ABSTRACT

Understanding the Moral Nature of Intrapartum Nursing:

Relationships, Identities and Values

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The establishment of effective relationships is fundamental to good nursing practice and the fulfillment of nurses’ moral responsibilities. While intrapartum nurses are uniquely placed to establish relationships that can directly influence a woman’s experience of childbirth, there has been limited investigation of the relationships, identities and values that underlie nurses’ varied approaches and responses to labouring women. The purpose of this study was to explore intrapartum nurses’ understanding of their moral responsibilities from a social-moral perspective, using Margaret Urban Walker’s “expressive-collaborative” model of morality. Interviews were conducted with fourteen registered nurses working in a birthing unit of a Canadian teaching hospital. Four themes were identified that captured nurses’ moral responsibilities, including: organizing and coordinating care, responding to the unpredictable, recognizing limits of responsibilities to others, and negotiating care with women and families. Nurses enacted their moral responsibilities to labouring women in a variety of ways depending on their personal and professional experience, the circumstances, the people involved and the context of care. A key factor influencing responses to women was the degree to which understandings and expectations related to birth were deemed to be
reasonable and mutually agreed upon among nurses, physicians, women and their families. Nurses also described limits on their responsibilities to others. Their choice of response to circumstances in which practice was constrained departed from the idealized expectations and ‘expert’ practices often reflected in professional guidelines.

While nurses were able to identify contextual influences that constrained their ability to maintain effective relationships with women, the influence of their own values on the care they provided was less apparent. This suggests a need to challenge normative assumptions related to care of women in childbirth, including the provision of choice and family centred care, in order to create environments that can support and sustain practices that build understanding, mutuality and trust between nurses and birthing woman. In addition, given the contested nature of childbirth and the lack of shared understandings of what constitutes ‘best’ care, there is a need to develop collaborative models of inter-professional maternity care that include the voices of women as a central component.
Dedication

To Heather Mains (1957-2007)

A tireless advocate for women and birth and a dear friend
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Chapter 1 – Introduction to the Study

A practice-based profession such as nursing embodies more than science, individual knowledge and technique but also includes styles and processes of relating to the families and individuals who are the recipients of care (Weiss, Malone, Merighi, & Benner, 2002). A key factor affecting the provision of health care and the achievement of positive outcomes is the way in which health care professionals interact with their patients (Bottorff & Varcoe, 1995). While in most Canadian hospital births, physicians are responsible for the medical care of childbearing women, it is intrapartum nurses who maintain sustained proximity to women during labour and birth and are therefore uniquely placed to establish relationships and care practices that can directly influence the woman’s experience of childbirth.

Childbearing women and their caregivers share a common goal of ensuring safe outcomes for both mother and baby. However, less tangible maternal outcomes, such as maternal satisfaction, are important to consider as these may influence a mother’s sense of competence and confidence in her new role, enhance initiation and duration of breastfeeding and reduce the incidence of postpartum depression (Hodnett, Gates, Hofmeyr, Sakala, 2007). Satisfaction in childbirth has been found to be directly related to the quality of the relationships women have with their health care providers, specifically the extent to which women are involved in decision-making and included in discussions about care options.

The establishment of effective relationships involving on-going negotiation with patients and other health care providers within the environment of care is fundamental to good nursing practice and the fulfillment of nurses’ moral responsibilities towards families and individuals in their care. However, there has been limited investigation of the factors that
underlie the moral choices that nurses make when delivering care to labouring women in a hospital birthing environment. This determination of who and what is worthy of our recognition and response constitutes our sense of moral responsibility (Walker, 1998).

Within intrapartum nursing, moral responsibilities are directed towards labouring women who are relatively vulnerable and in need of care.

Margaret Urban Walker’s “expressive-collaborative” model of morality (1998, 2003) highlights the connection between our social and moral worlds and the importance of accounting for the context in which relationships are situated. Her work has particular relevance to a study exploring the nature of relationships between nurses and childbearing women as it emphasizes the moral aspects of the sometimes less visible everyday situations that arise in the context of childbirth such as the negotiation that occurs between childbearing women and their nurses regarding options for comfort and pain management or weighing the risks and benefits of medical interventions.

Although the terms ‘ethical’ and ‘moral’ are often used interchangeably, in this study the term moral is used deliberately to connote something more broad and relevant to nursing than the more commonly used language of ethics. Chambliss (1996) argues that the term ethics within hospital settings is often linked to abstract, rights-driven, individualistic codes in which language reinforces the moral values inherent in medicine and law and within institutions. These moral values do not necessarily reflect the realities of nursing practice, which is enacted through relationships that are influenced by personal as well as contextual forces. Morality, instead, “arises and goes on between people” (Walker, 1998, p. 5) and is understood to apply to human experiences of right and wrong in the context of everyday life. Walker (1998) suggests that in order to understand what moral agents know, reason or decide
about how to act, we need to more clearly understand the connections between social positions, responsibilities and identities.

**Purpose of Study**

The purpose of this study was to examine how moral understandings were established and reproduced by nurses within a hospital birthing environment. Narratives of relationship, identity and value were used as a template or “interpretive grid” (Walker, 1998, p.212) for moral inquiry to understand how relations of trust and responsibility were determined and to identify opportunities to make moral changes in better directions possible. Nurses’ descriptions of everyday practice and interactions with people within their environment of care were used to explore the moral nature of nursing work.

The research questions in this study were:

- How do intrapartum nurses understand and negotiate their moral responsibilities towards women and their families during childbirth?
- What are the relationships, identities and values that shape the ability of intrapartum nurses to negotiate their moral responsibilities for women in childbirth?

This study constituted a ‘Critical Moral Ethnography’ which explores the parts of a social-moral order that are “invisible or if seen, not spoken, and if spoken, ignored or discredited” (Walker, 2003, p.211). This perspective highlighted the particularities of the social worlds and the contexts in which relationships and roles were established, developed and maintained on an intrapartum hospital unit. In-depth semi-structured interviews were used to engage nurse participants in discussions about the underlying assumptions that guided
their moral practices with women during childbirth and to consider ways of transforming the
environment of care in order to support the development of mutually respectful and
satisfying relationships.

This research builds on existing literature on intrapartum nursing practice and social
perspectives of childbirth through an exploration of the moral dimensions of relationships
between nurses and childbearing women. The goal of this research was not to identify the
morally ‘right’ thing to do, as ultimately there is no one single moral truth that can be applied
to nurses and women when considering conditions surrounding choices in childbirth. Instead,
this investigation provides a deeper understanding of the meaning and practice of moral
responsibilities in the relationships between intrapartum nurses and labouring women, in
order to enhance the birth experience and outcomes for women, newborns and their families
and to create nursing work environments that foster the provision of quality care.
Chapter 2 - Literature Review: Moral Contexts, Relationships and Practices

A conception of healthcare ethics that reflects the everyday moral concerns arising in nursing practice must attend to the institutional structures and processes that shape ethical practice (Austin, 2007; Pauly, Varcoe, Storch & Newton, 2009; Storch, Rodney, Pauly, Brown & Starzomski, 2002; Varcoe, Rodney & McCormick, 2003). This review of the literature focused on qualitative and quantitative studies¹ aimed at understanding and explaining the moral, relationships, identities and values inherent in nursing practice in general and intrapartum nursing in particular. Databases searched were CINAHL, Medline and Scholars Portal multi-database search, using initial key words including: ethics, childbirth, nurse-patient relationship, decision-making, choice, moral identity, moral climate, work environment, intrapartum and maternal-child nursing. Other sources of literature were found via word of mouth or through reference lists. Three themes of contexts, practices and relationships were developed through reading and analysis of relevant research. These themes also arose through the concurrent articulation of the theoretical perspective for this study based on the work of Margaret Urban Walker (1998, 2003, 2006). Although contexts, practices and relationships within intrapartum nursing are interrelated and mutually influenced by each other, for the purposes of clarity within this review, I chose to explore each area in a distinct section, using the summary and conclusion sections to highlight the interrelatedness and connections between the themes.

¹ Research studies are detailed in Appendix F
**Contexts and Nurses’ Moral Practices**

Contexts shape the daily choices and perceptions of human beings (Walker, 2003). Therefore, in order to understand the moral practices and decision-making processes of nurses, it was essential to explore the environments in which they work. This section will begin with an overview of the values and ideologies inherent in hospital work environments and an analysis of how these impact nursing practice and the establishment of relationships within the context of care. The focus will then be narrowed to the obstetrical hospital environment and an exploration of factors that affect relationships between nurses and other health care professionals as well as among nurses, childbearing women and their families.

**Institutional values and nursing ideologies**

Individual nurses and their settings are reciprocally and mutually defining in that both hospitals and nurses shape the social and moral working environment within institutions (Rodney, Varcoe, Storch et al, 2002; Chambliss, 1996; Weiss, Malone, Merighi & Benner, 2002; Peter, MacFarlane & O’Brien-Pallas 2004; Liashenko, 1997; CNA, 2010). In their interpretive phenomenological study of skill acquisition and clinical and ethical reasoning amongst critical care nurses in the United States, Weiss et al (2002) found that institutional pressures for economy and efficiency led to incongruence between the values of the practitioners and those of the institutions. They suggested that this model of care delivery did not allow adequate time for nurses’ relational work, thereby constraining the nurse’s ability to meet her/his professional ethical and practice standards. Structural constraints and inadequate time were thought to preclude relational activities, thereby jeopardizing the formation of a trusting relationship with patients and families. In addition, an efficiency
model contributed to the erasure of particular identities of both nurses and patients, positioning individuals as commodities within institutional structures and processes of care delivery. The authors concluded that there was a need to address the ways in which institutional resources and structures affect nursing practice and to develop a ‘moral ecology’ in which sustainable structures could be put in place to enhance the moral agency of nurses and ultimately to improve the quality of patient care (Weiss et al.).

The contextual and processual nature of nurses’ ethical decision-making was also explored using a constructivist qualitative inquiry (Rodney et al., 2002). In this study, nurses and nursing students in a variety of hospital-based clinical settings described a negotiated process of moral agency in which they worked ‘in-between’ the values of institutions, patients, other caregivers and themselves to achieve their goals on an ever-changing moral ‘horizon’. While negotiations were constrained by the privileging of biomedicine and corporate values of efficiency, they were facilitated by supportive colleagues, professional standards and guidelines and education which enabled nurses to use the language of ‘ethics’ to frame and interpret moral issues within their practice.

A meta-synthesis of three ethnographic studies aimed at understanding how relationships among patients, family members and health care providers were shaped by organizational context found that moral judgments and decision making in health care have relational as well as contextual components (Varcoe et al., 2003). The authors suggested that by offering prescribed solutions to individual patient problems, nurses were unwittingly using coercive power to “reproduce rather than challenge” hierarchical systems, thereby limiting the agency of both patients and health care providers (p. 967). They concluded that instead of focusing on the development of moral integrity, nursing leaders and educators
needed to emphasize the collective values and shared responsibility of nurses in order to foster ethical practice.

The spatial nature of the nurse: patient relationship may also influence nurses’ ethical concerns and responses. Using a geographical qualitative focus, Liaschenko (1997) found that the social spaces of hospitals were oriented towards homogenization of identity and influenced by the detached but dominant discourse of medicine as well as an ethos of economy and efficiency within the institution. This tendency towards standardization, which could be applied to both the givers and recipients of care, enabled subtle and often invisible structures to exert control over the choices and behaviours of nurses. For example, Liaschenko suggested that in order to prevent fragmentation of care while maintaining patient focused care, nurses had to ‘fill the gaps’ by increasing their investment of time (1997). However, because these investments of time, taken in lieu of scheduled breaks, remained largely invisible to others, nurses’ actions only served effectively to protect the public’s view of physician practice and institutional purpose while also limiting the public’s understanding of the nurse’s contribution.

The themes of institutional ideologies constraining nursing practice was also explored by Varcoe and Rodney (2002) who investigated the ways in which corporate ideologies were enacted within nursing practice, in health care in general, and by nurses themselves. Using a critical feminist perspective, these authors suggested that if nurses became more aware of the ideologies used to structure their work, especially those that may detract or act in opposition to the professional goals and values of nursing, they may be able to challenge some taken for granted assumptions such as the need for efficiency. This awareness may help nurses to recognize ways in which they are complicit in supporting the goals of the institution at the
expense of patient care, for example by contributing to a nursing culture that values efficiency over effectiveness and demeans those nurses who engage in emotional and relational care with their patients. While the scarcity of time was often cited by nurses as the reason for the discrepancies between the care they valued and the care that they were able to provide, Varcoe and Rodney (2002) theorized that the issue was not really lack of time but rather the lack of autonomy and control that resulted when nurses were not able to place priority on their relational work with their patients.

Peter, MacFarlane & O’Brien-Pallas (2004) examined the moral inhabitability of the 90’s post-restructuring hospital work environments for Canadian nurses and explored ways in which nurses shaped and were shaped by the moral environments in which they worked. Nurses in this study described their work environments as oppressive and dominated by medical and business values. Increasingly complex patient care responsibilities without corresponding authority left many nurses feeling powerlessness and marginalized. Nurses also experienced incoherent responsibilities in which their responsibilities and those of the other members of the health care team were not clearly defined, understood or fairly allocated in a transparent manner. They were overwhelmed by the expectations of the institution, families and other health care providers which they felt were impossible to attain, given their existing capacities and resources.

When divisions of responsibilities were made transparent, nurses had more than their share and were unclear where they began and ended. Due to their sustained proximity to patients, nurses experienced an intensified sense of accountability and therefore they often felt obliged to assume responsibilities that belonged to other members of the health care team. Nurses in this morally ‘uninhabitable’ climate experienced moral suffering which was
brought about by feeling emotionally exhausted, abandoned by institution, and having to constantly compromise their professional values. In order to cope with this, some nurses ‘resisted’ by moving to part-time or casual work, becoming more assertive or by forming a more cohesive work group so that nursing values could be retained (Peter et al, 2004a).

The concept of nursing resistance as ethical action was explored in an integrative literature review (Peter, Lunardi & Macfarlane, 2004) Within the hospital environment, sustained proximity of nurses to patients intensified nurses’ sense of accountability. Nurses often felt obliged to assume responsibilities that belonged to other members of the health care team and their capacity for moral action was influenced by their perception of their power within the institution. A central moral value in nurses’ descriptions of ethical conflicts was the importance of sustaining nurse-patient relationships. Nurses’ sense of responsibility to sustain patient well-being created possibilities for resistance within their relationships with other health care professionals such as physicians.

The authors found that many strategies of resistance rested on the nurse’s personal qualities and capacities such as assertiveness, diplomacy and unconventionality. The positioning of nurse managers within hierarchical power structures provided these individuals with the potential to create opportunities for resistance and possible change when ethical conflicts arose. Although nurses used indirect forms of resistance, such as covert communication, the authors suggested that by acting outside or around workplace structures instead of on them, nurses inadvertently allow themselves to be further exploited by keeping their subversive activities hidden. They also discovered that when nurses acted on their moral concerns, they experienced scapegoating and loss of support from nursing colleagues (Peter et al, 2004).
The impact of environment on nursing practice in the intrapartum context

Intrapartum nurses work in complex environments in which their ability to provide supportive care and implement evidence-based nursing practice is influenced by staffing levels, the physical environment, nursing leadership, the characteristics of the community and inter-professional struggles with physicians (Angus, Hodnett & O’Brien-Pallas, 2003; Carlton, Callister, Christiaens & Walker, 2009; Ontario Women’s Health Council, 2000; Payant, Davies, Graham, Peterson & Clinch, 2008; Ryan, Goldberg & Evans, 2010). An analysis of practice environments identified five program features that influenced and supported best practices on labour and birth units. These included: the attitude of hospitals towards childbirth that reflected a philosophy of birth as a normal, physiological process; program organization that included strong leadership and effective multidisciplinary teams; commitment to evidence-based practice and the knowledge and information to support this; connections and networks of communication to ensure staff could share information and avoid isolation in their work; and finally the ability and resilience to manage change in a health care environment that is constantly changing (Ontario Women’s Health Council, 2000).

Continuous supportive care in labour, which may include the provision of emotional support, physical comfort measures and information, has been identified as a desirable practice for labouring women as it provides maternal and neonatal benefits without any known risks (Hodnett et al., 2007). A systematic review of continuous support for women during childbirth (2007) noted that childbirth environments influence the healthcare professionals who work in them as well as the women who labour and give birth in them. This review included fifteen randomized controlled trials involving 12,791 women from
eleven countries worldwide. The authors found that the effectiveness of intrapartum support by nurses was influenced by policies in the birth setting and type of provider. Support provided by non-staff members was generally more effective than support by institutional staff, such as nurses. While the reasons for this remain unclear, it is believed that divided loyalties, additional duties besides labour support, self-selection, and the constraints of institutional policies and routine practices may all have played a role (2007). In their conclusions, the authors observed that some labour and birth units appeared to function according to a risk-oriented, technology-dominated approach to care which may have influenced nursing practice. In order to improve the provision of effective supportive care in labour by nurses, it was suggested that fundamental changes in the organization and delivery of maternity care would be needed, including changes to the content of health professionals' education and to the core identity of professionals.

In a related study, Davies & Hodnett (2002) assessed nurses’ self efficacy for labour support and described intrapartum nurses’ perceptions of the barriers and facilitators to the provision of supportive care. According to the self efficacy scale developed by the authors and distributed to the nurse participants, nurses expressed confidence in their ability to provide supportive care. However this did not translate into practice as evidenced by work sampling studies that indicated only 11-30% of time spent in labour support activities. Levels of staffing, the physical environment, management practices and teamwork were identified by nurses as the factors that could either enable or hinder the provision of labour support. Two related studies examining provision of supportive care in labour (Payant et al.2008; Carlton et al., 2009) found that subjective norms - including expectations of unit managers and other nurses - organizational barriers such as unit acuity, and the unpredictable nature of
the hospital birthing environment combined to influence nurses’ intentions to provide labour support.

Penticuff & Walden (2000) explored the relative contributions of the practice environment and nurse personal and professional characteristics on the capability of intrapartum nurses to act in resolving ethical dilemmas. They noted that being responsible for carrying out the decisions made by others caused personal and professional conflicts for nurses. Although previous theoretical assumptions suggested that nurses who saw their role as upholding professional versus organizational standards would practice more ethically, it was found that an exclusively professional role orientation was often not attainable. This was thought to stem from the realities of work environments in which nurses did not have sufficient autonomy to implement their desired roles.

