action research, termed feminist participatory action research (FPAR). The integration of the two is realised as they share theoretical and epistemological underpinnings, transformation, ethics, aims, and empowerment (Fine & Torre, 2019; Maguire, 1987; Shimei & Lavie-Ajayi, 2021). The FPAR methodology is defined as a “conceptual and methodological framework that enables a critical understanding of women’s multiple perspectives and works towards inclusion, participation, and action” (Reid, Tom & Frisby, 2008, p.316). Therefore, the participants in this research are involved in the research process over an extended period of time. FPAR has three important elements: addressing a problem determined by a specific community; use of the critical lens; and plan toward action to engender change (Reid et al., 2006). In accordance with PAR, the feminist lens has been used in this research and is explicit in the research design in the active involvement of the participants in the research as co-researchers. In this study, the FPAR design facilitated the co-creation of knowledge from the birthing woman’s perspective and helps explain the systematic constructs that undermine the ethical treatment of women in the maternity system. This research design ensures congruence with my theoretical and philosophical perspectives and allowed me to collaborate with women to construct a comprehensive understanding of the research problem and drive change. FPAR is chosen by researchers who have identified a social injustice affecting women.

FPAR is a complex research design, with a research arm and an action arm (Corbett et al., 2007; Reid et al, 2006). The action arm enabled me to meet my first research objective: to work in partnership with a team of women who would guide the research toward emancipatory action. FPAR was an effective research design which enabled me to work together with childbearing women who, as part of this study, agreed to co-convene for a period of three years as action-researchers to develop and act on a plan to inform maternity practice and create change. A Community Action Research Group (CARG) was formed with nine childbearing consumers, who determined the action arm of FPAR. Details of the methods of recruitment and data collection are presented in the following chapter. However, as one example of transformative action and methodology use, I include an
infographic (See Figure 4.) created by the consumer group, which depicted the CARG-informed a priori codes and showcased midwifery research to other communities, where it may not have previously reached. The CARG then disseminated these findings to the birthing community through social media links.
There are no defined steps to the FPAR research process, and as a novice researcher I developed a guiding framework for research practice. Next, I present a paper published that demonstrates the FPAR framework theory, steps, and an exemplar from practice of one complete FPAR cycle. The paper contributes to meeting research objective one, working in collaboration and community with women in transformative research toward change.

Published paper: Navigating midwife solidarity — A feminist participatory action research framework

**Background:** A core aspect of midwifery philosophy is the optimisation of normal physiology; however, this has been challenged as a radical idea in the medicalisation of birth. Research has demonstrated the benefits of midwifery in improving outcomes for both mothers and babies. The understanding of midwifery benefits fails to reach wider sociocultural contexts as births becomes more medicalised. Midwifery research requires an action arm, to help translate theory to practice and mobilise midwives in solidarity with women towards action and change.

**Aim:** The aim of this article is to describe a Feminist Participatory Action Research (FPAR) by establishing the philosophical underpinnings, theory and methodology with an exemplar.

**Methods:** FPAR has two distinct yet intertwined parts, a research arm and an action arm. The study was conducted using FPAR, and collaboration with nine women, who led transformative action within their community. The exemplar details the use of the FPAR framework.

**Findings:** A FPAR framework was developed through this research to guide researchers aiming to use the FPAR design. The framework details four steps: 1. Create, 2. Collaborate, 3. Consider, and 4. Change. The iterative FPAR cycles were shown in this study to centre women in the research and guide the community research group towards transformative action.

**Conclusion:** FPAR is shown in this project to assist midwifery researchers to realise solidarity and provides support for other midwifery researchers in applying feminist theory and participatory methodologies to bring about transformation within their research.

**Key words:** FPAR, feminist research, theory application, framework development, care ethics, midwifery research.

**Statement of significance**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Midwifery research has limited reach in the dominant medicalised sociocultural context. Feminist participatory action research (FPAR) is one way to extend the reach of research by collaborating with women but is underutilised in midwifery research.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is already known</td>
<td>Feminist theoretical positioning in qualitative midwifery research is common, feminist theory combined with Participatory Action Research (PAR) is less commonly reported but is an effective means of increasing the reach and impact of midwifery research.</td>
</tr>
<tr>
<td>What this paper adds</td>
<td>This paper proposes a FPAR framework to help guide researchers. The framework details four iterative steps: 1. Create, 2. Collaborate, 3. Consider, and 4. Change. The iterative FPAR cycles are utilised to ensure women are centred within the participatory research process. The paper provides an exemplar of FPAR framework use, demonstrating collaboration with a community research group towards action.</td>
</tr>
</tbody>
</table>

**Introduction**

Contemporary midwifery is situated in a sociocultural context that considers the philosophical underpinning of midwifery itself, including the notion of normal birth physiology as radical (1). The
international ‘definition of the midwife’ (2) presents the understanding that midwives should “optimise the normal biological, psychological, social and cultural processes of childbirth” (p.1) and yet these midwifery foundations have been labelled as ‘normal birth ideology’, not just a dangerous ideal but one that could harm mothers and babies (1,3). This is strongly countered by midwifery and other research which has demonstrated the importance of midwifery care as key to improved outcomes for women and babies (4). Unfortunately, research about the benefits of midwifery have yet to fully inform policy and practice (5).

Feminist criticism of positivist research have explained that research can and has been used to continue to control knowledge and the impact of research (6,7). Midwifery research is well-placed to explore the problematic constructs that underscore the surface issues that continue to oppress women’s agency throughout the pregnancy and birth experience, within the medicalised maternity context (8). Midwifery research is also underpinned by a feminist philosophy, that seeks to promote women’s empowerment and transformative intentions (9-12). However, research outcomes become more powerful with a strong plan for translating findings into action and change. Feminist researchers have been called to add an action arm to their research which “…can help feminist researchers move out of the academic armchair by engaging in more transformative research” (13, p. 94). Midwifery researchers argue for the integration of Participatory Action Research (PAR) and feminist theory to strengthen the foundation of women’s research, because they share the same theoretical and epistemological underpinnings, and emancipatory goals (14, 15).

FPAR methodology is defined as a “conceptual and methodological framework that enables a critical understanding of women’s multiple perspectives and works towards inclusion, participation, and action” (16) p 316). FPAR is a research design that includes a participatory action core with an explicit feminist theoretical lens (16, 17). The advantages of feminist participatory action research is that its method, addresses the real needs of participants, and through women representing their own interests they become empowered through the research process with the additional potential to improve and change practice and highlight power imbalances that prevent change (18-20). Despite its advantages, FPAR is still an underutilised methodological choice for midwifery researchers, where the latest Sage handbook of Action Research did not include FPAR, and there is limited midwifery literature detailing how to use it in research practice.

The complexity of FPAR is it has two distinct yet intertwined parts, a research arm and an action arm (13-20). The purpose of this paper is to present and demonstrate the application of the FPAR framework for midwifery research using a working example, and to provide recommendations for FPAR practice. The first part of the paper provides an overview of the philosophical and theoretical underpinnings of FPAR and presents the FPAR framework for midwifery research. The second part of the paper is an exemplar of the FPAR framework for midwifery practice and details the action arm of FPAR.

FPAR – A research design for transformation

FPAR is grounded in emancipatory and action research conceptualisations of Lewin (21), Freire (22) and Maguire (23) amongst others. FPAR is a research design that facilitates research participants to construct knowledge together and pays attention to power to overcome oppression of dominant systems (16,17). Within this approach: critical realist ontology, social constructionist epistemology, emancipatory axiology and feminist theoretical lens can be combined to position FPAR as a methodological choice that encompasses the values of midwifery research, as evident in Figure 1. Summary of FPAR philosophical and theoretical positioning.
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Figure 1. Summary of FPAR philosophical and theoretical underpinnings

Critical research is value-driven and reinterprets data in view of critical theory to help shape and inform methods and action (15). Feminist theory does not have a specific unified research methodology or framework but rather shares a concern for understanding ways that gender impacts women’s lives, seeking to reveal unjust power relations and contributes to transformative action (23, 24). In midwifery research, this feminist lens can be used to highlight the personal and social factors that uphold women’s disempowerment in the maternity system.

Feminist PAR is intended to give voice to the participants within the research itself, by collaborating with them to shape and design the research to build evidence and then enact the social change deemed necessary by the group (14, 24). FPAR utilises ‘bottom up’ or ‘ground up’ approaches where actions and outcomes involve the people who are directly affected by a problem, in addition to participation, collaboration and democratic inquiry (24). Thus FPAR, which brings together critical feminist theory and action research, has a flexible design that includes three important elements: to promote common good through addressing a problem specific to that community of women; to ensure a theoretical lens is evident in the research to clarify the social constructs of oppression; and to plan to engender change and immediate benefit to a community group (13, 16, 25).

The operationalisation of FPAR has therefore not been clearly delineated. Rather, FPAR has been described in terms of dimensions, elements, goals, research practices and principles that can be used to guide the research. Within FPAR, it is assumed that researchers will apply these elements to action research cycles. For example, Reid, and Frisby (13) have detailed the use of 6 dimensions to guide FPAR in their research, including: (1) centering gender and women’s experiences while challenging patriarchy; (2) accounting for intersectionality; (3) honoring voice and difference through participatory research processes; (4) exploring new forms of representation; (5) reflexivity; and (6) honouring many forms of action. Similarly, Shimei and Lavie-Ajayi (17) has described FPAR...
research with young women in social distress in Israel, using four FPAR research practices of: 1. coalescing into a group; 2. encouraging the shared ownership of the research process and its outcomes; 3. developing multiple centres of power; and 4. promoting interdependency. Also Sampson et al (26) have applied 5 principles of FPAR practice to create their concept mapping in addressing food security covering aspects of: inclusion, participation, action, social change and reflexivity. However, a guiding framework incorporating the feminist lends with the action research cycles has yet to be formulated to help researchers. These contemporary research projects, in addition to an exemplar from the doctoral research of the first author, was used to form a FPAR framework for collaborative, feminist midwifery research. A proposed FPAR framework may help fellow midwifery researchers navigate this research process.

**FPAR framework for midwifery research**

To clearly guide our research methods, an FPAR framework for midwifery research was designed (Figure 1). In this paper, we present four important aspects that guide the FPAR research and action process based on the three cyclical and reoccurring steps of action research; plan, act and reflect (25), with the design underpinned by feminist principles to better reflect the purpose, partnership and emancipation of FPAR with women through the research and action phases. The four steps bring together the many documented aspects and dimensions of FPAR into one clear framework.

**Create – Woman-centred**

The purpose of the ‘Create’ phase is to create an action research group with women who are directly affected by the research problem, and who wish to see change. Through a consumer-led and democratic process the group defines the problem from their perspective, create shared
values, goals and vision for the group. This group remains with the researcher through the research project and offers important advice and guidance. Community researchers help extend the reach of the research by helping produce results that are relevant, meaningful and potentially transformative to the community (13).

2. Collaborate – Shared ownership
The purpose of the ‘Collaborate’ is to democratise the research and equalise the power of the relationship between the researcher and community members. Feminist theory highlights that woman have an embodied, diverse and particular knowledge and these other ways of knowing are honoured through the research (22). Ownership of the research is shared, and participants lead the action and change phase of the research. Each step of the research process can be validated by the community research group to ensure equalised power and acknowledge embodied knowledge. The research methods applied to this context can be flexible and adaptable to each research project. Connectivity and understanding in turn build a collaborative group where ownership is shared. Ongoing relationship building is established through regular face to face communication and social media platforms and community led conversations to ensure community needs are being met.

3. Consider – Use reflexivity
Considered critical reflection is used by the researcher to level power differentials, honour different voices and build relationship with community members. Critical reflection ensures the researcher acknowledges their own philosophical positioning, safeguards transparency, and improves all aspects of interaction with the participants and the research (26). The researcher stance is open and reflexive, which encourages feedback and encourages community researchers to guide and lead research and action ideas. Each member of the group in this model is valued and honoured for individuality, diversity skills and abilities and accounts for intersectionality, whereby each voice is honoured in the group (13).

4. Change – interdependence and transformation
The ‘Change’ phase is the action arm of the research. ‘Action’ is the large or small changes, transformations or actions that are achieved by the group. This includes learning from actions taken, adapting and improving the research through the iterative FPAR cycles. Larger change may be the way the research is translated to practice, changes to policy or application of recommendations. It also includes promoting interdependency and working toward individual and collective empowerment. Feminist PAR acknowledges that smaller individual empowerments are as important and significant as larger outcomes (13, 23). This includes exploring new ways of action and feminist representation.

The next section details the working exemplar that utilises FPAR and is the experiences of KB lead author, written in first person.

FPAR framework exemplar
The research exemplar using the FPAR framework for midwifery research is described below. The overarching research aim was to derive an in-depth understanding of the perceptions and experiences of childbearing women within the context of ethics as told by women themselves. The first objective was to collaborate with a team of women to guide and conduct the research and to work with women toward change. The second objective was to understand women’s experience of ethical care in maternity settings. The final objective was to determine whether a care ethics model would address these needs. The FPAR design was chosen as it meets those aims and to ensure congruence with my own perspective and historicity (academic, practising midwife, feminist,
homebirth activist). This paper presents the first objective only, which correlates to the action arm of FPAR. Quotes used through this next section are not data collection for analysis but rather evidence of collaborative action within the FPAR framework.

**Ethical considerations**
This article does not report the findings of the study but conveys the methodological approach and provides a working example of FPAR framework collaboration between researchers and community members. Ethics was approved (REM xx and REM xx).

For three years (2019 - 2022), I used feminist participatory action research (FPAR) as a framework for conducting community-based action research. A Community action research group (CARG) was formed and guided the research project. Table 1. below summarises the FPAR framework exemplar, describing one complete cycle, accounting for the description, research and action processes and evidence of use.

**Table 1. FPAR framework for midwifery research: One complete cycle with examples from practice**

<table>
<thead>
<tr>
<th>FPAR</th>
<th>Description</th>
<th>FPAR Research arm</th>
<th>FPAR Action arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create</td>
<td>Create and consult with community group</td>
<td>Group defined the research problem</td>
<td>Community-led focus group met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group refined research question and aims</td>
<td>Identified the problem from their perspective</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Researcher validated their expert, embodied knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Values, goals and vision for action created by CARG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Relationship built through regular face to face</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>communication and social media platforms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data collection method changed on advice from CARG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Participant set two - snowball – Contacts from CARG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CARG member checked analysis and papers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CARG helped share research in different ways – infograph on</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Instagram to reach other women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CARG focused on social justice - Attend women’s march</td>
</tr>
<tr>
<td>Collaborate</td>
<td>Shared Ownership of research and actions</td>
<td>Group informed interview questions for data collection</td>
<td>Relationship built through regular face to face</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>communication and social media platforms</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CARG focused on social justice - Attend women’s march</td>
</tr>
<tr>
<td>Consider</td>
<td>Use reflexivity to honour different</td>
<td>Researcher maintained reflective journal</td>
<td>CARG led focus groups - democratised interaction and levelled power</td>
</tr>
</tbody>
</table>
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voices and level power  Group member checks findings  Encouraged different skills, abilities, and voices within the group  Encouraged groups ideas to be achieved  Expert supervision

Change  Promote interdependence toward meaningful change  Group disseminated findings in new ways  Created another maternity consumer-led groups  Created flow charts of dreams for change  Joined with health consumer networks to create maternity choices website  Networked with other consumer activists  Joined with government agencies to inform policy  Group morphed into interdependence  Research published

Create – a group, a vision and a research project

Participants and setting

The participants for the community action research group (CARG) were childbearing women with experience of childbirth in the West Australian setting with a midwife as primary carer (MLC). The purposive sample of childbearing women was self-selected from an electronic bulletin advertising the research amongst maternity consumer networks. The participants contacted me and were emailed a research information letter detailing the purpose of the community research group and the roles and commitment involved. The women returned via email their consent form. Verbal consent was also obtained prior to the first CARG focus group. Nine women formed the final Community Action research Group (CARG), after one moved overseas soon after the first focus group with demographics described in Table 2. Participant demographics.

Table 2. Participant demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Place of first birth</th>
<th>Place of second birth</th>
<th>Parity</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonnie</td>
<td>Hospital</td>
<td>Home</td>
<td>2</td>
<td>Birth photographer</td>
</tr>
<tr>
<td>Sara</td>
<td>Home</td>
<td>NA</td>
<td>1</td>
<td>Engineer</td>
</tr>
<tr>
<td>Solange</td>
<td>Birth centre</td>
<td>Home</td>
<td>2</td>
<td>Accountant</td>
</tr>
<tr>
<td>Amy</td>
<td>Birth Centre</td>
<td>Home</td>
<td>2</td>
<td>Hairdresser</td>
</tr>
<tr>
<td>Kylie</td>
<td>Birth Centre</td>
<td>NA</td>
<td>1</td>
<td>Physiotherapist</td>
</tr>
</tbody>
</table>
The CARG definition of the research problem
An important aspect of FPAR is that the community group define the research problem from their perspective (13 – 20). The CARG problem formulation generated by the CARG, created the basis of the research topic and guided the research questions and parameters of the research. The CARG defined the research problem thus:

The contemporary maternity system is unethical for many reasons. The care provided is not woman centred or individualised. Women don’t have access to information to make decisions about their own bodies and babies. The knowledge women are given is not evidenced based nor current. There are structural barriers policies and procedures and standardised care in place likened to financial companies - instead of marketing and adds they have policies and procedures. There is a sociocultural fear of normal physiological birth. (CARG, 2020)

Collaborate – shared ownership
Shared ownership of research and actions were a guiding principle to the research project and took on many forms. Firstly, my philosophical and epistemological stance, ensured an open and democratic approach to research and interactions with the participants. Following are examples of the CARG leading and guiding the research and action arms. In the initial meeting a shared vision and goals were developed through open discussion, honouring each woman’s voice, that set the tone for community ownership. The CARG developed ideas that guided the researcher and informed thematic analysis. The group also contributed to the interview questions for the second round of data collection, where data collection methods were altered with advice from the group. For example, an initial idea had been to capture women’s descriptions of their birth experience via other forms of data such as a photograph an image or poem. Early in data collection it was noted that women were not bringing a visual artefact to the interview, the CARG recommend removing this additional data source. The next set of participants were sourced through snowballing from the CARG contacts. The CARG members checked analysis and papers before publication. They disseminated findings to the community most directly affected by the problem through social media links such as Infographs.

Collaboration ensured decisions regarding planning and executing action were made by the group. The democratic levelling of power was aided by releasing control over the direction of the group including forming branching groups and connecting with other consumer groups. Renfrew et al (8) describes that through working in partnership with women, researchers and academics form alliances with women's advocacy groups. This inroad was an important collaboration result, opening up new inroads into consumer representation, whereby the researcher was invited to other consumer groups which in turn aids research dissemination and advocacy.

Consider – Use reflexivity
Reflexivity was both a stance and a process, and these were maintained through a commitment to journaling. Being a community member of the CARG group, I critically reflected on my position and power in the group and aimed for equality and transparency. A democratic style of interaction was fostered and quickly led to community-led group focus group meetings. Once the group was established, I became a passive participant, sitting quietly as the group discussed an issue or topic as the group took on its own identity and purpose. Reflexivity helped manage the two-fold role of the researcher in FPAR both as an engaged community member acting for change with the participants and as researcher focused on knowledge development (16, 29).

Reflexivity was invaluable through the research process whilst reflecting on the broader social and political context that shapes the research (15). I used a reflexive approach when analysing the data, which is important in feminist research, given that it stems from a position that identifies power imbalance and oppression. Reflexivity is important to maintain an openness about prior assumptions and experiences, identifying and acknowledging them while also staying close to the raw data to ensure that analytic rigour is maintained (30).

I ensured reflexivity by journaling for deeper understanding and meaning of the raw data and repeatedly going back to the data sources, audit trails and peer examination and CARG member checking. Reid & Frisby (2008) explains how a researcher cannot just “write ourselves into the text”; we must also write ourselves into action and activism and use our self-reflections to generate actions of self-discovery within the research process” (16). They detailed questions to guide the researcher in critical reflection which were used by this researcher through the FPAR journey. For example, this journal excerpt to the question - Who owns the research?

This has been the hardest thing to account for. On a logistical level I do due to answering to Higher education institute and required processes but it’s the women’s voice and words and passion and striving for change and action. How do I find other ways that they can feel more ownership, or do I surrender to the research continuing to be project led by me because there are simply steps that must be led and made by me? and yet understand and continue to foster and surrender ownership of the action wing is where the group find most excitement in planning and actioning the ideas they have? I feel a shift from feeling like I project managing two wings a research wing and action wing toward surrendering the action wing to the group (KB Journal entry, 14/4/2021)

Change – actions realised

Meaningful and transformative action was the CARG goal. They wished to see maternity transformation for the lives of other women being cared for in the maternity system. Being a consumer-led group and fully democratized, the group changed over time, subgroups were formed, and it became more than the original community research group, but rather a village of women supporting, inspiring and encouraging other women. Change occurred on both individual and collective levels. Some actions were realised and other remained a dream and a goal the group describing these as the butterfly effect – small ripples in time can make big changes that aren’t realised yet. Larger systems-based change was harder to realise but reassuringly Reid et al (15, p. 317) explain action as “a multifaceted and dynamic process that can range from speaking to validating oneself and one’s experiences in the world to the process of doing something, such as taking a deliberate step to changing one’s circumstance”. They described the action wing of action research as a dynamic process that not only determines the problem and develops strategies but also develops a sense of community and helps understanding of the world. This description therefore allows an understanding that all action no matter how small by the group is a form of
action, a view supported by feminist researcher Maguire (2004) who describes the importance of many forms of action both on an individual and collective level.

There were many larger transformative actions the CARG were involved in. For example, CARG members joined an existing maternity advocacy group which has political involvement, and one member became the state representative. Another member was inspired to create an offshoot group that supports intersectionality among birth workers and created a support group. The vision for the support group was to create a website to have a directory of birth workers and monthly group meetings. Since October 2020 it has morphed into a monthly meeting whose main vision is birth worker support with a focus on inclusivity and diversity – encouraging all women but particularly welcoming LGBQTI, marginalised and ethnic groups.

Smaller and individual empowerments were described by the group members for example one participant explained through being in the group she felt stronger and more liberated to choose a homebirth for her second birth, “from the support and connection in the group I went on to have a homebirth, the group expanded my mind, provoked a lot of thought, created in me a sympathy and empathy for other people’s lives and spurred off other ideas” (Georgie, 2021). Another participant described being in the CARG thus “It has been cathartic and having been unheard in society, for someone to hear my unheard voice because I’ve learnt my voice is vital on small, tiny levels. But also, to have been in this group and to be with other women during this journey has changed me” (Amy, 2022).

Discussion - Final reflections
This paper details FPAR methodology as a useful design for midwifery research in translating research to action. In this study, the FPAR framework comprised of four steps — create, collaborate, consider and change, umbrellaed by the feminist lens, helped navigate the research design. The feminist lens ensured the researchers were committed to the feminist aim of advancing social justice for women in the maternity system. The four parts of the framework provided steps to direct the path for the novice researcher, which together ensured the researchers remained true to women when journeying together over a long period of time. The ‘create’ phase, set up the community research group creating the vision and direction for the group and goals for transformative action. ‘Collaborate’ ensured ownership of the research throughout with the group becoming managers of the action plans. ‘Consider’ ensured researchers were using reflexivity to view things from the perspective of the women, checking power differentials and honouring the embodied knowledge of the group. ‘Change’ was the action realised by the group, both on an individual level and a collective level.

The inspirational aspects of the FPAR framework included seeing women empowered on the individual level, where the group grew and developed offshoot groups as well as the translation of the research to wider audiences of women where it may not normally have reached. The feminist goal of subversions of power relations, not just at the outset of the project but how power was balanced through the entire project, was a source of success but also a source of tension as described by other FPAR work (31, 32, 33). Ponic (2010) explains that tensions show that power relations are being destabilised in FPAR, which although difficult to navigate ultimately releases the power back to the group members. A more recent FPAR described similar tensions related to power that were mediated by researchers’ communication style and openness to critical reflection, highlighting the importance of researcher reflection (33).

My greatest learning involved releasing the action wing of the project to the group and seeing it go in directions I wouldn’t have chosen. Further, this involved discovering these other ‘ways of
doing’ an important learning for me about subverting authoritarian action and standing in solidarity with women. The CARG had answered patriarchal systems with new ways of doing, new truths and smaller grass roots action that met transformative goals of the group.

The limitations of FPAR design that have been previously described by other researchers, such as the time-consuming nature, juggling the demands of research and the time required for collaborative planning and executing action, were all true of this research (28). Successful change requires many resources, people, time, financial and structural. However, the FPAR framework ensured the women were centred through the entire research process and provided a clear path to realise transformational interdependent change, led by women.

**Conclusion**

FPAR is a powerful research tool for midwives to stand with woman in solidarity under the weighty medicalisation of birth. This study met the objectives of the study through co-creation of research with women and development of consumer recommendations that may be used to change policy and contribute to transforming maternity care towards more humanised, respectful and ultimately ethical birth practice. The use of the FPAR framework helped this midwifery researcher find solidarity with women in collaborating for change.

**References**

Chapter summary

In this chapter, I have presented the philosophical and theoretical underpinnings of this study to provide rationale for the choice of FPAR. The methodology was the ideal choice for transformative research into childbearing women’s experiences from an ethical perspective, through collaboration with women toward action and change. A published paper was presented that demonstrated the utilisation of FPAR and the development of a unique FPAR framework: create, collaborate, consider, and change. The paper demonstrates the success of transformative research and the women’s experiences of feeling empowered through collaborating with me on the research journey. Change and action was realised with the creation of consumer group offshoots, such as Birth Folk for nonbinary health workers, and political change, such as collaborating with governmental health organisations. The paper provided evidence of meeting objective one: collaborative research and emancipatory action. In the following chapter, I detail the methods used in this study, including the details of the participant recruitment, data collection for the research arm, and the analysis used on the data sets.
Chapter 4. The personal is the political

Participatory research taught me the necessity of being explicit about personal choices and values in the research process. Feminism taught me to recognize that the personal is political.

Maguire (1987, p.5)

Chapter overview

The previous chapter explained my arrival at choosing the FPAR methodology, citing critical realism, social constructionism, emancipatory axiology, and a feminist lens, and details and evidence of the action arm of FPAR were presented. In this chapter, the details of the research arm are given, with the particular methods chosen for this study. The study is presented in two phases. In phase one, a community action research group (CARG) was formed with nine participants, and the methods for sampling and recruitment, focus group data collection, and the a priori codes generated for the template analysis, are presented. In phase two, data was collected from ten other participants, plus data from five focus groups with the CARG. Both data sets were combined, and reflexive thematic analysis was applied to the data corpus. The chapter concludes with trustworthiness measures and reflexivity as tools to ensure research quality.

Participant sample and recruitment

The sample for this study was childbearing women who had experience of childbirth within a midwifery-led model of care. Purposive sampling is a form of nonprobability sampling, where participants are purposefully selected as the best informant based on having experienced the topic being investigated (Creswell & Creswell, 2018). Recruitment for participants was sent via Electronic Bulletin (Appendix 1) and an email was sent through professional platforms and networks such as Homebirth Australia, Maternity Consumer Network, and collegial networks. Heterogeneity was endeavoured through contacting collegiate networks in regional areas to recruit participants. The electronic bulletin included a Word document attachment with an explanation of my research, an invitation to partake in the study, and my contact details. The participants self-selected and contacted me in response to the bulletin via email. The total sample size was 19 women. In phase one, nine of these participants were recruited to form the Community Action Research Group (CARG) and data was collected from five focus groups. In phase two, a further ten women were
recruited for in-depth interview. Table 3 illustrates the two phases; participant sets and data sets.