The study suggested that if nurses were not able to fulfil their ethical obligations to patients due to constraints within the practice environment, nursing practice and the quality of patient care would be compromised (Penticuff & Walden, 2000). Nurses who perceived themselves to have influence in the practice environment and who emphasized individual aspects of a patient’s situation as opposed to abstract rules and standards were more likely to take action to resolve dilemmas and act on the patient’s behalf (2000). Although characteristics of the practice setting accounted for greatest variance in nursing activism, it was felt that nursing ethical practice was influenced by both nursing values and the practice setting.

A final study (Watson, Murtagh, Lally, Thomson & McPhail, 2007) used a geographical approach to consider the ways in which health professionals’ sense of place constrained and fashioned their approach and response to women’s choices for pain relief in
childbirth. Findings from focus groups conducted with prenatal educators, midwives, anesthetists and obstetricians suggested that flexibility was a necessary component of the “therapeutic landscape” of maternity care. This flexibility allowed for recognition of women’s differing experiences of labour pain and also highlighted the prevailing social discourses of choice and empowerment associated with childbirth.

**Critique and Summary**

The literature cited on the context of nurses’ moral practices suggested that oppressive structures and relationships within individual institutions constrained a nurse’s capacity to meet expected professional and ethical standards and to enact the full range of her moral responsibilities. Several themes were identified when analyzing the literature regarding the impact of the environment on the relational work and practice of nursing. Many nurses placed high value on establishing meaningful relationships with their patients and struggled to sustain these in environments which privileged efficiency and economy. When the dominant ideologies of the institution acted in opposition to the professional goals and values of nursing, the relational and emotional work of nurses remained hidden. Nurses who were not able to place priority on their relational work with patients because of the demands of the institution experienced a lack of autonomy and control.

Nurses who resisted the dominant ideology of the institution were demeaned and risked loss of support from nursing colleagues. If nurses chose to resist in subversive and hidden ways, they were sometimes able to better fulfil their moral responsibilities towards their patients but also perpetuated their own oppression by acting around and not directly on the dominant power structures within their work environment. The work of Varcoe and
Rodney (2002) is important as it suggests an active, participatory role for nurses in questioning, challenging and changing the dominant structures that shape their work environments. This perspective also avoids the position of powerlessness that leaves nurses less responsible and accountable for their actions and effectively maintains the status quo.

While compelling and important, these studies can be critiqued for the unidirectional influence assumed in creating and sustaining moral environments – that is, from the institution directed towards and upon the nurse. This may be due, in part, to the methods and questions posed to nurses. As noted by the authors in one study (Rodney et al, 2002), the focus group approach can engender a kind of ‘groupthink’ wherein participants may feel compelled to support a dominant viewpoint. Asking participants what they considered to be ‘good’ ethical practice may perpetuate the production of discourse that will be well received by a nursing audience but that may not reflect the realities of practice (Nelson & McGillion, 2004). The fact that nurses who volunteer for these studies may be quite different from those who do not must also be considered. Also, in setting up a ‘good-bad’ dichotomy, wherein ‘others’, including institutions, are identified as barriers to effective practice, the nurse’s role and responsibility remains hidden and unchallenged. Although Liaschenko (1997) notes that her study was not meant to be interpreted as gripe sessions against physicians, the nurses’ stories are oriented in that direction with limited understanding of the ways in which they may contribute to the moral climate. In short, the nurse-as-victim approach does not make sense when we consider that any number of nurses working in the same setting will still choose to enact a diverse range of moral responses.

Findings from the literature on nurses’ moral practices in intrapartum environments are similar to those observed in other areas of nursing practice within institutions. There is
evidence in the intrapartum literature that care environments, the healthcare professionals who work in them as well as the women who labour and give birth in them mutually define and influence one another (Hodnett et al., 2007; Angus et al, 2003). When emphasis is placed on efficiency, the particularities of women become less visible, challenging nurses to fulfil their moral responsibilities. When conflicts occurred between workplace and personal ethics, caregivers perceived a lack of support for birthing women and a limited capacity to exercise their professional judgment. The implication here is that nursing practice and ultimately the quality of patient care could be compromised if nurses were unable to fulfill their moral obligations to patients due to oppressive practice environments.

A final consideration is the continuing theme in nursing whereby organizational constraints influence the ability of nurses to implement their values in practice. A recent longitudinal study questioned the sustainability of long-held nursing ideals, such as the delivery of individualized, patient-centred holistic care, within the realities of our current health care system (Maben, Latter & Clark, 2007). The authors proposed that nursing’s overambitious mandate produces exaggerated expectations for nurses of what is actually possible in practice, leading to disillusionment and distress. Further exploration of the issues raised by the authors, such as the need to train registered nurses to assume roles in leadership and care coordination versus direct hands on care, are beyond the scope of this review. However, the question of sustainability of ideals is worthy of consideration given the nature of the moral concerns experienced by nurses in the studies within this review.
Relationships in Intrapartum Nursing

When women evaluate their experience of giving birth, four factors predominate including the amount of support from caregivers, the quality of relationships with caregivers, involvement with decision-making, and high expectations or having experiences that exceed expectations (Hodnett et al, 2007). The relationship between the nurse and labouring woman is the means through which intrapartum care decisions and practices are implemented. As such, it is in relationship that caregivers and labouring women negotiate and understand their moral responsibilities with one another.

In this section, the nature of relationships between nurses and labouring women was examined, as these relationships are strong predictors of satisfaction with childbirth (Brown et al, 2009; Hodnett et al., 2002; Sorenson & Tschetter, 2010). The perspectives of nurses and labouring women were considered, as both contribute to the establishment and maintenance of relationship throughout the process of childbirth. Specific attention was paid to the influence of communication strategies on the exertion of power and control in relationships between childbearing women and their nurses. The literature in this area pertaining to midwifery practice was also explored, as in many instances the practices of hospital-based midwives was very similar to that of intrapartum nurses (Thompson, 2003).

Experiences of nurses in relationship with childbearing women

Distinct differences in the quality of relationships and role dimensions between women and their nurses have been found, in which nurses were most attentive to women when providing care related to comfort and least attentive during instrumental aspects of care (Beaton, 1990). Using a social constructivist approach, Beaton (1990) explored the ways in
which nurses controlled the social construction of childbirth through verbal interaction. Analysis of nurse-patient verbal exchanges during labour and birth were classified according to three categories. These categories included attentiveness, acquiescence and presumptuousness. Attentiveness was described as the questions, acknowledgements, interpretations and reflections that concerned the other person’s experience and addressed the extent to which nurses and women listened to each other. Acquiescence occurred when the speaker allowed the other person’s viewpoint to determine the course of conversation, where one viewpoint or definition of reality could predominate the interaction. Presumptuousness reflected the degree to which the speaker presumed to have knowledge of the other’s experience (Beaton).

Both nurses and women were ‘nonacquiescent’ in that each interacted with the other from their own perspective, attempting to control the conversation and keep it in a familiar frame of reference. The author used the example of pain management to illustrate these exchanges, whereby the labouring woman used her own frame of reference to express her level of pain, while the nurse implemented what she considered to be the most appropriate action based on her interpretation of the woman’s level of discomfort. Overall, Beaton found that nurses regularly presumed to know what the woman’s perspective was or should be and women generally accepted the nurse’s presumption of greater authority and knowledge (1990).

While nurses do have knowledge and experience that constitutes a valued and integral aspect of intrapartum nursing care, their practice of maintaining control over the definition of the childbirth experience and presuming to know the labouring woman’s needs created an obstacle to establishing relationships marked by mutuality and negotiation. Beaton (1990)
concluded that failure to determine women’s perceptions of the situation and not acknowledging their viewpoints as relevant had a negative impact on the creation of a satisfying patient centred birthing environment.

In a related study, a survey was conducted of midwives, nurse managers and licensed practical nurses working in four labour and delivery units in Finland to determine the ways in which these health care professionals exercised power over childbearing women in communication (Sinivaara, Suominen, Routasalo & Hulpi, 2004). Almost all respondents agreed that women possessed the ability to make their own decisions and were encouraged to do so, although a smaller percentage acknowledged that women were persuaded to agree with the staff member’s opinion.

There was almost universal consensus that nurses and midwives aimed to have relationships with women that were based on equality and individuality (Sinivaara et al, 2004). However, caregivers were more likely to make decisions on behalf of women who were frightened, were from a different ethnic background, or those women deemed to be ‘mentally unstable’ as defined by criteria not specified by the authors. Limited information was given to women who were perceived to be ‘aggressive’, and caregivers’ relationships were ‘less warm’ with women who were either critical of their professional skills or those who expected ‘special treatment’ (2004).

The issue of ‘special treatment’ for those women who require extra support and resources was also addressed in an Australian collaborative, interactive study that examined the impact of caregivers’ assumptions on care provided to women and families from different ethnic communities (Blackford & Street, 2002). Although nurses initially assumed that they practiced in a non-discriminatory manner, treating everyone ‘the same way’, discussion with
colleagues and researchers over a seven month period revealed that this focus on equality actually masked cultural differences and resulted in the provision of inequitable care for women. For example, the necessity of using female translators to enable non-English speaking women to have their needs understood was often viewed as time consuming and therefore was often avoided. However, after discussion, caregivers understood that this special and ‘un-equal’ treatment was essential in order for these women to receive the care that their English-speaking counterparts enjoyed as a matter of course.

**Experiences of women in relationship with nurses during childbirth**

Women tended to be reluctant to assert themselves in their relationship with caregivers, as they recognized their dependence on these individuals and did not want to jeopardize the well being of themselves or their babies (Baker, 2005). Women also reported that their experience was enhanced when nurses recognize their uniqueness, knew the particulars of their situation and respected their ability to make competent decisions (MacKinnon et al, 2003). Besides being known by the nurses, women expressed a desire to also ‘know’ their nurses and to establish some form of mutuality in their relationship and goal setting for birth (Manogin, Bechtel, & Rami, 2000).

A qualitative Swedish study used direct observation of naturally occurring interactions between caregivers, women and their partners during childbirth and compared this with couples’ pre-natal expectations and reflections on actual birth experiences (Hallergen, Kihlgren, & Olsson, 2005). Midwives had a strong influence on the type of relationship that was established and that they differed significantly in how they implemented their caring activities. Four categories of midwifery relationships were identified, including
attentive companion, invading determiner, insensitive supervisor and task-oriented administrator. Midwives who were classified as ‘attentive companions’ used everyday language to exchange information and were able to strike a balance between overseeing the clinical aspects and progress of labour while also respecting a woman’s individual ‘rhythm’ of birth. The moral ‘demand’ in these cases was to not disturb the labour process but to preserve and promote a woman’s sense of confidence and trust in her body as well as the couple’s ability to move through labour together (Hallergen et al.).

On the other hand, midwives who were classified as ‘invading determiners’ interrupted the patterns that couples had established, took command and prescribed how the situation should be experienced. Examinations were conducted without explanations and clients’ questions were side-stepped. Women perceived these types of midwives to be ‘distanced’ and expressed feelings of being abandoned, uncertain and angry about being forced to make choices that were not their own. Interactions with these midwives left women feeling weak and powerless and ultimately resigned. The ethical demand to interpret the woman’s needs and desires and allow her to be an active giver of birth, on her own terms, was not met in this case (Hallergen et al., 2005).

Midwives who were classified as ‘insensitive supervisors’ were viewed by the couple to be non-cooperative and ‘disturbing’. An example was given of a midwife who visited a labouring couple infrequently, for short periods and acted immediately upon entering the room. The couple, who were working well together, was interrupted by the midwife but was able to re-establish connection with one another when she left the room. The midwife in this case failed to respond to the ethical demand to establish relationships based on mutual respect and sensitivity to the others’ particular needs in specific situations (Hallergen et al.,
The final relationship category to emerge was that of a ‘task oriented administrator’, in which the midwives involved did not meet the ethical demand to relate with respect and sensitivity to families within their care. In this case the woman was confined to bed with continuous monitoring and the midwives supervising her care appeared to be more engaged with the monitor than with the woman and her partner. The woman’s questions were answered evasively and the partner was ignored. In the postpartum period, these women expressed feelings of helplessness and uncertainty and the couple felt they had been ‘cheated’ out of the birth experience for which they had hoped.

The study concluded that ethical ways of relating involved demonstrating sensitivity and openness to the uniqueness of each woman and the ability to create a space for this type of caring relationship to emerge (Hallgren et al, 2005). Concentration on technical aspects of care was interpreted to be a protective response to situations in which midwives were unable to integrate both the task and interpersonal aspects of care. While this study did not examine the caregivers’ perspective or the contextual factors that may have influenced the kinds of relationships midwives established, the findings are important as they highlight the influence of relationships on expectations and outcomes experienced by childbearing women and their partners.

**Satisfaction, decision-making and control in relationships**

The attitudes and behaviours of caregivers have been shown to influence how women rate their satisfaction with childbirth (Hodnett, 2002; Hauck, Fenwick, Downie & Butt, 2007), although there is little known about the ways in which maternity caregivers influence a woman’s sense of self control (Bergstrom, Richards, Morse & Roberts, 2010). While the
nature of the nurse’s relationship with labouring women influences decision-making and satisfaction, not all women expect or want the same level of control and involvement in this area. A woman’s desire for control has been found to be influenced by pain, fatigue and access to information (Bergstrom et al., 2010; Matthews & Callister, 2003). While some labouring women prefer to remain passive and defer to caregivers to make decisions, other women want a balance between feeling in control and being dependent on caregivers. For example, in her study examining birth time and women’s experience, Maher (2008) found that some women knew that they were not being told ‘everything’, but felt this was appropriate. These women were content to proceed without an extensive exchange of information and indicated that this did not decrease their connection to either their caregivers or to the process of birth.

In her synthesis of qualitative research studies of women’s perceptions of professional labour support, Bowers (2002) identified three levels of decision making that occurred between childbearing women and their nurses. The first level, which involved disagreement between the caregiver and woman, resulted in emotional discomfort and decreased feelings of support. Unilateral decision making, by either the nurse or the labouring women, was marked by a lack of negotiation. In these situations, even being on the ‘winning’ side of a decision resulted in negative consequences and dissatisfaction for women. Joint decision making resulted in the most favourable outcomes, although the process by which this joint decision making occurred was not explained by the author.

Patterns of control in decision-making between labouring women and their caregivers were also examined through analysis of women’s birth stories. VandeVusse (1999) found that women’s expressed emotions became more positive as decision-making moved from a
unilateral to joint or mutual model. Strong negative emotions were evoked from women in situations in which they disagreed with caregivers’ unilateral decision-making, regardless of whether they eventually resigned themselves to the caregiver’s decision or refused the care. Outright refusals of care were rare and resulted in women feeling ‘punished’ for choosing in opposition to the caregiver.

This analysis was supported by a recent ‘Listening to Mothers’ survey (Sakala & Corry, 2007) in which women reported feeling pressure to have interventions such as induction of labour and caesarean sections, with 90% of those surveyed eventually agreeing to accept some form of unwanted intervention offered to them during their hospital stay. Women who initially objected but eventually complied with the caregiver’s decision remained unhappy about the experience. By contrast, shared control and joint decision-making, which involved mutual listening, planning and negotiation, was well received by women.

While a majority of women understood their right to have information to make informed choices, many reported that they did not have the knowledge available to make and enact these choices (Sakala & Corry, 2007). In a recent Canadian survey of women in the postpartum period (Public Health Agency of Canada, 2009), satisfaction with information given by health care providers was ranked at the lowest end of the scale as compared to other facets of interactions with providers including compassion, competency, concern and respect. Younger women appeared to be at a disadvantage in this area. While almost two-thirds (61.8%) of women reported being “very satisfied” with information given by their health care providers, less than half of the younger mothers (15-19 years) surveyed reported the same degree of satisfaction.
The use of obstetric interventions has also been associated with diminished feelings of choice and influence over decision-making. In one study (Baker, 2005), when medical interventions such as induction of labour were proposed, women felt that information related to the procedure was lacking or inadequate, and that the procedures themselves were contrary to their preferences and what their bodies were telling them. Some women reported feeling ‘bullied’ by staff to consent while others, particularly primaparas, did not ask for more information or speak out when procedures were against their preferences, expressing reluctance to question the staff’s expertise.

Expectations related to decision making and control have also been shown to influence women’s perceptions of their birth. Hauck at al. (2007) found that women adapted their expectations in subsequent births in order to avoid previous disappointments. In this exploratory study, maternity care providers played a role in assisting women to view their births as positive, even when expectations were not achieved. This was usually accomplished by encouraging women to be ‘flexible’ and reminding them of the importance of ‘having a healthy baby’. While these concepts are not inherently wrong, the authors questioned the consequences of reframing birth in this way, for example by allowing the system to remain unaccountable for women whose expectations for birth were unmet.

Socioeconomic background may also be a factor in differences in expectations and desires for control in childbearing women. One study found that while pregnant women in higher socioeconomic groups expressed confidence that they knew what they wanted and felt they could exercise their informed choices during labour and birth, women from the lower socioeconomic groups tended not to challenge the interventionist medical model and were most concerned about a painless delivery and a healthy baby (Machin & Scamell, 1997).
authors theorized that lower income women did not perceive they had choices and therefore did not see the possibilities for decision-making. In this group of women, control did not form part of their discourse or expectations; instead, their primary concern was the professional’s ability to ensure a safe passage for mother and baby.

In analyzing what women want, it is important to consider the social structure that influences the relationship between women and their caregivers, particularly in cases where the distribution of power is significantly weighed in favour of the caregiver. While it appears that all women want some information to be shared with them, to be treated with dignity and respect and to receive emotional support, the capacity to enact choices and control may also be more limited for poor women. Women with fewer economic resources often do not have the opportunity, experience, support and information required to choose, thereby reinforcing the dominant stereotype that these women are unable to make meaningful choices (Lazarus, 1997). There is also evidence that issues of class and choice are similar in other parts of the globe where feelings of discontent and passivity vary according to social class, with women in rural, poorer areas asking for and expecting less (Kabakian-Khasholian, Campbell, Shediac-Rizkallah, & Ghorayeb, 2000). Regardless of social class, the studies indicate that all women value warmth and good communication with their caregivers.

**Critique and Summary**

The majority of studies in this section were descriptive, exploratory and qualitative. These modes of investigation are understandable given the aims of the research. However, methodological shortcomings were evident, primarily concerning the lack of detail regarding the validity of the tools used to survey the opinions of caregivers and women, and lack of
detail concerning theoretical understandings and the process of analysis, particularly in the qualitative research. In addition, studies involving only the perceptions of caregivers need to be interpreted with caution, as the likelihood exists that actual practice may not be accurately reflected in self reports. Despite these issues, several interesting themes were identified through analysis of the relevant research.

Open communication and positive regard appear to be universally desired by all childbearing women, with a model of joint decision making, marked by mutuality and negotiation, being most positively received. A model of mutual, joint decision making, accounting for contextual and relational factors, aligns with a feminist perspective that contends that the process and outcome of negotiations is influenced by the context in which the care occurs (Sherwin, 1992). Nurses must be aware, however, that the way in which a particular woman is situated can influence the degree to which she wants to be involved in decisions about her care and that this needs to be constantly evaluated throughout the birth process.

One interesting finding was that the age and number of years experience of the respondent appeared to influence their perception of the degree to which power was exercised over women in communications, with less experienced, younger respondents noting a greater exertion of caregiver power in varied situations (Sinivaara et al., 2004). One possible explanation for this finding may be that over time, some nurses become desensitized to the subtle and possibly overt ways in which they use communication techniques to exercise control over women. While sustained and close proximity can heighten nurses’ awareness of their patient’s needs and concerns, it can also cause them to ignore the moral
concerns of their patients that they are unable to address due to repeated exposure to patient suffering and need (Peter & Liaschenko, 2004).

The research suggests that practices and relationships may differ according to the nurse’s perception of the characteristics of the women for whom they care. Nurses were more likely to establish controlling relationships and patterns of communication with women who were from different ethnic backgrounds, those who displayed non-conformist attitudes to dominant care practices or those who suffered from heightened levels of anxiety. This finding is troublesome as it suggests that marginalized women, who may be most in need of supportive relationships marked by respect and negotiation, may be least likely to receive this type of care and attention from their intrapartum nurses.

It appears that women perceive that the relationship between themselves and their caregivers is crucial to the development of informed choice and subsequent control over their childbirth experience. However, in reviewing the literature, I began to wonder about what appears to be a culturally based assumption that the exertion of ‘control’ by labouring women is a good thing, something to be pursued and attained. In my experience as a woman giving birth, a doula and an intrapartum nurse, I have observed that a relinquishing of control can be an integral part of being in and working with the process of labour and birth. It may be that a woman’s expressed need for control is more driven by fear than by desire and that the language we use to talk about control is driven by a Western-based ideology that values independence and self-sufficiency. Consequently, I believe that our ideas about control need to be challenged and brought to conscious awareness to determine the accuracy of our prevailing assumptions.
Finally, a theme emerging from women’s perceptions of their caregivers during childbirth is that the nurse’s approach and manner of communication influences the woman’s perception of support. This is different from some of the literature focused on oppressive contexts of care (Rodney et al, 2002; Chambliss, 1996; Weiss et al, 2002; Liashenko,1997) in which personal factors related to the nurse are not explicitly mentioned as factors that influence care provision. I wonder if this is an area that we, as nurses, are reluctant to explore, as there is an expectation in our ethical and practice standards as well as national guidelines (Health Canada, 2000) that all caregivers provide consistent, high quality family-centred care. To challenge the assumption that this is uniformly achieved by all practitioners would require taking a closer look not only into the structures of care but also to the individual’s responsibility for her/his approach and care practices towards labouring women, separate and apart from the influence of the environment and staffing and resource issues.

The Moral Nature of Intrapartum Nursing Practice

In this section, I begin by reviewing studies that looked specifically at the some of the practices that were considered to be an integral component of intrapartum nursing as well as the ways in which nursing practice may influence neonatal and maternal outcomes. I give special consideration to a small group of qualitative studies that explored the views of intrapartum nurses and midwives on the ethical nature of their practice. Finally, the way in which nurses’ beliefs about birth influence their approach to the care of labouring women was considered.

Components of intrapartum nursing practice
Although expertise in intrapartum practice is difficult to quantify, a recent metasynthesis of qualitative studies (Downe, Simpson & Trafford, 2006) identified three domains – wisdom, skilled practice and enacted vocation – of ‘expert’ intrapartum non-physician care. Wisdom included the reflective capacity of the practitioner as well as embodied, intuitive and theoretical knowledge. Skilled practice was marked by reflexive competence and confidence, which allowed practitioners to move beyond a dependence on standard protocols, requiring anticipatory and preventive action to deal with the uncertainties of labour and birth. Skilled practice also included clinical skills and judgment. Clinical skills involved both technical capacity and the ‘emotional intelligence’ to read a woman’s body and understand her needs for comfort and supportive care. Judgment required practitioners to negotiate the complexity of the labour process while also navigating the organizational and inter-professional barriers that existed in the institutional contexts of care. Enacted vocation included values, intuition and connected companionship. Values cited included belief and trust in a woman’s capacity to give birth, as well as courage to act in accordance to one’s intuition. Connected companionship was seen as relationship marked by an ‘engaged’ presence which involved being attuned to the labouring woman as opposed to assuming an objective professional stance.

Downe et al (2006) also identify a separate theme of ‘reaction to the context of childbirth’ in which they suggest that expert practice is ‘distorted’ by context. Examples are given of nurses having to use interventions they did not support in order to meet “technocratic labour norms” (2006, p. 137). This led the authors to wonder how intrapartum experts negotiate the dissonance between technocratic, industrialized models of care oriented
to risk management with professional values geared to belief and trust in the innate ability of women to give birth.

**Exploring the link between cognition, beliefs and intrapartum nursing practice**

Regan & Liaschenko (2007) hypothesized that when organizational policy or clinical indicators were not factors in nurses’ clinical decision-making, care decisions may originate from nurses’ beliefs about childbirth that are for the most part preconscious and unexamined. In analyzing the narratives of intrapartum nurses in their study who were shown an identical picture of a labouring woman, the authors found that nurses assigned a predictive risk to the process of birth which directed nursing actions and the focus of care along a specific trajectory. This trajectory limited, enabled or required the use of birth technologies.

Nurses’ beliefs about a woman’s ‘body knowing’ influenced their cognitive framing of birth (Regan & Liaschenko, 2007). Body knowing included three interactive capacities, described as physiological, perceptive and rational understanding. Physiological included beliefs about the body’s capacity to give birth without technological support. Within this category, nurses used empirical data, such as cervical dilation, to generate objective, scientific knowledge. Perceptive capacity entailed a belief in the woman knowing what she needed as part of her birth. Nurses who included this aspect as part of their narratives viewed birth as more than merely a physiological event, but also one having unique meaning for each woman. They saw themselves as expert guides who enabled maternal agency and privileged maternal desire, sometimes over the interests of more powerful others. This capacity reflected the use of intuitive knowledge and was not based on available objective ‘evidence’. Rational understanding referred to nurses’ beliefs that women understood what birth entailed,
specifically natural childbirth, and therefore they were able to support the woman’s choice for the type of birth she wanted. This required that the nurse have empathetic knowledge in order to remain attuned to the woman’s expressed needs (2007).

The findings of this study suggested a causal relationship between nurses’ cognitive frames of childbirth and trajectories of nursing actions that followed. Based on analysis of the nurses’ narratives, three categories of cognitive framing of birth were identified, including birth as a natural process (BNP), birth as a lurking risk (BLR), and birth as a risky process (BRP). Each of these ways of seeing and thinking had implications for how nurses might enact their moral responsibilities towards women in childbirth.

When birth was cognitively framed as a natural process (BNP), the mother and fetus were seen as one inseparable patient and birth was viewed as a normal physiological process not requiring routine technological management or active management. Nurses used empirical, intuitive and empathetic knowledge which supported all three types of body knowing, and nursing actions were directed towards supporting the mother through the process of birth. This was the only group whose narratives included details of the woman’s life. It was felt that these nurses supported maternal agency and choices because they believed that the woman was a credible knower for both herself and her unborn child and therefore by attending to the woman’s needs, the interests of the fetus would be met. The care described by these nurses responded to the woman’s perceived desires rather than organizational culture or caregiver preference. This was also the only group to suggest that technological interventions could actually compromise neonatal outcomes.

Nurses in the birth as a lurking risk (BLR) category identified two foci of care – the mother and fetus. While nurses’ narratives appeared to endorse a woman’s physiological
capacity to give birth, and her rational understanding of the process, this was only up to the point of transition, the final, most intense phase of the first stage of labour. At this point nurses suggested there would be a loss of control, leaving the woman ‘uncoachable’ and thereby hindering the nurse’s ability to manage the process safely and effectively. Nurses in this group attempted to balance maternal desire with fetal well being and organizational culture. They perceived there to be risk associated with ‘natural’ childbirth and that intrapartum nursing required childbirth technology. They perceived nurses as expert knowers versus expert guides and planned nursing care so that women would follow the nurse’s recommendations.

When birth was viewed as a risky process (BRP), risk was seen as inevitable. The birth process itself was defined by fear, anxiety and pain. Nurses who framed birth in this way did not believe women were capable of rationally understanding the process or perceiving what was needed. Therefore, the focus of nursing care was fetocentric and focused on the use of available technology to reduce risk to the unborn child. A woman’s rejection of this technocratic approach confirmed for nurses that these women were unable to rationally understand the birth process and the inherent risk to the fetus. The premise that cognitive frames can be used to understand nurses’ motivation to act, underscores the influence that nursing practice may exert on maternal choices, the contexts of care in general and on labour and birth outcomes in particular.

**Intrapartum nursing practice and childbirth outcomes**

There has been limited investigation into the effect of nursing practice as an independent variable that may influence birth outcomes for women. Gagnon, Meier &
Waghorn (2007) looked at the association between continuity of nursing care and risk of caesarean birth. Continuity of care variables included the number of nurses caring for each woman during labour, the number of time care switched between and among nurses, and the length of time each nurse was responsible for a labouring woman. Using data extracted from medical records of 467 primiparous women and controlling for factors know to be strong predictors of caesarean birth, such as length of labour, gestational age, induction and epidural use, an independent association was found between the number of nurses caring for labouring woman and the rate of caesarean birth. While this was an important finding, the authors were not able to determine what actually happened in the relationship between women and their nurses during time of contact, only the possible significance of lack of continuity of care (2007).

Radin et al (1993) conducted a retrospective study in which intrapartum nurses were grouped according to the caesarean rates of the healthy nulliparous women in their care. Large differences were found in rates assigned to particular nurses that were not explained by maternal age, the physician who attended the birth, use of epidural anesthesia, augmentation of labour, dilation when the nurse assumed care, infant weight or gestational age. Nurses with the lowest rates of caesarean births (4.9%) also documented psychosocial data more frequently than their counterparts within the highest quintile (19%) which suggests a greater awareness of and attention paid to the psychosocial needs and experiences of childbearing women.

Nurses’ and midwives’ views on the ethical nature of their practice
Although reports of the perspectives and experiences of individuals, also known as ‘views studies’, can be difficult to locate (Harden, Garcia, Oliver, et al, 2004), the importance of using qualitative methodologies to examine life-experiences from the perspective of the person having the experience is being increasingly recognized in health services research (Patterson, Thorne, Canam, & Jillings, 2001). Therefore, I identified a small number of qualitative studies (7) that looked specifically at the views of intrapartum nurses and midwives on ethical components of their practices and relationships, particularly autonomy and informed decision-making.

Goldberg (2005) used a feminist-phenomenological approach to explore intrapartum nursing practice from a relational perspective. Using the narratives of Canadian nurses and mothers, Goldberg identified themes that captured the essential aspects of relational practice, focusing in particular on ‘introductory engagement’, which she described as the initial encounter between the nurse and woman. Goldberg’s (2005) research revealed that a space for engagement, created through the nurse’s initial recognition of the uniqueness of each woman, allowed for the development of mutual understanding. These encounters included practices such as making sure that women were warm and comfortable and ensuring that the initial history-taking was as much about the questions the woman wanted to ask as the information the nurse needed to collect. These nursing actions helped to support and sustain trustful and mutually respectful relationships.

Four midwifery studies examined the relationships between caregivers and labouring women and the contexts in which care occurred (Hindley & Thomson, 2005; Hyde & Roche-Reid, 2004; Kennedy, Shannon, Chuahorm, & Kravetz, K, 2004). Thompson, 2003). Three of these studies, based in England, (Hindley & Thomson; Hyde & Roche-Reid), investigated
the ways in which midwives fostered informed decision making for women in childbirth. Hindley & Thomson (2005) found that midwives’ struggled with reconciling the ‘ideal’ of informed choice with the realities of practice, in which they sustained positions of authority over women and their choices in order to function within the dominant medical-technological model. Hyde & Roche-Reid (2004) identified similar themes, including the predominance of a medical-technological model of care influencing midwifery practice and ultimately the choices available to women.

Creating relational ‘space’ within the birthing environment, in which consensus could be reached through reasoned dialogue, was deemed to be essential to practice as was the importance of relationships marked by mutuality. Hyde and Roche-Reid (2004) described midwives’ creation of a symbolic space that enabled an appreciation of the views of women, reflexivity and relation, and the attainment of consensus through reasoned dialogue. Kennedy et al. (2004) theorized that relationship, marked by mutuality, disclosure and validation, provided the foundation for orchestrating the ‘environment’ of care in which a woman’s physical and emotional needs were met. In order to create this environment, the midwife had to be aware of the contexts of care, such as the nature of professional relationships, philosophies guiding practice and system-wide policies. As with Goldberg, Kennedy referred to an ‘engaged presence’ that occurred in this space, in which the midwife gathered observations and combined these with the woman’s subjective knowledge to more fully understand the situation and provide the appropriate care.

Some midwives perceived an inability to change a practice environment that was intolerable to professional integrity (Hindley & Thomson, 2005) and avoided working with certain medical practitioners or tried to ‘counter the system’ in order to advocate for their
clients. Hyde & Roche-Reid (2004) suggested that while the dominant medical-technological practice, with its claim to safer childbirth, exerted professional and political power over midwifery care practices, midwives retained power relative to women due to their expert knowledge and experience that was used to get women ‘on-side’ and to ‘push’ women through the system. Other midwives supported their clients’ autonomous choices by acting as a ‘conduits’, described as an invisible structure and a guiding force, thereby enabling women to retain the power to choose how to move through labour (Kennedy et al., 2004). This description suggested that while the woman had the power to choose, these choices were mediated and possibly restricted by the ‘invisible’ structure or guidance provided by the midwife.

The fourth midwifery study (Thompson, 2003) used personal narratives of Australian mothers and midwives, and articulated an ‘ethics of intimates and engagement’ that included both the relationships between midwives and labouring women and the contexts in which care occurred. Within this ethic of engagement, the midwife’s primary relationship was with the mother while the mother’s primary relationship was with the fetus. A central theme to emerge from Thompson’s study was the use and abuse of power in relationships that often became evident through conflicting values held by the institution and the individual, where the former valued ‘product efficiency’ while the latter valued attention to individual needs and preferences. Power imbalances within institutions and among caregivers resulted in a lack of support for labouring women and restrictions of the ability of midwives to use their professional judgment.

The final three studies examining intrapartum nursing were conducted in large hospitals in the United States that had higher than average rates of medical interventions such
as caesarean section, epidurals, and routine use of electronic fetal heart monitoring. Nurses in one study (James, Simpson & Knox 2003) felt that they were autonomous practitioners, although autonomy was described as “the power to determine what needs to be done in providing patient care” (p. 815). This suggests that the nurses’ interpretation of autonomy may not have included enabling or fostering informed choices of childbearing women, but was more focused on nurses’ autonomous decision-making relative to physicians. These nurses felt that a woman’s vulnerability in labour required advocacy; however, they described this in terms of the nurse taking control, using their intuition and judgment to make care decisions and “having the guts to do what you believe to be right and in the best interests of the woman and her baby” (James et al., 2003, p.820). Some nurses described different but equal knowledge or power between themselves and physicians; however the actual practices described by nurses were those prescribed by the physicians, and in practice the nurses were unable to deliver the ‘high-touch’ supportive care they described as being central to care (James et al, 2003).

Sleutal (2000) analyzed the labour support techniques that one nurse used to enhance labour progress and prevent caesarean birth. The unexpected finding in this pilot study was the conflicting descriptions of the nursing practice, which entailed both following the mother’s body while also taking action to hasten and control the birth. The nurse made several references to situations that illustrated misuse of power in relationship, noting that she had to “try to be tactful with the doctors so they feel in control” (p. 43). As a result, the nurse was at times a co-conspirator in supporting routine medical practices she questioned, such as induced labours without a medical indication, while on other occasions she would carry out the care activities she desired, as long as these were hidden from the physician. In
either case, in the nurse: physician hierarchy, the labouring woman was positioned as a passive recipient of care and would have been challenged to exert any choices of her own. Advocacy in this context involved balancing the needs of the mothers within the limitations imposed by the system (Sleutal, 2000).

A more recent study by Sleutel and colleagues (Sleutal, Schultz, & Wyble, 2007) examined nurses’ views of factors that helped or hindered their efforts to provide professional labour support. Participants in this study believed that medical interventions aimed at hastening and controlling birth hindered their care. Nurses also cited mothers’ lack of knowledge and preparation, their inability to speak English and allocation as ‘high risk’ as factors that negatively influenced their ability to provide care. Nurses were critical of the practices of their nurse colleagues who they believed sabotaged their efforts to provide supportive care by promoting the use of epidurals when providing relief during scheduled breaks, describing them as lazy, uncaring and unmotivated. However they were most critical of practices of physicians who were unwilling to endorse supportive care interventions and disregarded the expressed needs of labouring women.