**Table 2. Phase of study, participant set and data set**

<table>
<thead>
<tr>
<th>Phase one</th>
<th>Phase two</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data set 1</strong></td>
<td><strong>Data set 2</strong></td>
</tr>
<tr>
<td><strong>Participant set one (CARG)</strong></td>
<td><strong>Participant set one (CARG)</strong></td>
</tr>
<tr>
<td><strong>Nine participants</strong></td>
<td><strong>Nine participants</strong></td>
</tr>
<tr>
<td>Over the age of 18 given birth in the West Australian midwifery model of care</td>
<td>Same participants 9 participants</td>
</tr>
<tr>
<td>Focus group x 1</td>
<td>Focus groups x 4</td>
</tr>
<tr>
<td>A priori codes and template analysis</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Commit to research group over three years - Participants guide the FPAR and run the action arm of the research</td>
<td>Continued over three years in CARG – determining action arm continue to guide research</td>
</tr>
<tr>
<td><strong>Data set 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Participant set two</strong></td>
<td></td>
</tr>
<tr>
<td><strong>10 participants</strong></td>
<td></td>
</tr>
<tr>
<td>x</td>
<td>Over the age of 18 given birth in West Australian midwifery model of care</td>
</tr>
<tr>
<td>x</td>
<td>Given birth in the last 5 years</td>
</tr>
<tr>
<td>x</td>
<td>One-on-one in-depth interview</td>
</tr>
<tr>
<td>x</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td><strong>Total for data set one – 9 participants</strong></td>
<td><strong>Total for Data set two - 19 participants</strong></td>
</tr>
<tr>
<td><strong>Data corpus – 1 focus group</strong></td>
<td><strong>Data corpus – 5 focus groups plus</strong></td>
</tr>
<tr>
<td></td>
<td>10 in-depth interviews</td>
</tr>
</tbody>
</table>
Participant Set One. Community action research group (CARG)

All participants who responded to the initial invitation with an interest to participate were sent a participant information sheet with consent (Appendix 2). The information sheet provided information about what the study involved, and participants could choose to contact me if they wished to be in the study. I responded to their email with a phone call to further discuss with the participants what was involved in being part of a community research group and all participants who contacted me chose to continue in the study.

Nine participants were recruited in phase one, they committed to a three-year action research project and formed the CARG. They were not known to each other prior to becoming members of the CARG, nor did they come from the same midwifery-led service. Demographic details are set out in Table 4. The CARG managed the action wing of the project toward transformative change, and included meeting with other health agencies, stakeholders, and consumer groups and disseminating research findings. The CARG’s involvement in the research arm was to guide research and drive action through the three-year project and included identifying the research problem to member checking analysis. Data was also collected from these participants through five focus groups.

Table 3. Community Action Research Group (CARG) demographic data

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>1st birth</th>
<th>2nd birth</th>
<th>Parity</th>
<th>Occupation</th>
<th>Gender</th>
<th>Partner</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonnie</td>
<td>Public OB</td>
<td>Community Midwifery Program</td>
<td>2</td>
<td>Birth photographer</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc.</td>
</tr>
<tr>
<td>Sara</td>
<td>Endorsed midwife</td>
<td></td>
<td>1</td>
<td>Engineer</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc.</td>
</tr>
<tr>
<td>Solange</td>
<td>Birth centre</td>
<td>Community Midwifery Program</td>
<td>2</td>
<td>Accountant</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc.</td>
</tr>
</tbody>
</table>
Participant set two: In-depth interview

For participant set two, a snowball sampling strategy was used whereby participant set one shared the Participant Information Sheet (Appendix 3) via email with their contacts to help with participant recruitment for phase two. Snowballing is a sampling strategy that utilises the already acquired participants and ask them to recommend other people to the study (Sarantakos, 2013). The participants for phase two were childbearing women who had experienced a midwifery model of care in the last five years, to gain a contemporary perspective, and were recruited for one-on-one in-depth interview. Ten women were interviewed.
### Table 4. Participant Set 2: Demographics for in-depth interview

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>1st birth</th>
<th>2nd birth</th>
<th>Parity</th>
<th>Occupation</th>
<th>Gender</th>
<th>Partner</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathy</td>
<td>Endorsed Midwife</td>
<td>Endorsed midwife</td>
<td>2</td>
<td>Midwife</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
</tr>
<tr>
<td>Diana</td>
<td>Private OB</td>
<td>Community Midwifery Program</td>
<td>2</td>
<td>Personal trainer</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
</tr>
<tr>
<td>Taya</td>
<td>Community Midwifery Program</td>
<td>1</td>
<td>Social Worker</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
<td></td>
</tr>
<tr>
<td>Lucy</td>
<td>Endorsed Midwife</td>
<td>1</td>
<td>Bioscientist</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
<td></td>
</tr>
<tr>
<td>Mia</td>
<td>Endorsed Midwife</td>
<td>Endorsed Midwife</td>
<td>3</td>
<td>Midwife</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
</tr>
<tr>
<td>Olive</td>
<td>Community Midwifery Program</td>
<td>1</td>
<td>Singer</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
<td></td>
</tr>
<tr>
<td>Anna</td>
<td>Endorsed Midwife</td>
<td>1</td>
<td>Engineer</td>
<td>Woman</td>
<td>Yes</td>
<td>Spai n</td>
<td></td>
</tr>
<tr>
<td>Zoe</td>
<td>Endorsed Midwife</td>
<td>1</td>
<td>Teacher</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
<td></td>
</tr>
<tr>
<td>Fiona</td>
<td>Private OB</td>
<td>Endorsed Midwife</td>
<td>3</td>
<td>Psychologist</td>
<td>Woman</td>
<td>Yes</td>
<td>Italy</td>
</tr>
<tr>
<td>Ella</td>
<td>Private OB</td>
<td>Endorsed Midwife</td>
<td>2</td>
<td>General practitioner</td>
<td>Woman</td>
<td>Yes</td>
<td>Cauc .</td>
</tr>
</tbody>
</table>
Demographic acknowledgement

The women in this study had all chosen a midwifery model of care for either their first or subsequent birth. This group represents a small portion of the population, as only 4% of birthing people choose a midwifery model of care (AIHW, 2022). The demographic represented in this group were mainly educated, born in Australia, a high resource country, and identified as cis woman. This aligns with other research and confirms the participant sample is reflective of those who choose midwifery models of care (Sangster & Bayley, 2015; Grigg et al., 2015). Thus, recruitment via purposive sampling was appropriate as the participants, by choosing a model of care outside the commonly chosen medical model, are a marginalised group in the medicalised maternity setting. However, the participants had all had experience with the medical model of care, either for their first birth, or through midwifery-medicine collaboration and referral.

Both the Community Midwifery Program (CMP) and Family Birth Centre are midwifery-led models of care in Perth, Western Australia are government-funded, midwifery-led model for low-risk women choosing homebirth or birth centre. Although they are midwifery-led continuity of care programs the models are subject to overarching polices of the tertiary hospital. The midwives in these models are employed by the health department.

The endorsed midwife is a midwife endorsed with the Nursing and Midwifery Board of Australia competent to provide pregnancy, labour, birth and postnatal care to women and their infants; and is qualified to provide the associated services and order diagnostic. They are often privately practising and offer home births, a few of them have admitting rights to tertiary hospital in Perth, WA.

Ethical considerations

All research involving human participants must adhere to ethical principles to ensure participants do not come to harm (Creswell & Creswell, 2018). This research was guided by the National Statement of Ethical Conduct in Human Research (National Health and Medical Research Centre (NHMRC), 2018) and the University’s Policy for the Conduct of Ethical Human Research (2020). Ethics approval was sought from the Edith Cowan University [ECU] Research Ethics Committee to conduct the study (REM Buchanan 2019-00296 and REM Buchanan 2020-01707). Merit and integrity were ensured through considering current evidence, research method, rigour, and expert supervision. Justice was
ensured through consent and minimising burden for participants. Beneficence was achieved through minimising risk factors, and there may have been some personal gain for the participants involved as community researchers by driving change for the betterment of other groups who use the maternity system. Respect was maintained through continuous consideration of participants’ welfare, privacy, and confidentiality, and the valuing of diversity (NHMRC, 2018).

**Risk assessment**

In preparation for the commencement of the study, I assessed for risks of potential harm. The risks identified involved: the risk of emotional discomfort recalling birth stories, possible disclosure of personal identity, and COVID 19 exposure, however the benefits of this study were perceived as significant and outweighed any potential harm. Risk was mitigated through utilising the risk management services at Edith Cowan University. A specific detailed protocol was developed outlining potential risk and actions to prevent psycho-emotional risk exposure (Appendix 4). Details of a counselling service were provided; access to this service was not used. The ECU COVID 19 Research Checklist and Risk Management Plan was also in place for the duration of the study to minimise the risk of exposure of COVID 19 to participants. The participant information sheet also included the supports in place if the participant felt emotional discomfort while recalling of their birth stories. No participants withdrew from the study or sought counselling because of being in the study.

**Consent**

Respect for autonomy relates to participants having the right to exercise their agency and choose whether to enter the study without consequence. Participating in this study was voluntary. Participants demonstrated self-determination in signing and returning via email the signed consent form attached to the Participant information sheet (Appendix 2 and Appendix 3). The participant information sheet outlined the purpose and details of the study, as well as the contact details of the researcher, the primary supervisor, and the secretary of the University’s Human Research Ethics Committee. Participants were informed they could withdraw at any point of the study if they wished.

**Anonymity and confidentiality**

To ensure anonymity, participants were given a random pseudonym at the time of audio
transcription. A copy of the transcript was offered to all participants for member checking. Participants’ names on the consent forms are kept in a secure folder on OneDrive only accessible by me. I shared the data, analysis and transcripts with permission among members of my supervisory team. I remained contactable through the duration of the study and updated all participants on the progress of the study.

**Recording and storing data**

Data was managed according to the Australian Code for the Responsible Conduct of Research (2018) and in accordance Edith Cowan University’s Human Research Ethics Committee guidelines. The ECU System for Tracking Research Ethics Monitoring (STEM) was used for this study. A formal ECU Data Management Plan (DMP) has been completed. Physical data was scanned and upload to Share Drive with a password known only by myself and my principal supervisor, and then copies destroyed. This data includes participant consent forms, participant contact detail forms, and any written data from the participants. Digital data comprised transcripts and software data that included Word, Excel, Mail, NVIVO, and Contacts. Data was recorded via a personal iPhone 12 using Voice Recorder and the voice recordings were uploaded to OneDrive. Data was stored on a password-protected computer with multiple protection measures in place. The server is on a secure internal network behind a firewall infrastructure. Data was protected via backup on an external drive that is kept locked in a personal filing cabinet. Data will be stored in a university cloud-based account provided by RAMS after the formal ECU Data Management Plan has been fulfilled. Data will be kept for a minimum of seven years in accordance with NHMRC requirements, after which it will be destroyed beyond retrieval (NHMRC, 2018).

Further, care ethics was utilised to ensure relational care to the community researchers during the three phases. The care ethics research framework for participatory research guided the researcher’s interaction with the community participants (Banks et al., 2013). This framework enabled me to achieve ethical, responsive partnerships with the participants to build both community with the participants and maintain democratic decision making to inform directions for change. Attention was given to the role of privilege in terms of the positioning and power between me as primary researcher and the CARG through reflexivity. I demonstrated responsiveness through attentive listening and responding to build trust and solidarity. I was responsible in conducting the research in an
organised and professional manner. I demonstrated competence through thorough and careful research practices and detailed project management.

**Data collection**

The use of multiple forms of data collection aids the qualitative researcher in gathering a rich data set (Creswell & Creswell, 2018). Data was collected for this study via focus group interviews, one-on-one in-depth interviews, and observational data recoded in a reflective journal. Next, I detail the data collected from participant sets and data sets.

**Phase One: Participant set one, Focus group data**

Focus groups are a form of data collection for qualitative research and the interview generates knowledge between more than one participant (Denzin & Lincoln, 2018). Focus group interview was chosen to extract women’s collective knowledge, attitudes, beliefs, and perceptions (Kook et al; 2019; Then, 2014). The interaction of the group elicits rich data that is descriptive, but also generates and develops new ideas through the group interaction, providing a deeper understanding of the issues (Denzin & Lincoln, 2018). Thus, small numbers between eight to twelve are generally ideal for focus groups. Focus group interview was also chosen because it diminishes power relations between researcher and research participants toward emancipation (Denzin & Lincoln, 2018).

During the first focus group, the CARG collaborated and created the group’s vison, goals, and boundaries. During this focus group, data was also collected. A topic guide was developed in line with the research question, and by the research team (Appendix 5). The topic guide was comprised of four topics aimed at encouraging discussion around ethics, and included Midwifery-led care, Relationship with care provider, Decision-making, choice, and information and Care experiences - Ethical/unethical. The topic guide was sent to the participants prior to the focus group. The topic guide not only aids in consent to the research but provides the participants with prior information to develop discussions. This procedure aligns with the democratic approach of FPAR in empowering the participants through information sharing (Banks et al., 2013).

The purpose of the first focus group data collection was to generate a priori codes. Data collection was facilitated using the Nominal Group Technique. The steps to this process are displayed in Figure 5. The technique was developed in the 1950s and is a data collection method that is effective in group decision making (Foth et al., 2016; Harvey & Holmes, 2012). It is useful in forums that include stakeholders to discuss and rank the
hierarchy of importance for the women’s views (Foth et al., 2016; Harvey & Holmes, 2012). For the purposes of this study, NGT was used for generating a priori codes that would be used in creating the initial template for template analysis.

The NGT process began with the topic question, and each participant was asked their experience of this topic point. In round robin format, the next participant was invited to discuss their views of the topic. The moderator added comments and probing questions to encourage expansion and clarify understanding. After each topic was addressed, the researcher and group summarised the views expressed into five to eight key words. NGT therefore became the first pass of thematic analysis as the women themselves condensed and distilled their views into dot points on the whiteboard. The participants then ranked in hierarchy of importance, their top three key words that summarised the answer to the discussion. The hierarchy of importance was ranked by the women individually. After the focus group, I collated the results. These were then member checked by CARG, and the supervisory panel confirmed the final a priori codes for template data analysis. This process is an example of FPAR design: co-collaborating with the women during the research process.

In phase two, data was collected during four further focus groups. It was not necessary to use NGT at the remaining focus groups, as no data needed to be ranked and these focus groups were led by the participants using the topic guide. See Figure 6. All focus groups lasted between two to three hours and were audio recorded. The participants member checked the transcription and verified data collected.
The action arm also comprised of four other focus groups, not for data collection but for planning. These focus groups were held to plan and execute the action arm of the research described in the previous published paper.

**Phase two: Data set two**

The interview method is a useful method of data collection when the phenomenon could not be observed but the participants can share their experience of the research inquiry (Creswell & Creswell, 2018). It involves gathering information via stories and perspectives that are elicited by talking with people (Kelly, 2018; Kvale & Brinkman, 2015). This method is chosen when research questions seek to find deeper meaning of events to research participants, whilst also accessing the concepts, cultural understandings, and classification of the world of interview respondents (Kelly, 2018). In this study, the interview aimed to understand how the participants conceptually understand ethics, how they categorised the care they received, and the causes of unethical care, in order to meet the research aims.

The medium of semi-structured interview was chosen as the method of data collection for this study as the most used qualitative interview technique (Kelly, 2018). It is defined as “an interview with the purpose of obtaining descriptions of the life world of the interview
in order to interpret the meaning of the described phenomenon” (Kvale & Brinkman, 2015, p.6). It allows a greater degree of flexibility than standardised interviews, but less than naturalistic field interviews. This is appropriate for research questions that seek to explore a concept within a theoretical lens, rather than an individual’s whole experience of the research topic.

An Interview protocol was developed with guiding open-ended questions to understand how participants think about this topic (Green & Thorogood, 2012). The number of questions for semi-structured interviews is between five and ten (Creswell & Creswell, 2018). The interview questions included: Why did you chose midwifery-led care? Can you tell me about your births? Can you think of an example that shows the best part of your care? Can you describe an example of unethical care? Can you describe a situation where you exercised choice? (Appendix 5). Probing was used toward fuller explanation, ensuring all aspects of the question were explored, using active and reflective listening. Probes were used to encourage participants to reflect on their own stories to illustrate experiences of what they felt was ethical or unethical in their care. Probes included verbal elaboration prompts such as repeating a key phrase and asking the participants to further describe, or nonverbal probes such as smiling and nodding the head (Sarantakos, 2013). Green and Thorogood (2012) describe the importance of language as not just the words the participants use but the language itself becomes the data, how people talk about their world. For example, the participants in this study may talk about ethics without using the word ethics, the language remains implicit. But they may talk about it through events, situations, problems, or how they felt. Through comparing interviews, I was able to build a picture of categories of ways participants represent ethical concepts.

**Observational data and reflective journal**

Participant observation is a source of data commonly employed in FPAR. The researcher becomes part of the setting, hearing, seeing, and experiencing the reality of the experiences described by the participants, and a deeper understanding of the experiences are developed (Reason & Bradbury, 2004).

Reflection was utilised during and after the focus groups and in-depth one-on-one interviews (Figure 7). It is acknowledged that in qualitative interviews skills are required to enhance communication and make the participant feel comfortable in disclosing. As a midwife and counsellor, I felt that my interviewing skills, although good, were improved
after the first few interviews. Reflections I used post interview were: Did I interrupt the participant? Were there points I could have prompted for more information? Did I use probing effectively? Did I leave silences for added thoughts? Were my questions leading, judgemental, or too inquisitive? Together, these reflections quickly improved my line of questioning during interviews. I kept notes about each interview using an interview protocol and reflective journal. My own thoughts and reflections about the woman’s experience and the emerging theory were kept as formal qualitative data collection documents. I engaged in multiple observations directly after the interview with descriptive notes about observations, surrounds, and sketches of the women to capture observations, insights, and impressions. The multiple forms of data collection aid in reflexive thematic analysis and finding deeper meanings during data collection (Braun & Clark, 2019; Creswell & Creswell, 2018).
Data analysis

Data set 1. Template analysis

In phase one, template analysis was utilised to demonstrate whether there was a link between care ethics and midwifery-led care. Template analysis is a form of deductive thematic analysis for qualitative data, which uses a coding template and is useful for working with theoretical ideas and extrapolating explicit themes as summative and semantic meaning (Braun & Clark, 2019; Brooks et al., 2015). Template analysis is a flexible set of procedures that systematically organises the whole data set to allow ease of looking for patterns across codes (Brooks et al., 2015; Cassell & Bishop, 2019).

I chose Template analysis as the most suitable method to support the mapping of the
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theoretical concept (care ethics) to practice (midwifery-led care), with a key benefit being that it enabled me to ask a direct question of the data; in this case, does midwifery-led care demonstrate care ethics? It is useful for testing how well a theoretical concept applies to the whole data set, by systematically organising the examples from the data set into the template (King, 2012). Template analysis utilises a priori codes, which forms the categories for the template (Brooks et al., 2015; King, 2012). For this study, a template was created using the four characteristics of care ethics as set out in the published scoping review (Table 6). These became the headings of the table (template). Then, a priori codes were generated from the focus group interview and were mapped to the four headings (Table 7). The raw data had been colour-coded to each assigned a priori code and these examples were added to the table.

Table 5. Care ethics domains as categories for template

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Practice of care</th>
<th>Attention to Power</th>
<th>Sociocultural context</th>
</tr>
</thead>
</table>

Table 6. A priori codes as subcategories

<table>
<thead>
<tr>
<th>1.1 Midwifery-led continuity of care</th>
<th>2.1 Trust women’s bodies and abilities</th>
<th>3.1. Information provision</th>
<th>4.1. Birth culture of fear (MLC counter cultural)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Woman centred care</td>
<td>2.2. Protect normal physiological birth</td>
<td>3.2. Respect autonomy</td>
<td>4.2. Recognition of rite of passage</td>
</tr>
</tbody>
</table>

The template analysis achieved the second objective of the research which was to determine whether midwifery-led care demonstrates care ethics. The template also provided foundational thematic analysis that could be further investigated. Thirdly, the use of the CARG-generated a priori codes provided evidence of collaboration with community through the research process. Evidence of the use of a priori codes and template analysis and further detail is set out in a published paper: ‘Does midwifery-led care demonstrate care ethics?’ A template analysis’ (Buchanan, et al., 2021) located in the results chapter 5.

Data set 1 and 2. Thematic analysis

In phase two, reflexive thematic analysis (RTA) was utilised to explore and understand women’s experiences of ethical maternity care (Braun & Clark, 2019). Reflexive thematic analysis is compatible with the assumptions of qualitative paradigms. Reflexive Thematic
Chapter 4. The personal is the political

Analysis was chosen as it supports my constructionist epistemological assumptions about knowledge generation, my critical realist ontological view, and feminist research stance (Braun & Clark, 2017, 2019). The analytic process involved deep thinking, reflection, and immersion in the data, with head space and time to allow for iterative theme development. The analysis process was conducted over six months (Braun & Clark, 2022).

Themes were the final ‘outcome’ of data coding and were generated as significant patterns of shared meaning around a central concept in answering the research question (Braun & Clark, 2019). Both inductive and deductive themes are reported, which are viewed as a continuum rather than a dichotomous (Braun & Clark, 2019). The inductive approach is grounded in the data and is often used to understand experiences when little is known about a research topic (Braun & Clark, 2021). In this study, no known evidence exists that captures women’s experiences of care from an ethical perspective. The deductive, or top down, theory driven approach was also used during analysis, which is a commonly chosen approach when using a feminist lens (Braun & Clarke, 2013, 2019; Cassell & Bishop, 2019). The deductive approach was utilised in phase one of the research to generate the template analysis which detailed the four domains of care ethics as categories for coding. In phase two, the deductive approach was evident in analysis where the feminist lens was used to analyse and interpret data. Both inductive and deductive themes allow both the reporting of women’s experiences whilst drawing attention to greater societal discourse using the feminist lens.

Finally, meaning was interpreted across the spectrum from semantic (explicit, obvious, surface level) to the latent (implicit, hidden). Semantic themes were chosen because critical realism allows the whole data set to be reviewed and honours the participants’ experience and own words. Latent themes were also created through the theory remaining strongly linked to the data set (Braun & Clarke, 2013; Braun & Clark, 2019; Cassell & Bishop, 2019). A tool for evaluating thematic analysis manuscripts for publication was used (See Appendix 6). This twenty-point checklist ensures thematic analysis remains aligned to Braun and Clark’s (2019) methodology and helps identify research trustworthiness and quality.

Thematic analysis is helpful for both qualitative feminist research and participatory research and was utilised for both focus group data and interview data (Braun & Clarke, 2006, 2017, 2019). I commenced analysis during reflective note taking during the focus groups and interviews and transcribing process. The coding and theme development
processes was reflexive, and involved active researcher engagement (Braun & Clark, 2019).

Figure 8 provides a working example of exploring patterns. Themes were created from the data and present the main elements of the participants’ descriptions with the aim of not only understanding the research topic, ethical care, but also understanding the structures that underly the complexity of ethics in the maternity system (Braun & Clarke, 2006; Brooks et al., 2015; Green & Thorogood, 2009).

The phases of thematic analysis as set out by (Braun & Clarke, 2019) are:

1. Familiarising yourself with your data: Transcribing data reading and re-reading the data, making reflections, and initial ideas.
2. Generating initial codes: Systematic process of coding interesting features of the data in and across the entire data set, collating data relevant to each code.
3. Generating themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes: Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes: Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.
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Coding

Coding as a method in RTA provides the foundation for identifying and conceptualising possible significant patterns of shared meaning toward the development of themes (Braun & Clark, 2019). Coding was conducted to group similar units of meaning together into families that share characteristics to help identify patterns in the data toward developing a theme (Saldana, 2018). Coding was conducted line by line or sentence once the data corpus had been transferred to NVIVO 9, a qualitative data management system. Codes which shared common elements were grouped into subcategories (Saldana, 2018). Analysis was an iterative process over six months, with many code revisions to refine the data as categories, and then to themes. I conducted the analysis and the supervisors’ checked processes and reflections and gave advice and guidance as needed. Final analysis was shared with the CARG members and feedback accepted. An example of coding steps and process is in Table 8.
### Table 7. Examples of coding

<table>
<thead>
<tr>
<th>Raw data</th>
<th>Level 1 coding</th>
<th>Level 2 coding</th>
<th>Subcategory</th>
<th>subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z - And I think just because she seems really passionate about women's experiences and a natural birth was really important to us, every homebirth midwife we met there was just like no power imbalance there, like it was like just person to person, like woman-to-woman conversation instead of I'm the expert on everything, which obviously I definitely respect their expertise. But it was like I could approach them with anything</td>
<td>Normal birth valued Significant</td>
<td>Normal birth valued</td>
<td>Midwife in solidarity</td>
<td>Claiming power</td>
<td>Radical desires</td>
</tr>
<tr>
<td></td>
<td>Relational person to person no power imbalance</td>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midwife respecting woman as expert of her body</td>
<td>Woman as expert</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F - I look back, it was it was a very coercive, fear driven appointment and about risk of future rupture and stuff like that, and he started telling me about his own study that he'd been doing the in KEMH, that it was more like a one in 30 chance of rupturing. But he couldn’t show me the data on it.</td>
<td>Feeling unsafe Threatened abruption</td>
<td>Feeling unsafe/ gendered safety</td>
<td>Saving women from themselves</td>
<td>Surrendered power</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision making based on risk and fear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L - I didn’t have a good relationship with the obstetrician and but I didn’t feel strong enough to probably question more or actually change my decision around it and then two male doctors came in and stood over the bed and started to say that they needed to talk to me, And I said, can we not talk about</td>
<td>Didn’t have a good Relationship</td>
<td>Relationship affects birth experience</td>
<td>Uneasy alliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>that right now? and they didn't respect that. And he was like, no, we need to talk about it now. And just every time I tried to implement boundaries; they would not listen</td>
<td>Didn't listen didn’t respect</td>
<td>Patriarchal deafness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reflexivity

Reflexivity is an important attribute for the qualitative researcher and especially so for the standpoint feminist researcher. Reflexivity is a critical element of the research process that contributes to rigour by contextualising the researcher position and being open about biases whilst remaining true to the data (Braun & Clarke, 2013; Creswell & Creswell, 2018). All knowledge is shaped through context; thus I acknowledge my position: as a feminist midwife; a mother who gave birth at home; and an advocate for women with a social justice worldview.

Positionality

Reflexivity grew out of feminist postmodern, post-structural, and post-colonist theories (Leavy et al., 2018). The researcher uses reflexive skills to position themselves in the research, through their role in the research process. The researcher reflects on both the research and the experience of conducting the research (Sweet, 2020). Feminist researchers practice reflexivity by being conscious of how their assumptions affect their research practice, from the selection of the research problem and choice of method to the ways they analyse and interpret their data (Hesse-Biber, 2012). I practised reflexivity which made me more conscious of what values, attitudes, and agenda I brought to the research project through the use of reflexive journalling, CARG discussions, supervision and detailed research processes.

I utilised a reflexive journal throughout the research journey. The reflexive journal had a three-fold purpose. To record observations during interviews and focus groups, to reflect on positionality and used through analysis and to describe rationale around decision making. I particularly used the reflexive journal during moments of doubts or discomfort, to remain sensitive to the group dynamics or complexities of working with FPAR. The following reflexive questions are excerpts from the reflexive journal: How does my position in society affect the way I observe and perceive others in my daily life? What particular values and biases do I bring to and/or impose on my research? What particular ideas on the nature of knowledge/reality do I bring to my research? (Hesse-Biber, 2012). An example of the reflexive journal is provided in Figure. 7.
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Power and congruency

Reflexivity subverts power imbalances through flattening power structures and generating research toward emancipatory ends (Johnston & MacDougall, 2021). When the researcher pays attention to power in relation to participants, it reveals personal involvement and engagement in the research. The two-fold role of the researcher in participatory action research must also be managed during the research process. In this project, my role is both a community member working with the CARG on the action arm and also as a researcher focused on knowledge development (Ponic et al., 2010). Through reflexive practices I was able to critically reflect on my position and power in the group dynamics and hand over parts of the project to the CARG members. Congruency with the CARG was essential for reflexive and responsive research. Maguire (1996) explains that feminist philosophy and daily behaviour must align, recognising the interconnectedness between the personal and the political. Therefore, congruency of this research project aligned with the CARG where there was personal involvement of the members in the research, and the researcher in the action generated from the CARG.