Facilitators to the provision of supportive care included teamwork, collaboration and a shared belief in the ability of women to give birth (Sleutal et al, 2007). Nurses also believed that ‘good’ nurses, described as those with experience and autonomy, could have a positive impact on labour and birth outcomes. The authors concluded that significant interplay existed among the attitudes, practices and behaviour of nurses and physicians who provide intrapartum care.

Critique and summary
The notion of identifying ‘expert’ practices in intrapartum nursing may be a desirable goal by which to mark professional development and competence. However, the use of ‘exemplary situated revelations’, as narrated by individual nurses identified as having ethical and/or practical expertise, may occlude the focus on collective, everyday, less ‘exemplary’ practice and the ways in which nurses enact their moral agency in routine situations and encounters (Nelson, 2004). The reality of nurses’ daily capacity for ethical response was more evident in the compilation of studies on nurses’ views of their practice, when it was acknowledged that at times nurses did not, or could not, challenge and overcome oppressive contexts of care.

While characteristics of the practice setting have been shown to account for variance in nursing actions, ethical practice also appears to be influenced by the personal and professional values of individual nurses. This suggests that in order to mediate power imbalances within relationships and improve the effectiveness of moral responses, both context and individual considerations must be taken into account. Regan and Liaschenko’s research (2007) points to an interesting relationship between nurses’ cognitive frames of childbirth and the direction of their nursing care activities, which either enabled or required the use of birth technologies. As with the study by Penticuff & Walden (2000), nurses who emphasized individual aspects of a patient’s situation as opposed to abstract rules and standards, were more likely to take action to resolve conflicts and act on the patient’s behalf.

The narratives of nurses and midwives reflected the centrality of creating a space for relationship with labouring women that allowed caregivers to realize some of their moral responsibilities. The experience of encountering environmental constraints within hierarchical moral-social arrangements involving nurses, midwives, physicians, and
institutions was a common theme across the studies. These arrangements often inhibited the actions of the participants and created moral practices and understandings that were often surreptitious in nature. Other elements of the moral-social order that shaped the everyday choices, perceptions, and actions of these nurses and midwives focused on the culture of hospitals, including their ethos of efficiency and economic profit, and use of technology.

A new understanding as a result of this review was the symbolic meaning that relationships with women held for nurses and midwives. While they recognized when and why they were falling short of the ‘ideal’, there was a sense that this relationship was something integral to practice that needed to be safeguarded. There was also recognition that the value of promoting informed choice, usually enacted through relationship, was not always carried out in practice. Thompson (2003), for example, made a distinction between actual practice and midwives’ “preferred ethical response” which included supporting and knowing the woman (2003, p. 592). The discrepancy between real and ideal practices was most often attributed to factors outside the control of nurses and midwives, including hierarchical power imbalances, dominating medical models of practice, system-wide pressures for efficiency and economy, and the use of technology. It was interesting to note that some of this discourse was shaped in such a way that attention was deflected away from the agency and the capacity of nurses and midwives to make choices about how to provide care. For example, when agency and intention were attributed to ‘technology’, nurses and midwives seemed to be side-stepping responsibility for how and when technology was used. There was also inconsistency between the self-understanding of nurses and midwives as powerless and their narratives that described ways in which they exerted power over labouring women.
A clear theme emerging from the literature was the moral centrality of the nurse-patient relationship. However, there appeared to be different conceptions regarding the direction and focus of this relationship. While Thompson (2003) contended that the midwife’s prime relationship should be with the mother and the mother’s prime relationship is with baby, Regan & Liaschenko (2007) found an orientation to nursing care that was either directed at the mother and fetus ‘in-relation’ or specifically towards protection of the fetus. This is an important consideration, as there are implications for the interpretation and enactment of the nurse’s role as advocate. There was general agreement, however, that the way in which a practitioner interpreted his/her role and identity in childbirth, either consciously or at a pre-conscious level, could influence the ethical nature of his/her ethical decisions and responses.

**Concluding Thoughts**

Analysis of the research selected for this review suggests that morality in intrapartum nursing practice is contextual, interpersonal and collaborative, requiring responsiveness to others and mutual accountability. The findings address the importance of creating environments that can support and sustain nursing practices that build understanding, mutuality and trust between the intrapartum nurse and birthing woman. While nurses were able to identify contextual influences that constrained their ability to maintain effective relationships with women, the influence of their own values and beliefs on the care they provide has not been fully examined. The work of Regan and Liaschenko (2007) provides the most extensive look into the psyche of nurses and the direct influence of their beliefs on the way in which they choose to see and care for childbearing women.
In understanding the moral practices of intrapartum nurses, the views and experiences of women must be taken into account. The literature suggests that we cannot make assumptions about what any woman may want and need in her relationship with her nurse and the degree of control she might want to enact. The varied contexts of women’s lives necessitates an individual approach to understanding what is desired and highlights the need for nurses to make special efforts to understand and recognize the needs of women whose lives are very different from their own.
Chapter 3 - Theoretical Understandings of Intrapartum Nurses’ Moral Practices

This chapter describes the major features that distinguish feminist ethics from other bioethical theories, primarily through the work of Margaret Urban Walker (1998, 2003). This includes a conceptualization of rights and responsibilities that are interdependent and negotiated as opposed to an individualistic notion of autonomy and the application of moral theory and decision-making to ‘everyday’ versus crisis nursing practice situations. Walker’s (1998, 2003, 2006) work highlights the connection between our social and moral worlds and the importance of considering the context in which relationships are situated. Her perspective has particular relevance to nursing practice as it emphasizes the moral aspects of the sometimes less visible everyday situations that nurses experience in contrast to the more catastrophic and highly charged ‘life and death’ decision-making that is highlighted in more traditional ethical theories. This perspective also fits well with a study related to relationships in childbirth in which the particularities of the settings, care providers, women and their families need to be considered.

Feminist ethics

The philosophical study of ethics addresses value questions about human conduct and attempts to define the meaning of “right and wrong” when applied to persons, actions, character, and social practices (Sherwin, 1992). Feminist ethics is distinguished from traditional ethical theory as it considers the experiences of women as moral agents and includes a political perspective that attempts to uncover the patterns of dominance and oppression that shape human interaction (Brennan, 1999). The focus of feminist ethics is not limited to the moral lives of women, but includes members of society who have been
marginalized in some way, for example due to gender, ethnicity, disability, socio-economic status or sexual orientation. This perspective can help us to consider who controls moral decision-making and the effect that control has on more vulnerable persons (Sherwin, 1992). While mainstream moral theory was built on the design and application of abstract principles to hypothetical ‘cases’, feminist ethics considers the details of particular experiences and social situations when evaluating practices of moral deliberation. While it could be argued that both feminist and more traditional theories of bioethics recognize the importance of addressing the relationships between agents performing an action and those who are affected by it, the feminist perspective also pays special attention to the interdependent, unequal and emotionally charged relationships that shape human lives and interactions (Sherwin).

A feminist ethics perspective is appropriate for a research project focused on issues related to childbirth, as it is women who give birth and are most directly affected by the political and social forces that shape health care practices in this area. Women’s reproductive functions, including birth, have historically been subjected to control and domination of powerful and often invisible structures which a critical feminist perspective could help to make visible in order to effect change. In addition, although there is substantial accumulated knowledge about the process of labour, the experience of childbirth is unique to each woman. This highlights the importance of considering the particularities of each childbearing woman as a unique individual, which is a prominent feature of feminist theory, versus a generalized ‘other’. Intrapartum nurses are almost exclusively women and therefore are subject to similar considerations of the influence of gender roles, power within relationships and institutions and the bio-technical environment in which they work.

**Negotiating rights and responsibilities**

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Concepts such as advocacy and choice are related to issues of rights and responsibilities. According to traditional ethical principles such as autonomy, rights are tied to an individualistic notion of self, wherein people are separate from one another and each person pursues his/her own interests separate from others’ similar pursuits (Brennan, 1999). Feminist ethics rejects the assumption of rights requiring independence and separation. Instead, rights are viewed as not something you merely ‘hold’ but rather something that requires claiming and negotiation, often in relationships between persons of differing power or status (Sherwin, 1992). Negotiating within relationships fits well with the practice of nursing and the philosophy of patient centred care whereas a stance of non-interference found in traditional ethical theories could be considered to be antithetical to the idea of patient-centred nursing interventions to promote health and healing.

The mutuality implied in the negotiation of rights within relationships has the potential to worsen the dependence of those with less power, if the underlying social arrangements that produced the pattern of interaction are not considered. The feminist conception of ‘self’ as relational and socially constructed requires that a moral analysis using a feminist perspective include the examination of persons and their behaviours in the context of political relations and experiences (Sherwin, 1992). When applied to the issue of childbirth, the particular and interdependent nature of rights and responsibilities suggest that while birth is unique to each woman, the experience of childbirth for all women, regardless of their status and privilege, is connected to and influenced by the political and social structures surrounding birth. As their caregivers, intrapartum nurses should attempt to respect the preferences of the individual women in their care and negotiate plans of care within those relationships. However, the process and outcome of that negotiation would necessarily be
influenced by the context in which the care occurs. A feminist ethics approach to responsibilities, as it applies to nurses, other health care providers, and women in childbirth, would allow for structures of power within relationships and institutions to be made visible, thereby giving a voice to vulnerable persons and allowing space for each person to be heard and to make his/her perspective known.

**Feminist ethics and the ‘everyday’**

Moral practices in the context of childbirth often revolve around ‘everyday’ aspects of labour, such as options for comfort and pain management or weighing the risks and benefits of medical interventions versus non-clinical ‘supportive’ alternatives such as positioning, hydrotherapy, and relaxation techniques to reduce maternal anxiety. This emphasis on everyday nursing practices versus more catastrophic life and death situations aligns with Walker’s expressive-collaborative model of morality. Within this model, morality is “a socially embodied medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response” (Walker, 1998, p.9). In other words, Walker theorizes a moral world that is inextricably linked with the social world, in which our responsibilities for each other and for ourselves are mutually negotiated, ideally in a climate of reciprocity and understanding. In the realm of care during childbirth, this would mean that intrapartum nurses remain open to understanding a woman’s preferences and desires for managing labour pain while also giving a clinical perspective about progress of labour and the range of interventions that might be helpful. The end result would be a mutually negotiated understanding regarding how best to meet the woman’s need for pain relief and other birth preferences.
According to Walker (2003), practices of morality are practices of responsibility and accountability that define our scope of agency and who we are and affirm what we care about. This view is different from a more standard approach that applies abstract theoretical principles to crisis events. These responsibilities are not independent but are shaped by social identities and roles in which hierarchical power relations are generally the rule. Nurses would, therefore, understand their social-moral world differently than other health care workers, by virtue of their unique social identities and relationships in their place of work. This understanding could not be uncovered by detached objective observation but would be embedded in nurses’ narratives of their day to day experiences.

**Moral Agency**

The Canadian Nurses Association Code of Ethics for Nurses (2002) lists values for nurses and the expected responsibilities that flow from these. Nurses are expected to recognize that they are “moral agents” and have a commitment to “behave ethically” (CNA, p. 7). In traditional ethical approaches, the moral agent is rational, autonomous, motivated by self interest, and uses generalizations, abstractions and application of principles to judge the rightness of an action. Feminists critique this dominant thinking in moral theory by noting that individuals do not always have control over the people, values and circumstances that shape the ways in which their moral responsibilities are perceived and fulfilled (Walker, 2003). These ideological and structural influences on an individual’s choice of action must be accounted for when considering the ways in which nurses understand and enact their moral agency in practice. Therefore, while individual nurses will enact and interpret their moral responsibilities in different ways, the focus cannot be on measuring or judging the degree to
which a nurse’s practice meets a particular moral standard but on considering all of the internal and external factors that may influence a nurse’s capacity to act as an effective moral agent. The challenge of describing and noting specific moral practices within this model are also apparent when one considers that the agent must continuously negotiate her or his moral responsibilities by blending new understandings with past experience to inform future moral practices (Walker, 1998).

Moral Practices

Moral practices - Practices of responsibility

A practice-based profession such as nursing embodies more than science, individual knowledge and technique but also includes styles and processes of relating to the recipients of care (Weiss, Malone, Merighi, & Benner, 2002). These multi-faceted practices, through which we define and express our agency, are shaped by social institutions in which they occur. Walker refers to these practices as ‘practices of responsibility’ (1998). Within nursing, practices of responsibility are directed at people who are vulnerable and in need of health care services and are therefore susceptible to the choices and actions of nurses (Peter & Liaschenko, 2003). However, moral practices of responsibility are not fixed entities in that agents and their actions are often judged in light of normative and moral assumptions related to social roles and community expectations. These practices are dynamic and can be changed by shifting blame and responsibility, the introduction of new information or through changing social roles and normative expectations. These practices could include habits of paying attention, interpreting human actions and responding in thought, action or feeling to situations and circumstances. In this model, morality is viewed as interpersonal and
collaborative as it is constructed between people and requires self-direction, responsiveness to others and mutual accountability (Walker).

Moral knowledge is understood to be produced and processed in a communal manner, and so it may be that within the intrapartum setting, nurses interpret their moral responsibilities in similar ways. However, moral responsibilities are lived out within relationships which are collaborative ventures influenced by the particularities of the birth itself, as well as the social roles, relative positions of power of the people involved and the environment within which they occur (Jameton, 1993). Therefore, nurses may hold divergent views regarding the scope of moral responsibilities and their accountability for actions taken or avoided.

Moral Contexts

According to Walker, context is the place of moral thinking, and encompasses “information crucial to understanding what we or others are doing” (2003, p.xiii). Context includes a range of factors such as personal history, social position, institutional roles and relationships – all of which shape daily choices and perceptions of human beings. Walker (2003) notes that context can be obscured by cultural settings and social organizations that promote particular roles and ideals while leaving others invisible. As moral understandings of what is required and how one may be called to account circulates among individuals within a practice setting (Walker, 1998), it is important that nurses, and those who study them, become aware of the ways in which context shapes nursing practice and the choices that are made regarding how to care for childbearing women.
According to Walker (2003), morally habitable environments are those which foster cooperation and recognition and in which differently situated people experience their responsibilities as intelligible and coherent. In order to achieve this type of environment, moral arrangements and social orders must become transparent, revealing who has responsibility for what and identifying specific criteria for distributing and evaluating those responsibilities. The nature of relationships within the multidisciplinary team and among nursing colleagues also has a direct influence on the moral practices of nurses (Peter, Lunardi & Macfarlane, 2004). In the intrapartum setting, when team members have confidence in each others’ skills and respect the perspective and contributions of all team members, staff will be more likely to raise issues and seek the support of one another which promotes a more trusting and calming milieu for the labouring woman and her family (Women’s Health Council, 2000).

**The Social-Moral Context of Intrapartum Nursing**

Walker (1998) describes a morality that is made up of culturally embedded practices of responsibility. She argues that in order to know what to hold ourselves and others accountable for, we must be able to identify and acknowledge the separate and mutual histories and understandings that we bring to situations requiring a response (1998). The way some people are noticed and known, or not, is in part a result of the social identity that has been conferred upon them by the dominant group in any particular society. These identities are not based on facts about people or groups of people but are facts about relations of power and resistance, response and recognition between people (1998). Through social identities, Walker (1998) suggests that we are able to recognize interpersonally significant roles,
responsibilities and expectations. She notes that those who are marginalized are often discredited as knowers, even though they are in the best position to know what it is like to be in their place. However, because their social identities are fixed and sustained by the dominant group, these individuals can be effectively discounted as accurate reporters.

**Practices of Moral Recognition**

As part of a critical moral epistemology, Walker argues that there is a need to explore ‘culturally normative prejudice’ and to understand more fully the structures that influence the perceptions and understandings which may impede our moral recognition of those who are marginalized or different (1998). She suggests that the enactment of these prejudices are often not noticed or experienced as problematic by those who hold them as they are considered to be ‘normal’. Walker challenges the assumptions of impartiality inherent in contemporary moral theory by suggesting that in order to recognize features such as intelligence and rationality we must first be able to ‘see’ those features in other human beings. Our representational practices, through which we construct social identities of others, are based on culturally-based assumptions which may or may not be an accurate representation of specific individuals. In some cases, what is different can be evaluated as ‘inferior’ resulting in the imposition of external moral judgements on marginalized individuals who are already oppressed (Sherwin, 1992). However, it is through these representations that we interpret morally significant perceptions and responses. As these representational practices often remain unchallenged by the dominant group, they may be erroneous and lead to moral misrecognition.
Walker (1998) notes that we tend to interpret what others are experiencing, for example in the case of pain, by paying attention to obvious or more subtle cues such as wincing, crying or a change in complexion. However, these cues might mean something different for each person, depending on their personal mode of expression and the circumstances in which they occur. Through experience within our own cultural context, we are taught to recognize particular expressive styles as familiar and natural. However, Walker notes that bodily expressions are highly variable among and also within cultures and societies. Pain related behaviours while giving birth are culturally defined and therefore the way a woman experiences, perceives and makes meaning of her pain will be unique to that individual (Callister et al, 2003). Therefore, the distinct possibility exists that intrapartum nurses may therefore fail to recognize or misrecognize a labouring woman’s beliefs, reactions or feelings related to pain as well as other responses to the process of labour and birth.

According to Walker (1998), failures of recognition can arise from inattention or unfamiliarity or through feeling a lack of obligation to pay attention to what is going on. Alternately, a person may not notice what another individual is expressing because they are certain that they already know what is felt, or because they habitually notice only certain things, or because what is ‘seen’ may be different in some people’s cases than in others. Walker concludes that moral misrecognition is a social problem with moral dimensions that results when we have not learned to recognize or interpret certain psychological or emotional states in people or when we have learned to attend to only certain things. When the failure to recognize is persistent, it may signify a particular bias towards certain categories of people.
Our natural tendency when alternate value systems are incomprehensible to us is to try to ‘translate’ them into familiar modes of understanding or assume they are misguided (Sherwin, 1992). When certain groups of people are viewed as unfamiliar and possibly inferior, their human personalities remain unseen and unknown, thereby affecting our capacity for moral response (Walker, 1998). Walker notes that ‘diminished’ individuals may receive a lesser degree of respect, compassion and reciprocity and therefore may be subjected to paternalistic attitudes when they are in fact capable of making appropriate choices for themselves. This differential moral recognition can work to disqualify some individuals from enacting their moral agency.

Women who have relocated to a foreign country and are giving birth in an unfamiliar environment and cultural context are subjected to high levels of stress due to the loss of social support networks and resultant feelings of isolation as well as changes in conceptions of gender roles and family structure (Taniguchi & Baruffi, 2007; Tummala, 2004). Walker (1998) suggests that people who are unfamiliar with the predominant cultural norms of a society may also find it difficult to represent themselves as persons with moral agency. This may be due to many factors, including their differing social position or limited experience, understanding and possibly resistance to socially normative standards and expectations regarding how to behave. If individuals are aware that stereotypes exist concerning people who have similar backgrounds and cultural characteristics, they may anticipate a restricted response from others and therefore choose to modify their behaviour either to confront or compensate for these preconceived ideas ascribed to them. Walker makes the point that free agency in this sense is relational and requires both reception and appropriate recognition, as a
person represents themselves in a particular way while also being represented by others in a particular manner.

Walker’s theoretical constructs relating to moral recognition have significance for this study which is attempting to understand intrapartum nurses’ interpretation and enactment of their moral responsibilities to childbearing women. The need for reciprocity and mutual understanding is highlighted when we consider our different and culturally embedded ways of viewing the world and each other. This can only be accomplished ‘in relation’ and understood by taking into account the structures and institutions that shape the social-moral environment of birth.

Summary

Nurses recognize and respond to the moral concerns of childbearing women through their relationships in everyday practice. The interconnection between the social and moral worlds is apparent in complex hospital birthing environments which may enable or constrain the establishment of collaborative and mutually satisfying relationships among and between intrapartum nurses, childbearing women and other care providers. In addition, each relationship between nurses and the women they care for is unique as it reflects their particular life experiences, knowledge and values of those individuals and the specific circumstances of that birth.
Chapter 4 - A Narrative-Based Approach to Critical Moral Ethnography

Qualitative inquiry is one means of expanding the scope of our understanding of the subjective experiences of intrapartum nurses and capturing the complexities of the moral-social contexts in which they work. This chapter describes the epistemological foundation that shaped my approach to the methodology for this study, which was grounded in feminist ethics, critical ethnography and narrative-based inquiry, and was informed by the study’s purpose and research questions. Specific attention will be paid to the way in which Walker’s expressive-collaborative theory of morality directed both the collection and analysis of data.

A Critical Perspective: Ethnography and Feminist Ethics

The theoretical underpinnings for this study stemmed from a critical social perspective. Although there is disagreement among critical theorists regarding precisely what critical theory ‘is’, there are certain basic assumptions that inform this viewpoint. These assumptions include a perspective that a) thought is mediated by power relations that are socially, politically and historically constituted; b) facts cannot be separated from values; c) language is central to the formation of subjectivity (Kincheloe & McLaren, 2005; Young, 1990).

Feminist epistemology acknowledges that authoritative assumptions shape the direction, practice, interpretation and results of inquiry (Walker, 1998). This type of research is most clearly identifiable by the processes used to create knowledge, which are considered to be at least as important as the outcome of the research. Within a feminist-based critical methodology, power is understood to be a basic constituent of human experience that operates in various and complex ways (Kincheloe & McLaren, 2005). Inquiry stemming
from this perspective challenges notions of expert power, the appropriation of voice, and how power is implicated in the production of knowledge and ownership of the research products (Thorne & Varcoe, 1998; Deutsch, 2004). This approach seeks to understand experiences from the standpoint of those being studied and attempts to identify how private experiences of oppression can be understood as part of a general system of social and environmental constraints that shape experiences (Brennan, 1999). As moral values are interconnected with political structures, an investigation into moral practices needs to explore the community or institutional standards that are in place, how these were reached and whose interests they serve (Sherwin, 1992). In addition, as the researcher is generally in a position of power relative to participants, the pre-existing understandings, experiences and theoretical perspectives used by the researcher become integral to what is analyzed and described.

Ethnography studies people as socially situated beings whose realities are constructed through interaction with others in the social, political and cultural environments of their lives (Madison, 2005). Critical ethnography is marked by an exploration of the ‘self-other’ interaction that mediates the production of narratives (Foley & Valenzuela, 2005). Careful description of contexts is integral to a critical ethnographic approach as this allows for the exploration of systems of meaning and emotions that inform actions. This approach requires negotiation and dialogue with the participants in order to understand their experience.

**Critical Moral Ethnography**

Walker’s understanding of a critical moral ethnography is one that acknowledges “that moral standards, statuses, and distributions of responsibility work through social differences, rather than in spite of them” (2003, p. 211). The goal of this approach is to
uncover moral epistemology through an exploration of how moral understandings are established and reproduced through social differences. Within this understanding, morality has distinct expressive and collaborative features. These elements are linked by the notion of narratives, in which people’s emotions, intentions and circumstances are arranged in characteristic ways over time and configured into a story. In Walker’s words, moral thinking involves the “intertwining of selves and stories in narrative constructions which locate what is at stake, what is needed and what is possible” (p. 74).

In order to examine moral practices and understandings, Walker suggests the use of many kinds of factual research, including “documentary, historical, ethnographic and sociological” (1998, p. 11). Walker’s interpretive moral ethnography (1998, 2003) highlights the interpersonal nature of moral justification by examining the ways in which differently situated people experience and interpret their moral responsibilities. Within this approach, stories represent lived experience as well as moral problems, as they reveal the ways in which morally relevant information is identified and organized within an event. In turn, participants are viewed as active constituents within their social worlds.

Ethnographic and narrative approaches have become one of the primary methods used in empirical nursing ethics research that seeks to explore the moral concerns articulated by nurses in their everyday work (Peter & Martin, 2007). Although ethnography is not typically associated with narrative-based research, this form of analysis attends to how participants make sense of each other, negotiate their identities and characterize the worlds they talk about (Baker, 2001). From an epistemological standpoint, what we know is seen to be “negotiated within the culturally informed relationships and experiences, the talk and the text, of our everyday lives” (Angen, 2000, p. 384).
The Analytic Lenses of Narrative-Based Inquiry

Narrative-based inquiry adopts a view of experience as the phenomenon being studied, and attempts to understand the ways in which social identity and social action are comprised and guided (Miller, 2000). This type of approach incorporates not only ordinary lived experience, but also seeks to understand the social, cultural and institutional narratives within which individual experiences are constituted, shaped, expressed and enacted. Social reality is considered to be relational and subjective and is produced during the research process in which the researcher and participants together build the descriptive, exploratory and explanatory knowledge. The knowledge constructed through this process varies depending on the participants, place and time and is therefore always evolving in light of new theoretical insights, problems and social circumstances (Carter & Little, 2007; Kincheloe & McLaren, 2005). The value of the research is not on whether or not it is replicable but how it adds to substantive knowledge on a particular subject (Clandinin & Connelly, 2000).

Sociality is an integral feature of narrative-based inquiry and highlights the fact that people are always in interaction with their personal and social situations in any experience (Clandinin & Connelly, 2000; Miller 2000). As such, we are continually called upon to make practical and ethical choices about how to act and interact (Angen, 2000). Insights of moral agents are conditioned by their social experiences and locations and therefore the process of moral understanding is collaborative and interpersonal, as opposed to individual (Walker, 1998). Walker asserts that moral knowledge is constructed intersubjectively, with the ‘knowers’ situated in multiple, overlapping epistemic communities. It is through social interactions within these communities that knowledge and reasoning are interpreted,
qualified or disqualified. Narratives that emerge within these contexts are therefore partial, situated and provisional rather than universal or absolute (Walker, 1998, Jaggar, 2000).

Another feature of the narrative approach is temporality, which acknowledges that events, narrators and their stories are influenced by and understood in terms of past, present and future (Clandinin & Connelly, 2000; Miller 2000). Any interpretations are always open to reinterpretation which is illuminated and understood through social discourses (Angen, 2000). Moral understandings and resolutions are also temporal, transitional and continuously negotiated as new situations are understood in relation to previous experiences and projected onto future possibilities (Walker, 1998).

Narrative analysis incorporates the use of multiple and interconnected analytic lenses that distinguish this approach from other forms of interpretive discourse (Chase, 2005). Within this approach, narratives become a means through which speakers understand their own and others’ actions, organize events and objects into a meaningful whole, make connections and see the consequences of actions over time. Unlike experimental approaches to scientific discourse, narratives include not only a description of what happened, but also express the thoughts, interpretations and emotions of the teller, highlighting the uniqueness of each human action and event rather than merely their common properties (Chase).

The issue of voice is of specific interest in narrative-based inquiry. Voice is viewed, analytically, as an intermingling of what the narrator says, how it is communicated, as well as the position and social location from which he/she speaks (Chase, 2005; Angen, 2000). There has been considerable debate in the narrative literature around the issue of voice, authenticity, interpretative authority and representation (Walker, 1998; Chase, 2005; Lecompte, 2002; Morrow, 2005). There is agreement that both the interviewer and the
interviewee are implicated in the construction of knowledge. However, tension arises between those who suggest that voices should be treated as if ‘raw’ and untouched by ideology versus others who support in depth interpretation and critical analysis of the text in order to reach new understandings of the phenomenon under investigation (Olesen, 2000; Deutsch, 2004).

There is a compelling argument, however, that a reflexive approach, whereby the researcher is obliged to pay attention to sociocultural location, representation of voice and text in ways that reflect the participants, can mitigate against obfuscating the voices of the narrators and privileging those of the researchers (Chamberlain, 2000; Thorne & Varcoe, 1998). Seeing the narrative as actively created and particular moves the questions away from the credibility and believability of what is being said, and highlights instead the versions of self, reality and experience produced by the storyteller (Carter & Little, 2007; Chase, 2005).

Within narrative-based inquiry, the separation of the researcher’s voice from narrator’s through interpretation is seen as legitimate, as both have a different interest in the stories. The goal of this approach was to use questions to open up ways of understanding what the narrators were communicating through their story (Chase, 2005). Interpretation addressed the ways in which cultural and organizational discourses were used to make sense of experience, and to understand the use of metaphors and narrative linkages developed in relation to conflicting discourses. While this approach may be critiqued as privileging the researcher’s voice at the expense of the narrator, Chase argues that this form of interpretation and analysis constitutes a different, but not disrespectful, representation of particular stories that can illuminate “taken-for-granted practices, processes and structural and cultural features of our everyday social worlds” (2005, p.664).
By asking questions such as “who we are, how we got this way, and where we might go from here”, critical inquiry directs researchers to move beyond the realm of contemplation in order to influence concrete social reform (Kincheloe & McLaren, 2005, p. 309). Oppressive narratives were revealed by interconnecting the narrator’s story with my explanation of how the narrative was influenced by contexts including roles, relationships and personal identity. This opened up possibilities for social change (Chase, 2005).

Transformation may also result when readers whose members identify with the narrators’ stories might be moved to understand their own stories in new ways while those in different social locations might consider thinking and acting in ways that address oppressive structures and relationships (Morrow, 2005).

As stories are enabled and constrained by social resources and circumstances, it follows that narrators construct the self and reality in ways that are understood within their local setting, organizational and social memberships and cultural/historical location (Chase, 2005). Within the profession of nursing, it has also been argued that narratives which highlight only the individual actor and disregard the context of practice may impede our understanding of nursing practice by producing only “desirable discourse” for a nursing audience (Nelson & McGillion, 2004). An analytical approach that separates the person’s story from their context leaves discourses disconnected from their functions and can result in narratives being differentiated without consideration of the work they are doing (Chamberlain, 2000). Therefore, the ways in which structural features of institutionalized relations combined with everyday situations to enable or constrain the ability of all concerned to hear and be heard (Walker, 2003) was included in the analysis.
While defensible, coherent methodological approaches to research are important, an obsession with issues related to technique and procedure can overshadow the humanistic purpose of the research (Kincheloe & McLaren, 2005). A key feature of narrative analysis was to ensure that interpretations moved beyond a listing of thematic categories that may have captured what participants said, but reduced the complexity of analysis, thereby erasing the social aspects of how the data were constructed, for whom and in what social context (Chamberlain, 2000; Hollingsworth & Dybdahl, 2007; Miller, 2000). Walker concurred that it was important to consider the scope of the narrative one was trying to achieve and questioned the value of themes, tropes and ‘global’ narratives in helping to understand and interpret moral life (1998). The substantive nature of narrative analysis was achieved through the exploration of patterns that narrators created in particular times and places. The process included seeking disconfirming cases and conflicting understandings, as well as analysis on similarities and differences across narratives (Angen, 2000; Chase, 2005)

**Data Collection**

A central feature of data collection in narrative-based inquiry is to invite and encourage stories. Stories “constitute the empirical material that interviewers need if they are to understand how people create meanings out of events in their lives (Chase, 2005, p. 660). As institutional environments conditioned narrators’ voices and the stories they had to tell, I needed to understand what was ‘story worthy’ within the narrator’s social setting. From there, a broad question was developed that invited the participant to tell stories that other people, similarly situated, could tell.

**Setting**
Nurse participants were recruited from a Labour and Delivery unit within a medium-sized Ontario hospital. This institution provided a range of obstetrical services to childbearing women and their families, some of whom had complex obstetrical and social needs. This setting was selected in part due to its size and location and also because there was an interest on the part of the director of nursing research in having a study of this nature conducted within the women and infant’s program area.

Sampling

Insights generated from qualitative inquiry have more to do with the information-richness of cases selected and analytical ability of researcher than with sample size (Morse, Barrett, Mayan et al, 2002; Kuzel, 1999). Sampling within qualitative research is guided by investigative purpose rather than by the need to generate findings that are statistically representation of a population (Carter & Little, 2007; Angen, 2000). According to Walker’s expressive-collaborative model of morality, generality and abstraction detracts from the adequacy of moral understandings. These understandings are comprised of perceptive and expressive skills and capacities which enable connection with our own realities and those of specific others (2003). Therefore, participants, who had experienced a particular phenomenon based on questions guiding the research, were selected to provide information rich data.

Appropriateness and adequacy are important quality issues to be considered when making decisions regarding sampling in qualitative inquiry. Appropriateness speaks to how the sample fits the research purpose and the phenomenon of interest, while adequacy implies that who and what comes next depends on what came before and involves continually
adjusting the sample in response to developing interpretations and theories (Chase, 2005). Within ethnographic research, participants are selected who are able to reflect upon practices within the group or setting under investigation (Higginbottom, 2004). Sampling for this study was purposeful, as the participants had specific experience or knowledge that was relevant to the research questions. While the range of narrative possibilities within any group of people can be limitless, given different subject positions, social and historical conditions, a projected sample size for this study was 12-20 participants. This number supported the range of convergent and contrasting narratives required to interpret and understand nurses’ perceptions of the social-moral orders in which they practiced.

**Participants**

Participants included fourteen intrapartum registered nurses who had been practicing on the unit full time for at least six months or regular part time for at least a year. In order to ensure that nurse participants have sufficient recent experience, nurses who worked less than .5 FTE (full time equivalent) were excluded. All nurses who met the criteria and expressed an interest in participating in the study were included.

**Recruitment**

Recruitment proceeded as follows:

- I held an introductory session in conjunction with a regularly scheduled staff meeting on the unit. At this time the purpose of the study was briefly outlined, initial questions were answered and a flyer inviting interested nurses to participate was distributed (Appendix A). Additional flyers were made available on the unit for those nurses not able to attend.
• Additional flyers outlining the study and inviting participation were also posted in the nurses’ lounge and information boards on the unit.

• Interested nurses were invited to contact me directly

• Following the introductory information session, I made regular visits to the unit to answer questions related to the study and to invite interested nurses to participate.

• If recruitment of participants had not been satisfactory to meet the study needs after the above mentioned strategies were implemented over a three month period, a second site would have been sought to engage additional participants. However, this was not deemed to be necessary based on the number of participants who agreed to take part in the study and the on-going analysis of data collected during the interviews.

**Interviews**

As narrative is understood as the site for the production of meanings, tape recorded interviews were used in order to capture the details of the interaction between interviewer and interviewee and the form of the narrative (Elliott, 2005). An optimum length for an in-depth narrative interview is suggested to be approximately 90 minutes, with a second interview conducted in situations where it becomes evident that the quantity of material to be covered cannot be accomplished within this time frame (Elliott). Within this study, each interview was approximately 50 to 90 minutes in length and was tape-recorded. Although participants were offered an additional interview if they felt more time was required, none of the participants requested a subsequent interview. The length of narrative interviews was such that there was adequate time for respondents to have their stories listened to, rather than suppressed. Although ‘verbatim’ transcription of audiotaped interviews is considered to be a
valid means of capturing social reality as it is expressed and experienced by respondents, logistical and interpretive challenges can occur in the translation of audiotaped conversation into written form (Poland, 2001). In order to optimize the accuracy of the transcribed data, I used strategies identified by Poland (2001), including flagging ambiguity in the interview and using field notes in the interpretation of difficult passages.

Within narrative inquiry, the researcher needs to be well prepared to ask good questions on one hand while also acknowledging that a particular story cannot be known, predicted, prepared for in advance (Chase, 2005). Types of questions that can elicited stories which reflected moral thinking and understanding centred on stories of everyday practice which described the social-moral world of intrapartum nurses. An interview guide (Appendix C) based on Walker’s work was used. Differentiation of stories about identity, relationship and value and interpretations by Peter and Martin (2007) was also used to guide interview questions and on-going data analysis.

Demographic information related to country of birth, educational level and number of years as registered nurses as well as labour and delivery room nurses was obtained by use of a Participant Demographics Form (Appendix D). Given the institution’s request to have the results of the research presented at the study’s completion, additional information related to participants’ ethnicity and other identifying information was not requested in order to preserve the anonymity of participants. While it was left to the participants to decide which narratives were ‘story worthy’, prompts and questions to guide the narratives included who the parties were, the terms of their relationships and the social or institutional factors that shaped their range of moral responses.
Narrative Analysis

A narrative strategy for interpretation and analysis of data listens to the voices within each narrative, rather than merely looking for themes across interviews. Of particular interest is how participants construct themselves in their stories and the connections between the various stories that the narrator tells over the course of the interview. This approach helps to draw attention to the complexity within each narrator’s voice as well as diversity among narrators (Chase). The potential for discontinuity of a narrative is ever present due to the unpredictable nature of human life (Miller, 2000). Therefore, narrative analysis focused on complexities within the stories, including attention to subject positions, ambiguities, and interpretive practices used by the narrator to make sense of an event.