Reflexive methods

Reflexivity is valuable in the research process when reflecting on the deeper sociocultural constructs that shape the findings to ensure trustworthiness and that the women’s voices were illustrated with verbatim quotes. (Green & Thorogood, 2009). Reflexivity is ensured in this research by declaring my epistemology and theoretical framework, keeping a reflexive journal, remaining true to the voices of the women by repeatedly going back to the data sources, and peer checking by supervisors (Denzin & Lincoln, 2018). Transparency was achieved through a clear account of the methodological process, along with detailed decision making. Through analysis I was open to aware of disconfirming data I ensured I was open to polemic and stereotyped findings. As such, I remained open and aware to disconfirming data. For example descriptions of private midwives or homebirth care as not being attentive to ethical concerns, and recording anomalies to of disconfirming data.
Rigour and trustworthiness

The validity of this study is ensured through strategies that strengthen its trustworthiness. Trustworthiness refers to the credibility, transferability, confirmability, and dependability of qualitative research (Denzin & Lincoln, 2018). Credibility is demonstrated by presenting the data truthfully, prolonged engagement with the participants, triangulation of the data sets, and member checking with the CARG and supervisors. Prolonged engagement was particularly important in this study. The CARG members were involved in the research and action arms of the research over three years. They were sent all the findings and papers for review prior to publication. The participants were asked if they recognised the themes that were generated as true to what they felt they had experienced.

Transferability refers to how transferable the results may be to other settings. In qualitative research it may be more applicable to think of this in terms of transferable concepts and how they can be applied to practice (Green & Thorogood, 2009). The findings may be transferable to other settings in which women birth and other care fields where ethics are applied. Given the prevalence of documented disrespect and abuse in maternity care setting, it is likely that the findings from this research will be relevant to other settings.

Dependability is shown through findings that are consistent, in this case the preliminary findings of phase one, where the a priori codes generated by the participants were triangulated with the one-on-one interviews with other childbearing women. A detailed description of the methods also ensure that future investigators will be able to replicate the study. Expert supervision also ensured dependability.

Confirmability means that the research is accurately shaped by the participant’s voices, rather than influenced by researcher bias. This was achieved through triangulation of the data sets and repeating the data collection in phase two, reflective journaling, audit trail of analytical decision making, member checking, and peer review (Brooks et al., 2015; Green & Thorogood, 2009).

Chapter summary

This chapter detailed the research methods undertaken in this study. Nineteen participants were recruited, the participant recruitment process and demographics were described, and the process of data collection, analysis, and interpretation were discussed. Audio-recorded interviews were the primary source of data collection, with supplementary observational data collected and recorded in the reflective journal. Transcribed interviews were analysed...
Chapter 4. The personal is the political

using both template and thematic analysis. Trustworthiness measures were offered, with
reflexivity highlighted as the essential quality of feminist methods and thematic analysis.
In the next chapter the findings are presented from both phases of the FPAR.
Chapter 5. Women afire: Descriptions of ethical experiences

From women’s eyes this doctrine I derive. They sparkle still the right Promethean fire; They are the books, the arts, the academes, that show, contain, and nourish, all the world.

Shakespeare, Love’s Labour’s Lost

Chapter overview

This chapter describes the results of the research in which 19 women were interviewed in Perth, Western Australia. This study sought to investigate women’s experience of maternity care from an ethical perspective and ascertain whether a care ethics paradigm would better suit midwifery care. Data was collected via both focus groups and one-on-one interviews. First, I present the findings from phase one, a published template analysis (Buchanan et al., 2021) which maps raw data to care ethics theory and provides evidence toward meeting research objective two: determining whether midwifery-led care demonstrates care ethics. Then I describe the findings from phase two, which explore women’s experiences of maternity care from an ethical perspective. The overarching theme, radical desires: individuals’ values and context, represents the woman’s values and context as central to understanding ethics. The ethical and unethical care the woman received are described in subcategories, woman-centred ethics and authoritarian ethics. Following this are two subthemes which represent the consequences of the care received, claiming power: embodied and strengthened and surrendered power: disembodied and diminished, exploring how care affects participants’ reordering of sense of self during the liminality of childbearing. I present the findings in a published paper. The findings contribute new knowledge about ethical and unethical care, and I offer a conceptual model, woman-centred ethics to guide midwifery practice. This chapter addresses a gap in the existing ethical literature by presenting empirical evidence of what women value and what constitutes ethical care.

Findings from phase one: Template analysis

The findings from phase one were an important first step in determining if there were correlations between the normative theory care ethics and midwifery-led care. The template analysis provided a means to map empirical evidence of participants’ descriptions of the care they received from an ethical perspective with the four domains of care ethics.
Template analysis, as a deductive approach to analysis, is useful to test theory (care ethics) with practice (midwifery-led care). As outlined in the methods section, the template was constructed using the results of the scoping review. The four domains of care ethics were used as template headings: relationship, care practice, attention to power, and context. Then, the a priori codes generated by CARG were applied to the template. These were: Relationship with the midwife, woman-centred care, trust in women’s bodies, protecting normal birth, information provision, respect for autonomy, birth culture of fear, and respect rite of passage. Evidence from the participants’ own words were added to the template. The template analysis published in *Nursing Ethics* is now presented, this analysis determined that care ethics theory is demonstrated through midwifery-led care (Buchanan et al., 2021).

Published paper: 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 consultive 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.
Chapter 5. Women afire: Descriptions of ethical experiences

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>
<thead>
<tr>
<th>A priori codes</th>
<th>Care ethics characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care ethics codes</td>
<td>1.Relationship</td>
</tr>
<tr>
<td>Midwifery-led care codes</td>
<td></td>
</tr>
<tr>
<td>Evidence</td>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>A priori codes</th>
<th>Care ethics characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care ethics codes</td>
<td>1. Relationship</td>
</tr>
<tr>
<td>Midwifery-led care codes</td>
<td>1.1 Relationship with Midwife</td>
</tr>
<tr>
<td></td>
<td>1.2 Woman-centred care</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Care ethics major codes</th>
<th>1. Relationship</th>
<th>2. Practice of care</th>
<th>3. Attention to Power</th>
<th>4. Socio-cultural context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery-led care codes</td>
<td>1.1 Relationship with Midwife</td>
<td>1.2 Woman centred care</td>
<td>2.1 Trust women bodies</td>
<td>2.2 Protecting normal birth</td>
</tr>
<tr>
<td>Evidence</td>
<td>“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”</td>
<td>“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.”</td>
<td>“MLC would respect that you’re the expert of your body.”</td>
<td>“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”</td>
</tr>
<tr>
<td></td>
<td>“a holistic approach, Midwives look at the whole picture, she will look at the body language and is”</td>
<td>“empowerment through knowledge of what the body can do.”</td>
<td>“it’s because we are trying to follow physiological birth and the midwife ensures that”</td>
<td></td>
</tr>
</tbody>
</table>
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"

"Having one midwife that I would see each time"

"the relationship with the midwife is an open relationship"

"Transparency was something I experienced too"

"if I hadn't had the relationship with my midwife led by how she knows the woman."

"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"

"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"

"and if someone had gone by 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)"

"the midwife said we don’t call them (DR) till later, the 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.”

"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"

"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.”

"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?”

"even talking through the processes or"

"I wanted to have my choices respected and I felt that would happen in MLC”

"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.”

"Empowerment is choice."

"yes, in MLC you have true informed consent”

"women’s bodies, that we can’t do it without help They have forgotten the fundamentals of women birthing”

"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 given some significance”

"How impactful the birth experience is to bonding breastfeeding and mental health”

"when a baby is born the mother is born”

"so, we keep these stories inside of us, so really careful not to diminish anyone’s choices.”

"and to what extent do we acknowledge that its an impactful event in this day and age, in other cultures and
| and she hadn’t known 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. | relationship, its tailored to me” | “midwives) are listening to women” | “limit when I gave birth” | 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 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” | telling my good birth story.” | earlier in our culture that women gave birth and got on with it and it was normalised in the family” |
| “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” | “she’s (midwife) genuinely excited” | “I felt nurtured by the midwife, “she (midwife) would sit next to me and fill in notes together” | “I chose midwifery care to go without having the interventions” | 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 | “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 the baby at home actually and they turned and walked away, and I burst into tears.” | “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.” |
| “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 | “the perfect birth environment – the middle of the night, no one was there just my midwife and partner” | “I chose midwifery care to go without having the interventions” | “it was the perfect birth environment – the middle of the night, no one was there just my midwife and partner” | “I chose midwifery care to go without having the interventions” | “I got abused because they confused HypnoBirthing with home |
| of the last birth in hospital before this birth" | when presented with all the information. “ | birthing, and they said I can’t believe you would put your children at risk.” |
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.

Georgie: “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.

Amy: “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-centricness is described by Amy 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. Amy- “It’s a transparent relationship” confirmed by another Kylie- “Transparency was something I experienced too”. Elise 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.

Solange: “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.

Sara 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”.

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

Eve 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.

Jenna 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.
Chapter 5. Women afire: Descriptions of ethical experiences

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.

Sara 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. Bonnie said – “I wanted to have my choices respected and I felt that would happen in midwifery-led care” and Eve 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.

Amy 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.

Eve 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.
Amy 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.

Kylie 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.”

Elise 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
Chapter 5. Women afire: Descriptions of ethical experiences

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 though 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

Chapter 5. Women afire: Descriptions of ethical experiences

Findings from Phase two: Thematic analysis

The template analysis determined that midwifery-led care demonstrated care ethics using a deductive form of analysis and the CARGs *a priori* codes describing midwifery-led care. These findings were important in providing empirical evidence to midwifery theory of care ethics and to embrace the CARG involvement in the research. In the second phase an inductive form of analysis was undertaken, using Reflexive thematic analysis to explore participants experiences of care from an ethical perspective (Braun & Clark, 2021). The *a priori* codes were not used through this phase rather the rich thick descriptions and women’s voices were emphasised to ensure congruency with FPAR.

The central theme, **radical desires: individual’s values and context**, situates the woman at the centre of the care, recognising that her values and context are central to understanding ethics. Secondly, the care described by the women was categorised as ethical or unethical. These were assigned to the categories **authoritarian ethics** (made up of uneasy alliance, opaque information, and saving women from themselves) and **woman-centred ethics** (made up of harmonised relationship, transparent knowledge, and midwifery solidarity).

Lastly, two subthemes are presented as outcomes of ethical and unethical pregnancy and birth experiences, **claiming power: embodied and strengthened** and **surrendered power: disembodied and diminished**, whereby the experiences either strengthened or reduced the sense of self. These outcomes highlight the importance of attention to ethical care because conflict occurs when the woman’s values are at odds with the values providing the care. The relationship of categories to the central theme and the subthemes and are set out in Figure 9. Using pseudonyms, participant quotes are used throughout to provide space for women’s voices and to provide raw data to evidence the findings.
Central theme: Radical desires: Individual’s values and context

The central theme of these findings represents what the women valued in pregnancy and birth context from an ethical perspective. **Radical desires: individual’s values and context** situates the woman at the centre of the care in determining what is ethical, through understanding her values and context. **Radical desires** describes how the participants valued birth as a meaningful, transformative experience and that normal physiology was desired to facilitate these transformations. The values and desires held by the women were in contrast with the dominant sociocultural context of medicalised birth. The theme interrelates the woman’s values (ethics) with lived experiences (context of pregnancy and birth ethics), how she is cared for (ethical care), and the inner change through this liminal life experience (transformation). This study highlights that maternity care is morally laden with normative meanings of what good care should be as decided by rules, principles, and dominant social norms, with little regard for what may be deemed ‘good’ by the woman.

The theme **radical desires** captures what women say is ethical — relationship, choice, agency, to be physically and psychologically safe, and the meaningfulness of the pregnancy and birth journey. Ella described that contemporary western society does not acknowledge the importance of the pregnancy and birth experience:
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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 it was a rite of passage for her, and it was normalised in the family.

_Ella_

And the benefits of natural childbirth and how that sets up a baby for life and not only the baby, but also the mother all of those little things and to have your own midwife who aligns with your beliefs or family or what’s right for you and your circumstances.

_Mia_

The desires of the participants were set against a broader sociocultural context that did not value normal physiology, nor place importance on the meaningfulness of the experiences.

_We spend more time researching what car to buy than childbirth, than how we’re going to give birth to our babies on the most important day of our lives, but I think if women were told up front - this is going to be the most memorable and important day of your life, it will stay with you forever. And if you don’t understand the process or things happen in your birth and that could be bring up some fear for you or even be traumatic, that can seriously impact you for the rest of your life and your child’s life._

_Kathy_

This study highlights that the participants had different and divergent values to what was accepted in the medicalised contexts. The theme _radical desires_ captures the desires participants had for normal physiology because they felt that birth experiences had lasting impact, set in contrast to the medicalised context, which pathologised and reduced the experience. Described by participants as meaningful beyond the physical experiences in language such as “impactful life event,” “most important day of your life,” “a ripple effect that affects you forever more.” Deeper descriptions like “changed me as a woman” and “evolved” point to changing perceptions of self. These quotes capture the idea that pregnancy and birth experiences are far more meaningful than just the physical, with personal meaning beyond the experience felt long after the pregnancy and birth. Participant Fiona exemplified this when she shared that the pregnancy and birth shaped her personhood beyond the experience itself. She associated the effects of this experience
with increased confidence, critical thinking, decision making, power, and finding her voice.

*I think it's [the birth experience] huge, it’s empowered me as a mother and a woman and a person far beyond just thinking I had a VBAC at home. And it’s the learning that I’ve had about myself and my intuition that sets me up better making decisions in life about what is right for me and my children and my family. And I have more confidence and less anxiety, and I think more ability even to just critically think about things like decision making, life decisions, it’s hard to explain the ripple effects, like I sort of found a power or a voice within me that I didn’t have before.*

_Fiona_

Olive also described the experiences as meaningful beyond the physical experience of birth, but made links to her sense of womanhood:

*When a baby is born a mother is born and that is every time you give birth. And that is not acknowledged at all in the medical model, it’s all about the baby and you’re not nourished as a woman and a new mother which is a part of the birth experience, I don’t think you can separate it.*

_Olive_

Elise described the pregnancy and birth experience as one of self-discovery, that she got to know herself on a deeper level and learned to trust herself. Through the embodied experiences of the pregnancy and birth, finding she could trust her body, flowed into other aspects of her life. And she attributed this journey to the experience of trusting normal physiology:

*The birth experience brought home to me the importance of knowing myself and trusting that. Which is very difficult to describe getting to know myself more and on a deeper level trying to know myself and trust myself and I guess being connected through my pregnancy and birth experience being able to know and trust myself and know that my body can do and has flowed on to so other aspects of my life that I’ve almost taken for granted. All that comes from that starting point of trusting in the birth process.*

_Elise_

The theme, **radical desires: individual’s values and context**, is based on the understanding of the participants’ collective experiences and stories of pregnancy and birth
from an ethical perspective. The theme represents the importance of the women’s experiences of pregnancy and birth as central to understanding ethics. This led me to understand that women’s ethical perspective supersedes codes, rules, and principles, but rather is discussed in terms of relationship, knowledge, and care. Next, unethical and ethical care is described, using the categories relationship, knowledge, and care. Figure 9 (p. 109) shows the relationship between the categories and themes, demonstrating how ethical or unethical care contributes to a woman’s sense of self.

In this study, three categories — relationship, knowledge, and care — were assigned as contributing factors to whether pregnancy and birth experiences were experienced as unethical or ethical. The subcategories encapsulate the quality of the relationship with the care provider, the provision of information, and the care given to the woman. Through the analysis, unethical care was assigned as authoritarian ethics: uneasy alliance, opaque information, and saving women from themselves. Ethical care was categorised as woman-centred ethics: harmonised relationship, transparent wisdom, and midwifery solidarity. The outcomes of the two different types of care were summarised in the subthemes surrendered power and claiming power. In the next section, authoritarian ethics will be discussed first, then woman-centred ethics.

Category: Authoritarian ethics

Subcategory: Uneasy alliance

An uneasy alliance was described by women who had experienced fragmented systems of care. They characterised the experience as standardised and devoid of any real relationship. The women were bound to the care giver by default, which implied that the relationship was more like a working alliance that met standardised needs and system processes. The women in this study used terms such as “just a number,” “didn’t feel cared for,” “superficial,” and “standardised.”

Georgie best summarises the participants’ experiences demonstrating uneasy alliance. She describes an uneasy relationship with the obstetrician, feeling powerless, unheard, trapped in her choice, and uncared for:

*And I just went with that I didn’t have a good relationship with the obstetrician, but I didn’t feel strong enough to probably question more or actually change my decision around that. I never felt like my obstetrician really cared one way or another. He just really wanted everyone to have a pulse at the end of the day and,*
you know, not be sued. I think that’s what he cared about. Yeah, yeah, yeah. I never felt like he actually had any idea what I wanted and how I wanted the birth to be.

Georgie

Hearing was replaced by ‘patriarchal deafness,’ a code I assigned to explain experiences when woman’s wishes were unheard. The idea of patriarchal deafness summarises the experiences of not being listened to, questions shut down, and not feeling heard, instead feeling they were being judged as a “stupid girl” or “silly” for questioning the system or wanting an alternative to what the system offered. Amy shared, “when I attempted to talk about my well-being, how I was feeling, in a more holistic sense, he listed a lot of stats around other things. It felt very invalidating.” Fiona shared her experience of the six-week check-up, where she questions why she had had a caesarean section:

And it was quite directive questioning because I knew that was my last chance to get any answers. And I had nothing to lose anymore, … I ended up deciding I didn’t think it was going to really change anything. I think I felt like he would have just thought ‘the stupid girl’.

Fiona

The uneasy alliance was also based on the idea of a standardised approach and was described by the participants as a way of treating all women the same. The lack of being heard left the women with unsettling feelings of being unknown, unguided, and unsupported, and trust became uncertain. The women described often being left unguided in the medical model of care, with little time spent on getting to know the individual woman or discussing the women’s concerns, this was described by Fiona who said:

He was conscious of like checking things like I wasn’t too high on the depression anxiety scale and that sort of thing. But it was to cover him rather than him having a genuine care in my wellbeing.

Fiona

Uneasy alliance also captures the idea that women were expected to behave in a certain way, not challenging authority, nor asking questions of the obstetrician. This idea of conforming and accepting care implies an unsafety, behaving like a ‘good girl’ to feel safe in a male care provider’s care:
And I had probably a lot more of those questions all throughout my pregnancy, but I felt very like invested in this and he's going to be the one who's there delivering my baby. So, I don't want him offside, and I don't want him to be against me.

Bonnie

Zoe describes the distant relationship with the obstetrician as the reason for her decision to switch to a midwifery-led model of care five days before her birth:

But obviously at that time I was vulnerable and, you know, like, I'd cry in the lift on the way down from the office after the appointment and was just really not happy with it. And that's when I started ringing around about five days or six days or so before I went in to labour, I started ringing around and asking the CMP midwives for recommendations for a private midwife.

Zoe

Lucy, who also switched from the medical model of care to the midwifery-led model, compared the appointments thus:

The Obstetrician just has his head down in the file and distant and so far away from me. he’s telling me what it is and what’s it’s like. Whereas with the private midwife it’s a lot more touch, eye contact, pensive listening, ready to write your answer down in the folder, they would look at me and wait for me to answer, not just ticking the box.

Lucy

A conversation in a CARG focus group described the uneasy alliance as one in which the women were treated as uneducated or lacking the capability to understand information, thus decisions defaulted to the care provider. The conversation was summarised thus:

It’s because you are a mother — I educated myself, I did all my research, I knew what was going on, but they spoke to me like I were the lowest person... who didn’t care or know anything... As though I was that person pregnant and smoking out the front of the maternity hospital! There was no difference in how they would speak to me as to that person.

Lana

The routine procedures, everyone who comes in gets this, they don’t even think about it, no questions were ever asked. They have already made the decisions as
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to what is right for you, they have taken that decision away from you - in any other industry, like hairdressing if we all got the same cut — it wouldn’t work.

Amy

The result of the uneasy alliance is that health professionals are in control of the pregnancy and birth experiences. Power was maintained by the caregiver in terms of how decisions were presented, remaining in control of the decision making.

But I was also in a state of shock at that point in time and the Doctor saying “I’m the decision maker and I’m the last decision maker. And I’m making a decision that if you want to have a home birth, you can’t do it with the CMP. You need to come into the hospital and we’re recommending that you get induced as soon as possible.” And so, I’m in the state of shock — f@ our homebirth just got taken away.

Lucy

Subcategory: Opaque information

Opaque information was built around the misuse of evidence and information, and women described how information was withheld, used incorrectly, shared in a biased way, or old evidence or standardised information was presented. Women described care providers using knowledge to coerce her toward a decision that suited the care provider, as opposed to what the woman may have chosen, had all information been given in a transparent way. The women in this study described the provision of information as being given in a threatening way such as “your baby will die” and “your placenta stops working,” intended to invoke fear (and compliance). The women in this study felt as though they had to remain strong to stand firm in their knowledge in the face of the coercive threats. Georgie describes her compulsory appointment with an obstetrician, as she was trying to have a VBAC:

I had to have an obstetric appointment and it was a very coercive, fear driven appointment about the risk of rupture and stuff like that, and he started telling me about his own study that he’d been doing, and that the statistics were more like a one in 30 chance of rupturing. But he couldn’t show me the data on it. He’d gone through my notes and explained that actually the way my notes had been written that it was really code for I’m about to rupture. He was playing into whatever fears I had. He said “Homebirth is really risky because they always end in hospital, and
we have to rescue them.” He actually had said that “we need to rescue them”. And he said the way my uterus looked from the notes - he actually made a visual where he said, “you know, we wouldn't even need to put the knife on it. And it would do this” [exploding noise and hands like an explosion].

Georgie

Taya relayed the conversation with the obstetrician when she had to come to hospital for a compulsory postdates CTG, where the ‘dead baby card’ (Kumar-Hazard, 2018) was used:

After CTG monitoring I had to wait and get an ultrasound because I felt if I don’t get one, they are going to get annoyed, and if I get one it might just shut them up and they’ll let me go. But then I had an Obstetrician come and see me and said “basically your placenta stops working at 40 weeks and blah blah blah” and all those scary things and I’m like ok mate again I don’t know who you are, you don’t know me and you’re just telling me this? But then another Obstetrician came and saw me and said did I know that placentas stop working at 40 weeks and that my baby would die — she said my baby will die!!

Taya

The women in this study challenged the idea that the maternity system was providing current research and evidence to guide best practice, leading to the category opaque information.

I think if my midwife had presented it in a way that most people in the system do, which is “this is the routine care and this is what most women do”. So, you just do what everyone else does. I think there’s an assumption that hospital policy is evidence based, but it’s not always or takes a long time for the evidence to catch up. There was probably lots of policies around you need to dilate so much per hour and actually none of them have any evidence to really back them up. There are so many archaic things around what’s done.

Eve

Opaque information also captures the idea that information provision is often given with bias toward the prevention of perceived mortality of either mother or baby, rather than to support the woman’s decision making.
You know, and I'm listening to the statistics and I'm listening out for risk factors, but I was like ‘this is my baby’. I'm totally happy if we've got a risky situation here to take some action around that. So, I'm really listening for what I should get worried about. And she was listing off these studies and I just hear, infinitesimally small risks here. But what she’s talking about is inducing a baby, which the risk is greater for having all of the other interventions which are actually more like one in three ending in section or depression in the mother. And like all of the risks, they don't talk about. They were just talking about these mortality risks, which were tiny. So, I say ‘I'm still not hearing the problem’.

Olive

Women in this study perceived when they were being coerced. They also felt confused when the risk they had been threatened with never eventuated, and it was difficult to reconcile the intervention with the information they had been provided.

So, you know, it was classed as an emergency caesarean, but she was born with good Apgars. And you know, it's sort of probably more I've since learned that that's fairly standard from other friends’ experiences and its often not questioned that you’ve been pushed for a section with some reason or other and your baby comes out and its fine.

Ella

I was less concerned as to why he had cut my baby’s face in the section and more concerned about why I had a caesarean, and I did a lot of questioning around why I had a section, and I still can't quite get why I had ended up being a caesarean.... Apart from having a slash on her face, but. Yeah, it was very much kind of, I think, it was communicated that we were lucky that she wasn't sick because had we left it any longer, you know, it was good obstetric care because they had acted before she got sick. That was kind of, I guess, how it was communicated to me.

Fiona

Opaque information results in a mistrust between women and the maternity system. The participants felt coerced, bewildered, lied to, or deceived, and that information was used to arm and coerce. The way knowledge was misused in order to meet the health professional’s agenda demonstrates a power imbalance.
Subcategory: Saving women from themselves

Women described unethical care as being when the health professional or the system took control of the pregnancy journey and the birth experience. The implications of the system retaining control over the experiences is that it removes the decisions from women. Care was often given without consent and at times reflected behaviour that could be considered abusive, with unethical actions to the woman defended because they were ‘saving’ the mother or baby.

And so, in some ways, then the feelings of feeling traumatised and devastated and disappointed and upset in some ways were so invalid because I should just be happy that I was saved and that my baby’s safe and You’ve got a healthy baby. So, ‘stop complaining’ kind of feeling.

Fiona

It’s because doctors are just too powerful, and they don’t know their power and they think what they’re doing is the best outcomes for everybody and saving mothers. And they’re not and I don’t think they understand otherwise.

Bonnie

So, yes, I think that’s kind of how it was portrayed to me like we’ve kind of saved you, saved things here, we rescued you because things could have been worse. And I remember being quite confused that my baby wasn’t sick.

Solange

The women also described a power imbalance where they felt scared, unsafe, and abused through coercive actions such as derogatory language or questionable behaviour. The women then conformed, behaved, and consented in order to feel safe.

I was on the bed in my gown, and so he came and checked me (vaginal examination), and he broke my waters without my consent at that time, to which I wouldn’t have known any different. He just he checked me and said, “your waters are gone now too”, but it’s just so abusive when I think back to it.

Lana

Fiona and Ella also both described intimate interventions that left them scared into conformity with coerced consent:

It was quite rough compared to the other VEs and he came up with the same number and he left. And then I said to the midwife who was young, she would have
been in her early twenties. And I said, “do you mind just checking me again? Because when you checked me before, it was really gentle, and you came up with a different number and he was really rough ... it was.... it hurt...... And I, I, I don't trust him. Can you just can you check me again? “. And she's said, “I can but I have to let him know that I'm going to do it first.” And I was like, “well then there's no point.”

Lucy

I remember being in the shower and the midwife coming in and saying, “you know, the doctors coming, he's on his way. He will want you in a gown on the bed.” And I just remember feeling so afraid of, like, ‘oh, shit, I've got to get out of the shower and get on the bed and he's going to come and check me.’ And I had had a check when he arrived, which had been far more rough and painful than I think was necessary. And I think in that moment I just went, ‘oh, I can't do that again and that’s when I thought I need an epidural’.

Anna

Saving women from themselves describes the idea that women are perceived as ill equipped to make good decisions for themselves or their babies. The care provider acts as advocate for the baby, prioritising the baby over the mother’s wellbeing and birth experience. The women become the passive recipient of caregiver actions.