Narratives can be used to understand the moral construction of our lives and the ways in which responsibilities are kept coherent (Walker, 1998). Walker (1998) identifies three types of narratives – identity, relationship and value - that were used to frame the analysis within this study. Narratives of relationship spoke to the content, expectations and trust within a relationship that enabled individuals to understand what might be owed to others. These narratives encompassed past, present and future possibilities and were purely episodic, as in the case of client-nurse relationship, or continual, as in the case of nursing and physician colleagues. Relationship-centred narratives challenged the narrator’s integrity, as that person had to decide how to respond to others’ needs and demands and whether or not there was room for postponement, substitution or release from the demand (Walker, 1998).

Narratives of moral identity addressed what a person “cares for, responds to and takes care of” (Walker, 1998. p. 112). They reflected characteristic patterns of valuation and the development of selective responses whereby individuals paid attention to particular kinds of
things and people. Narratives of identity and relationship were interconnected as identities were produced in connection to others. The third type of narrative, narrative of moral values, addressed shared understandings of things, relationships and commitments that were important (Walker, 1998). While some moral choices reaffirmed values and principles already understood, other choices led to a reinterpretation of the standards to which participants held themselves accountable. This involved moral justification and coherence within and between individuals and communities and on-going refinement and revision of moral concepts and understandings.

**Process of Analysis**

In accordance with a qualitative approach, data analysis began following the first interview and continued simultaneously with data collection throughout the research project (Maxwell, 2005). The interpretive process within a study depends on the aims of the research (Josselson, 2007) which, in this case, was to use participant’s narratives to more fully understand the social moral nature of intrapartum nursing practice. A critical approach demands an active interpretive stance on the part of the researcher in order to determine power relations, roles and the inter-subjective structures within relationships (Carspecken, 1996). Although the analytic process in this study derived from multiple perspectives described in qualitative literature, each phase of analysis was grounded in a critical approach, attending to context, social relationships and the maintenance of an active, interpretive, reflexive stance on my part as the researcher.

In the initial phases of analysis, field notes from interviews and audio transcripts were reviewed at the end of each session. This timely review of notes and audiotapes constituted a
broad first level of analysis and allowed for refinement of the interview approach as well as the development of tentative ideas about emerging themes and relationships (Maxwell, 2005). Once the tapes were transcribed, transcripts were read in their entirety and certain passages highlighted for thematic similarity. Also highlighted were ‘key incidents’ (Emerson, 2007), understood by the researcher to be, intuitively, particularly telling or revealing incidents within the data. This initial phase of immersion in the transcripts side-stepped a more restrictive coding approach to analysis, allowing for the evolution of analytic thought (Thorne, 2008).

The subsequent phase of analysis was more in-depth, and involved working back and forth between the data, the research questions and Walker’s theoretical underpinnings as outlined in chapter three. This ‘retroductive’ process (Emerson, 2007) involved moving back and forth between observations and theory, employing processes that were both inductive and deductive. Retroduction employs a type of hermeneutic-circle approach to interpretation, allowing the researcher to understand the interplay between individual’s lives and larger social and contextual forces (Kincheloe & McLaren, 2005). This phase of analysis was broken down into four major steps, although it should be noted that this was an iterative process, which involved working back and forth between the steps, standing back to look at emerging themes and then re-entering the data set to check interpretations and understandings.

In step one, each transcript was reviewed for indications within the nurse’s stories of how she understood her moral responsibilities. As explained by Walker, these responsibilities can be revealed through stories, for example by what is noticed, how a person chooses to respond and what is deemed to be ‘story-worthy’. Chase (2005) describes a ‘narrative strategy’ whereby the researcher makes connections within the stories told by a participant
while also attending to the complexities within their subject position. As I read and re-read each interview, I noted certain themes that were repeated, looked for common threads of consistency within the nurse’s approach to care and relationships and also identified areas in which there appeared to be inconsistencies. The search for consistency is one facet of analysis within critical ethnographic studies (Carspecken, 1996). This ‘normative-evaluative’ approach seeks to identify behaviours that are appropriate, conventional and shared within a given culture, allowing the researcher to identify certain cultural behaviours and to consider their meaning within specific contexts. Conversely, the identification of inconsistencies or negative cases reveals complexities within the data and constitutes a valuable form of ‘meaning-making’ that enriches analysis by considering linkages that go beyond shared understandings (Gubrium & Holstein, 2009, Emerson, 2007).

Within this first step, I tried to identify specific narratives of relationship, value and identity, the three categories identified by Walker as being central to living responsibly (1998). The allocation of sections of transcripts to narrative ‘types’ proved to be somewhat problematic, as the categories tended to blur together. Although the process was not clear cut, I persisted, as Walker suggests that the stories of relationships, value and identity, while distinct, are also inter-related. When writing this section of the analysis, similar understandings that were revealed in different parts of the interview were grouped together under one descriptive ‘moral understandings and responsibilities’ heading, followed by all of the identified influencing factors. Relevant quotes were included to ensure that the words of the nurse participants were accurately reflected in the analysis and to limit inferences of the researcher at this stage of analysis. In addition, ‘quotable quotes’, or those passages that appeared to be especially poignant or powerful, were identified and set aside. Thorne
recommends this approach as a means of ensuring that these vivid anecdotes are on one hand preserved, but are not allowed to dominate the “evolving analytic structure” of the findings (Thorne, 2008, p. 149).

In the second step, a list of only the headings that were identified from step one was generated. The act of ‘listing’ allowed me to actually ‘see’ the main ideas that were emerging and to identify areas of overlap or interrelatedness of the headings. I was also able to move back and forth more easily between the headings and the research questions to ensure that I was staying as close as possible to the original purpose of the study and the theoretical underpinnings of Walker.

In step three, moral understandings, responsibilities and influencing factors were synthesized for each nurse and interrelated headings from step two were combined and condensed. The process of synthesis enables the researcher to make connections between an individual’s story and theoretical categories while at the same time analyzing the conceptual implications of those understandings (Josselson, 2007). In order to ensure that the original words of the participants and the contexts of their stories were not lost, the synthesis process included a constant back and forth between the writing from step one of analysis, the original transcripts themselves and the research questions. This strategy, characteristic of narrative ethnographies, was used to maintain the researcher’s interactive voice and highlight the intersubjective nature of the analytic process (Chase, 2005). As steps one to three were undertaken with each participant’s transcripts, commonalities and differences that began to emerge were noted in a separate journal and discussed during supervisory meetings.

The fourth step involved the identification of themes. Initially, I attempted to do this by ‘clumping’ the responsibilities, identities, relationships and values identified through the
previous steps of analysis. While this was helpful in terms of managing the data, identifying
commonalities, and keeping the data contextually embedded, I discovered that this controlled
and contained approach restricted the higher level of creative thinking and synthesis required
in moral understanding. Emerson proposes that while the examination of ‘how and what’
helps us to understand the means by which specific forms of everyday life are accomplished,
it is the ‘when and where’ questions that direct us to “patterns in which distinct contexts
come into play in particular settings” (2007). By setting aside the detailed notes of analysis
that I had generated up until that time and taking a step back, I was able to recognize the
patterns or themes that appeared to capture the trends emerging from the data set. I also
found it helpful to reflect my understandings visually, working with different drawings,
shapes and arrows, in order to ‘see’ the connections between emerging ideas. Once the main
theme and sub-categories had been identified, I was able to go back to the data set for
verification. This was accomplished by revisiting the understandings from steps one through
three and checking to see if these were captured within the theme and categories, once again
going back and forth, and fine-tuning to ensure that I was satisfied with the ‘fit’ of the theme
and the data.

An important and surprising aspect of the analytic process was the way in which the
‘expressive and collaborative’ nature of moral understanding was lived out within my regular
supervisory meetings. Although it was my responsibility to bring emerging themes and
interpretations to these sessions, it was the act of discussing, reflecting, debating and
engaging with a knowledgeable and interested ‘other’ that, I believe, helped me to more fully
understand the moral nature of nursing practice and to identify some of the underlying values
and identities threading within and between the nurses’ stories.
Rigour

Measures of Validity and Reliability

There is little consensus on what constitutes ‘goodness’ in qualitative research (Sandelowski & Barosso 2003). Nursing studies have tended to emphasize conformity and procedural rigour, while other standards for qualitative research have focused on the real-world significance of the research question and the practical value of the findings. While there are some universal standards of rigour or trustworthiness in qualitative research, these standards will vary across paradigms with some standards, such as attention to subjectivity and reflexivity, considered to be essential components regardless of the paradigm being used. As the assessment of the quality of data and analysis is linked to epistemology, methodological ‘fit’ or internal validity occurs when the theoretical assumptions, research question, and method of data collection and analysis are congruent (Angen, 2000; Carter & Little, 2007; Chamberlain, 2000).

While imperfect understandings can be seen as a problematic outcome for research projects, Walker views conflicting judgments and incomprehension as opportunities for rethinking moral understandings and searching for mediating ideas (1998). This “moral incompleteness” (p. 79) is necessary in order to remain open to interpretations of ‘outsiders’ and to prevent depersonalizing and paternalistic attitudes that may occur when what is known becomes closed off for discussion and exploration. The complexity of human experience figures into every aspect of the investigative process and results in conclusions that provide new possibilities and remain open to alternate interpretations (Angen, 2000). Validity within this approach can be problematic for the same reason that we find it difficult to find meaning
and confirm the goodness of our actions in daily life. In either realm, interpretation requires
the same “negotiation, acceptance of ambiguity, and reliance on dialogue” (Angen, p. 392),
and therefore any conclusions we make are open to continued interpretation based on our
relationships, situatedness and temporality.

Morse et al (2002) offer a critique of the measures of validity and reliability typically
used in qualitative research. They argue that while trustworthiness, which includes
credibility, transferability, dependability and confirmability, may help to evaluate rigor,
relevance and utility at the completion of the project, these measures do not address the need
to ensure rigor during the process of the research itself. Similarly, audit trails, which provide
‘proof’ of decisions made throughout the project and document the course of the
development of the analysis, do not speak specifically to the quality of those decisions or the
rationale behind them.

Morse et al (2002) suggest that verification, which involves interweaving
mechanisms into the research process itself to aid in the detection and correction of errors
before they subvert the analysis, is a credible measure of rigor in qualitative research.
Insights revealed through on-going analysis enables the modification of sampling and data
collection to enhance the integrity and focus of the continuing analysis and ultimately the
final research project (Carter & Little, 2007). Use of this technique required my
responsiveness as the investigator, including the ability to let go of poorly supported, but
deeply held ideas. A lack of responsiveness can result from a researcher’s inability to abstract
and move beyond data coding, working deductively from previously held assumptions or
adhering to instructions rather than listening to the data.
Specific verification strategies identified by Morse et al (2002) include: methodological coherence or congruence between the research question and the components of the method; theoretical sampling and sampling adequacy, whereby participants are chosen who best represent or have knowledge of the topic and sufficient data is collected to account for all aspects of the phenomenon; an active analytical stance, in which data is collected and analyzed concurrently, forging an iterative interaction between data and analysis; thinking theoretically, to ensure that ideas emerging from data are reconfirmed in new data, thereby avoiding ‘cognitive leaps’; and finally the development of theory as an outcome of the research process rather than a framework to move analysis along.

Validation can also be reflected in the ability of the research to transform social actions (Angen, 2000). The researcher’s interpretations of narratives can reveal oppressive meta-narratives and open up possibilities for social change (Chase, 2005). For this to occur, an approach in which I avoided assuming the role of privileged ‘expert’ was required. The analysis attended to the participant’s story as well as my explanation of how the narrator’s story was inhibited by the interceding aspects of culture and institutions. In this way, readers might recognize these influences in their own practices and begin to think and act in ways that promote change (Angen; Chase).

The development of a valid interpretation also depends on the characteristics and abilities of the researcher, as that person will continually have to make choices regarding how to proceed (Angen, 2000). Characteristics such as patience, flexibility, persistence in the face of ambiguity and meticulousness in the planning and implementation of the research project enhanced my ability to make decisions that contributed to the integrity of the project (Angen).
Positionality and Reflexivity

Within a narrative approach, clarifying researcher bias through reflexivity, with the hope of creating an objective distance between the self and the research being undertaken, can be seen as misguided (Angen, 2000). Instead, reflexivity within this form of inquiry is undertaken to highlight the researcher’s original sense of the topic and to track changes over the course of the study. Researchers need to understand themselves if they are to understand how to interpret narrators’ stories. The intersubjective nature of stories means that researchers examine, and make transparent, their subject positions, social locations, interpretations and personal experiences through the medium of the narrator’s voice (Carter & Little, 2007; Chase, 2005).

Moral recognition is also shaped by emotional responses that may not be sensitive to socially marked differences (Walker, 2003). In other words, when participants described practices or relationships with women, families, nursing colleagues or physicians that did not align with the my experience, my own dominant interpretations were not upheld. This can lead to feelings within the researcher of impatience and frustration and may signify a form of moral disqualification based on our biased understandings of ourselves and others. Field notes helped to clarify some aspects of the interview context while also noting details pertinent to the setting (Poland, 2001). In this study, interview field notes served the purpose of marking and reflecting upon my reactions and impressions during and following the interview sessions. A template was used to serve as a means of organizing relevant observations and reflections (Appendix B). While key words or feelings were jotted down throughout the interview, most of the interview notes were recorded immediately following the sessions so as not to disrupt the flow of the narratives.
Social position is critical to morality, as it influences the way we understand our own and others’ identities, relationships and values which in turn informs the ways in which we accept, assign or deflect responsibilities (Liashenko & Peter, 2006). Feminist researchers have highlighted the importance of positionality, which encompasses the researcher’s awareness of her own subjective experience in relation to her participants as well as to the world as a whole (Deutsch, 2004). A feminist informed methodology openly acknowledges the tensions that may arise from differentiated sociocultural locations of the researcher and participants (Finlay, 2002).

The distribution of power also influences what kinds of narratives will socially predominate (Miller, 2000). The ways in which power is used has moral significance and it is therefore important to determine power differences that are unavoidable and those that are not (Liashenko & Peter, 2006). This can be accomplished by the researcher making her positionality accessible, transparent, and vulnerable to judgment and evaluation, and by taking responsibility for her subjectivity and political perspective. There is a counter-argument, however, that the imperative of locating oneself as, for example, white, middle class, is problematic as it puts the reader in the position of having to make assumptions about what is meant or inferred through these labels (Thorne & Varcoe, 1998).

Through the process of narrative inquiry, the researchers themselves become narrators through developing their own interpretations and publishing their work (Chase, 2005). The narrated ‘result’, or the findings of any study, is enabled and constrained by social resources, values and circumstances embedded in the researcher’s own discipline and culture (Carter & Little, 2007). In the case of this dissertation, my personal history of childbirth, my professional experience as a nurse, doula and educator as well as the expectations of doctoral
students to produce knowledge that has relevance to the profession of nursing combined to shaped my interpretations and the findings from this study.

Throughout the process of analysis, the narrative itself changes ownership, moving from the participant’s story to a co-constructed text, relying on the interpretive ‘authority’ of the researcher. (Josselson, 2007). Although qualitative feminist research at times claims to be representative of the authentic voices of women, it is impossible to ignore the fact that there will be choices made by the researcher, based on her own experiences and values, about which stories constitute a reliable, accurate and even valuable perspective (Kitzenger, 2007). I found that the analytic phase of the study required constant reflexivity on my part. Decades of experience as a maternal child nurse, doula and educator have led me to have strong feelings and values concerning the ‘correct’ approach to care and relationships. I found it helpful to tune into my emotional state as I listened and re-read the transcripts, noting which passages engendered anger, which nurses I felt an affinity towards and why. It was interesting to note that the process of analysis undertaken through the steps described above actually functioned to shift my emotional reaction away from certain participants and their voices in order to focus on the data as a whole. This enabled me to understand the ways in which their experiences – both personal and professional – influenced the ways in which they enacted their moral responsibilities.

Ethics

Risks and Benefits

There were no known immediate risks identified with participation in this study for nurses. It must be noted, however, that though the act of intently listening, I may have
reflected the self back to the respondent in ways that were not anticipated (Warren, 2001). In other words, there could have been aspects of the revealed and reflected ‘self’ that caused discomfort or distress for participants. As this could have happened during the course of the narrative or following, as the researcher I would have been unaware of the impact of storytelling on the respondent. This was addressed by discussing this possibility with participants at the outset of the interview.

Possible benefits to participants included the inherent value of being able to tell their stories to an interested and active listener. As moral understandings are co-constructed, the possibility exists that through the medium of narrative, nurses may have come to have a fuller appreciation of the way in which their moral responses were shaped by relationships, identities and values within the contexts of intrapartum care. This creates the potential to look for new ways to practice that transform incoherent moral responsibilities in order to create a morally habitable work environment.

**Privacy and Confidentiality**

Researchers must do whatever is necessary to protect individuals who have participated in the research project (Johnson, 2001). However, any evidence of professional misconduct must be reported to the College of Nurses. Steps must also be taken to avoid causing harm to reputation or social standing of informants’ professional collective communities. While it is difficult to predict these types of future consequences, it is important for the researcher to be mindful of these possibilities when analyzing and reporting on the research.
Confidentiality maintains the privacy of the participants and ensures that no identifying data will be used in the study. Participants were assigned pseudonyms and none of the published or presented text described identifying details of the person beyond general demographic information. All field notes and transcripts were kept on my personal computer that is password protected. Paper copies and encrypted memory sticks containing field notes and transcripts, as well as audiotapes, were kept in a locked cabinet, accessible only to me as the researcher. Notes and transcripts will be stored in a secure cabinet at the faculty of nursing for seven years.

As this is a doctoral thesis, notes and transcripts were shared with my supervisory committee. All of this was outlined in a formal letter of consent that was signed when participants agree to be part of the study (Appendix E)

**Compensation**

Nurses who agreed to participate in interviews were compensated for their time with a gift certificate in the amount of twenty dollars per interview.