And I was like, “no!”. And he just he just looked at me in a really firm way. And he said, “if you don't consent to this C-section, you will have a very sick baby” It just made me feel like I'm not doing the right thing by my baby if I don't agree. And so, I consented. But it was forced consent. I've read things now that say if you’re made to feel afraid to say no to things then it’s not consent.

Ella

The women also discussed their experiences of interventions being pressed on them during pregnancy and birth with a seeming disregard for time and physiology. The women felt they were in a constant battle with the system to protect their bodies. This was discussed in one focus group conversation thus:

Sara: He was trying to get me to have an induction of some kind from 37 weeks it was just push, push, push, push, push.
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Lana: Yeah I think the threshold for a watch and wait, it doesn’t exist in the medical model.

Bonnie: Yeah, I think probably naively, at my birth, I just thought because I had told the doctor that I wouldn’t have the drip in [syntocinon] it became a fight ... there was still that coercion from the doctors coming in trying to say that I needed these interventions. And I think I was fight and flight mode for the majority of the labour and that didn’t help things.

The outcomes of the category saving women from themselves is care that has left the woman feeling as if they have no control and having to fight through their pregnancy and birth experiences. The women discussed this in terms of an imbalance of power and the resulting lack of trust meant the women left the medical model of care seeking other alternatives.

Subtheme: Surrendered power: Disembodied and diminished

The consequences of the unethical care given under subcategories uneasy alliance, opaque information, and saving women from themselves were brought together in subtheme surrendered power: disembodied and diminished. The participants in this study revealed how they had surrendered their power, felt infantilised — deemed incapable of looking after their own health — removed from their bodily experience and diminished in themselves. Examples were given that showed being subject to coerced consent, derogatory language and/or behaviour, abusive interventions, feelings of entrapment and fear, intervention used to force conformity, feeling unsafe, and feeling unheard.

Surrendered power encapsulates conformity leading to disembodied and negative or diminished sense of self, their instincts, and their bodies. The women used language like “was left traumatised,” “doubted myself,” “left fearful,” as explained by Sara:

So I was postdates and the obstetrician did an ultrasound and he said “I need to book you in for an induction” so I did consent to a stretch and sweep because I was like getting desperate at that point because I didn’t want to birth at the hospital like really didn’t want to... so I had a stretch and sweep and that was like the really worst experience that was worse than birth, it was horrible. Birth was fine - that was horrible, I cried and my midwife cried.

Sara
Mia alluded to the power differential between the woman and the health professional who had the authority, accepted knowledge, and a system behind them. If a doctor did not think a woman should have a homebirth the woman questioned themselves and their decisions:

Yeah, I suppose the biggest thing you begin to doubt yourself — have I made the right choice, the fact the doctor said to me ‘maybe think about whether you do want a home birth?’, like I was an uneducated person. I would think ‘well the doctor has a lot of education they know that’s the reason why I should listen to them.’

Jenna

Taya also described the doubt created when a health professional challenged her decision for a homebirth:

I had come in for a check at 37 weeks as I thought my waters had broken, even the midwife saying to me ‘you might have a baby in a couple of days’. I was thinking in the back of my head that is not happening!! but I also felt like I wanted to do what was best for the baby so if that’s what has to happen so be it. If my waters had broken, then of course I will. If I wasn’t educated, I would probably go ‘ok have the baby now and get it over and done with and make sure the baby is ok’ I suppose. I think the biggest thing is the doubt, you doubt your ability.

Taya

Fiona also described the feeling of having a lack of knowledge, connecting that fear with not wanting to challenge or make a decision that would mean she was responsible for any outcomes of these decisions:

I was just afraid, and I didn’t know enough. And I had put my trust in that system and I was afraid of the midwives expression, and I was afraid of his ultimatum, and I don’t want to be responsible for my baby being sick or whatever that was going to mean. So, I said yes.

Fiona

As a society, some women very easily give up that power and ability because they feel other people will do it better, the doctor knows better, because x,y,z and I can trust them but that is so often not the case.

Kathy
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The subtheme **surrendered power** explains the experiences of **uneasy alliance**, **opaque information**, and **saving women from themselves** as unethical. The women in this study describe that when the relationship, knowledge, and care is unethical, their sense of self is diminished, and this reduced their confidence in themselves. The pregnancy and birth are transformative in the negative sense, meaning women are left disempowered and harmed by these experiences.

**Category: Woman-centred ethics**

**Subcategory: Harmonised relationship**

A harmonised relationship was one depicted by the women as formed over time and through continuity with, for these women, a midwife. Although it is important to note that midwifery models of care do not automatically confer ethical behaviours, the possibility of relationship/relationality probably contributes somewhat to the behaviours described in this section.

The attributes of a harmonised relationship were described as hearing and respecting, honouring, and advocating. Relationship was viewed by the women in this study as important for informed consent and decision making because it strengthened and emphasised respect for autonomy, thereby ensuring the woman’s selfhood remained intact. The midwife was seen by women as a guide through the pregnancy and birth journey toward self-actualisation via a trusting and empowering relationship; the implications being that trust was required for the woman to feel both physically and emotionally safe. Empowerment meant that the woman was fully able to exercise her agency in the relationship, and as a result she was transformed through positive, edifying experiences.

A **harmonised relationship** was described as being created over time, with continuity with the same midwife or small group of midwives. Time involved long appointments, often carried out at home, where detailed attention was given to the woman and her pregnancy, and she was included in all aspects of pregnancy care. Physical aspects were attended to, but the women also shared that attention, time, and space were also given to their emotional and psychological wellbeing. The women described the midwife as understanding their individual needs and wishes, resulting in a sense of being deeply known.
There’s a knowing in the relationship that’s different to other care. It comes to the quality/qualities of the midwife. But it also just it comes with time. And when I think about appointments that went for two hours, that were filled with tears and hugs and a deep sense of knowing my pain and helping to heal that — that’s therapy! And you can’t replicate that in 15-minute hospital appointments.

Diana

And, you know, that’s about knowing people and you only know people when you give them time to actually unpack stuff. We spent far less time talking medical stuff and more unpacking past experiences, and getting to know me over the course of nine months or six months, getting to know someone beyond a piece of paper.

Ava

Lucy depicts the communication in the relationship as one of openness, an attentive way of speaking and listening; not just of listening but actively hearing, waiting for and appreciating the response of the woman, listening with the whole body, reading body language for deeper meaning. The participants often aligned the feeling of her voice being heard with respect. One participant described it thus:

My midwife knew me. My values, consent, trauma history, declining tests, and it allowed sharing of boundaries/expectations/needs and by having her know me, I didn’t have to re-cover or re-advocate for a need or boundary no matter the interactions with other people or settings — it was something that became part of the relationship. I think this probably also created the sense of safety needed to uncover more vulnerability and rawness which for me was essential in being able to let go and trust.

Elise

The women also described harmonised relationship as appreciating the uniqueness of each woman as an individual; that the carer understood the woman as an individual from a holistic perspective, paying attention to more than the physical but also the psychosocial, spiritual, and mental wellbeing. Through this deep knowing the relationship was more responsive to the needs of the woman. Jenna described the holistic relationship thus:

I felt like my midwife looked at everything — from a holistic point of view, it wasn’t just physical it was mental emotional and even spiritual and took to understanding who I am. She debriefed my last birth, I felt that she debriefed a lot with me, mental
health was really important. Any obstacle that could come up during my labour being a VBAC, we went through all of that first, breaking things down and the emotional trauma of the previous birth.

Jenna

The deep knowing that came from time and continuity in the harmonised relationship resulted in a responsiveness from the midwife to the woman and her partner. The midwife was further able to respond to needs when the woman was known individually and uniquely.

So, it’s both the medical knowledge she gives for reassuring you but also empowering you to make the call that’s right for your baby. Yes. And that balance is a tight rope to walk but if you know a woman really well, you can do that better I mean, because she knew me, she knew exactly that was my thought straight away He’s not crying, you know. And, you know, that’s what knowing people and you only know people when you give them time.

Zoe

Solange described the socioemotional care and support as important as the information the midwife gave. She described the growth of intuition and confidence in knowing what was best for her and her family, which she assigned to the supportive, individualised relationship she had with her midwife.

Yeah, I can see that information is so important, but I guess the information more that I was trying to seek throughout which she supported me to gain, was information about my intuition and my doing what was best for me and for my baby and for my family and which is unique. And that’s actually what’s an individualised approach.

Solange

The women described a harmonised relationship as the relationship with the midwife as open and honest where there was a sense of emotional safety. Olive described her experience of disclosing mental health issues to her midwife, where she felt she hadn’t been judged, which in turn fostered a vulnerability where the woman felt she could disclose what was important to her.

She was very open and honest, non-judgemental. There was no judgment, which for me allowed a really allowed me to express what was important to me without
creating any hindrance and feeling judged. I’ve got this history of mental health issues and she really just listened, she wasn’t like oh she’s got mental health problems or that’s going to be an issue — she was like oh and just wrote it down and went you know what’s going on and my husband was there, and he was also like really oh that was really good.

Olive

It wasn’t just about being caring and supportive and respectful, there was a bit more than that. It was it was kind of this sense of holding space and being there. And she was confident in her skill set and told me I’m hearing what your preferences are and I like that she would respect them.

Georgia

The responsiveness the midwives demonstrated was described by the women as hearing and respecting, individualised and unique which together built trust, something deeply important to the women in this study. Both that the woman could trust the midwife and that the midwife could trust the physiological processes. Trust, that has been built over the course of the long relationship, has implications for safety, from the perspective of trusting physiological processes but also knowing when to act when things didn’t go to plan. Ella described trust in the relationship with the midwife thus:

Trust, the fact, the continuity builds trust, my midwife knows what I’m capable of and what my limits are, and I trust Sam completely and know she has good judgment on birth and what she thinks is normal.

Ella

Relationship described similarly by Eve:

I’ve always felt that relationship was first and foremost. Even for my partner not having that medical mindset or that medical understanding, he really feels that because of that relationship that when she said something, that she’s concerned or that it’s important that we listen to her.

Eve

An interesting anomaly that disconfirms harmonised relationship within the midwifery-woman relationship was one woman’s experience where trust was broken. Elise’s decision to move from her first Private Practice Midwife (PPM) to another PPM for her second pregnancy, after her husband felt trust had been broken when the midwife
didn’t arrive in early labour as he had requested her to. This demonstrates not only the important role of trust, but also her deep grief in losing that original relationship with the midwife, and speaks to the depth and meaning of the relationship to the woman’s journey through childbearing.

*My husband didn’t feel as connected with my first midwife, and he felt let down by some of the decisions she made, and when we became pregnant with our second child, he wanted to seek support with a different midwife. I struggled with this, but I felt it was important that I could trust the relationship between my husband and my midwife in being able to let go and surrender to birth when I was in it, and so we found another midwife who he felt he connected with, and so did I. She was also amazing, and she held so much space for me as I grappled with some of my feelings around making that decision. But it cost me the relationship I had with our original midwife, and I continue to struggle with this, and I think it is a form of grief - which speaks to the level and importance of that relationship to me. I do feel that it had quite an impact on my second pregnancy and birth experience.*

*Elise*

The outcomes of the category **harmonised relationship** are the woman and midwife working in harmony through the pregnancy and birth experiences. Philosophies around women’s bodies and normal birth processes are aligned. The woman feels heard, supported, and cared for as an individual. Trust is an important outcome of the relationship.

**Subcategory: Transparent wisdom**

Ethical care also included information that was provided in a transparent way, accessible and shared openly with the woman. When current evidence was discussed, and the midwife was knowledgeable about how to provide evidence-based care, with both benefits and risks outlined for all options, women felt empowered and respected. Transparent information provision levelled power, built the woman’s repertoire of knowledge and enabled her to make decisions and hold responsibility for those decisions. When midwives respected women’s knowledge, acknowledging the woman as expert of her body and respecting other ways of knowing as an important wisdom, it contributed to ethical care, or ‘good’ care. Tacit embodied knowledge and women’s ways of knowing were all respected in the ethical category **transparent wisdom**. The woman’s wisdom is
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acknowledged and encapsulates both the inherent and embodied wisdom women described as “trusting my body,” “knowing what was right for my baby,” and “trusting my instincts,” as important sources of information that were respected in the midwifery model of care. Kathy summarises the exchange of information thus:

The way 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? And I didn’t always choose the natural one necessarily sometimes I chose the middle one, just depending on what I wanted.

Kathy

The women identified in transparent wisdom that there was an effective use of current research.

Midwifery-led care it was more evidence based than medicine I do think it was more respectful. Yeah. And I do think it was more individualised. Yeah. And supportive. Yeah. I think that there was more informed consent because of the way they use current research.

Amy

This was summarised best by Fiona who connected being educated on research and evidence with being empowered to make decisions that were best for her:

She wasn’t making decisions for me, rather, she was really encouraging me to stand in my truth and own my own decisions and look at the evidence and the research and decide what was best for me.

Fiona

The subcategory transparent wisdom highlights the perception that true informed choice is possible when all the information is revealed. The women identified when information was evidence based, contemporary, and she was freely able to exercise agency in choosing what was right for her. Coupled with a respect and support in growing embodied knowledge (wisdom), the women were free to claim bodily autonomy, make the decisions, and take responsibility for those decisions.

Subcategory: Midwifery solidarity

Midwifery solidarity captures the idea that midwives provide care that was individualised, holistic, and woman-centred. Physiological pregnancy and birth and processes were
trusted, and midwives used a unique set of skills to enhance the physiological processes. Midwifery care acknowledged pregnancy and birth as an important rite of passage and psychosocial aspects of the pregnancy and birth journey were guarded and honoured. Midwives acted as advocates and protectors of physiological pregnancy and birth. The women in this study gravitated to midwifery-led care to give themselves the best chance of normal pregnancy and birth.

And just that support. I think I had a newfound respect for midwifery care too that she had me all along like she knew all along that I was completely capable. And she 100 percent believed in the natural birth that we didn’t necessarily need anything else or if we did need something else that it was going to be obvious.

Solange

To me the essence of midwifery-led care that I experienced is the woman-centredness and the midwives who we had supporting us believed in that — they believed in empowering us and supporting our choices and sharing information to make informed choices, so I guess the values they carry with them in their practice that enabled the normal birth to happen for us.

Elise

Amy speaks to the role the midwife plays in “walking alongside” and the “journey” of pregnancy and birth, demonstrating the idea that there is a journey of growth and that the midwife is part of that growth journey:

I guess our experience with birth came from us wanting normal birth process — it’s not necessarily like the midwives led us to that journey, they were with us — we wanted that — but that they were with us — they walked along side us.

Amy

The midwife was also willing to protect and stand with women in solidarity, upholding their choices and being a voice for the woman when she was vulnerable. This was exemplified by Lana and Kylie’s experiences:

And she would fight for you and not side with the hospital, she would be like, ‘no, we’ve discussed this. This is what this family wants and has agreed to. And she does not consent to this.’ But I also knew that if things did change and she needed to tell me something that might change her mind, I knew that she would tell me the truth and she wouldn’t sugar-coat it or minimise it or overemphasise that it
would just be the straight this is what the facts are, and these are your options now.

Lana

Yeah. And if you’d been any other people with less information and without the midwife advocate. Yeah. The story would have been derailed way before this.

Kylie

Midwifery solidarity captures the importance of support for normal physiology along with care for psycho-emotional wellbeing in providing ethical care. Many participants describe the importance of advocacy for normal physiology as they recognised the growth through this rite of passage in serving the woman to trust herself and her instincts. The participants acknowledged the alignment of midwifery-led care with advocacy and protecting woman’s wishes and wellbeing, guarded from unnecessary intervention and harm.

Subtheme: Claiming power: Embodied and strengthened

Summarising the outcomes of harmonised relationship, transparent wisdom, and midwifery solidarity the subtheme Claiming power represents the woman’s positive growth and salutogenic journey through her pregnancy and birth experience. The care experiences, described as ‘good’ and therefore ethical, resulted in a sense of empowerment and her understandings of herself were strengthened. The women in this study felt empowered when they were supported in relationship, given free access to information and normal physiology was supported. The women linked the midwifery models of care with being able to claim their own power when their capabilities were strengthened. The sense of ownership, control, and strength through the childbearing journey fostered the woman to liberate her agency and become empowered.

Taya directly linked how she was treated by the midwives with this idea of empowered transformation:

I probably used to just think of it as the midwives just there to help that birth experience, whereas now that I think what that midwife actually helped me do was more things like finding my voice and my truth and my intuition and things that have served me and will continue to serve me long beyond my experience. And that’s the power that a midwife can have.

Taya
Chapter 5. Women afire: Descriptions of ethical experiences

And just oh it’s just such a euphoric feeling it’s quite hard to describe to people who haven’t experienced just how much of a high it is. And I think because of my journey, that feeling just I did this I did it without anything, without any intervention, without any exams, without any checks, without any drugs, without it felt even more empowering.

Zoe

The women described the sense of accomplishment and confidence they gained from making their own decisions and taking responsibility for these decisions.

I found with time I felt that that was a good way to go because that was about more tuning into myself and my body and trusting my body to show me if something was needed or had to be done So that was probably actually really wise to allow me to lead that in some ways.

Olive

Claiming power captures the meaningfulness of positive experiences as building and fortifying women’s innate abilities, and in turn women identified the ripple effects from these experiences. Women linked the positive experiences with being able to successfully breastfeed and protecting their mental health issues and wellbeing.

It really enabled me to trust my body and know it could do what it was meant to do. I was so lucky obviously some days were really hard, but I never got any mental health issues like no real blues and my recovery was so good like a stopped bleeding after nearly two weeks of birth. Because I had no intervention my body was allowed to do what all the things it was meant to do. And the breastfeeding came really naturally, and she was a really good breast feeder.

Kathy

But yeah, the power of the midwife in supporting or whoever it is supporting, like in such a position of power that they can actually help that woman. It’s not just being about this medical care and her wellbeing and the baby’s well-being that actually they can be in a position to create a ripple effect for the woman in raising her family and forevermore.

Kylie
When talking about positive birth experiences, women describe empowered pregnancy and birth experience as a journey to finding inner truth, intuition, embodied knowledge, and wisdom that would be with the woman well after the birth experience.

*Before this experience I never realised how important emotional safety was just overall functioning. And holistic definition of health and not just being about a live baby, not just being physical, all the facets of health but also emotional, psychological side is so important.*

Georgia

The subtheme **claiming power** represents **harmonised relationship**, **transparent wisdom**, and **midwifery solidarity**, which together demonstrate ethical care, contributing to positive growth and a salutogenic journey through the pregnancy and birth experience.

**Summary of subthemes: Claiming power and Surrendered power**

The two subthemes, **claiming power** and **surrendered power**, captures a construction of ethical and unethical experiences as impacting sense of self. The data suggests a woman’s understanding of herself (self-identity) is affected by these formative experiences, and positive caring experiences appear to result in a sense of empowerment and realised agency, whereby self-identity is strengthened, and positive growth achieved. Negative caring experiences, such as gendered unsafety, disrespect, and coercion, results in harm to selfhood and confidence. The outcomes of the either negative or positive experiences are captured in subthemes **claiming power** and **surrendered power**, expression of self that is powerful or expression of self that is diminished. A changing sense of self occurring through the meaningful experiences of pregnancy and birth gives evidence as to the importance of ethical care.

**Chapter summary**

The results present a picture of women’s perceptions of what was ethical or not in the care they received during pregnancy and childbirth. The findings were generated from two types of thematic analysis: Template analysis and reflexive thematic analysis. The results from phase one were important in identifying the correlations between theory — care ethics and practice in midwifery models of care. From the template analysis, using the a priori codes generated by the CARG, it was identified that women perceived midwifery models
of care to demonstrate qualities of care ethics; relationship, caring practices, attention to power and socio-cultural context.

The results from phase two provides a theory of women’s experience of maternity care from an ethical perspective. The main theme radical desires represents the importance of the woman’s experiences of pregnancy and birth as central to understanding ethics. What women value is centred in this theme: that pregnancy and birth are valued by the women as holistic, individual, transformative, meaningful life experiences. The women desired normal physiology and sought midwifery-led care for woman-centred care to protect physiological processes. The women experience these desires as radical or countercultural to the dominant model of birth, which the women felt disregards the meaningfulness of this liminal life phase.

Secondly, three supporting subcategories — relationship, knowledge, and care — are described as factors that affect the quality of the pregnancy and birth experiences. The women in this study identified care as either ethical or unethical and these were labelled as authoritarian ethics or woman-centred ethics. Authoritarian ethics contained subcategories uneasy alliance, opaque information, and saving women from themselves. Woman-centred ethics described ethical practices: harmonised relationship, transparent knowledge, and midwife in solidarity.

Lastly, two subthemes were presented as outcomes of ethical and unethical pregnancy and birth experiences, claiming power and surrendered power. The woman’s experiences of ethical or unethical care are embodied and contribute to self-understandings, whereby the experiences either strengthened or reduced sense of self, highlighting the importance of paying attention to ethical care.

The findings contribute empirical data to ethical theory and underpin recommendations to improve ethical conduct within the maternity system, discussed in the following chapter.
Chapter 6. Rational woman: Women’s experiences integrated with feminist and care ethics theory

By not noticing how pervasive and central care is to human life, those who are in positions of power and privilege can continue to ignore and to degrade the activities of care and those who care. To call attention to care is to raise questions about the adequacy of care in our society. Such an inquiry will lead to profound rethinking of moral and political life.

Tronto (1993, p. 111)

Chapter overview

This study has reviewed the perspectives and experiences of the way women are treated in the maternity system and gathered women’s experiences to better understand ethics. I used feminist participatory action research focus groups and interviews, to explore how women explain their pregnancy and birth from an ethical perspective. What these findings highlight is that day-to-day maternity care is morally laden with meanings of what good care should be as decided by dominant medical models, with little regard for what may be deemed ‘good’ by the woman. The participants shared a unique perspective, as they had experienced the midwifery model of care but had also in a previous pregnancy or birth experienced a medical model of care.

In phase one, the findings from the template analysis paper, presented in the previous chapter, made correlations between theory and practice and achieved research objective two in determining that midwifery-led care demonstrates care ethics theory. A priori codes generated from the CARG were used, providing foundational analysis for phase two. In phase two, the central theme from the reflexive thematic analysis, radical desires: individual’s values and context, situates the woman and her unique context and value at the centre of ethical care. The participants determined it was ‘good’ or ethical to have access to midwifery-led care, be in relationship with the care provider who supports normal physiology and recognises the rite of passage as transformative. In their experience, these values had been set against a medicalised context that had different and competing values, which did not value the ethical components to the same degree. In this chapter, I will interrelate and interpret the key findings using both feminist ethics and care ethics theory, drawing on current literature.

First, I use feminist theory to discuss the central theme, radical desires, and again later
in the chapter to discuss the consequences of ethical practices when addressing subthemes claiming power: embodied and strengthened and surrendered power: disembodied and diminished. The feminist lens is a powerful tool to rethink ethics from a feminist relational aspect that resists the patriarchal principles that fail to incorporate the complexity of the pregnancy and birth context (Westergren et al., 2021).

I then use care ethics theory to discuss the subcategories woman-centred ethics and authoritarian ethics. Relationship, knowledge, and care, which are central to care ethics theory, are used as a frame to discuss how women perceived the care they received. Finally, I close the chapter with a paper in review with Midwifery, ‘Woman-centred ethics: A feminist participatory action research,’ in which I present a conceptual model — woman-centred ethics.

In this discussion, I seek to explore how women’s experiences inform maternity ethics and how a focus on the woman as being at the centre realigns ethical theories and practices and contributes to new ways of thinking about maternity ethics. These findings make an original contribution to the body of knowledge around ethical understandings and ethical care in the maternity setting. The integration of theory with the findings of this study provides evidence for a midwifery ethics that is not derived from principle-based ethics that conceal underlying patriarchal structures, but which situates the birthing person’s values at the centre of ethics. In this study, I have embarked upon a reimagining of maternity ethics by focusing on women’s experience of maternity care.

**Radical desires: A feminist theory**

The theme radical desires situate the woman — her values and context — at the centre of the findings. The theme interrelates the woman’s values (ethics) with lived experiences (context of pregnancy and birth ethics), how she is cared for (ethical care), and the inner change through this liminal life experience (transformation). Radical desires described the woman’s values as central to the ethical experience of the woman and in determining what is ethical or not. I determined radical desires as a theme to describe what the woman valued as ethical — relationship, guarding normal physiology, respect for informed choice, and honouring the transformative experience of pregnancy. These values were found to be at odds with the wider sociocultural context of medicalisation. The participants in this study belong to the 4% of the population who choose or can access a midwifery model of care.
Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory

(AIHW, 2022). In this sense, the views of the participants can be seen as marginalised, radical almost, despite other aspects of privilege, given the demographic of white, middle class, educated women who were participants in this study. Radical desires thus highlight the juxtaposition of these women’s values in contrast to the dominant medicalised values. The quality of the relationship, shared knowledge, and care was central to whether the woman perceived the care as ethical or not. How the care was given, through this important rite of passage, shaped and gave meaning and understandings to the woman about herself. Ethical tension occurred when the women’s values were at odds with the values of the care provider, which the women perceived as superseding their own values. A reoccurring theme throughout the women’s stories was that the mainstream childbirth systems of care expected birthing people to surrender to these systems.

The participants connected normal birth with positive transformation and felt that midwifery-led care would guard normal physiological processes and honour the liminality of the experience. The inner change and transformation recognised by this present study is described as liminality — the transition between life stages, with pregnancy and birth being transformative experiences (Davis-Floyd, 1994; Rich, 1986). The data from this study suggests that midwives honour pregnancy and birth experiences as psychologically and emotionally transformative and thus care for women in a way that recognises these experiences as a important rites of passage for women. Childbirth as a rite of passage has been explored by other authors, who explained that it is a profound, significant, and meaningful experience (Davis-Floyd, 2022; Reed, et al., 2016; Reed, 2021). Reed (2021) explored childbirth as a rite of passage as a framework for care, where the words and actions carried out during birth reflect and reinforce the transformative experiences. Thus, it appears that midwifery-led care was chosen by the women in this present study because they shared the same values in honouring the liminality of the birth experience.

Fahy et al. (2008) describe the spiritual, sexual, and emotional transformations of pregnancy and birth. Fahy and Parratt (2006) have explored the transformative power of pregnancy and birth in the development of their ‘birth territory’ theory. They described the idea of positive or negative changes as ‘integrative power’ or ‘disintegrative power.’ ‘Integrative power’ supports integration of the woman’s mind so that she feels able to respond to her bodily sensations (instinctive birthing) and ‘disintegrative power’ undermines the woman’s confidence to be able to respond spontaneously to the same.
They challenged the traditional view of matrescence, a term coined in the 1970s Dana Raphael, that described the phenomenon of emotional and psychological transformative during pregnancy and birth, with matrescence theory (motherhood) presented as the result of transformation. According to Parratt and Fahy (2011), matrescence is a limited view of pregnancy and birth transformation, influenced by patriarchal discourse, which reduces women’s experiences to simply becoming a mother and positions the baby at the centre of the experience, minimising the inner transformative journey, which in turn may contribute to the mistreatment of women (Parratt & Fahy, 2011).

Recently, Kurz et al. (2021) developed the theory of parturescence to address women’s transformation through pregnancy and birth. Kurz et al., describes the transformation as moment-to-moment embodied change of spiritual and sexual potential that results in inner power and inner knowing. They described an interaction between the physicality of birth with the rematerialisation of the woman’s transformation and ‘becoming.’ My findings add to this theory, with the women describing their ethical and unethical care experiences as impacting on their sense of self. They described how the midwifery continuity of care, based on relationship, paid attention to psycho-emotional aspects through the pregnancy and birth journey and recognised the liminality and transformation of the birth as a rite of passage through which women can empower themselves. In contrast, the women also described unethical care, which they perceived as the rituals of medicalised procedures and intervention and elevation of baby over mother. The participants explained that this minimised liminality and transformation and disempowering them.