**Conflict of Interest**

I did not anticipate any conflict of interest as I am not employed by the hospital. While I was familiar with the specific unit to be used in this study and knew some of the nurses through my work with students and doulas in the past, I did not experience a conflict of interest, as there was no continuing relationship or contingencies related to these other activities.

**Informed Consent Process**
The consent process began with an introductory meeting with nurses on the unit at which time the purpose of the research, the expected nature and duration of participation and a description of the proposed method and data collection techniques was explained. Flyers outlining the research (Appendix A) and inviting nurses to participate also formed part of this process. Nurses gave verbal consent once they confirmed their interest in participating in the study.

On the day of the scheduled interview, I reviewed the requirements and implications of participating and obtain signed written consent (Appendix F). Consent forms included a description of the purpose of the study, how long the study would last, what the participants were expected to do, expected risks and benefits, and the ways in which the results from the project would be used. The title of the study, as it appeared on the participant flyer and consent form, did not include the word ‘moral’, as it was felt that the common understanding of moral as an investigation of ‘good and bad’ practice would lead to misinterpretation of the intent and scope of the study. As the analysis proceeded, I gained a deeper understanding of the connection between the social and moral dimensions of nursing practice and the importance of highlighting this inter-relationship and therefore decided to insert the term ‘moral’ into the final title of my dissertation. All participants received a copy of the consent form that they signed. It was made clear to participants that their participation in the research was voluntary and that they could refuse to participate in any or all aspects of the research, at any time, without penalty or loss.
Chapter 5 - Findings

Fourteen nurse participants were recruited between November, 2008 and February, 2009. The nurses ranged in age from 24 – 62 years with a median age of 50. Equal percentages of nurses were diploma and degree educated (43%) while two participants had advanced levels of education at the nurse practitioner or master’s level. The majority of the participants were Canadian born (9) and all had lived in Canada for a minimum of 10 years. Participants had worked as registered nurses for a range of 1-40 years, with a median of 29. The median number of years working in labour and delivery was 20, with a range from 1 - 32 years.

The first research question in this study asked how intrapartum nurses understood and negotiated their moral responsibilities towards women and families during childbirth while the second research question aimed to explore the identities, relationships and values that shaped the ability of intrapartum nurses to negotiate their moral responsibilities in order to provide care to labouring women. After careful examination of the range of moral understandings captured within the nurses’ stories, four themes were identified which captured the dimensions of these understandings and their influencing factors. The themes included: organizing and coordinating care, responding to the unpredictable, recognizing limits of responsibilities to others and negotiating care with women and families (Table 4.1).
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In this chapter, a detailed description of each theme and subtheme, using participant quotes to illustrate the findings will be presented. This will allow for a coherent interpretation of the data while providing a link between the research questions, the theoretical underpinnings of the study, and the voices of the nurse participants, as revealed through their narratives. In addition to considering the data in relation to the research questions, an exploration of the context of care will also be included because, as Walker notes (2003) context is an essential component of understanding the choices and perceptions of individuals and takes into account our social positions as well as institutional roles.

Organizing and Coordinating Care

The narratives of nurses in this study reflected a shared understanding of their responsibility for the organization and coordination of care. The enactment of those responsibilities was shaped by patterns of relating and responding to physician and nursing colleagues who worked with them on the intrapartum unit. Consistencies within each nurse’s narrative indicated that many of their patterns of relating to colleagues were established over time. The motivation for building relationships varied amongst the participants. For example, while one nurse viewed effective relationships as a means to creating a safe environment for patients, nurses and other care givers, another participant valued relationships and collegiality as a necessary social element of her work that was linked to her sense of satisfaction with her work.

The notion that moral and social practices are inextricably linked is a corner stone of Walker’s model of morality (1998). The findings within this theme support Walker’s assertion that “moral understandings are affected through social arrangements, while the all
important social arrangements include moral practices as working parts” (Walker, 2003, p. 107). In other words, the ways in which nurses approached and responded to their relationships with nursing and physician colleagues revealed what they cared about and why. Nurse’s narratives within this theme addressed two main dimensions of relationships with nursing and physician colleagues including working in a team and responding to conflict. An additional category of mentoring and training was also identified within nurse-to-nurse relationships. Each of these aspects will be examined separately, interweaving the nurse’s stories with my theoretical interpretation.

**Relationships with nurses.**

**Working in a team.**

The unit where study participants worked was based on a team model, whereby nurses generally worked their shifts with nurses from the team to which they had been assigned. Nurses mentioned many factors that made for a ‘good’ team including the dynamics of the team, the work ethic and the personalities of the members. The supportive function of the nursing team was evident in this novice nurse’s description of her experience with two different teams on the same nursing unit:

I’ve been on teams where working together really makes a difference… sometimes, even though the monitors are beeping and clearly, like, the baby’s in trouble, nobody gets off of their seat, nobody will go into the room… I’m the one that’s going in, I would say maybe, like, 7, 8 times out of 10…And the others - I don’t know where they go, it’s like they all disappear - like when I need help, nobody’s around, right? Sometimes I just feel like, I’m always running around - running, running, running, running around, and other people are sitting at the desk…I worked on another team where, y’know, the alarm goes beeping and you’ve got five nurses beside you suddenly, right? I didn’t ask for them, they just like, all come into your room for help. I don’t know, I just find that that’s kind of nice, you know that you’re being well
supported and that, if anything happens you can rely on them to come and help you right? (Andrea\textsuperscript{2})

In this excerpt, the first team described had many elements that were upsetting to this nurse, including expectations of assistance that were not met and feeling alone and exhausted. In the second example, team members could be relied upon and seemed to know when support was needed without being asked. In the latter example, the ‘practices of responsibilities’ of the nurses on the team matched the expectations of the nurse and confirmed her understanding of who must do what for whom. This type of team environment that fosters cooperation and recognition and allows people to experience their responsibilities as intelligible and coherent, would be described by Walker as morally inhabitable (2003). In the first example, the nurse’s moral understandings did not appear to be shared by the team. In this case, trust was not sustained, which resulted in feelings of decreased worth and vulnerability.

Nurses agreed that it was important for team members to understand each other’s strengths and preferences in order to effectively support one another. While one nurse indicated that it was the job of the nursing team leader to have this information, a more senior nurse participant explained that experienced nurses recognized who among them had specific skills. These nurses knew who to call on and likewise, would make themselves available to help others in situations where they knew their skill set would be needed and valued. While epistemic communities, such this intrapartum nursing unit, maintain the resources, procedures and technologies for obtaining knowledge, it is through social

\textsuperscript{2} pseudonym
interactions and within specific relations that “some people, more than others, are assumed to know, or know how” (Walker, 1998, p. 57) It seems reasonable, therefore, that nurses who have interacted with each other over a protracted period of time would be able to identify each others’ particular strengths and capacities:

As the years go by, you develop really good relationships with your nursing friends and colleagues, and in times of stress and high anxiety, we are very kind to each other, and we really try to help each other through a time, because we need to keep working together. So I find nurses are quite supportive to each other, in many instances, everyday in nursing. Of course we bicker back and forth, and complaining, like, y’know, everyone does in departments and so on, but when it comes to crises, I think we’re pretty good – pretty good at helping each other. (Brenda)

Narratives of relationships reveal what people reasonably expect from one another, often based on prior history and actual contact (Walker, 1998). This nurse’s description of her experienced colleagues supporting each other can be interpreted as one way of honouring their shared history of relationship. The assertion by another nurse that casual members of the team were viewed as detracting from the cohesiveness of the group is understandable in this context, as their nursing colleagues would not be able to initially discern their strengths and whether or not they could be called upon to help out.

Knowledge-sharing, including being clear about the extent of one’s knowledge, admitting when one does not know something and seeking out help as required, was a key element of effective collegial relationships for some nurses. This nurse perceived that willingness to share knowledge in this way had a direct influence on the patient’s experience, specifically her confidence in the nursing care team:

If you bluff your way through, then you’re giving them false information, and the patient goes by that because ‘the nurse has told me’. So when the next nurse comes along, and says something different, then you got a problem, because this patient is saying ‘wait a minute, do these nurses know what they’re doing?’ There has to be
consistency, y’know? When I’ve precepted somebody, my thing is, y’know, ‘tell me what you don’t know, because I will work with you, but if you bluff, and I ask you if you know something and you tell me you do, and you don’t, and we run into a problem, then I will be very angry, because not only have you put me in a situation, but the patient – and the patient is the priority’ (Beth).

Underpinning this nurse’s narrative is the notion of reliability, which Walker views as a component of integrity (1998). Integrity, as a moral quality, includes “responsiveness to the ongoing fit among our accounts, the ways we have acted, and the consequences and costs our actions have in fact incurred” (p.116). This involves being able to explain what we are doing and why and following through on the expectations that others have of us. For this nurse, reliability was an important dimension of her relationships with colleagues. The perceived consequences of unreliability included confusion and altered trust for the labouring woman and anger on the nurse’s part.

**Responding to conflict.**

Unresolved conflicts among nurses fostered an environment of mistrust, impacting negatively on nurses’ ability to organize and coordinate care. One senior nurse alluded to past conflicts amongst nurses, where these conflicts had contributed to her belief that nurses could be their own ‘worst enemies’. She felt that nurses needed to ‘stick together’, defending each other and showing compassion towards one another:

I think nursing needs to stay with nursing. I don’t like talking about other nurses to physicians – I think that’s very demeaning. I think that happens a lot in the workplace – lots of times? And, I don’t condone it, and I don’t practice it myself. I don’t mind having a general conversation, but I think if there’s issues with other nurses, that that’s not my place to talk about it or discuss it with other physicians… and I find sometimes that happens a lot of times (Patricia).
From a feminist ethics perspective, the notion of ‘sticking together’ is a form of agency that those in a position of subordination may enact in response to oppression (Sherwin, 1992). This nurse’s suggestion of the need to form of new relationships, or new rules for relationship within the group, can be interpreted as a form of resistance. While the nurse’s response may have the initial desired effect of strengthening nurse-to-nurse relationships, closing off this discussion and avoiding questions of ‘needs and harms’ can impact the future and character of relationships as well as expectations around trust (Walker, 2003).

Another nurse who felt misunderstood and hurt by a nursing colleague in the past, believed that nurses were responsible for working with and learning from each other. She felt that nurses were entitled to have special expectations about how to treat each other and were obliged to ‘clear the air’ if they had issues with another nurse, especially if it affected patient care.

I’ve felt more hurt by staff obviously - with patients I can’t feel hurt. People have said some hurtful things to me…nursing in particular. Physicians, because we’re not colleagues per se, you have different expectations in that relationship. As to your own colleagues, you have different expectations on how we should treat each other. If I pick up that somebody appears to have misunderstood, then you have to take time to clear the air and I’d rather people do that (Heather).

**Mentoring and training.**

Both senior and novice nurses identified training and mentoring as areas that influenced the organization and coordination of care. Newer nurses felt that their senior nursing colleagues had a responsibility to help out with workload or complex cases, be available ‘if anything happens’, to be supportive of the younger nurses and help them to build confidence to ‘do their job’. The more experienced nurses viewed their relationships
with novice nurses as ‘teaching-supportive’ whereas relationships with senior nurses were described as ‘peer-to-peer’ and included a dimension of friendship that transpired over time.

Senior nurses described wanting to help retain novice nurses by helping them to feel ‘adequate’ and diminishing the ‘fear factor’. However, there seemed to be a disconnect between the expressed needs of the novice nurse and the good intentions of more experienced senior nurses. Practices of responsibility reflect understandings of people’s identities and are sustained by commonly intelligible values (Walker, 2003). This nurse’s use of the term ‘generational change’ suggested a difference in values and identities between experienced and novice nurses. As a result, this nurse felt that the newer nurses did not value her approach to patient care, her knowledge or contribution to their learning:

It’s a major generational change … it’s a different sense of their worth - but we’re all worth something but they feel that they shouldn’t have to do things, and this is really hard, y’know, they don’t take part. Like, you have to almost force them to be involved in something that they haven’t done. I said, ‘what are you going to do when I’m gone? I’m not going to be working forever. This is your opportunity to learn’. But the problem is, that they don’t want to take part and then when they run into a crisis then they call for help...they sit at the desk, they’re on the computer, and when you take over for them on a break, it becomes a major issue because you go in and it looks like a pig sty. You say, what the heck is this? The patient is filthy - how can you possibly be watching her? (Beth)

The way in which newer nurses were oriented and mentored appeared to have a lasting effect on their practice. As moral knowledge is ‘produced and sustained’ within communities (Walker, 1998), mentoring is one way in which nurses come to understand what they need to know in order to function within their work environment. When asked about the one thing that had most influence on her current practice, this novice nurse stated it was her preceptor:
When I was a student, I trained with her and then I continued it on with her afterwards and we worked on the same team. I just think she has really good work ethic, and um…just, she’s always supportive. I think supporting your younger nurses is really important. Y’know the whole story about like, y’know, the older nurses feed on the young? I think that’s—um, that’s just so horrible. If you’re a senior nurse you really have to be supportive of your younger nurses in order to help them build that confidence. And I think my preceptor really did that? And…whatever I do now is really, um, based on whatever she does. (Andrea)

For some novice nurses, more than one member of the ‘team’ was responsible for mentoring during orientation to the unit. This nurse’s experience of being mentored by the team had a substantial impact on her self confidence, her sense of belonging, how she viewed herself professionally and her desire to continue in intrapartum nursing work. Through their actions and responses, team members delivered a consistent message to this nurse about how they viewed their responsibilities with respect to training and supporting new team members. The support of the team and the availability of time to provide reassurance and assistance also had a direct influence on the nurse’s ability to meet her responsibilities towards her patient:

I had a lot of questions, and I needed someone to kind of go through things with me. And so the team leader and I kind of worked together. And that really reassured me, and it kind of gave me a sense of team work. That’s the evening when I started to establish different relationships with people - that’s when I started to get to know people. So it technically was a big night, because I had this big case, big new team, establishing relationships with this new team, and with this patient. And I feel kind of like, looking back, I could have just easily, I don’t know, maybe like quit at that point in time because it could have been like a big disaster. People could have been – oh, you know ‘she’s new – she should know better’ you know ‘why is she asking me?’ And, lucky enough, it wasn’t a busy night, so everyone was really there to help me. Everyone had time to kind of help me and reassure me. (Melanie)

**Relationships with Physicians.**
The nature of relationships between nurses and physicians either enabled or constrained the nurse’s perceived ability to organize and coordinate care. According to many participants, working cohesively as a team was helpful to nurses, physicians and labouring women ‘no matter what the situation’. As one nurse explained, nurses and physicians did not provide care in a ‘silo’. Instead, the actions and responses of each practitioner influenced the way in which other providers on the intrapartum unit functioned. Positive nurse-physician relationships were very important to nurses and had a direct impact in how they viewed themselves as practitioners, their sense of accomplishment and their approach to care. Participants’ narratives spoke to two main components of these relationships including establishing effective collaborative relationships and resolving inter-professional conflicts. While physicians had a responsibility not to ‘take over’, nurses had a reciprocal responsibility to share their feelings and findings with physicians, letting them know what they were trying to achieve and seeking input as necessary so that they could have the ‘same plan’.

Establishing collaborative relationships.

A key consideration for most nurses in the establishment of effective relationships was the presence of trust and mutual respect. When practices of responsibility are clearly understood and enacted, the common fabric of trust is strengthened between people within specific communities (Walker, 1998). Although the precise mechanisms for having confidence in one another and building trust and respect were varied between nurses, essential components included having assessments accepted at face value and being heard.
Being proactive and giving physicians facts so they ‘believe what you’re saying’ also resulted in the establishment of trust.

Trust is also tailored to particular relational histories, with expectations of trust constantly being adjusted with each encounter (Walker, 1998). For the nurse quoted below, respect from the physician was earned over time and was indicated by being courteous, trusting the nurse’s judgment and expressing confidence in her abilities. The mutual nature of respect and recognition was signified by the fact that the nurse valued the physician’s presence and wanted him there. In this case, what would normally be the woman’s sense of accomplishment with a ‘beautiful birth was shared by both the nurse and the obstetrician:

I’ve had incidents where the obstetrician has come in and I’m coaching and things are going well, actually he’s been very courteous. They have worked with you long enough to have the confidence to let you do the delivery. I mean they’re there - trust me, I want him there, you know, but I think that’s a compliment that you’ve worked hard with this lady, and everyone has (a sense of) accomplishment and had a beautiful birth. And I think that, in itself, states that the obstetrician trusts your judgment. It’s not about you and me, but working together, and building a relationship, or a rapport that they trust you – they trust your judgment, and, I don’t know, it’s just a mutual respect. (Patricia)

For another nurse participant, key elements of collaborative relationship included taking time to get to know each other, watching each other, noticing and ‘tuning in’.

When residents have worked with us, like, they know, when a nurse and a family have really bonded and they’re sensitive to that? They notice and they will sometimes just step back and let us do that management more and focus on what they’re doing ... I find that a lot of them are very sensitive to that, and in a situation where they’re seeing that the nurse does not have a handle on what’s happening or there’s just too much happening? Then they’ll step up and do what they need to do as well... I think its just with spending a lot of time working with each other, just kind of watching how each other works with the physical as well as all the psychological things that we do, and just getting a feel...Its kind of like the emotional intelligence sort of stuff that they’re just kind of tuned into or not tuned into and then we’re tuned into each other or not. (Maggie)
This participant’s narrative reflected the complexities that underlie the precise nature of moral understanding that occurs between nurses and physicians. The ability to pay attention and to communicate knowledge and understanding are forms of intelligence that are often not considered as a resource for resolving moral problems (Walker, 2003). In this instance, it appears that the perceptive capacities of the resident enabled him to recognize and value what the nurse was trying to accomplish. Her story also highlights the blurring and cross-over of roles and responsibilities for the management of the labour that can occur in trusting relationships between nurses and physicians. This overlap appears to work regardless of the busyness of the unit, as long as there is some consensual agreement and a type of attuned ‘sensitivity’ between doctor and nurse.