Midwifery models of care were valued by the participants because midwives were perceived as understanding the transformative rite of passage, supporting normal physiology, and considered a woman’s context and individuality. Contemporary feminist and midwifery literature has also explained the role of the midwife in protecting physiology and honouring the experience and linked these with a woman’s feelings of growth and feeling strengthened and empowered (Carlsson et al., 2015; Dahlberg et al., 2006; Davison et al., 2015). These findings were supported in the current study, which confirmed women valued the recognition of pregnancy and birth as important life experiences and described the liminality of birth as not being honoured in the medicalisation of birth. The women in this study had chosen midwifery-led care to avoid the medicalisation of birth, which in their
previous birth or interactions had left them feeling their values had not been respected, leading to a feeling of disempowerment which they described as unethical care.

Considering a woman’s context helps the health professional take into consideration the woman’s individual values, culture, family, and self. An early care ethics philosopher, Held (2006), described the individual’s context as influential on what is valued by them and alters the lens of how a situation is seen. Held describes this as particularity — the attention to “particular other in actual context” (p.62). Confirmed by other care ethicists, ethical practice requires knowledge of the whole person, as the moral self is influenced by a person’s history, context, family, and background is attached with deep moral meaning (Tronto, 1993). Care ethics proposes ethical care as occurring within social interaction and relationship and influenced by social contexts (Held, 2006; Tronto, 1993). Particularity contrasts with the impartial maternity systems where standardised care fails to consider context and what the individual woman may value. Responding to the subtleties of women’s lived experience, to honour their context and values is to practice care as a fully moral agent. The import of values and context from care ethics are supported in midwifery research. The qualitative meta synthesis by Downe et al.’s (2018) of 35 articles (from 19 countries) identified particularities of what women value, and these consisted of the psychological, cultural, and emotional experience of pregnancy as well as the health of themselves and their baby. The authors also suggest that most women would prefer a physiological birth, though intervention was accepted if needed, if they retained control over the decision making. Downe et al. (2018) recommended that maternity care should be designed to fulfil or exceed women’s personal beliefs and expectations. Healy et al. (2017) more recently described in their qualitative research the differences between midwives’ and obstetricians’ perception of risk in the maternity context. They proposed that the lens of medicalisation viewed medicalisation as superior to normal birth philosophy in preventing risk and as endemic to maternity systems but also to wider society. The women in this current study valued normal physiological birth, trusting their bodies and themselves and they perceived the care as more ethical when this was supported.

Medicalised childbirth, described by Davis-Floyd (2022) as the ‘technocratic model’ is based on an alignment by medicine with science and technology, which in turn influenced dominant discourses such as patriarchal social structures. The technocratic birth model is
seen as holding technocratic values in higher esteem than social values and is described as being fearful of normal physiological processes. Davis-Floyd metaphorically conceptualised the body as a machine to describe the medical view of pregnancy and birth. The mechanicalised view of the body can be attributed first to Rene Descartes (1596 -1650), an early post-Enlightenment philosopher, who challenged religious thinking about the body toward a more practical, mechanical imagery of the body. He is attributed to conceptualising the mechanisation of the body as made up of discrete and separate parts (Descartes, 1964). However, the mechanicalised paradigm was based on the male body, rather than science or technology, and the woman’s body during this era was obfuscated, insignificant or impure which would have far reaching effects for women (Martin, 1989).

Martin’s (1989) anthropology of western medicine describes the cultural authority of science, where the woman’s body as likened to machinery, governed by hierarchal control. Martin (1989) likened birth in hospital to the production of goods, fixed with artificial interventions and measured with external systems, managed by obstetricians, with the baby as the end product. The dichotomies of body and mind, physical and emotional, individual and relational required the unruly woman to be controlled (Martin, 1989; Rothman, 1989; Newnham et al, 2018). The resulting mind/body separation attributed to medicalisation reduces the woman’s body to dysfunctional machines and normal physiology as abnormal (Newnham, et al, 2018). Thus, the care given to the woman is also separated, as object and alien from the practitioner; where the institution becomes more important than the woman, the care standardised and intervention the norm. When women choose to birth outside the system, the medical and public discourse determines they are selfish in favouring their experience over the safety of the baby (Martin, 1989). Davis-Floyd (2022) argues childbirth medicalisation creates a dissonance between what practitioners want and what women want as one reason for rising birth trauma. My interpretation of the findings, radical desires, describes the value women place on the liminality and transformation of pregnancy and birth, but they do so against a medicalised context, where the body is viewed in the physical, and as mechanised. An ethical dichotomy exists with the women’s radical desire for normal physiology and with it the psycho-emotional transformation set against the sociocultural dominance of medicalisation.
Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory

**Radical desires: individual’s values and context**, as an overarching theme, captures the pregnancy and birth experience is important to women because of the reordering of self that occurs and that women see care that honours the change as ethical care. Positioning the individual at the centre of their experience and understanding the context of pregnancy and birth as powerful life experiences aligns the practitioner with what women value as important when contemplating ethical care. Thus, how the woman is treated is embodied, and contributes negatively or positively, to her internal change. The specific inner change as empowered or surrendered power is discussed in a later section.

In the following section I describe the care given and interpret this using care ethics theory. Very little has been described in terms of how good and bad care and experiences (ethics) are embodied and contribute to women’s sense of self. This thesis contributes examples of ethical and unethical care and the effects this had on the women, described as claiming power or surrendered power.

**Relationship, knowledge, and care: Care ethics theory**

In this study care ethics theory in this study has been defined, described, and related to midwifery philosophy. I identified from the scoping review four categories as important aspects of care ethics theory: relationship, context, power, and caring practices. In the previous section, I discussed care ethics ‘context,’ and in this section use relationship, knowledge, and care as a framework to discuss the care experiences the participants described in **woman-centred ethics** or **authoritarian ethics** to interpret the care provided. The care ethics framework considers relationship, knowledge, and care in building an alternate ethical picture to the principle-based bioethics. Care ethics links ontology and epistemology together with caring practices. Care ethics theory considers people to be ontologically relational, knowledge generated through relational practices (epistemology), and good care emerges from care ethics practices (ethics) (van Reenen & van Nistelrooij, 2019).

The participants in this study described ethical dichotomies through their pregnancy and birth journey: ethical versus unethical care, medicalised versus physiological, embodied versus disembodied, agent versus hegemony, relational versus standardised, knowledge versus uninformed. These categories present the ethical and non-ethical care that women experienced that either empowered, strengthened, and supported women or disembodied, mechanicalised, decompartmentalised, and diminished women. This section
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highlights pregnancy and birth as sensitive to the effect of good and bad care in the reordering of a woman’s sense of self and identity during pregnancy and birth. The positive or negative experiences were identified as contributing either growth or diminishment in the woman’s sense of self.

An ethic of relationship

The concept of relationship in this study was between the health professional and the woman and was identified as important to participants in the provision of what they described as ethical care. The women assigned a significance to the doctor/woman or midwife/woman relationship. The quality of the relationship was described by the women in this study as the vehicle through which understandings of the woman’s values were known (or not) and which gave insight into ethical care.

The importance of relationships in understanding ethical care was first highlighted by Gilligan (1982) in her seminal work, *In a different voice*, which identified that women have a different moral perspective to the status quo held at the time. Gilligan’s philosophies were in response to research around moral developmental stages which presented the argument that moral maturity was when one could remain impartial, ideal, and universal in a moral dilemma. Women were deemed as ethically immature and unable to attain mature justice reasoning because they were helpful pleasers and committed to family relationships, and thus couldn’t remain ethically impartial. Gilligan’s work was among the first to highlight the importance of relationships and the web of relationships in ethical theory. She describes that through relationship, the sense of self is affected. In this current study, it was identified that the quality of the relationships was linked with the reordering of the sense of self.

In this current study, the participants had all experienced midwifery-led care and described relationships as ethical because they were individualised, woman-centred, and holistic. I coined the term harmonised relationship to describe relationships that developed through time and with continuity. Time and continuity were important aspects of harmonised relationships and created understanding of the woman’s context, culture, values, beliefs, and expectations. Through the woman-centred holistic approach the women described the care as more responsive, not just in considering physical safety but also emotional and psychosocial care. The findings of this study showed the individualised
relationship was valued by women and increased ethical sensitivity. The largest randomised control trial of models of care in Australia, of 2314 women, 1,156 to caseload care and 1,158 to standard care, determined that women who were in the caseload midwifery-led model of care had increased satisfaction across all aspects of care (Forster et al., 2016). The study highlighted that through the continuity and time in caseload midwifery the women felt more supported because both physical and emotional safety was acknowledged as they were more informed and more active in decision making (Forster et al., 2016). Similarly, a recent Swedish study was conducted where midwives were the primary care giver during pregnancy and birth and confirmed that women who had had a known midwife were more likely to have had a positive birth experience (Hildingsson et al., 2021). The findings supporting the central position of relationship, and continuity, as a requirement for a positive empowered experience.

Trust was an important outcome of harmonised relationship findings in this current study. The women described trust as resulting from the time spent with, and continuity in, the relationship with the midwife. The participants required trust in the midwife to feel confident in the care given and, in the information provided, to foster choice and autonomy. Trust was required for the woman to feel both physically and emotionally safe during the liminality of the pregnancy and birth experiences. Trust was crucial in this study as an outcome of ethical relationships. Other studies have linked the midwifery model of care based on a woman-centred, time-rich antenatal care with trust. Studies which describe midwifery-led care detail the woman-centred focus, knowing the individual, and fostering relationship as the foundations required for trust (Bradfield et al., 2019; O'Brien et al., 2021). This current study corroborates the importance of relationship as the central tenet that facilities trust; whereby the woman trusts the midwife with her psycho-emotional well-being and the midwife trusts physiological processes (Kirkham, 2010). McCourt (2009) describe relationship as the key to building trust which enabled midwives to practice ‘watchful waiting’ and physiological timings of pregnancy and childbirth.

In contrast, the women in the current study described another type of relationship, termed here as uneasy Alliance. This type of relationship was between the doctor/woman or midwife/woman in the fragmented, medicalised maternity system. The women described a superficial relationship, likened to a working agreement, as consumers of a service in the medical model of care. The women in this study described these relationships
as standardised, void of acknowledgement of individuality or emotions, with little time for knowing. I used the label uneasy alliance because the women described being bound to the doctor/midwife in a working alliance, but it felt uneasy in the knowledge that they were not fully known, and therefore trust had not been attained. One study has identified that obstetricians have problems establishing empathic relationships with women when they treat them for the first-time during childbirth (González-Mesa et al., 2021). The authors of the study described how doctors retained authority and had minimal communication with the women, which resulted in a lack of reciprocal trust between the woman and the doctor. The obstetrician then found it easier to opt for interventions they deemed to be safer, albeit possibly unnecessary, due to the lack of familiarisation with the woman. Lack of time may be one reason for the lack of relationship in medicalised care. The other reason for a contractual style of relationship and emphasis on task-orientated care may be due to the deontological underpinnings of biomedical ethics or obligation theory (Beauchamp & Childress, 2019; van der Waal et al., 2021). A study that utilised the Lancet Quality of Maternal and Newborn Care Framework (QMNC) conducted by Symon et al. (2019) confirmed that time is a limited resource in the hospital system, adversely affecting the quality of maternity care outcomes. Symons and colleagues described how the busyness of antenatal clinics which reduces effective communication and thus the opportunity to develop trust.

In this current study, the time required to build relationship and thereby trust was not available in the medical model of care. Standardised care limits time for relationship, and the women described that this contributed to the perceived lack of concern, and the relationship was viewed as less caring. McCourt’s (2010) critical analysis on the concept of time and childbirth describes how biomedical care imposes time frames on childbirth. The biomedical approach dictates lineal models of time, which mark and measure pregnancy and childbirth, resulting in retained authoritative power. The case studies presented demonstrate how women and midwives are affected by power and control but offer more cyclical understanding of time, such as the midwifery skill of ‘watchful waiting’. Similarly, Gleeson et al. (2014) describe time in midwifery as a gift. They interviewed six women about their breastfeeding support and defined midwifery presence as creating space for all aspects of care. They concluded that standardised models limit time and called for systems restructure toward models of care that fostered longitudinal midwifery time, midwifery
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presence, and relational-based care.

Other than time, the difference between the woman’s values and the medical model values may also have been a factor for lack of relationship perceived by the women in this current study. By choosing midwifery care, the women valued physiological pregnancy and birth over the medicalised view of pregnancy and birth held by the medical model, which may also explain the task-orientated, rather than relational-orientated, approach to care. The Lancet series (2016) on the state of the maternity system described the move from physiology to hospital-based childbirth as resulting in an excessive use of interventions in overmedicalised contexts (Miller et al., 2016). The findings highlight that some interventions had equivocal benefit and other interventions cause outright harm. Benyamini et al.’s (2017) longitudinal study of medicalisation of birth described women’s attitudes to medicalisation was a contributing factor to the overuse of obstetric technology. Benyamini and colleagues identify that women were active contributors as to whether they received technological intervention or not, and challenged the view that women were passive victims in intervention use. The authors described that it was women from lower socioeconomic groups who may have had less access to education who chose intervention. These findings also highlight the sociocultural acceptance by most women that intervention and medicalisation is necessary. This is evidence of the overarching social beliefs of the moral good of technology. In contrast, the women who participated in the current study who desired normal physiology and thus identified feeling countercultural but also that they had to be ‘armed’ with research and information to counter the medicalisation of birth.

Within this current study, it has been demonstrated that the women were sensitive to the standardised care that lacked relationship or understanding. It has been demonstrated that women’s ethical perspectives prioritised relationships. Relationships in this study were central to trust, good care, and was the difference between alienation or agency.

An ethic of knowledge

In this study, knowledge was found to be an important concept, and women described it as being used ethically or unethically. I coined the epistemic differences as transparent wisdom and opaque information. Transparent wisdom summarises the freely given information provision, based on research and tailored to the woman, and also considers
other ways of knowing. Opaque information is when information is restricted and standardised, and policy does not reflect current research. In this section, I will first discuss transparent wisdom and analyse the concept using care ethics theory which presents knowledge as generated relationally and through understanding context. Care ethics seeks epistemic justice by valuing other ways of knowing, such as intuition and emotions, which give a wider moral understanding (Buchanan et al., 2022). Following this, opaque information is analysed using a feminist lens. Feminist theory highlights the gendered politics and power imbalances related to knowledge (Johnston & MacDougall, 2021; Walsh, 2010). Epistemic justice describes the injustice of knowledge misuse to maintain forms of control, which includes gender as a part of the assemblage of power misuse (Byskov, 2021).

The women in this study were informed agents and engaged with knowledge; they had all attended childbirth classes and were highly knowledgeable about pregnancy, birth, and their own bodies. The women detailed the benefits of midwifery care and the reasons for guarding normal physiologic processes that benefit mother and baby. Knowledge about pregnancy and birth was the means to confidence in trusting midwifery care and normal physiological processes. The women described midwifery-led care as unique among health professionals in the transparent use of knowledge and information. Participants shared that transparent information provision in this model of care was important for informed choice, decision making, and exercising agency. They also expressed that the midwives honoured women’s ways of knowing and embodied knowledge which held up the woman as expert and agent of her own body. Together, this transparent wisdom was perceived to be more ethical because it freed women to make decisions about their bodies, as to what was right for them, their responsibilities, and their contexts. This, in turn, strengthened their capabilities and sense of self.

Transparent information provision was important for women in making informed choice. The women in this study all utilised multiple sources of knowledge to make informed choices and they took responsibility for those choices. They felt empowered to make the decisions that were best for them with all the information transparently available to them. They felt supported by the midwives in making decisions, as they provided current evidence-based information and the risks, benefits, and alternatives of each option, and supported the women in their decisions as to what was best for them individually and thereby honouring context. These findings are supported by other studies, for example,
one phenomenological study conducted with seventeen participants who were interviewed about their choice to birth at a standalone birth centre describe that the woman made the decision in the context of relationship with the midwife. In the study the midwives placed the woman as central to the decision-making process, and decisions were made though relationship and time which aided the woman to exercise personal agency (Wood et al., 2016). Similarly, Chadwick and Foster (2014) described women’s ways of knowing as an alternate knowledge source that is sometimes referred to as embodied knowledge, which were honoured in the midwifery-led model of care over risk-based expert knowledge exercised in the medical model of care. Embodied knowledge has been shown in the medialisation of birth to be undervalued and reduced and viewed as lacking authority (Davis-Floyd & Davis, 1996; Hunter, 2008).

The women in this current study who had chosen the midwifery-led model of care felt both equipped and free to decide what was ethical for them and readily accepted responsibility for those decisions. What this study demonstrates is that the women felt that decisions about their bodies were theirs to make and they were willing to take responsibility for them, provided they were empowered with the information, time, and support required to make the decisions. **Transparent wisdom** encapsulates these elements of the midwifery model of care. An important aspect of information sharing described by the women in this study was the time taken by midwives to have conversations about the decisions, revisiting them as required by the women. Midwives levelled power by really partnering with women in sharing information, honouring intuition, and respecting women’s processes and decisions, which in turn equipped the women to take responsibility for the decision. Held (1993) described the link between choice and responsibility and knowledge and empowerment thus: “the experience of consciously choosing, of voluntarily accepting or rejecting of willingly approving or disapproving of living with these choices, of acting and of living with these actions and their outcomes” (Held, 1993 p. 68). O’Brien and colleagues (2018) also linked information provision with informed choice in their action research. Fifteen postnatal women were interviewed and made decisions based on the quality of their relationships with maternity care professionals along with their sense of responsibility towards their baby and their sense of self. O’Brien and colleagues described relationship as important to women’s perceptions and experiences of informed choice. Their findings demonstrate that informed choice meant more than just the provision of
information, rather it required an in-depth discussion with a professional who was known to them. Similarly, a study conducted in Sweden gathered data from women’s birth plans and found that women wanted a natural birth and to be supported by midwifery-led care, but also autonomous in their decision making over their own bodies (Westergren et al., 2019). These studies linked informed choice with responsibility and empowerment, which reflects care ethics theory.

The women in this current study also made connections between knowledge and power. I coined the term opaque information to describe the many ways that knowledge was misused in medicalised context. The participants described that when the health professional retained authority over knowledge or misused research, the health professional retained the power of decision making, which the women describe as disempowering and diminishing of their sense of self. All the women had experienced power imbalance when the dominant forms of knowledge held by the medical model was used to usurp their own understandings, research, or embodied knowledge. Self-doubt was created when women had to defend and provide evidence for their pregnancy and birth choices or when their embodied knowledge wasn’t believed. The women felt they were both misunderstood and unsupported in making non-medicalised decisions or choices that did not align with the dominant medical model. In this study, I coded examples of this as ‘patriarchal deafness,’ where woman’s wishes were unheard and questions were not encouraged, where hearing had been replaced with directives, policies, and standardised information. Midwifery research has detailed that when information is provided to women in terms of statistics, risk, and medicalisation, it priorities or favours medical authority of knowledge over the woman’s knowledge and the language used often skewed to reproduce dominant social norms (Newnham et al, 2018; Dahlen et al., 2013).

When knowledge is retained by the care provider, a power imbalance occurs whereby the dominant medical model retains control of a woman’s body and thus the responsibility for the decisions (Cole et al., 2021; Deherder et al., 2022; Farnworth et al., 2021). A large international mixed methods study into diagnosed breech presentation and birth decision making confirmed that access of women to information was restricted and the information presented was limited and biased (Petrovska et al., 2017). They described encountering coercion and fear and searching for information and support as key themes to understand how knowledge is restricted from women attempting to make informed decisions about
breech birth. The authors argued that evidence-based practice determines that vaginal
breech is safe and that clinical guidelines should support this and access to this option
should be available to women. A recent discussion paper on obstetric violence discussed
the patriarchal use of knowledge as a silencing weapon, where technology is believed over
the body, and the woman experiences consequential self-distrust and self-doubt (Shabot,
2021). The author argued that women are not autonomous agents, but rather
interconnected and vulnerable, thus the role of health professionals in care is critical to
informed choice (Shabot, 2021). Recently, the Supreme Court in the United Kingdom in
Montgomery v Lanarkshire Health Board detailed the importance of health professionals
in providing information to women to make informed choices (Independent Maternity
Review, 2022). The outcomes of this case emphasised the need for health providers to
provide transparent information for all options for care — risks, benefits and alternatives
— as a means of not only respectful maternity care (beneficence) but to save lives (non-
maleficence). Knowledge was essential for the women in this current study to make
decisions over their bodies which they valued as ethically essential for both safety and to
exercise agency.

**An ethic of care**

**Midwifery solidarity** captures the idea that when midwives are attentive to the woman
and are able to support physiological pregnancy and birth, women feel like they have
received good care. To do this, midwives exercised competence with a unique set of skills
to enhance the physiological processes, which were trusted by the women in this study.
Midwives also demonstrated responsiveness to the psychosocial and emotional needs of
women. All the participants in this study described an alignment of midwifery-led care with
advocacy and protecting woman’s wishes in solidarity. These descriptions align with care
ethics theory. According to an early founder of care ethics, Joan Tronto, in her seminal work
*Moral boundaries* (1993), care has “four elements as a guide for more caring practices:
Caring about — attentiveness; caring for — responsibility; care giving — competence; and
care receiving — responsiveness (with a fifth added in 2013 — solidarity). Relationship
underpins these five elements and the good (ethical) emerges from the caring practices
(Held, 1993). The women in this current study had all chosen midwifery models of care as
representing good care practices.
Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory

Woman-centred care is a key philosophical underpinning of midwifery care (ICM, 2015). A recent review of the midwifery standards from 139 nations described seven phrases related to woman-centeredness as core components of woman-centred midwifery care. These were: a woman’s right to choice (89%), being culturally sensitive (80.5%), a woman’s voice and right to be heard (78%), the woman as an individual (68%), universal human rights (40%), being holistic (39%), and being self-determined (17.5%) (Crepinsek et al., 2022. P. 1). These elements are supported by what women say in other studies evaluating midwifery continuity of care models. Midwifery continuity of care has been described as strengths-based care with resulting women’s empowerment, achieved through individualised care that is sensitive to culture, based on relationship and communication which fosters woman’s decision making (Bohren et al., 2020; Perriman et al., 2018; Prosser et al., 2018; Mathias et al., 2021; Webb et al., 2021).

In contrast, in this study unethical care was termed saving women from themselves, which I used to describe care that was standardised, monitored, investigated, pathologised, and policed. When the pregnancy and birth were more medicalised, the women in this study became more dissatisfied with the care, especially if the interventions were viewed as unnecessary. The women described care as being governed by the practitioner’s desire to ‘save,’ which created a pressure for intervention that conformed to these wishes but may not have been fully informed. The resulting intervention was often then described as harmful, violating, or coerced, and in turn the woman felt diminished through the action and behaviours of the care provider. Descriptive research by Cook and Loomis (2012) on the impact of choice and control of women’s childbirth experiences described perceived control over the experience as having more impact of whether the experiences was perceived as negative or positive, rather than the interventions themselves. The evidence from this analysis demonstrates that carers who did not hold a normal physiology philosophy often retained power and used coercive control and the woman surrendered the rights to exercise bodily autonomy. The implications of health professionals retaining control over the pregnancy and birth experience is that the decisions were removed from the women, even when they were capable of making a decision, in the name of saving the mother or baby.

The women described that in the medical model they felt pushed to have interventions and then had to arm themselves with strategies to avoid intervention. Other studies have
linked the medicalisation of pregnancy and birth as driving factors on intervention. One study demonstrated carers’ attitudes toward women’s bodies, physiology, and risk results in often unwanted interventions (Chadwick & Foster, 2014). The Lancet Maternal Health Series described that most women would prefer not to have interventions unless they are necessary for the safety of their baby and/or themselves (Miller et al., 2016). A discourse analysis by Cole et al. (2019) analysed 106 publicly available birth stories and described women’s experiences of compliance to unwanted medical intervention to protect the baby or themselves or conform to hospital policy. The authors detailed that medical interventions were routinely offered, but women’s preference was to avoid the intervention, but that they felt unable to do so, leading to disempowerment.

In the current study, where care and interventions were perceived as unnecessary, women perceived them as unethical, harmful, and coercive. Some described vaginal examinations as far rougher than necessary, and the women linked this with surrendering power and coerced conformity. Obstetric violence, trauma, and abuse have previously been described in the literature as causing physical and psychological harm in the short and long term (Adinew et al., 2021; Betron et al., 2018; Bohren et al., 2015; Strong & White, 2021). This study has contributed to highlighting the consequences of such unethical care, the diminishment of a woman’s courage, confidence, and self-esteem. This suggests that a non-collaborative childbirth may facilitate the development of negative birth experiences and diminished sense of self.

The categories relationship, knowledge, and care highlighted a dichotomy of experiences that were perceived by the participants as either ethical or unethical care. The care was distinct between different models of care and exacerbated when the values of the women were at odds with the medical model. Where the woman wanted support and respect for decisions around normal physiology, they were often met with being challenged, condescended, or even treated badly to force conformity to standardised care. This next section demonstrates how ethical and non-ethical care directly contributes to either a strengthened sense of self — **claiming power** — or a reduced sense of self — **surrendered power**.
Consequences of unethical/ethical care: Claiming power or surrendered power

The previous section described the ethical and non-ethical care women experienced during their pregnancy and birth journey. How the woman described her experiences as either woman-centred ethics or authoritarian ethics determined how the woman emerged from the pregnancy and birth, either empowered or disempowered. This next section demonstrates how women’s embodied experiences of ethical and non-ethical care affected understandings of self. A reduced sense of self as a result of care experienced was named surrendered power. A strengthened sense of self was named claiming power.

Pregnancy and childbirth experiences have long been linked with the changing sense of self (Parratt, 2003; Parratt, 2010). Transformation through the liminality of pregnancy and birth, described in the theme radical desires, determined that women desired normal physiology as significant to transformation, in contrast to these being unnoticed in the medicalisation of birth. This section develops this idea further to show the relationship between experiencing ethical or unethical care and the reordering sense of self. Parratt’s (2003) literature review about sense of self detailed how having control, communication, and relationship which influences how the woman feels about herself.

In this section, feminist theory is used to frame thinking around power and control as affecting a woman’s sense of self.

Surrendered power

This study provided further evidence of psychosocial and emotional harm as negative consequences of unethical pregnancy and birth experiences. The subtheme surrendered power encapsulates women’s response to mistreatment as surrendered conformity, leading to a diminished or negative sense of self. The negatively perceived experiences resulted in negative psychological outcomes which women described as forms of disempowerment. This study explores beyond the more obvious obstetric violence definitions to provide evidence of more subtle forms of oppression that shrinks selfhood and demonstrated gendered silencing.

Being coerced into submission through violent vaginal examinations, language use, and shaming are examples of obstetric violence that left women in this current study feeling disempowered. Obstetric violence is defined by Sandler et al. (2016) as hostile
sexism, which refers to misogynistic antipathy toward women during pregnancy and childbirth. For example, women describe their wishes being ignored, misogynistic language use, and disregard for embodied knowledge. One woman shared her experience of a vaginal examination in the medical model as far rougher than needed, and another woman described requesting an epidural, not for the labour contractions but for the rough vaginal examinations that left her feeling scared and helpless. What was interesting about the women in this study was the way they described themselves post-unethical interaction: ‘I felt less confident’, ‘not trusting intrusion or trusting myself’, ‘I had no power.’ This study highlights the diminishment of self, following unethical ordeals during this liminal life phase. When experiences are described by the woman as unethical; the woman surrenders to the power exercised by the medical model of care and becomes in turn, disembodied and diminished.

The effects of unethical care and thus disempowerment have been shown to have direct correlations with identity. Crowley (2013) in her dissertation ‘The negative psychological effects of medicalized birth,’ reported that women felt disconnected from their bodies during medicalised childbirth and that there was a “constant undermining of their sense of self and their sense of wholeness” (p. 83). These findings are in line with previous research, that pregnancy and birth can have negative emotional transformation following trauma, abuse, and harm (Liese et al., 2021; Reed et al., 2017; Taghizadeh et al., 2021; Villarmea & Kelly, 2020). This was highlighted in a study by O’Brien (2018), in which women were interviewed about informed choice in a three-phase action research study following the events of their childbirth experiences. The authors describe that a freedom to exercise informed choice impacted sense of self. Women reported consequential diminished sense of self when choice was surrendered. These findings related to my study findings in supporting the idea that a reordering of the sense of self occurs through how the woman was treated during childbirth and how she felt about herself.

Drawing from literature about traumatising behavioural responses experiences (Katz, 2021), I make the correlation that the women in this study described a surrendering to feel safe: fighting the system (fight), refusing care (flee), feeling trapped, unable to escape (freeze), to keep the care provider onside (fawning). These contemporary terms are utilised to describe strategies women use to keep safe when confronted with power imbalance and abuse (Frothingham, 2021). I theorise an underlying concept of gendered safety as a root
cause of surrendered power. Early research identified that the dominance of patriarchal structures are detrimental for women during pregnancy and childbirth (Donnison, 1978; Rich, 1986; Walsh, 2010). More recently, Shabot (2021) described obstetric violence from a feminist perspective as being misrecognised and underacknowledged, emphasising that it was not just medical violence but gendered violence. Gendered violence is defined as violence directed toward women because they are women, where women are treated in a physically and emotionally infantilised manner, which explains a diminishment in self. Contemporary feminist literature accepts the notion that women are generally unsafe and although they have the right to occupy space (bodily autonomy), the ethical agonism is that they must keep themselves safe (Fanghanel & Lim, 2017). This is particularly pertinent to women during childbirth because they are physically vulnerable. Midwifery literature has identified obstetric violence and abuse during childbirth as a gendered phenomenon (Pickles & Herring, 2019). Other works have described gendered safety as women having to behave like a ‘good girl,’ or conforming to treatment as a form of discipline and avoid antagonism and keep themselves and their baby safe (Chadwick & Foster, 2014; Hawke, 2021). Betron et al. (2018) explains mistreatment and abuse in childbirth as gender related. They explain care providers behaviour as having “thwarted women’s capacity to act with agency over their pregnancies” (p.143), for example, by deciding what position women will give birth in, and that women were too scared to speak out against mistreatment. The building evidence of obstetric violence and evidence of mistreatment points to women’s experiences as being internalised, and the women in this present study described surrendering to the unethical experience to keep safe, resulting in them feeling powerless with long term effects of reduced confidence and losing trust in herself and her body.

**Benevolent sexism and paternalistic protection**

Gender inequality remains a form of oppression and power imbalance and contributes to mistreatment and disrespect toward birthing people. I used the terms patriarchal deafness, uneasy alliance, opaque information, and saving women from themselves to explain the unethical care that has a gendered undercurrent. Women from this action research articulated the core issues of unethical care as rooted in patriarchy and misogyny and called for feminist resistance in the birth room as it remains a gendered and political issue. The nine women in the community action research group described the problems in the maternity system as a gendered issue and identified that the patriarchal systems were
limiting women’s agency. Through the action arm of the study, they are finding ways to subvert the patriarchal institutions and call for more midwifery-led models of care, which they understood as better ethical care of women’s emotional and psychological safety during pregnancy and birth. Not enough has yet been accomplished to disrupt the patriarchal systems still prevalent in the maternity system. Power relations still need to be uncovered and ideologies and systems that create gendered oppressions need to be removed. Applying feminist theory to the ethical concerns highlighted by the women may help explain the findings.

In this study, women described not being allowed to ask questions, having choice removed, and decisions limited or controlled which together contributed to them feeling disempowered. The women conformed to stay safe and submit to the authority of the maternity system: ‘I was too scared to ask,’ ‘I thought he’d think I was stupid,’ ‘I was afraid and wanted my baby to be safe.’ Psychological research posits sexism may be hostile (overt) or benevolent (patronising), both which serve to maintain gender inequality and lead to decreased self-esteem (Oswald et al., 2018). Dardenne et al. (2007) define benevolent sexism as patronising paternalistic behaviour that positions women as being not fully competent and who therefore need a dominant figure, usually male. Benevolent sexism may appear innocuous, even friendly, but dependency-oriented undermines the woman’s sense of self and feelings of competence. Dardenne and colleagues’ study demonstrated that benevolent sexism reduced women’s cognitive ability on psychometric tests and the results showed this created self-doubt, interfering negative thoughts, and affected women’s self-esteem. Oswald et al.’s (2018) study of nearly 500 young women’s experiences of benevolent sexism found that it negatively impacted their self-concept, well-being, and self-esteem. They discuss the ‘good girl’ theory, where benevolent sexism supports women to conform to gender-stereotyped behaviours and traditional expectations and are therefore more likely to submit to authority and justify the current gender status quo. Other authors appeal that benevolent sexism is not to be viewed as benign (Sutton et al., 2010).

Midwifery researchers have described benevolent sexism, where women are doubted in their ability to be rational and make good decisions, and thus their behaviours and decisions are restricted, to be in line with the dominant risk-based medical model (O’Brien et al., 2018; Rothman, 1994; Woollard, 2021). Sutton et al.’s (2010) study linked non-
evidence-based medical advice for pregnancy and birth as examples of sexist judgments. Their findings describe sexist ideology, where advice was given that was not evidence-based and this restricts women’s freedoms of choice. The authors note that female obstetricians and midwives also act paternalistically, often in standardised systems, in subjecting other women to sexism. I parallel the results from my research with these studies, in that unethical behaviour may be rooted in gendered sexism which certainly has negative effects on women’s sense of self, confidence, capabilities, and resulting feelings of disempowerment.

Claiming power

The women in this study recounted positive transformation through their pregnancy and birth experiences, where they felt strong and powerful with a positive changing sense of self. The term ‘empowered’ was used to demonstrate these inner changes, with women in this study describing: ‘finding my voice,’ ‘increased my critical thinking,’ ‘had more confidence,’ ‘unlocked of an inner power,’ ‘trusting of intuition and trusting myself.’ The implications of feeling empowered meant that the woman was fully able to exercise her agency in the relationship and was transformed through positive, edifying experiences within the relationship. The positive changes described in this study are examples of strengthened capabilities, with protection of mental health and feeling of well-being. An empowered woman is one who emerges from birth emotionally stronger, her capabilities strengthened. Authors describe empowerment as positive self-concept, self-awareness, personal satisfaction, self-efficacy, a sense of mastery, and sense of control; they feel ecstasy, believing in or falling in love with themselves for the very first time, which together demonstrates an inner transformation (Hawke, 2021; Hermansson & Mårtensson, 2011). This was fostered via midwifery models of care where women have authority over the birth, their body, and the surrounding environment and linked with the way a woman is cared for, with an emphasis on trustful relationships and informed choice (Hawke, 2021; Hermansson & Mårtensson, 2011). The recent study conducted by Symon et al. (2019) linked relationships with a strengthening of a woman’s capabilities. This had previously been confirmed in an early systematic review, where the primary finding identified that “the midwife-women relationship is the vehicle through which trust is built, personalised care is provided, and the woman feels empowered” (Perriman & Davis, 2018, p.222).
Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory

This current study demonstrated midwifery-led care as a relational model of care that had the capacity therefore to demonstrate better ethical care and understanding of the importance of woman’s transformation through pregnancy and childbirth. The midwifery-led care philosophy and epistemology honours and protects this inner transformation by recognising the ethical importance of this rite of passage. This study has contributed to the body of knowledge that describes these positive inner changes that occur through empowerment. Long-term, meaningful, continuous relationships between women and midwives in midwifery models of care were sought after by our participants. Midwives have long been the ones who sit with women through birth and are quite rightly positioned to understand the woman’s inner transformation through pregnancy and childbirth as important rite of passage to becoming and self-discovery.

Rational woman: Blending dichotomies

In this study, the women valued the liminality of pregnancy and birth, recognising a reordering in sense of self and subsequent empowerment. However, the women felt at odds with the maternity system that neither valued the importance of pregnancy and childbirth nor recognised the inner change in the same way. Theoretical ideas to explain the findings of this study are described in dichotomies: ethical/unethical, midwifery-led/medical-led, risk/safety, embodied/disembodied, matrescence/parturescence, empowered/disempowered. The feminist theory ‘rational woman’ may help explain how these hierarchical dichotomies are dangerous to women, because one is viewed by society as superior to the other and thus keep women in oppression (Prokhovnik, 1999). Prokhovnik demonstrates that society is full of dichotomies that are dangerous to women such as the separation of mind/body, culture/nature, justice/care in society. The hierarchical opposition places woman at the bottom and men at the top of the ordered hierarchy in a patriarchal society, where man is considered rational and women irrational. Prokhovnik coined ‘rational woman,’ which brings two dichotomies together — the superior component of one dichotomy, normally assigned to men (rational) with the subordinate component of the related dichotomy (woman). The feminist wishes to invert the dualism, to value diversity and difference and abolish polarising dichotomies that harm women. Midwifery literature has highlighted the dangers of the institutional paradox, describing the way that medical interventions are discussed in the maternity system as safe despite having risk, and physiological birth and practice that support it are viewed as
dangerous ideology despite evidence supporting these as safer. Whilst some interventions are needed, regular birth intervention has grown in part to control the unruly woman, her body, and her choices (Newnham et al., 2017; Rothman, 2014, Villarmea & Kelly, 2020).

The women in this study are themselves a dichotomy — white, middle class, educated, and living in a resource-rich country and yet deemed marginalised, countercultural, and radical because of their choices. The demographic of the participants is a limitation of this study, as purposive sampling was conducted from a small pool of women who chose midwifery-led model of care. But the dichotomy is a strength of the study. It was the middle class, white suffragettes that had the privileged platform to bring the women’s right to vote in Australia in early 1894 (Keating, 2020). However, it is now acknowledged that black women and working-class woman were a part of suffragette history and were campaigning not only for women’s rights but human rights of racial equality (Yang, 2020). Thus, there are criticisms and limitations of white feminism, mainly around unacknowledged intersectionality. Whilst there is still a long way to go for feminism, what is highlighted is that feminism is very much needed to lift the oppression of women in the birth room.

The subthemes claiming power and surrendered power capture the outcomes of the care received through the pregnancy and birth journey. A feminist lens was applied to highlight the gendered issues still at play in the maternity system and to examine how the oppression of women still occurs in the 21st century. The women in this study chose midwifery models of care due to the midwifery feminist philosophy, the relational and woman-centred care, and because midwives sought to understand women’s values and context.

The following section presents a paper that is under review with Midwifery journal, which further explores women’s experiences of ethics and the presentation of the woman-centred ethics conceptual model.
Published paper: Woman-centred ethics: A feminist participatory action research

Abstract
Introduction: Contemporary ethical issues in the maternity system are nuanced, complex and layered. Medicalisation and the reported rise in incidence of mistreatment and birth trauma, has been described as unethical. Some authors suggest bioethical principles are limited in terms of guiding everyday care of pregnancy and birth. There is currently no known published research which explores what birthing people say is ethical.

Aims: This study sought to explore women’s experience of maternity care from an ethical perspective.

Method: Feminist Participatory Action Research (FPAR) was utilised. A Community Action Research Group (CARG) was formed of nine participants, who had had a midwifery model of care. Data were captured from the CARG via five focus groups. A further ten participants were recruited for individual in-depth interviews, totalling 19 participants from Perth, Western Australia. Thematic analysis was applied to the data corpus.

Results: A unique ethical perspective was described by the participants. The central theme: ‘Radical desires: Individuals values and context’ placed the woman at the centre of the care, in determining what is ethical. Two categories captured the care experienced: Woman-centred ethics or Authoritarian ethics. A conceptual model Woman-centred ethics is offered to enhance everyday ethical midwifery care.

Discussion: The participants in this study perceived care as either ethical or unethical based on the quality of the relationship, the knowledge that was shared and the manner of the care given. The Woman-centred ethics model may be a starting point for moving the field forward in ethical discussion.

Key words: FPAR, feminist research, midwifery philosophy, care ethics, ethics, woman-centred care

Introduction
Ethical issues in the maternity system are rooted in the philosophical underpinning of medicalisation, where pregnancy and birth are seen as pathological, dangerous and requiring intervention to control birth and save women and babies (Clesse, Lighezzolo-Alnot, de Lavergne,
Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory

Hamlin, & Scheffler, 2018; Jones, 2022; Salter, Olaniyan, Mendez, & Chang, 2021). The phenomenon of overmedicalisation may be contributing to the increasing trend of disrespect and mistreatment (unethical care) in the maternity system (Downe, Byrom & Topalidou, 2019; Miller et al., 2016). The World Health Organisation (WHO) formally recognises mistreatment in pregnancy and labour and detailed an explicit guide to respectful care to minimises harm (Stanton & Gogoi, 2022). And yet there remains an enduring and worsening crisis of rising incidence of psychosocial, emotional and cultural harm described by women in the maternity system (Glazer & Howell, 2021). These problems have not yet been researched from an ethical perspective with attention to what constitutes good (ethical) care; thus, research into the ethics that guides health professionals’ behaviour is imperative.

The International Confederation of Midwives Code of Ethics [ICM] (2014) guide midwifery practice and considers four domains: Midwifery relationship, Midwifery practice, Professional responsibilities and Advancement of midwifery. However, within the health system, the medicalisation of pregnancy and birth is driven by the medical model and the bioethical principles of non-maleficence, beneficence, justice and autonomy (Beauchamp & Childress, 2019); supersedes midwifery ethics, autonomy and care practices (Newnham & Kirkham, 2019). Feminist researchers have described bioethics as abstract, difficult to translate to practice and as having the potential to derail women’s authority over their own decisions and bodies because of patriarchal assumptions and interests (McLellan, 2014; Newnham & Kirkham, 2019). Further research exploring women’s experiences of pregnancy and birth from an ethical perspective may reveal key factors that contribute to more ethical maternity care. This paper presents findings that connect empirical evidence with theory to create a conceptual model for every day, embodied ethical midwifery practice.

Objective: The aim of this research was to explore women’s experiences of maternity care from an ethical perspective.

Ethical statement
Ethics approval was given by the University’s Human Research Ethics Committee (HREC) (REM 2019-2019-00296 and REM 2020 – 01707).

Methods
Feminist participatory action research (FPAR) integrates a feminist lens with participatory action research iterative cycles. FPAR is a complex research design with two branches, a research arm, and an action arm, designed to meet real needs of the participants, and generate transformative research (McDiarmid, Pineda, & Scothern, 2021). The FPAR framework for midwifery was used to guide this study, and includes four intertwined elements; 1. Create, 2. Collaborate, 3. Consider, and 4. Change (Buchanan, Newnham, Geraghty, & Whitehead, 2022).

The methods in FPAR are flexible, in this study iterative cycles of action research were used with two main research phases. In phase one, the ‘Create’ element of FPAR, a community action research group (CARG) was formed (Participant set one), who guided the research over the three years. In ‘Collaborate’, the CARG defined the research problem, data were collected from one focus group (Data set one) and the CARG generated a priori codes, as set out in Table 1. Phase One, participant set and data set.

In Phase two, ten further participants were recruited (Participant set two), and data were collected from in-depth interviews. Further data were collected from the CARG via four more focus groups. The two data sets in phase two were combined for analysis, as set out in Table 2. Phase Two,
participant set and data set. FPAR ‘Consider’ element was demonstrated through Reflexive Thematic Analysis, which was applied to the data corpus (Braun & Clark, 2019). FPAR ‘Change’ was organised and managed by the CARG as described in Table 3. CARG involvement in FPAR.

Participants and context: A total of 19 women were recruited for this study, nine women in the CARG focus group and ten women for in-depth interview, in Perth, Western Australia. Participants who had chosen a midwifery-model of care were recruited via purposive sampling. Purposive sampling is useful for qualitative research in a small participant pool, relevant to this study because only 4% of birthing people can access a midwifery model of care in Australia (Australian Institute of Health, 2022; Campbell et al., 2020). An emailed participant information sheet was distributed via midwifery networks to birthing people who had experienced a midwifery model of care. The information sheet explained the purpose and details of the study as well as contact details of the researchers, and the secretary of the University’s Human Research Ethics Committee. While all the participants had received midwifery model of care, they had also either experienced the medical model of care for a previous birth or had experienced an interaction with the medical system during their pregnancy or birth. The demographic represented in this group were educated, partnered, employed, born in Australia, and were cis-gender women (Table 4. Community Action Research Group (CARG): Demographic data and Table 5. Participant set 2: Demographic data). Although this is not representative sample of people who seek maternity care, it is reflective of people who choose or can access midwifery models of care (Sangster & Bayley, 2015; Grigg et al., 2015).

The term woman is used when referring to a participant who identifies as cis woman, or where we refer to other research which has used the term woman, or when following the ICM definition and scope of woman-centred care (ICM, 2017). We acknowledge that people who identify as male or non-binary give birth, and support inclusive language and care. We also use the term ‘woman-centred’ - a pillar of midwifery philosophy of care – as being inclusive of care given to the non-binary person. When none of these terms are in play, the more inclusive term, birthing person is used.

Consent: Participants self-selected to be included in the community action research group (CARG) and the study. Consent was voluntary and the participants exercised agency in responding via return email with the signed consent form having read the participant information sheet. Also included within the information sheet was the action to be taken if the participant felt discomfort during the interview or focus group. No participants withdrew from the study or sought counselling as an effect of being in the study.

Data collection: Multiple forms of data collection aid the researcher in gathering a rich data set (Olsen et al., 2018; Saunders et al., 2018). Data were collected through semi-structured interview methods using both focus group and individual in-depth interviews, from two participant sets. Focus group interview was chosen for participant set one (CARG) in line with feminist research methods, to democratise research, and produce rich data that is not just descriptive, but generates new ideas and the validation of opinions provides a deeper understanding of the issues (Kook, Harel-Shalev, & Yuval, 2019). Three to six focus groups are suggested to provide enough data to identify prevalent themes (Guest et al., 2017). The focus groups were held between 2019 – 2021 at a local University, with one focus group held online due to COVID 19 restrictions, with the CARG and generally lasting two hours. The first author was a co-member of the group, with another CARG member allocated to direct the sessions, to equalise power in accordance with FPAR. A topic guide per focus group was used, each focus group had a different topic as a guide to instigate discussion;

In phase two, as guided by CARG, ten more women were recruited for in-depth, semi-structured interviews. The rationale, to provide further rich data about the research topic and triangulate the data (Saunders et al., 2018). The topic guide with interview questions were developed by the research team, piloted and adapted with CARG feedback (Table 6. Examples of in-depth interview questions). The qualitative data were audio recorded and transcribed, and notes and reflections made during the interviews were recorded in a reflective journal. To ensure anonymity, participants were given a random pseudonym at the time of audio transcription.

Data analysis: reflexive thematic analysis: Both data sets were combined, and the data corpus was uploaded into NVivo, and the entire data set was initially coded line-by-line (Saldana, 2016). The data were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2019). Analysis involved a recursive and reflexive process that developed over six months of deep thinking, refining and revising categories and themes, with four researchers involved in the analysis process, and member checked by the CARG (Braun, Clarke, & Hayfield, 2022). Reflexivity is a critical reflection of the research process that contributes to rigour by contextualising the researcher position and being open about biases whilst remaining true to the data (McDiarmid et al., 2021).

Line by line coding resulted in sixty-two first level codes (Saldana, 2016). First level codes were assigned to what was considered important in participants words and were more descriptive in nature (Braun & Clark, 2019). A record was kept which recorded the code, definition, salient points about the code, reflections and examples. The reflective journal assisted in developing the second level of codes. Second level coding grouped similar codes together and these were assigned code names such as patriarchal deafness, gendered safety, woman as expert, relational strength and were further developed into six subcategories. These categories were more interpretive (Braun & Clark, 2019), drawing categories together to describe unethical and ethical care. An example of the analysis process is set out in Table 7. Example of coding. Further analysis led to the construction of a central theme, and two subthemes, which describe the outcomes of unethical and ethical care.

Rigour and trustworthiness: The validity of this study was ensured through strategies that strengthen its trustworthiness. Trustworthiness refers to the credibility, transferability, confirmability and dependability of qualitative research (Olsen, 2018). Credibility is demonstrated in this study by engaging reflexively with the data, prolonged three-year engagement with the participants, and triangulation of data sets. Theory has been integrated through the discussion section and linked to contemporary literature which adds to credibility. Confirmability was adhered to by detailed record keeping of decision-making, recorded in a reflective journal, and the provision of raw data. Dependability is achieved through member checking with the CARG at each stage of the research, such as analysis, preliminary themes and providing feedback, and expert supervision. The Standards for Reporting Qualitative Research (SRQR) checklist was utilised as a guideline to ensure quality of reporting (O’Brien, Harris, Beckman, Reed, & Cook, 2014). The Reflexive Thematic Analysis checklist for quality was also used (Braun & Clark, 2019) to ensure dependability.

Reflexivity: The feminist researcher is addressing issues of power and oppression, as such they are often aware of their position and approach. Being open and reflexive about this position is therefore integral part of the research process (Redi & Frisby, 2008). Our stance as feminist midwives, nurses, cis women and researchers is acknowledged. Reflexivity has been ensured in this research by declaring the epistemology and theoretical framework, using reflexive journaling, as
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well as keeping true to the voices of the women by repeatedly going back to the data sources and though member checking (Braun et al., 2022; Shimei & Lavie-Ajayi, 2021).

**Results**

The findings from the analysis present new information about how women view the care they received from an ethical perspective. The participants clearly described what was ethical and unethical care, and the outcomes of their respective care. The central theme: Radical desires: Individual values and context represent the person at the centre of the care – their values and contexts. The categories represent the care received, as either: Woman-centred ethics or Authoritarian ethics. The subthemes represent how the woman was affected following care: Claiming Power: embodied and strengthened or Surrendered Power: disembodied and diminished. The relationship between central theme and subthemes and categories is set out in Figure 1. Relationship of central theme, subthemes and categories

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**Woman-centred ethics or Authoritarian ethics**

[Diagram showing the relationship between central theme, subthemes, and categories]

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The women in this study valued: relationship with their care provider, being provided with information free of bias, being able to exercise choice and agency, as well as receiving care that encompasses both physical safety and psycho-emotional wellbeing. The experience of the care they received as ethical or not, had consequences for the woman and the outcomes of the care are presented as empowered or disempowered. This research amplifies women’s voices by identifying what is valued as ethical care during pregnancy and birth and that this is core to understanding ethics in the maternity system.

The central theme: ‘Radical desires’ situates the woman at the centre of the care, in determining what is ethical. The theme ‘Radical desires’ was named because the women in this study chose a midwifery model of care, which could be considered ‘countercultural’ because it is a minority option, and the medical model of hospital is the mainstream option. The women in this study
considered birth to be a normal, physiological process, and desired this process to be supported, placing value on the experience of pregnancy and birth as a rite of passage that they understood to contribute to a changing sense of self. This study revealed that pregnancy and birth were experienced as more meaningful than just the physical process, with personal meaning going beyond the childbirth experience and being felt long after the pregnancy and birth. When a woman’s values and contexts were supported by the care provider, she deemed the care more ethical, and felt empowered. Acknowledging the meaningfulness of the pregnancy and birth experience and recognising the experiences were deeply important and are further supported by the categories, which describe how the care was given. First Authoritarian ethics are described, then Woman-centred ethics, where the conceptual model is presented and described.

Authoritarian ethics

Authoritarian ethics is made up of; Uneasy alliance representing relationships, Opaque Information representing how knowledge was used and Saving women from themselves captures how the care was given. Together, Authoritarian ethics describe a devaluing of the process of birth and of the woman, and result in perceived unethical care.

An uneasy alliance was described by women who had had an unsatisfactory experience of the hospital system or a medical model of care. They described the experience as standardised and devoid of any real relationship. The women were bound to the care giver by default which they described as being like a working alliance that met standardised needs and system processes. The women in this study used terms such as ‘just a number’, ‘didn’t feel cared for’, ‘superficial’ and ‘standardised’. Zoe best summarises the participants’ experiences of uneasy alliance, describing an uneasy relationship with the obstetrician as feeling powerless, unheard, trapped in her choice and uncared for:

‘And I just went with that I didn’t have a good relationship with the Obstetrician, but I didn’t feel strong enough to probably question more or actually change my decision around that. I never felt like my obstetrician really cared one way or another. He just really wanted everyone to have a pulse at the end of the day and, you know, not be sued. I think that’s what he cared about. Yeah, yeah, yeah. I never felt like he actually had any idea what I wanted and how I wanted the birth to be.’ (Taya)

Opaque information is built around the experiences, described by the participants, of information being withheld or used incorrectly, or shared in a biased way, or of old evidence or standardised information presented, without alternatives. Many of the women in this study described information being reduced to threats to gain conformity to the recommended decisions, such as ‘your baby will die’ and ‘your placenta stops working’ as a way of conforming decision-making. Georgie describes her compulsory appointment with an obstetrician, as she was trying for a vaginal birth after caesarean (VBAC).

“I had to have an Obstetric appointment. It was it was a very coercive, fear driven appointment and about the risk of future rupture, and he started telling me about his own study that he’d been doing and that it was like a one in 30 chance of rupturing. But he couldn’t show me the data on it. He’d gone through my notes and explained that actually the way my notes had been written that it was really code for I’m about to rupture. He was he was playing into whatever fears I had. He said homebirth is really risky because then they always come into hospital, and we have to rescue them. He actually said that we need to rescue them. And he said the way my uterus looked from the notes – and he actually made a visual where he said, you know, we wouldn’t even need to put the knife on it. And it would do this (exploding noise and hands like an explosion)” (Georgie)
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Unethical care was described by women as when the health professional or the system took control of the pregnancy journey and the birth experience, which we labelled ‘Saving women from themselves’. The implications of retaining control over the experiences is that the pregnancy and birth decision are removed from the woman. Care is standardised, women’s bodies are policed, and physiology impeded through interventions, thereby removing women’s agency and choice. Care was often given without consent, and at times was seen by the women as abusive, with unethical actions defended because they were justified as necessary to ‘save’ the mother or baby.

“And as a society and like the sisterhood, we’re all in good girl mode like. we’re going along with it (intervention) even though I don’t agree it” (Eve)

“And so, in some ways, then the feelings of feeling traumatized and devastated and disappointed and upset in some way so invalid because I should just be happy that I was saved and that my baby’s safe and You’ve got a healthy baby. So, stop complaining kind of feeling.” (Fiona)

The consequence of Authoritarian ethics was described by the participants as leaving them ‘disempowered’ because there was a lack of relationship, information was withheld, and standardised care removed control from the birth person. Surrendered power: disembodied and diminished encapsulates a surrendered conformity leading to a woman’s negative or diminished sense of self, their instincts, and their bodies. Women reported ‘I was left traumatised’ ‘I doubted myself’ ‘left fearful’ ‘didn’t want to be responsible and didn’t have faith in my body anymore’

“Then you mistrust yourself, and I think this play into the postnatal period, when a baby is born a mother is born and that is every time you give birth. And that is not acknowledged at all in the medical model, it’s all about the baby and you’re not nourished as a woman and a new mother which is a part of the birth experience, I don’t think you can separate it” (Ella)

The category, ‘Woman-centred ethics’, brings together: Harmonised relationship, Transparent wisdom and Midwifery Solidarity. A conceptual model was created from the empirical evidence of what women described as ethical. This model contains four elements, these are: 1. Individuals’ values and context 2. Harmonised relationship 3. Transparent wisdom and 4. Midwifery solidarity.
A. **Individuals’ values and context** – The person at the centre of the care determines what is ethical for them

B. **Harmonised relationship** – Relationships built through continuity with a primary carer, through which all the other elements are realised

C. **Transparent wisdom** – Information provision is transparent which equalises power and recognises woman’s agency

D. **Midwifery solidarity** – Unique midwifery practices, care and advocacy

The participants identified that ethical care was demonstrated when there was consideration of individual’s values and context. The person at the centre of the care determines what is ethical to them and is central to understanding ethical care. This element of the model draws from the central theme **Radical desires: Individuals values and context**.

**Harmonised relationship**, one described as formed over time and through continuity with, for these women, a midwife. The women in this study acknowledged the role of the midwife in supporting them through their pregnancy and birth journey, through holistic care of both physical and emotional safety that recognised the liminality of the experience. The attributes of a harmonised relationship were described as hearing and respecting, as well as honouring and advocating, which over time developed trust. Relationship was viewed by the women in this study as important for informed consent and decision making because it strengthened and emphasised respect for autonomy, thereby ensuring the woman’s selfhood remained intact. Through relationship and trust a woman was free to exercise her agency.

“**Having a known midwife, I didn’t have to re-cover or re-advocate for myself … it was something that became part of the relationship, she knew my values, trauma, history, ... I think this probably also created the sense of safety needed to uncover more vulnerability and rawness which for me was essential in being able to let go and trust.”** (Fiona)
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Ethical care was also described by the women in subcategory **Transparent wisdom**; as information that was provided in a transparent way, which was accessible and shared with the woman. Current evidence was discussed, where the midwife was knowledgeable about how to provide evidence-based care, and both benefits and risks were described for all options. Women were respected in the knowledge they had accessed, acknowledging the woman as expert of her own body and respecting other ways of knowing as an important wisdom. Through accessing current research, and transparent provision of information, women could provide truly informed choice.

“The way my midwife presented information; she wasn’t making decisions for me, rather, she was really encouraging me to stand in my truth and own my own decisions and look at the evidence and the research and decide what was best for me.” (Jenna)

**Midwifery Solidarity** describes midwives supporting physiological pregnancy and birth via holistic care, with a unique set of midwifery skills, and advocacy for women’s rights. The women in this study gravitated to midwifery models of care, which they understood to share their values and felt midwives were advocates for physiological pregnancy and birth.

“To me the essence of midwifery-led care that I experienced is the woman-centredness and the midwives who we had supporting us believed in that – they believed in empowering us and supporting our choices and sharing information to make informed choices, so I guess the values they carry with them in their practice that enabled the normal birth to happen for us.” (Elise)

The participants described experiences where the midwife had advocated for them during times of necessary medical intervention. They described the midwife as ‘holding space’, ‘fought for me’, ‘protected my wishes’ which ensured the woman retained decision making and felt they had retained control over the experiences. Lucy describes the move from home to hospital thus:

‘She gave me back that sense of control (despite intervention) and oh ok it is my birth and I put my name on the birth certificate as the one who caught the baby’ (Lucy)

**Woman-centred ethics** was perceived by the participants as empowering, which we termed **Claiming power: embodied and strengthened**, as best representing the woman’s positive growth and salutogenic journey through their pregnancy and birth experiences.

‘Through pregnancy and birth, I’ve changed, a huge change I say that often – you’re still the same person but you’ve changed and evolved so much. I think the hormones help that change but going through the process of preparing through pregnancy and then the normal birth I’m a lot more compassionate and thoughtful and empowered. It changed me as a woman, how I see the world and my perspective’ (Georgie)

The women in this study felt empowered when they were supported in the relationship with their midwife, when they were given transparent knowledge in order to make the made the decisions about their body and baby and takes responsibility for their own choices. Taya directly linked how she was treated by the midwives with this idea of empowered transformation

“I probably used to just think of it as the midwives just there to help that birth experience, whereas now that I think what that midwife actually helped me do was more things like finding my voice and my truth and my intuition and things that have served me and will continue to serve me long beyond my experience. And that’s the power that a midwife can have” (Taya)

**Discussion**

The central theme of this research ‘**Radical desires; Individuals Values and context**’ situates the woman’s values and context as being at the centre of understanding what is ethical to the birthing person. Participants described ethical care in terms of being known in relationship, with care of
socioemotional aspects, and care that enhances physiologic processes, with recognition of the liminality of pregnancy and birth. These values were set against a medicalised sociocultural context, that is risk averse and has less trust in childbirth physiology and promotes medical intervention to increase perceived safety (Clesse et al., 2018). The participants explained their views were deemed to be counter-cultural to mainstream ideas about safe birth, because in standardised, fragmented hospital systems, the idea of physical safety, upheld by intervention, is prioritised over the care of socioemotional, cultural, sexual or psychological safety. Thus, participants’ views were deemed ‘radical’ despite the fact the demographics would describe them as mainstream. Contemporary literature supports our findings that women, generally, appreciated systems that support birth physiology, and value the idea of giving birth with minimal intervention but this can be hard to avoid in current medicalised systems (Cole, et al., 2019; Deliktas et al., 2019; Downe et al., 2018).

The central theme of this current study identifies the person at the centre of the care as the one who determines what is ethical for them, which is a key feature of care ethics theory (Tronto, 1993). The elements of care ethics theory are utilised to further describe the **Woman-centred ethics model**. But first, feminist theory is used to explain the subtheme: **Authoritarian ethics** and highlight the increased disrespect and mistreatment in the maternity system as a gendered issue.

**Authoritarian ethics**, as applied in maternity systems, can be experienced by women as unethical. The majority of the women in this current study, often found their expectations of good care to be regularly in conflict with medicalised and authoritarian principles, standards and policies. The care given which retains control over the pregnancy and birth experience, decentres the woman’s voice, described in this study as ‘**Saving women from themselves**’. This reflects deeper social meanings such as not trusting normal physiology, that women’s bodies are broken, and women need saving from themselves and their ideas. With this experience, women felt they had been infantilised and deemed as incapable of looking after their own health. We identified this as a form of ‘benevolent sexism’ (Beauvoir, 1989), which is an underlying sexist belief and ambivalence toward women, whereby the women are not treated as fully competent adults and who need a subordinate figure, usually male, to save them. The manner of this saving may seem innocuous, but dependency-oriented saving undercuts the recipient’s self-regard, competence and women’s cognitive ability, and can lead to increased self-doubt, affecting mental health (Dardenne, 2007; Borgogna, 2020).

Benevolent sexism can be recognised in the maternity system, where women’s behaviours and decisions are restricted, or their intuitions minimised, because they are deemed unsafe or because the medicalised model doubts women’s ability to be rational and make a good decision. Research into women’s experiences of benevolent sexism in the maternity system have described scenarios such as: non-evidenced based medical advice for pregnancy, sexist valued judgments, as well as restricting women’s freedoms of choice with outcomes that negatively impact their self-concept and wellbeing (Perrotte et al., 2020). A recent study in Sweden of 190 women’s experiences of birth were collated and analysed from a gender perspective (Westergren et al., 2021), describing how woman conform to gendered roles during birth as passive and conforming agents in a medicalised setting, which in turn affects birthing women’s ability to assert themselves and be involved in decision making. Van Der Waal et al. (2021) theorise how students entering the ‘obstetric institution’, both medical and midwifery, are pushed to cross ethical boundaries to collude in obstetric violence, as rites of passage into what is an inherently violent system, that does not inadvertently create systems of oppression but is founded on them.

The consequence of unethical care was described in the subtheme ‘**Surrendered power; disembodied and diminished**’. The participants described a sense of surrendering as a
consequence of unethical behaviour, derogatory language, retained authority of the birth by health professionals. Surrendered power negatively affected sense of self, related to women’s confidence and capabilities. In this current study, evidence of unethical care resulted in a diminished sense of self.

Woman-centred ethics

In contrast, the participants described care that they had received within midwifery models that prioritised her values, that supported her beliefs about the birth physiology, and where power was equalised through transparent information provision, as being ethical. The subcategories Harmonised relationship, Transparent wisdom and Midwifery solidarity together with Radical Desires: Individual’s values and context make up the Woman-centred ethics model. Woman-centred care is a core midwifery philosophy, which is individualised, holistic and respects human rights (Crepinsek et al., 2022; Davis et al., 2021; ICM, 2014). The label Woman-centred ethics, encapsulates midwifery philosophy and practice (ICM, 2014; ICM 2017) with feminist care ethics (Gilligan, 1992; Tronto, 1993). Woman-centred ethics identifies the person at the centre of the care as the one who determines what is ethical for them, which is a key feature of care ethics theory (Tronto, 1993). Care ethics theory highlights that beneficence or the good care, comes from the way the care is given (Gilligan, 1982; Tronto, 1993). So, rather than abstract ethical principles guiding care from in a top-down way, care ethics is bottom-up – starting with the individual at the centre of the care (Gilligan, 1982). Care ethics is understood through relationship, which fosters individualised care and considers more than just physical factors, also encompassing a person’s context, culture, environment and values (Held, 2006; Tronto, 1993). Care ethics places importance on paying attention to power imbalances, as well as structural and individual power, and aims to reduce authoritarian power (Held, 2006; Gilligan, 1982; Tronto; 1993). Next each element of Woman-centred ethics is described, which supports the Woman-centred ethics conceptual model, as way to enhance ethical practice.

Harmonised Relationship

The participants in this study explained that relationship was a central feature of ethical care. The women assigned a moral significance to this relationship, noting the quality of the relationship was described by the women in this study as the vehicle through which the woman’s values were known (or not known). The importance of relationship was central to the person feeling that their family, context, culture, emotions and values were understood. The participants described this knowing as fostering greater ethical sensitivity; thus, better quality of care.

Research highlights that continuity of midwifery care supports both physical and emotional aspects of pregnancy and birth, where women describe being more informed and active partners in decision making, with their wishes respected because of the relationship (Brady, Lee, Gibbons, & Bogossian, 2019; Perriman & Davis, 2018). A review by Perriman et al. (2015) and more recently Brady et al (2019) around core aspects of midwifery explain that relationship, underpinned by personalised care, trust and protecting normal birth, results in empowerment where care and attention is given to the psycho-emotional aspects of the woman which was described as ethical in this current study.

Transparent wisdom

In this present study the transparent provision of information, free of bias or coercion, was shown to be valued by women, because it balanced power in the relationship and fostered agency. The women described themselves as being informed through reading research, discussions with their midwife, and through trusting their bodies. Free sharing of knowledge, which acknowledges the...
agency of the person receiving it is more useful than fixating on a right to autonomy and informed consent processes, which can be undermined by coercive behaviours.

The women in this study viewed the midwifery model of care as more ethical because it gave them power and knowledge to make decisions about their bodies and take responsibility for their choices. These findings align with contemporary literature that information provision in relational contexts, supports women to fully exercise their agency (O’Brien, Casey, & Butler, 2018; Woollard, 2021). In this current study, shared information and respect for embodied knowledge was essential for women to make decisions which they perceived as ethical for safety, to exercise agency and balance power.

Midwifery solidarity

Midwifery solidarity captures the alignment of midwifery care with values held by the women in the study. Midwifery, as an autonomous profession, works in supportive partnership with women and is the only profession to have expertise in normal, physiological pregnancy and birth, relational practices and advocacy, toward the promotion of women’s capabilities (International Confederation Midwives, 2017). The unique midwifery skills that support normal physiological processes were valued by participants in this study, featuring as the reason why they sought midwifery models of care. The midwifery support for physiology is reinforced by other studies which demonstrate the benefits of midwifery guardianship and trust rather than intervention to support normal pregnancy and birth (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018; Perriman & Davis, 2018). Similarly, an integrative review by Olza et al. (2020) link normal physiology and psychological aspects that facilitate optimal adjustment to motherhood and recommended that birthing people have continuity of care. With the support for physiology comes the midwifery role in advocacy. Advocacy is highlighted as an important aspect of midwifery models of care (Downe et al., 2018; Perriman & Davis, 2018; Webb et al., 2021). Solidarity in this study was described by the participants as the unique midwifery care that supports physiology, the liminality of the experiences, and advocacy for the individuals’ values.

These three subcategories Harmonised relationship, Transparent wisdom and Midwifery solidarity together demonstrated a different kind of ethics: Woman centred ethics. What was significant about the findings in this current study, is that when the care was perceived as ethical the women described themselves as feeling more powerful. We used the term ‘Claiming power: embodied and strengthened’ to describe the positive inner changes with women in this study describing. This study also highlights that the pregnancy and birth experiences go beyond the physical process, with personal meaning extending to a changing sense of self. Thus, how care is given, such as in Woman-centred ethics, recognises birthing peoples changing sense of self and transformation. A hallmark of midwifery care is supporting birthing people to have authority over the birth and their own body, as based on trustful relationships, informed choice, holistic care and empowerment (Downe et al., 2018; Menage, Bailey, Lees &Coad, 2020). The positive experiences described in this current study are examples of ethical care which fosters women’s empowerment. This current study contributes to this literature by identifying ways to circumvent and rupture the obstetric institution using an ethical model that can only be upheld by centring the values of the individual, but also the advocacy of these values, offering a framework to resist institutional violence and unethical care. The Woman-centred ethics model offers a practical tool to guide everyday, embodied, ethical midwifery practice.

Limitations: This study included women who represent only a small portion of society, they were: white, educated, from higher socioeconomic backgrounds, were self-selecting and had experienced
midwifery models of care. This homogeneity is acknowledged as a limitation because it does not address diversity or intersectionality. However, it presents a model of ethics from midwifery which, by placing the individual at the centre, can be used, tested and adapted with more diverse groups. One other limitation of this study is that the primary research was a member of the CARG, which may have influenced focus group responses; however, this was countered with the allocation of another member to lead group discussions. Reflexivity and the guidance of care ethics for researchers were used to minimise undue influence.

**Conclusion**

The findings of this study contribute empirical evidence of what childbearing people might value as ethical. The participants clearly detailed what was ethical and unethical from their perspective, and this new knowledge contributes to a better understanding of the ethics within the maternity care context. Centring what birthing people value at the core of any ethical care is an important first step to challenging the unethical aspects of care described in this study. Recognition of the context of pregnancy and birth as ethical liminality may change care to be more supportive of psychosocial aspects, to reduce unequal power relationships and oppressive behaviours. Equally, the identification of equal knowledge-sharing as experienced as increasing the power of the woman is an important contribution. Not knowing the woman, her context, her values, and not centring the woman in ethical understandings, is to not fully comprehend how ethics is lived out in everyday maternity care. This study has contributed to the body of knowledge that describes how women perceive ethics in the maternity; and therefore, contributes to philosophical underpinnings and practice issues within midwifery. The findings may be transferable to other health professions who care for birthing people during pregnancy and birth in providing ethical maternity care. There is opportunity for future research to explore ethics from other models of care, from more diverse backgrounds and to test the Woman-centred ethics model in practice.

**COI:** nil to declare

**References**


Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory


Chapter 6. Rational Woman: Women’s experiences integrated with feminist and care ethics theory


McDiarmid, T., Pineda, A., & Scothern, A. (2021). We are women! We are ready! Amplifying women’s voices through feminist participatory action research. *Evaluation Journal of Australasia, 21*(2), 85-100. doi:10.1177/1035719X21998479


Chapter summary

The discussion presented above has highlighted a central theme, radical desires, which positions the woman at the centre of ethical understandings. The context of pregnancy and birth were described as important and valued by the woman with acknowledgment that liminality of the experience is important in the reordering of sense of self. Three subcategories — relationship, knowledge, and care — were assigned to build a picture of care as unethical and ethical. Unethical care was analysed and assigned as uneasy alliance, opaque information, and saving women from themselves. Ethical care was categorised as
harmonised relationship, transparent wisdom, and midwifery solidarity. It was demonstrated that the care contributed to how a woman viewed herself and the reordering of her sense of self. The subthemes claiming power and surrendered power explained the outcomes of the care the woman received. These themes have been explained, discussed, and contrasted against the extant literature related to midwifery and the maternity system using two theoretical perspectives, feminist theory and care ethics theory. Together, these theoretical perspectives assist in explaining why birth matters to women and help explain why unethical care may still be found in the maternity system.

Health care professionals have a moral commitment to caring practices. The bioethical principles are abstract and difficult to apply to everyday ethical issues. Bioethics is also based on principles which are seen as equally applicable to everyone. Thus, standardised care in the maternity system states that everyone should be cared for in the same way using policies, procedures, protocols and this not only potentially ignores the woman at the centre of care, it also fails to consider the role of power in health care. Rules and codes do not fully equip health professionals, universalism fails to accommodate the individual at the centre of care, who holds diverse values, cultures, religions, ethnicities, dreams, hopes, expectations, knowledge, and priorities. The danger of standardised principles is that they have the potential to preserve powerful positions. Principles, codes, and polices provide one way or one answer to what is deemed right action, but to remain impartial is to not fully grasp moral reasoning, lived experience, relationship, emotions, interpretations, choice and understandings. The women in this study valued a different kind of ethics and desired emotional safety, a right to exercise agency, and acknowledgement of context and rite of passage. They were seeing ethical care through a different lens.

Care ethics challenges non-maleficence, beneficence, justice, and autonomy with relationship, caring embodied ethical practices, attention to context, and power. Feminist and relational care ethics have been used in this study to further understand the way in which ethics can only be determined by the one at the centre of the care. Without knowing the woman, her context, or her values, without centring the woman in ethical understandings, it is not possible to fully comprehend how ethics is lived out in everyday practices.
Chapter 7. Catching fire: Conclusions, limitations and recommendations — woman-centred ethics a model for practice

This knotted dilemma lies at the centre of women’s development. How can girls both enter and stay outside of, be educated in and then try to change, what for millennia has been a man's world?

Gilligan, 2011

Chapter overview

This thesis has explored the theme of ethics and presented new insights into how women perceived ethical care. Feminist theory and care ethics theory have been used as tools to analyse the findings. The previous chapter discussed the themes developed from the data and related these to two theoretical perspectives, care ethics theory and feminist theory. This research also confirms other research that associates care experiences with outcomes that impact childbearing women’s psycho-emotional well-being. In this chapter, I further develop the discussion by relating these to recommendations for midwifery practice, maternity service design, and education. In this concluding chapter, I first summarise the current study, consider the degree to which the study aims were achieved, the significance of the findings, and make suggestions both for application of the findings and for future research.

Summary of the research

Table 8. Research highlights

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<th>Findings</th>
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<td>Findings</td>
<td>Empirical evidence of women’s voices related to their maternity care experiences clearly describing ethical and unethical examples of care</td>
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Contemporary midwifery literature regularly investigates ethics from the perspective of the principles of bioethics (Hajiesmaello, et al., 2020; Jafar et al., 2019; Kantrowitz-Gordon, 2020) or in terms of ethical dilemmas and ethical decision-making discourse (Honkavou, 2022). The bioethical principles are helpful in the education and training of midwives and for developing guidelines, practice policies, and decision-making frameworks to support ethical dilemmas. However, they are limited in their ability to advance midwifery philosophy and the further development of midwifery ethics. Thus, it remains timely that this study offers an alternate view to the body of knowledge of maternity ethics.

The aim of this research was to explore women’s experiences of maternity care from an ethical perspective and to determine whether a care ethics paradigm could better inform midwifery practice.

The following three objectives guided the study:

*The first objective was to generate transformative research; to collaborate with a team of women to guide and conduct the research toward emancipatory action.*

*The second objective was to determine whether midwifery-led care demonstrates care ethics.*

*The third objective was to explore women’s experiences of pregnancy and birth from an ethical perspective.*

This study sought to explore women’s perception of ethics, because ethics cannot be
fully understood without the voice of those at the centre of care. FPAR was the chosen methodology for the research to centre childbearing women in the research collaborate with them in action.

The participant group was chosen to explore how women experienced ethics within the midwifery model of care. Interestingly, when the participants described ethical care, they all contrasted the care with care received in previous medical model experiences and the research developed in a way that had not been expected, the data set was much larger, and the outcomes clearly showed that these participants’ views of ethics didn’t align with the medical model as guided by bioethics.

In this study, a metaethical critique of the bioethical principles was conducted and revealed they had not fully prevented the experience of mistreatment, nor did they ensure respect for autonomy or beneficence. The metaethical critique demonstrated a gap in the literature and created an argument for the need to explore women’s perspectives of ethics and ethical care. Care ethics as a possible solution was presented. The scoping review resulted in the creation of a definition of care ethics for health practice and a framework for practice. Care ethics and midwifery philosophy were determined to align in promoting the primacy of relationship, with the person at the centre of care, attention to power differences, context of the situation, and particular caring practices. Through a template analysis, using a priori codes created by the CARG, I identified that care ethics and midwifery models of care align, and I suggested further development of a midwifery ethic.

Through five focus groups and ten in-depth interviews of 19 women I applied thematic analysis to the data corpus. I proposed the central theme radical desire: values and context which highlighted that midwifery models of care were chosen because there was value or ethical alignment between what women wanted and valued and what midwifery offered in woman-centred care, as countercultural to what wider society perceived as ethical. A feminist view explicated pregnancy and birth transformation as honoured by both women and midwives as an important rite of passage. Thus, the midwives were perceived as more ethical because they understood the pregnancy and birth as transformative rites of passage, were supportive of normal physiology, and held consideration of a woman’s context and individuality. The context was explained through the lens of medicalisation, through which it is proposed that medicine as a dominant social structure has been positioned as having a superior knowledge in comparison to midwifery and to normal birth
philosophy, and that this medicalised view is endemic to maternity systems but also to wider society. Considering context helps the health professional take into consideration the woman’s individual values, culture, family, and self.

**Woman-centred ethics or authoritarian ethics** described the care experienced by the participants which they clearly detailed ethical and unethical care. Care ethics theory was utilised to explain how these subcategories of the care ethics framework relationship, knowledge, and care were developed. The findings in this study have provided insight into how the care provided to women and experienced as ethical or non-ethical contributes to her experience of transformation during the liminality of pregnancy and birth.

The significance of how care is experienced as either ethical or unethical was highlighted in the subthemes **claiming power** or **surrendered Power**. A reordering of sense of self was identified as a result of how women were treated during the pregnancy and birth journey. This highlighted the critical importance of ensuring ethical care is given and demonstrates the need for more ethical frameworks for practice in the contemporary maternity system. I used feminist theory to emphasise the potential harm to women caused by medicalisation and the bioethics which obfuscate the ethical nuances in the maternity system. Benevolent sexism and paternalistic protection were factors taken from feminist theory to explain unethical treatment of women with evidence of more subtle forms of oppression that shrink selfhood and demonstrates gendered silencing. Gender inequality remains a form of oppression and power imbalance that contributes to mistreatment and disrespect toward birthing people. Women from this action research claimed the core issues of unethical care as rooted in patriarchy and misogyny and called for feminist resistance in the birth room as it remains a gendered and political issue.

Finally, the feminist theory ‘rational woman’ was used to explain the dichotomies that are dangerous to women such as the separation of man/woman, mind/body, embodied/disembodied, knowledge/technology, medicalisation/physiology in society. The hierarchical opposition places women beneath men in the ordered hierarchy in a patriarchal society. To date, the principles of care ethics and feminist research theory have not been applied together in the context of midwifery. Women’s experiences were combined with care ethics and feminist theory, along with midwifery philosophy, to create a new conceptual model for practice. Woman-centred ethics details four elements that may help midwives embody ethics into daily practice.
This study has demonstrated that midwifery models of care demonstrate a different kind of ethic and midwifery care described by the participants as having the potential to underpin provision of more ethical care. A standalone midwifery ethics as presented in the woman-centred ethics model may enhance ethical care of birthing people and give midwives a clearer path to navigate ethical nuances during pregnancy and birth.

**Significance of the research**

There has been little empirical work related to ethics in the maternity system, due to philosophical, paradigm, and context differences. This research project advances midwifery philosophy by exploring women’s experiences of the maternity system from an ethical perspective. The unique findings add women’s ethical voice to bioethical principles and may be useful in the development of future professional ethical frameworks. The findings of this study were set out in a conceptual model which will help midwives to understand ethics in everyday practice. The Woman-centred ethics model combines care ethics theory, midwifery philosophy and empirical evidence which together offer a unique contribution to knowledge.

**Implications**

The contribution to midwifery philosophical underpinnings – this research is the first to try and capture empirical evidence related to ethics and midwifery. I have created a body of work that further advances midwifery philosophy and a greater understanding of midwifery ethics. To date, there has been no alternative model for ethics for maternity care that reflects women’s own contribution to its design. The conceptual model woman-centred ethics provides one solution to these ethical complexities.

This study has actively engaged consumers of maternity care in the research process. The opportunity to co-create research with the CARG and development of a care ethic consumer recommendation, described in recommendations section, may be used to contribute to transforming maternity care towards more ethical maternity care. The Consumer recommendations created by CARG may be of interest to policy makers.

The Woman-centred ethics conceptual model – captures elements of care that midwives in midwifery-led models demonstrated. The findings that describe the outcomes of
medicalisation and patriarchy may provoke readers to consider the Woman-centred ethics model as a way of countering this issue. It is anticipated that the findings from the study may provide another way of thinking about ethical care. The results framed within care ethics may support midwives in challenging the medicalisation, thereby improving the care of women and families.

**Transferability**

Transferability is strengthened in this research through description of the maternity system background and participant context and the thick rich descriptions in the findings. The Woman-centre model draws on midwifery philosophy and care ethics theory so may be transferable to midwifery-led settings.

Different settings may also consider adopting the findings where there is a desire for more ethical care; as such, it may be transferable to other health professionals, policy makers, or hospital management. The voice of these participants as to what they deem as ethical is transmissible to wider midwifery models, medical models, and other health professionals caring for women during the liminality of pregnancy and birth. It is possible that other women in other setting would have the same or similar ethical ideas of good care.

For women who are from marginalised backgrounds such as LGBTQi and First Nations this model may enhance ethical sensitivity by ensuring relationship is central to ethical requirements for care.

In the same vein women who choose or need medical intervention, the Woman-centred model ensures as a first step that the woman is asked what is ethical for her. That there is balancing of power through information provision that enhances informed choice and decision making. The element midwifery solidarity and the role of the midwife in advocacy provides a means through which collaboration between health professionals is fostered.
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Recommendations

Woman-centred ethics - a praxis for the future

The findings of this study presented the radical desires that women held, that pregnancy and birth was valued as transformative, and this was juxtaposed with a system that medicalised the experience. The women in this study gravitated to midwifery models of care, in the understanding that midwives would share similar birth philosophies. The results of the analysis and theory integration along with the women’s experiences were compiled to create the woman-centred ethics framework.

When considering the findings, a more ethical future is possible where every woman would have a known midwife through pregnancy and birth and where the person at the centre of care determines what is ethical for them. This study has shown that the potential to develop more ethical relationships where power is balanced, and women’s capabilities are strengthened is important to women. The provision of more ethical information underpinned by knowledge transparency, evidence-based information, and respect for women’s embodied knowledge determines a woman’s agency to make informed choices and hold responsibility for decisions.

This model provides an ethical prototype based on care ethics and midwifery theory. It is an additive model to the existing bioethical principles which guide all health care. The Woman-centred ethics model differs however from abstract principles of bioethics or a set of values that is applied to care given. Rather, rooted in care ethic theory, caring practices are viewed as ethical in themselves, thus ethics start with the person at the centre of care and what is ethical for them (Gilligan, 1983). This research project advances midwifery philosophy by exploring women’s experiences of the maternity system from an ethical perspective. The unique findings add women’s ethical voice to bioethical principles and may be useful in the development of future professional ethical frameworks. The findings of this study were set out in a conceptual model which will help midwives to understand ethics in everyday practice.
The model is presented as embodied, rather than top-down, abstract principles that are applied, but rather a stance or way of being – based on relationship. The elements bring together both midwifery theory about relationship and care ethics theory about relationship and combined these with evidence of women’s experiences. The elements therefore are demonstrated through an embodiment of relationship. That through relationship the woman at the centre of care is understood and knowledge about what is ethical for her drives ethical care. Power is balanced through transparent information provision, which fosters decision making and her taking responsibility for those decisions and finally midwifery solidarity is the unique midwifery practices that is attentive and responsive.

The model presents ethical caring as a practice with moral significance, where the good or ethical arises from how the care is given. Relationship is central to caring practices and the person at the centre of the care is the one who determines what is ethical, as the expert of their own life and experiences. The model is woman-centred which takes into consideration the complexity of a person’s context, the person’s values, emotions, thoughts, and views, which enhances decision making.

The four elements that were derived from the findings to construct the model, Woman-centred ethics. The four parts comprise: 1. Individuals’ values and context; 2. Harmonised relationship; 3. Transparent information; and 4. Midwifery solidarity.
Woman-centred ethics model

A. **Individuals’ values and context** — The person at the centre of the care determines what is ethical for them.

B. **Harmonised relationship** — Relationships built through continuity with a primary carer, through which all the other elements are realised.

C. **Transparent wisdom** — Information provision is transparent which equalises power and recognises woman’s agency.

D. **Midwifery solidarity** — Unique midwifery practices, care, and advocacy.
Future development of Woman-centred ethics model

- The model is a way of being that enhance ethical embodiment – rather than “applied” in the way of principled ethics
- The model has combined theory and empirical evidence of what women described as ethical thus an understanding of care ethics theory and midwifery philosophy would be helpful to the practitioner in realizing the elements of the model
- Woman centred – acknowledges that all ethical care starts with the woman at the centre – what is ethical to her.
- The model advances midwifery philosophy by detailing ethical elements demonstrated in midwifery-led models of care
- The model was generated from this research about midwifery-led models of care, but further research would determine whether autonomous midwifery practitioners resonate with the model
- The model would benefit from empirical testing, the model may be adapted through researching other groups perspectives.

Consumer recommendations

The CARG developed a list of recommendations for maternity providers, that they have shared with the Maternity Consumer Network Australia and in the working group for the new maternity hospital in Perth, Western Australia.

CARG recommendations for better ethical care of childbearing women (Nov 2021):

- That women are given the funding for birth and may choose the model of care they wish.
- That midwifery-led caseload continuity of care be the model available and funded for all women.
- That the options for models of care are discussed at the first appointment, with statistical outcomes of each model readily available to consumers.
- That care is woman centred, individualised, holistic, and culturally safe.
- Education and information provision is provided early and is evidence based.
- Woman are recognised as decision makers and responsible for decisions.
- Provision of independent childbirth education available for all women.
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- A political advisory body be formed by consumers that are consulted for any maternity changes.
- Evidence-based care and current research used in all practice.
- School-based education about normal birth process is provided that is not fear based.

Recommendations from the study

In summary, the recommendations from this current study are as follows:

- The model be used as an additive approach - Woman-centred ethical framework for midwifery practice.
- Develop educational tools of feminist relational ethics that aligns with midwifery philosophy.
- Advance relational care ethics and feminist ethics as important philosophical underpinnings that guide health care codes.
- Advocate for midwifery models of care are supported by government funding and private health insurance, that women have control of the fundings and choose their model of care.
- Continue action towards Midwifery-led care as distinct from medical jurisdiction.

Research dissemination

The findings from this research have been disseminated in various ways and plans are in place to share the research. Knowledge mobilisation has occurred through the publication of the four papers, presentations and through community members. The CARG used social media platforms and community connections to share the findings. The collaborations with policy makers and other health departments that the CARG have been involved with have advanced the research to other areas that may not have been researched using other methodologies. Four papers were prepared and three published in quality journals: *Nursing Ethics, Women and Birth*, and the last paper is in second review with the *Midwifery* journal. One book chapter is in preparation: ‘Care ethics and midwifery, towards a reproductive justice’ in van der Waal & van Nistelrooij’s *Care ethics, birthing and mothering*. Finally, two university-based oral presentations have been shared and one future speaking event will
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occur at the International Confederation of Midwives international conference in Bali, 2023.

Dissemination Plan

*Education* - I plan to create an educational package (Articulate 360 learning package) on midwifery, care ethics and the Woman-centre ethical model as an additive approach to education. With the aim to advance midwifery ethics beyond bioethics and ethical dilemmas toward a relational approach to ethics.

*Engagement and Networking* – I aim to make connections at the ICM conference in June 2023. Through building a collegiate network at the ICM conference I may find opportunity to seek a meeting to further discuss the Woman-centred ethics model with the ICM International Code of Ethics for midwives’ team.

*Co-Production* – Dr Elizabeth Newnham and I whilst writing a book chapter together also plan to do future research together advancing the research topic.

*Midwifery Practice* – The learning package can be presented at the clinical level at Hospital Inservice, whilst the model isn’t tested or clinical practice and can’t be generalisable, the model align with midwifery theory and midwifery philosophy thus elements of the model may be recognised in midwifery practice and strengthen ethical sensitivity.

*Social media* – I will create an infographic with the CARG on the latest paper and release to Twitter and Instagram. The CARG continue to share the research findings at a community level, and we meet regularly to discuss these and other actions we are still involved in together.

Dissemination of the research may result in consumer driven change and be transformative for future birthing people.
Limitations
The limitations of this study have been considered and addressed in various ways throughout the thesis, highlighted in the introduction chapter and presented in each of the manuscripts.

Feminist standpoint
All knowledge is situated and shaped by context. The Feminist standpoint and lens poses the risk of limiting objectivity. The feminist lens drove the motivation for the research, the methodology and analysis. Trustworthiness measures were in place to ensure credibility and confirmability of the research. Other researchers may have explored women’s experiences of ethical care with a different lens.

Participants
The sample is drawn from a very small portion of the population 4% of women who choose midwifery-led care and of that 0.4% who choose homebirth. The homogeneity of the participants is acknowledged as Caucasian, educated, were self-selecting and does not account for diversity or intersectionality. 50% were health professionals, which may give us important information about knowledge and health professionals access to knowledge that other people don’t have access to.

The CARG members guiding and contributing to the study over three years is a limitation and a strength of this study. The women were educated about pregnancy and childbirth and gravitated to midwifery models of care, in the understanding that midwives would share similar birth philosophies. The CARG members were willing to be involved in action and drive change. This commitment to activism shows a strong discontent, sense of agency and capacity that other participants may not have done.

Fourth wave intersectional feminism may have issue with the amount of information and language use in the information content sheets. The decision was made to present that level to be in line with FPAR which levels power through information provision, but it may have inadvertently excluded a set of participants due to the level of language and use of concepts.
Limitations to Methodology

One other limitation of this study is that I was a member of the CARG, which may have influenced focus group responses; however, this was countered with the allocation of another member to lead groups discussions. However, ten feminist women in a focus group has driven a very feminist study. Reflexivity, member checking, and the guidance of care ethics for researchers were used to minimise undue influence.

Recommendations for future research

On the basis of the findings, strengths and limitations of this study, further research is determined to be necessary to explore ethical care in the maternity system. The discussion chapter explored some aspects of sexism and gender prevalent in the maternity system and further feminist research to highlight the continued injustice of oppression of women in the maternity system is needed. These issues of power imbalance were determined in this study to correlate with women’s reordering of the sense of self through the transformative experiences. This study offered empirical evidence of this, but further study would consolidate midwifery understandings of the liminality of the birth experience and the reordering of sense of self.

Further research is required to test the woman-centred ethic conceptual model. This study has presented the model as in alignment with feminist and care ethics theory and midwifery philosophy. How it would be understood in practice is to be determined by further research, which would advance midwifery philosophy and practice as separate from biomedical ethics and practice. Future research may test the model being utilised by midwifery models of care and investigate whether midwives found it enhanced ethical care.

Exploring the perspective of birth people from other models of care is prudent. Participants from other models of care may offer different views from those offered here and further research is recommended for these specific groups. Birthing people from medical models of care may described their experiences of ethics differently and further research into women who had experienced only standardised care may add elements of ethics not understood in this study. Minority groups such as LGBTQIA+ birthing people and
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First Nations women may offer perspectives of ethical care that may further enhance the Woman-centred ethical model.

Qualitative research exploring Endorsed midwives’ perspectives of the Woman-centred ethics model would triangulate the findings presented in this study. The model was informed by women’s descriptions of midwifery-led care. It would enhance the model to understand how Endorsed midwives perceive ethics, particularly from the perspective of embodied rather than applied ethics.

Concluding comments

This research project has contributed to the existing body of knowledge around ethics, care ethics, and women’s perceptions of ethics and thereby advances midwifery philosophy. This thesis has therefore provided a unique contribution to midwifery knowledge. Despite other professions like psychology and social work embracing care ethics, midwifery ethics remains dominated by hegemonic, technical approaches such as abstract reasoning (Kant), normative rules and regulations (deontology), consequences (utilitarianism), and/or individual character (virtue). Whilst there remain systems that continues to oppress women, such as the structures within the current maternity system, now more than ever a review of the ethical underpinnings of maternity care is timely.

The Consumer group was essential to the success of this study, when I met the CARG group for the first time I knew this was going to be a much more feminist study than even I had anticipated. The women were passionate about women’s issues, named the patriarchy and felt liberated from the system and wanted to see change! Their commitment to journey with me over 3 years doing action and change, showcases their level of passion. Their voice is as strong in this study as mine and my reflexivity was wrestling with ensuring congruency with the group and their values ...as FPAR challenges us to do.

The woman-centred ethic model challenges the bioethical view and adds important missing elements required for ethical care. The ethical model presented may empower midwives and childbearing people through a reframing of everyday, embodied ethics. This research has produced a unique perspective of ethics and honours women’s voices as central to ethical care. And my hope is the research further contributes to advancing midwifery philosophy.
Chapter 7. Catching fire: Conclusion, limitations and recommendations — woman-centred ethics a model for practice
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Appendices

Appendix 1. Electronic Bulletin Advertising for research participants

Women’s experiences of maternity care from an ethical perspective - A participatory research project

My name is Katherine Buchanan, I am a midwife, mother, researcher and counsellor. I am studying at the School of Nursing and Midwifery at Edith Cowan University for a Doctoral Degree by Research (PhD). This research project is being undertaken as part of the requirements of a PhD at Edith Cowan University.

The aim of this study is to work collaboratively with childbearing women to better understand women’s experiences of maternity care and women’s perceptions of their birth from an ethical perspective. The information provided will be used to enhance the understanding of ethical midwifery care.

If you are a postnatal woman over the age of 18 years, who has had midwifery-led care and wish to be involved in providing your birth experiences through a focus group (or one-on-one interview), then I invite you to contact me. Discussing your birth experience may elicit some emotions both positive and potentially negative emotion.

You do not have to participate in the study but if you decide to take part, you can change your mind and withdraw from the study at any time up to the point of data analysis, you do not need to give a reason and there will be no ramifications if you withdraw.

The information will be presented in a PhD thesis and may be published in journal articles or at conferences. Your identity can be anonymous.

Ethical approval has been granted for this study (ECU HREC No2019-00296-BUCHANAN). If you would like to be a part of this research, please contact Kate via email at k.buchanan@ecu.edu.au for further information.
Appendices

Appendix 2. CARG Participant Information/ Consent

Women’s experiences of the maternity system from an ethical perspective - A feminist participatory research project

Principal investigator - Katherine Buchanan

Principal supervisor – Sara Bayes

My name is Katherine Buchanan and I am a midwife. I am also studying at the school of Nursing and Midwifery at Edith Cowan University for a Doctoral Degree by Research (PhD).

The overall aim of the study is to explore ethical issues in maternity care from women’s perspective through the work of a research team of maternity consumers.

What is this study about?

Childbearing over the last one hundred years has changed: a move from home to hospital has meant maternity care has become increasingly medicalised with nominal improvement in fetal and maternal mortality rates. Women, the World Health Organization [WHO], Human Rights in Childbirth, United Nations [UN] and maternity consumer activists are advocating for change in current global maternity care to reflect the need for respectful, women centered, ethical, maternity care. One area that hasn’t been explored is ethics in maternity care.

Why am I doing this study?

This study will address the significant global issue of maternity ethics from the childbearing women’s perspective. Understanding the ethical needs of childbearing women can help future directions of maternity care. The aim of this study is to work collaboratively with childbearing women to create research but also to drive change toward a more ethical maternity care system.

What is involved in taking part in the study?

If you decide to take part in the study, you will be asked to join a community advisory research group of 6 – 8 participants. You will help guide the research and co create the research over two phases, three years of the PhD study.
Appendices

If you decided to participate in the study your commitment would be;

Phase one – This phase will involve building relationships with maternity consumers to create a community advisory research group (CARG) that will guide the research. A 2-hour focus group session in September 2019. The collaborative exercise conducted in this phase will facilitate the collection of qualitative data. The focus group will discuss ethics, maternity care, justice and autonomy and midwifery led care. You will be invited to share your experiences and views of the care you received in the maternity system. From the discussion research we will finalises the study’s overall research questions and the participant interview questions for phase two. You will be asked via email to review a summary of focus group conversations (and our interpretation of the key messages) to confirm they are representative of those discussions, to add anything you think relevant and to elaborate on any points you made that we ask you about. You will be given refreshments during the focus group discussion.

Phase two – four 2-hour focus group sessions to collect data, from September 2020 – Dec 2021. This session will be to update group with research progress, ensure ties to the community are maintained and collect qualitative data from group discussion.

Over the three years – Participatory research includes participants in the research to enact the social change deemed by the social group. Together a plan is made to enact change from the research; it may be a standard operating procedure of ethical practice, a conference paper, lobbying the government with the research data – the choice is for the group to decide. The community research group will determine the timeline.

Topics that will be discussed over the three years include:

- What has been your birthing experiences? How would you define / describe ethical care? How did the midwife make you feel supported? How did the midwife make you feel? What is good midwifery care? How does the midwife-woman relationship enhance ethical care?

From this information we will derive research interview questions to take to a wider group of participants. With your permission this will be audio recorded and transcribed by Katherine Buchanan.

What are the potential risks in taking part in the study?
A potential risk is that you may feel discomfort when talking about emotionally charged experiences, thoughts and opinions about birth. If you feel too uncomfortable the audio recorder will be switched off at your request and should you wish you may withdraw from the study. Contact details of counsellors are provided from Skill collective West Perth or centre care 9325 6644 centrecare.com.au and Lifeline 24/7 counselling service 131114

What are the potential benefits taking part in the study?

The potential benefit you may experience is being a part of a community research group. This research group will co create research that meets the needs of childbearing women. The study also enables you to share your experiences and drive change that you want. Your experiences will contribute to the development of knowledge of ethical maternity care.

Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part or wish to withdraw at any time you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you wish to withdraw.

How will my privacy be protected?

Anonymity will be assured in publications and other dissemination of findings. Only my academic supervisors and I will have access to your personal details. Any information that may identify you will be removed during transcripts of the interview.

A PhD thesis will be produced as a result of this research but no names will be used. Any information that identifies any person during the study will be removed. Study findings will be published through health journals or communicated at conferences but no names or identifying information will be published or communicated. By agreeing to take part in this study, you agree not to restrict the use of any data (up to the point of data analysis), even if you withdraw. (If you withdraw before data analysis, all information supplied by you will be destroyed). Your rights under any applicable data protection laws are not affected.

Being a research participant in a community focus group means that you and your fellow participants will get to know each other. At the start of the focus group meeting, participants will be told that they must keep what is said at the focus group and the identity of other participants must remain confidential.
Appendices

Storage of information

All the collected material will be stored in a locked filing cabinet and retained for a minimum of 7 years post project completion. The master computer containing personal details will be kept in a separate location to the interview transcripts. All files will be password protected. All data will be managed in accordance with the National Health and Medical Research Council (NHMRC) guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at Edith Cowan University (No: 2019-00296-BUCHANAN)

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this study.

PhD Candidate: Katherine Buchanan

Supervisors: Associate Professor Dr Sara Bayes

Dr Deborah Ireson

Email: 

Who to contact if you have any problems about the organisation or running of the study?

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

ResearchEthicsOfficer
EdithCowanUniversity
270JoondalupDrive
JOONDALUPWA6027
What do I do if I would like to take part in this study?

If you would like to take part in this research study please respond via email to Katherine Buchanan at: [redacted] and I will contact you to make an appointment for a telephone discussion to clarify participation involvement and answer questions.

THANK YOU!

Consent to participate — focus group

Principal investigator — Katherine Buchanan

Principal supervisor — Sara Bayes

Participant Statement

I…………………………………………………………………… (Print Full Name)

have read the information on the attached participant information sheet regarding the study referred to above.

I understand the nature and the intent of the study and any questions I have asked have been answered to my satisfaction. I have also been informed where to direct any future questions. I agree to participate in this community research group but understand that I can change my mind and withdraw from the study at any time, up to the point of data analysis, without ramifications. I understand that all information provided is treated as confidential.

I agree to participate in a focus group and give consent for the focus group discussion to be audio-taped and transcribed. I also agree that any data gathered for this study may be published, provided my name or any other information that may identify me are not used.

I acknowledge that I need to respect the confidentiality of other focus group members and will not disclose anything discussed in the focus group discussions.
Appendices

Signature

Name

Researcher signature

Appendix 3. Participant information / consent: In-depth interview

Women’s experiences of maternity care from an ethical perspective - A feminist participatory action research project - In-depth interview

Principal investigator: Katherine Buchanan
Appendices

Principal supervisor: Deb Ireson

My name is Katherine Buchanan and I am a midwife, mother, researcher and counsellor. I am also studying at the school of Nursing and Midwifery at Edith Cowan University for a Doctoral Degree by Research (PhD).

You are invited to take part in this research. Please read over the information carefully and discuss with your family or friends if you wish. Please contact me for further clarification and make certain before you sign the consent form.

What is this study about?

The overall aim of the study is to explore ethical issues in maternity care from women’s perspectives. Childbearing over the last one hundred years has changed: a move from home to hospital has meant maternity care has become increasingly medicalised with nominal improvement in fetal and maternal mortality rates. One consequence of unnecessary intervention is women report dehumanising experiences that result in short- and long-term negative outcomes to both mother and baby.

Women, the World Health Organization [WHO], Human Rights in Childbirth, United Nations [UN] and maternity consumer activists are advocating for change in current global maternity care to reflect the need for respectful, women centred, ethical, maternity care. One area that hasn’t been explored is ethics in maternity care.

Why am I doing this study?

This study will address the significant global issue of maternity ethics from the childbearing women’s perspective. Understanding the ethical needs of childbearing women can help future directions of maternity care. The aim of this study is to work collaboratively with childbearing women to create research but also to drive change toward a more ethical maternity care system.

Why is this study suitable for me?

As a woman who has chosen a midwifery model of care you are in the unique position of being in only 3% of the population who chooses this care and have insights and experience that others do not. You are invited to share your experiences, perceptions and reflections.

What is involved in taking part in the study?
Appendices

Participation in this study is voluntary. If you decide to take part in the study, you will be asked to participate in a one-on-one interview with Kate in the setting of your choice to share your birth experiences. Some of the interview topics we may discuss will be: What has been your birthing experiences? How would you define / describe ethical care? How did the midwife make you feel supported? How did the midwife make you feel? What is good midwifery care? How does the midwife-woman relationship enhance ethical care? You will be asked to bring a creative piece to the interview that reflects your birth experience from an ethical perspective. This may be the written word such as a sketch, photo, sculpture, poem, a journal entry, letter, diary or email or precious object. This data collection is envisaged to give further supporting insights into what is significant to you when sharing your birth experience. The interview may last for up two hours.

With your permission this will be audio recorded and transcribed by Katherine Buchanan. Feedback will be given to you as to the progress of the study and publications from the data collected.

Are there reasons I should not be in this study?

You should not participate in this study if you do not want to talk about your birth experiences. If you do not wish to take part in the interview or have your birth story audio recorded and transcribed, then you should not consent to the study.

Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part of wish to withdraw at any time you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you wish to withdraw.

What are the potential risks in taking part in the study?

A potential risk is that you may feel discomfort when talking about emotionally charged experiences, thoughts and opinions about your births. If you feel too uncomfortable the audio recorder will be switched off at your request and should you wish, you may withdraw from the study. Contact details of counsellors are provided from Skill collective West Perth or centre care 9325 6644 centrecare.com.au and Lifeline 24/ 7 counselling service 131114

What are the potential benefits taking part in the study?
Appendices

The potential benefit you may experience is being a part of research that aims to improve the care of childbearing women. The study also enables you to share your experiences and birth story. Your experiences will contribute to the development of knowledge of ethical maternity care.

How will my privacy be protected?

The information you provide will be analysed by the principle investigator and the supervisors no one else will have access to the data. You will be allocated a participant number and any identifying information will be de identified prior to being transcribed.

A PhD thesis will be produced as a result of this research but no names or identifying information will be used. Study findings will be published through health journals or communicated at conferences but no names or identifying information will be published or communicated. By agreeing to take part in this study, you agree not to restrict the use of any data (up to the point of data analysis), even if you withdraw. (If you withdraw before data analysis, all information supplied by you will be destroyed). Your rights under any applicable data protection laws are not affected.

Storage of information

All the collected material will be stored in a locked filing cabinet and retained for a minimum of 7 years post project completion. The master computer containing personal details will be kept in a separate location to the interview transcripts. All files will be password protected. All data will be managed in accordance with the National Health and Medical Research Council (NHMRC) guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at Edith Cowan University (No 2019-00296-BUCHANAN)

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this study.

PhD Candidate: Katherine Buchanan

Email: [redacted]
Appendices

Supervisors: Dr Deborah Ireson

Who to contact if you have any problems about the organisation or running of the study?

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027

What do I do if I would like to take part in this study?

If you would like to take part in this research study please respond via email to Katherine Buchanan at: and I will contact you to make an appointment for a telephone discussion to clarify participation involvement and answer questions.

Consent to participate — Interview

Study title: Women’s experiences of maternity care from an ethical perspective — A participatory research project

Participant statement

I ...........................................................(print full name)

Have read and understood the information on the attached participant information sheet regarding the study referred to above.

I understand the nature and the intent of the study and any questions I have asked, have been answered to my satisfaction. I have also been informed where to direct any future questions.
Appendices

I agree to participate in this research but understand that I can change my mind and withdraw from the study at any time, up to the point of data analysis, without ramifications. I understand that all information provided is treated as confidential.

I agree to be interviewed and give consent for the interview to be audio-taped and transcribed. I also agree that any data gathered for this study may be published, provided my name or any other information that may identify me are not used.

Signature............................................................................................................................

Name.................................................................................................................................Date..............

Researcher signature..............................................................................................Date...............
# Appendix 4. Risk reduction and action protocol

<table>
<thead>
<tr>
<th>Potential psychological risk</th>
<th>Prevention of risk exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved in a study that discusses birth experiences</td>
<td>1. Introductory research letter and consent forms</td>
</tr>
<tr>
<td></td>
<td>Participants will have access to explanation of the research in an introductory letter including interview questions and may choose not to be included in the study. Thereby exercising their agency and choice about what is psychologically safe for them</td>
</tr>
<tr>
<td>Discussion around birth experiences</td>
<td>2. Briefing and procedures for referral explained before interview</td>
</tr>
<tr>
<td></td>
<td>Prior to the interview it will be reiterated that birth discussions may bring up both positive and possibly negative feelings. At this point the participant may act on her autonomy and self-responsibility to remove herself from the interview.</td>
</tr>
<tr>
<td></td>
<td>The participant will be offered phone number for counselling service if she should wish to discuss her personal birth experience in greater depth with a health professional</td>
</tr>
<tr>
<td></td>
<td>Gain further verbal consent</td>
</tr>
<tr>
<td>Participant becomes upset during interview</td>
<td>3. Researcher responsiveness, reflexivity and is a registered counsellor</td>
</tr>
<tr>
<td></td>
<td>If a woman feels unexpectedly saddened, the interview will stop, and I will attend to the woman in order to give immediate support but not to give private counselling.</td>
</tr>
<tr>
<td></td>
<td>A referral will be made to a counsellor for further debriefing and counselling support and phone numbers for 24/7 Lifeline are on participant information sheet</td>
</tr>
<tr>
<td>Participant becomes upset after the interview has ended</td>
<td>4. Researcher contactable after interview. The researcher will be contactable after the interview to debrief about what was discussed or clarify any issues that may have come up for the woman (but counselling not offered by researcher) Referral to counsellor and 24/7 Lifeline numbers given on participant information sheet</td>
</tr>
<tr>
<td>Participant wishes to speak about her birth experience with a health professional</td>
<td>5. Referral list of Counsellors and Psychologists The researcher has contacted a counsellor and psychologist who is willing to take on clients who wish to discuss their birth further.</td>
</tr>
<tr>
<td>Participant has overwhelming feelings outside of business hours</td>
<td>6. After hours emergency contact numbers given 24/7 Lifeline numbers given on participant information sheet</td>
</tr>
</tbody>
</table>
### Appendix 5. Semi-structured interview guide and reflections

Women’s experiences of maternity care from an ethical perspective - A participatory research

Principal investigator - Katherine Buchanan

File name for digital copy -

<table>
<thead>
<tr>
<th>Date / time / setting / consent</th>
<th>Gain verbal consent prior to commencing</th>
</tr>
</thead>
</table>
| Introductions / format / definitions | Purpose of the study  
Format of the interview  
Definitions of ethics, care ethics, bio ethics, |
| Opening question | You may start by telling me how many children you have and your birth history... |
| Content questions or variations of – keep open | Can you tell me about your birth?  
Why did you choose midwifery led care?  
Can you share an experience that you thought was unethical or wrong in the care you received?  
Can you share an experience that you thought or felt was good about the care you received?  
Can you share with me an example of making a decision during pregnancy and childbirth? |
<table>
<thead>
<tr>
<th><strong>Closing question</strong></th>
<th><strong>Is there any further information that you would like to share that has not been covered?</strong></th>
</tr>
</thead>
</table>

Appendix 6. Reflexive Thematic Analysis checklist for quality

A tool for evaluating thematic analysis (TA) manuscripts for publication: Twenty questions to guide assessment of TA research quality.

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using TA, even if only briefly? Y

2. Do the authors clearly specify and justify which type of TA they are using? Y

3. Is the use and justification of the specific type of TA consistent with the research questions or aims? Y

4. Is there a good ‘fit’ between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)? Y

5. Is there a good ‘fit’ between the methods of data collection and the specific type of TA?

6. Is the specified type of TA consistently enacted throughout the paper? Y

7. Is there evidence of problematic assumptions about, and practices around, TA? N

8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively? N

9. Are the theoretical underpinnings of the use of TA clearly specified Y

10. Do the researchers strive to ‘own their perspectives’ (even if only very briefly), their personal and social standpoint and positioning? Y

11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures? Y

12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA? N

13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA? Y

14. Is it clear what and where the themes are in the report? Y

15. Are the reported themes topic summaries, rather than ‘fully realised themes’ – patterns of shared meaning underpinned by a central organising concept? N

   ● Have the data collection questions been used as themes? N

16. Is non-thematic contextualising information presented as a theme? (e.g. the first ‘theme’ is a topic summary? N
Appendices

17. In applied research, do the reported themes have the potential to give rise to actionable outcomes? Y

18. Are there conceptual clashes and confusion in the paper? N

19. Is there evidence of weak or unconvincing analysis, such as: ● Too many or two few themes? N