Other nurses also spoke of the importance of an intuitive type of ‘knowing’ in nurse-physician relationships, whereby knowing allowed the nurse to ‘influence (the doctor’s) thinking’, facilitated getting advice from each other and promoted discussions about what was going on. One nurse explained that when residents know the nurse’s ‘personality’ and ‘know what you’re thinking’, they will ‘back away’ and let the nurse carry on with her care. Conversely, when the nurse knew that a certain physician may tend to ‘rush things’ she actively advocated for her patient to ensure that she had the time she needed to labour and birth.

While the nurses in the stories above described a fluidity in roles and responsibilities for themselves and their physician colleagues, others saw these as more distinct and clear cut and did not want to have ‘total responsibility’ for decisions being made by physicians. This can be understood in light of societal hierarchies of status and power which result in expected and predictable divisions of responsibilities and recognition (Walker, 1998). One
experienced nurse expressed the opinion that doctors were responsible for maintaining the orders of the day while nurses had the responsibility to be disciplined professionals with high standards who could adapt to what the doctors ordered. Another senior nurse described a kind of mutual responsibility in which nurses were responsible for being knowledgeable, competent, organized and working within their established policies and standards while physicians were expected to ‘come when they’re called’, make independent decisions within their scope of practice and respect the nurse’s work by not taking over.

Within each nurse’s narrative, their relationships with physicians were constantly in flux, depending on the situation and people involved. This required constant adaptation and flexibility, described by one nurse as ‘finding her place on the team’. This nurse understood the need to assume or deflect responsibility. As this was done in the absence of any negotiation with the physician, the nurse’s effacement of her self and her role remained invisible to both the physician and the couple:

It’s an awareness that I have as nurse, as to who I am as a player in the team, and if, say, the doctor is more important for that couple, then where I need to put my place in that team, to be able to be a participant – from a nursing perspective – and not have to be competitive, to being non-judgmental, and to understand the role I play in all of this (Brenda)

A combination of the time and place of the nurse’s professional socialization and training as well as the particular personality of the nurse appeared to influence how she approached relationships with physicians and ultimately the coordination and organization of care. This participant valued flexibility and believed that a nurse needed to have the ability to adapt to changing circumstances and other members of the team:

I think it stems back to maybe where one is trained, the standards of practice that you start off with, and the type of experience you’ve had during your training as to where,
then, the first footing to your career moves you and if you’re the type of nurse that is sensitive to being empathetic, supportive, compassionate to the feeling, emotional part of interaction, or if, in fact, you’re more of a technical nurse that really has a focus towards electronics and medications and that. In fact we all have to do everything – we have to cross over, always. You have to have the both. But sometimes there are situations when, um, the compassion is needed more, at this particular time, and then other players – maybe the doctors, or other nurses – can focus in on the technology bit. (Brenda)

Positive inter-professional relationships appeared to be especially important to the practice of novice nurses, even though these nurses appeared to be at a disadvantage when establishing relationships with physician colleagues. One nurse reported that she felt stronger, less nervous and more confident and able to gain the woman’s trust when physicians were open to ‘working together’. Walker notes that moral responsibility attaches to people who are identified by a history of ‘patterns and actions of response’ over time (1998). This nurse felt that the establishment of these relationships was hindered by her relatively limited experience, her age and a culturally imposed view of the ‘proper’ nature of these relationships. The time required for ‘watching’ and ‘tuning in’ described by more senior nurses as an important element of inter-professional understanding and relationship was not available to this young nurse who felt that she was not ‘known’:

I guess its part of my culture, also, you know, as a kid, we were taught that someone who is significantly older than you, to kind of, you know, give them a sense of respect, you know, sense of superiority. So I kind of use that still. I could never call them (doctors) by their first names. The nurses who’ve been working there, they have this, like you know, a long relationship of working together, so everyone calls each other by their first names. But, they don’t really know me (Melanie)

Even for more experienced nurses, the cultural system in which they trained, and the unique set of values that supported that system, influenced the nature of their relationships with physicians:
I’m never fully comfortable with them, and I’ve seen a lot of nurses relax and chat and laugh and joke and stuff. I can do that with maybe a couple of them but I’ve never been comfortable. I think just because I was trained in England, and I was the Nightingale kind of nurse. I was terrified of the sisters, terrified of the doctors...and so, I’ve always had that intimidating kind of gap between me and, and them. And I’ve tried to push myself not to be that way, cause I can see, um, all the Canadian nurses are not like that - they’re more relaxed (but) I’m a product of my experiences. (Esther)

**Responding to conflict**

The values adopted by a community are shaped by power relations (Sherwin, 1992). Interprofessional conflicts arose when physicians did not acknowledge the nurse’s role or listen to and value her assessment, body of knowledge and education. The result of conflict could have a negative impact on not just the nurse, but the labouring woman as well:

It’s like we’re not a part of their team, you know? And I find that very frustrating …the collective knowledge on this floor is incredible. We’ve got people here who have done it for 30 years and they feel frustrated, you know? They feel people don’t listen to them and, you know, you just sit there and it annoys me that that patient is suffering unnecessarily. (Joy)

Some nurses struggled with trying to respect the doctor’s role while also wanting their own contributions to be acknowledged and recognized by both the physician and the labouring woman. This novice nurse struggled with trying to reconcile two conflicting values: the need to respect the doctor’s role while at the same time having her contributions recognized:

I feel like at the end of the labour, like when we’re pushing and the doctor comes in…I feel like I lose control, depending on who’s on that day, like who’s on call. A lot of them are really good and like to respect the nurse’s position, and really, um…try and work together with the nurse to try and deliver the patient. And then there are others who just come in and take over, as if your role was nothing, right? Like, wow, I laboured with this patient for, like, ten hours, and now she’s ready to deliver and you’re just going to come in and take over and, y’know, coach her on pushing? It kind of makes me feel like all the work that I’ve done is nothing. I think that’s really hard. I haven’t quite figured out what to do. I usually respect that...
A nurse’s need to maintain integrity can be challenged by the non-negotiable and disadvantaging response to situations involving oppression and subordination (Walker, 1998). There was a sense in this nurse’s narrative that her contribution went unnoticed by both the doctor and the patient. Although she experienced a loss of control in the situation itself, she was not able to ‘figure out what to do’ to address the perceived injustice. As a result, her narrative has a tone of resignation and acceptance of her experience being the status quo.

Another, more experienced nurse, described a similar situation, but appeared to have developed strategies to resist the care being ‘taken over’ by the physician. By directing her attention to the labouring woman, effectively ignoring the resident, she was able to silence him and stop the ‘take over’.

I’ve been with this patient, and I have a good rapport with this patient, and I’ve had them for the whole shift, and I’m pushing with them, and the head’s starting to crown so I call them. And the resident comes in and starts taking over, and yelling over me…I have this patient totally calm and doing it perfectly, and they come in and yell ‘Push—Harder, harder, harder’ – yelling. Then I say, to the patient, which gives them the hint, I say, ‘Listen to my voice’. When I have done that the resident has totally stopped talking. That’s how I do it, because that confuses people and they don’t need to start yelling at somebody, when they’re having they’re baby. (Ginette)

Conflicts and tension between nurses and physicians sometimes resulted from a lack of understanding and appreciation for the everyday work the nurses did. According to this
nurse, the extent of their responsibilities was only made visible when things went wrong. In those cases, the recognition nurses received was that of blame:

I still think that maybe people think that we (nurses) just walk around and say ‘there, there’. I maintain that a labour and birth unit is like an emergency - so anything can happen. Any complication, any emergency can happen during the activity of giving birth. We’re fortunate in most cases people are healthy, and in most cases babies do come out and they thrive really well, and everybody’s happy. But there is that other percentage where things do not turn out well, when we have, I don’t say disasters but near misses. And they’re the ones that I have difficulty coping with, because it’s almost like, let’s do some finger pointing here to find out what went wrong, and often it’s the nurse first, who gets the finger pointed to: Did the nurse call for help? Did the nurse do this, did the nurse do that? And for me, near misses are always team work - team work. It’s always team work. And sometimes nature takes a turn and gives its own call, and the outcome is beyond anybody’s hands. (Brenda)

Walker suggests that practices of responsibility have a regulating function within communities, whereby “specific distributions of responsibility to and for persons, by situation, role and relationship, are made common knowledge” (1992, p. 94). When expectations for performance of responsibilities are not met, blame results. This nurse’s narrative suggests that the scope of what nurses do is not ‘common knowledge’. In addition, because patterns of ascribing and deflecting responsibility are socially shaped (Walker), nurses’ subordinate positioning within the relational hierarchy relative to physicians makes them more likely to be the target of blame.

While nurses appreciated that the scope of practice and responsibility was distinct for nurses and physicians, in that nurses could have inter-professional ‘discussions’ but that decision-making was the purview of the physician, they still expressed frustration when their opinions were not valued and acted-upon. For this nurse, frustration stemmed from a lack of recognition of her knowledge and experience. She also understood that her ability to respond was limited by the fact that medical decisions were the doctor’s ‘call:
There’s often times when doctors will react to a fetal heart rate tracing, for example, ‘oh – we have to do a stat section right away’…it’s one variable, ok? Can we look at the whole picture here? There’s variability, the fetal heart rate was fine before this happened, this baby’s got good reserve, you know, there’s no reason to rush and do a section right this second, do you know what I mean? Let’s wait for a minute – see what’s going to happen. I can bet you this kid’s going to recover… But oh no, we have to run and do the section right now. So, there you are running and of course by the time you get to the section room the variable’s back up just like you said it was going to be - and you can’t – I can’t control that, because I can’t make the decision – even though I can have the discussion. It’s frustrating sometimes, ‘cause you know that you were right. But, um, ultimately it’s their call. (Wendy)

The nurse in this next narrative, was uncomfortable with leaving the doctor’s ‘call ‘unchallenged’, as she believed that he was not fulfilling his responsibilities to the labouring woman. She described feeling intimidated and was effectively silenced. This nurse wondered what options were available to her, and raised concerns regarding consequences from her nursing regulatory body if she had refused to participate in a plan of care that was, in her opinion, unwarranted.

The patient was being wheeled down to OR to have a stat-section and we called the anesthetist - we always find that the anesthetists are reluctant to come to labour and delivery - so when they come you better have a reason why they’re there. I was told to take out the scalp clip, so I was taking out the scalp clip and I couldn’t - it wouldn’t come off. So I examined the patient so I could maybe get it off directly, only to find that the baby’s head is right on the perineum - she’s fully dilated, ready to go! And so I told the obstetrician, and we were talking about it amongst ourselves, y’know great, she can deliver, and anesthesia said, um - are we going to do the section or not? And he goes, come on let’s do the section, and I’m like, huh? So they carried on, and they did the section…It was like they were frightened of this staff anesthetist - everyone was intimidated, so they went ahead and did the section. And I’ve always said to myself, what would have happened if the nurses had walked out? What would the college have said, if we’d done something like that, because I think that’s the only way we could have stopped the section. (Esther)

The concept of “standing up for one’s own best judgment under pressures and penalties from other people” is a form of relational integrity (Walker, 1992, p.116).
However, in this nurse’s example, her positioning in relation to both the physicians and her regulatory body and the consequent feelings of intimidation, greatly compromised her ability to take responsibility for her part in allowing the situation to occur.

In cases where conflict arose between nurses and physicians, nurses were aware of trying to minimize the disruption to the labouring woman. The result was that nurses often stayed silent in the moment and hoped to de-brief after if there was opportunity:

Sometimes you just, you’re not going to say anything cause you’re in the midst of it and you just have to get out of a bad situation, so you’re not going to say something. The other thing is if you say something up front, then it sets up a whole thing with the patient, and um…y’know your perception is one but then the patient then takes it beyond that, so you, you’re caught. It’s better sometimes not to say anything and then afterwards, if you get a chance (Beth)

**Summary of Organizing and Coordinating Care**

The ability to organize and coordinate care within the intrapartum unit revolved around relationships between and among nurses and physicians. Walker suggests that the basis for these ‘narratives of relationship’ is trust (1998). Trust is more than mere reliance and includes an interpersonal attitude that involves mutually agreed upon expectations of others as a matter of response (Walker, 2006). As these expectations are developed over time, novice nurses and medical residents, the latter whose commitments to the unit and the nurses was limited by the length of their rotation, were more dependent on these relationships to organize care but in many ways less able to enact these trusting relationships.

Nurse participants described the importance of collegial nurse-to-nurse relationships in either enabling or restricting their ability to provide care for labouring women. The extent to which nurses are able to ‘know’ one another, share similar expectations and understandings of their responsibilities, and demonstrate reliability and reciprocity in their
everyday interactions were all elements of the social-moral connections between nurses. The organization and coordination of care was influenced by the nature of these relationships. Outcomes of positive relationships included an environment in which nurses felt supported, appreciated and recognized for their particular contributions to the team and patient care. When responsibilities were not clear and expectations differed, the result was a culture of blame, anger, hurt and misunderstanding.

Key components of effective collaborative relationships between nurses and physicians included understanding, acknowledging and valuing each others’ contributions. There was also an element of sensitivity or attunement to the other that enabled recognition of the work that nurses did. Increased feelings of confidence and competence on the part of the nurse as well as an enhanced experience for the labouring woman were some of the positive outcomes of effective collaborative relationships. Power imbalances were at the root of many of the inter-professional conflicts. Nurses tended to avoid inter-professional conflict by making themselves invisible or accommodating the physician, in order to minimize disruption for the labouring woman. Within a social-moral model of morality, responsibilities are cultivated through forms of power that are used to control, educate and influence (Walker, 2003). Inter-professional conflicts engendered feelings of anger, frustration, and intimidation among the nurses. In addition to feeling devalued themselves, nurses felt that the needs of labouring women were also less visible when conflicts occurred.

Responding to the Unpredictable

According to several of the nurse participants, labour and birth is ‘like an emergency’ where ‘anything can happen’. Although nurses are obliged to respond to particular others
who were relatively vulnerable, Walker (1998) notes that those responses and the values underlying them may change and become re-ordered based on the situation at hand. The unpredictable nature of birth shaped the responses of many nurses as illustrated through stories that described the need to anticipate and control the process. This need often superseded the value of involving women in decision-making regarding the process of labour and birth.

Although some elements of the ‘unpredictability’ cited by nurses in this study, such as relationships with colleagues, staffing and family, could be applied to any area of nursing, the nature of birth itself, including the process of labour and the maternal-fetal response, added a layer of complexity and uncertainty, unique to the practice of intrapartum nursing. It was interesting to note that ‘nature’ was mentioned frequently as an unpredictable factor controlling the process and outcome of childbirth and was either blamed, feared or trusted, depending on the nurse and the circumstances. The extent to which nurses expressed that it was their responsibility to control and anticipate the process of birth varied between nurses and was also inconsistent within some nurse’s interviews. The way in which nurses interpreted and enacted this responsibility appeared to be grounded in the nurse’s values related to pain management, controlling the process of birth and ensuring safety.

**Managing pain**

While there was a shared understanding among nurses that the extent and intensity of labour pain was unpredictable, participants varied in their approaches to the management of pain. The issue of pain was central to nurse’s stories on anticipating and controlling the unpredictable. Some nurses felt they needed to work with mothers to help them anticipate
their need for pain management – often with epidural anesthesia – explaining that they could not ‘control’ when the anesthetist would be available. This nurse attempted to counsel her patient, who was coping with an unexpected rupture of membranes before labour began, about ‘when’ to request an epidural, by explaining some of the functional aspects of the unit. The disjuncture between what the woman perceived to be her ‘right’ to choose the timing of her epidural and the realities of the unit were evident in this story:

I said ‘the unfortunate things that’s happened is, that your water has broke, but your labour isn’t that good yet, so’ I said, ‘we’re going to give you some time to see if you establish a good labour, but if you don’t, you’re going to end up with oxytocin, with an IV, with all of that. My suggestion to you is, when that happens - and that’s going to be their (the doctors’) choice - that you take the epidural early… I said ‘now, make sure, if you change your mind, that you don’t change it at 7 o’clock, because we may have a difficult time getting the anesthetist at that time’ ‘Well, it’s my right’, she said. And I said ‘I’m not saying it’s not your right, I’m saying that there are times when situations happen and that may not be an appropriate time… (Beth)

By acknowledging the woman’s right but also placing this right in the context of the intrapartum unit, the nurse’s narrative highlights the ways in which certain structural features of institutionalized relations “can enable or deform the abilities of all concerned to hear and be heard” (Walker, 2003, p. 80). This need to balance the woman’s expectations with the nurse’s knowledge of the structures within the environment that affected the availability of the anesthetist created considerable tension for the nurse. In the cases where there was a mismatch between the timing of a woman’s request and the availability of an epidural, nurses felt as though they were the unfair target of blame:

And then it became clear to me that she thought that I didn’t want her to have the epidural. It wasn’t stated, but I got that sense...and so we explored that, and I explained all that and I told her that I was just helping her to cope with them until they could get there, and she accepted that. But it was interesting that she felt that way… because I’m not in control of anesthesia...I was really glad that I talked with her - explored that with her before I moved her over to the postpartum unit, because
she probably would have gone home thinking ‘oh, that horrible nurse who was making me suffer!’ (Heather)

Practices of responsibility define the degree to which what takes place ‘belongs’ to the individual. Part of holding others responsible is the expression of feelings and attitudes, such as blame, which send messages about shared expectations regarding trust and connection (Walker, 1998). In this case, the nurse worried about being the unfair target of blame when the woman’s expectations were unmet. According to Walker, practices that shape and correct an individual’s sense of responsibility involve mutual recognition (1998). By following up with the woman following the birth, this nurse attempted to clarify the extent of her responsibility as a way of re-establishing connection and trust.

Nurses had to juggle the needs of women and their partners with the availability of staff and the acuity of the unit, all of which were elements of the ‘unpredictable’. Complexities ensue when different demands of different persons pose conflicting options (Walker, 1998). When this happens, decisions must be made about what can be accommodated and what must be sacrificed. Integrity is most strained in these situations, as reflected in this nurse’s narrative, in which she describes an exhausting effort to placate a distressed woman and her angry partner until the anesthetist arrived, while also fulfilling her responsibility to remain present. As her narrative makes clear, the husband’s and woman’s expectations regarding the epidural were at odds with what the nurse understood to be normative on the unit – that is, people often had to wait for the anesthetist. However, because the nurse was present, it was her relationship of trust with the woman that was strained. By continuously calling out of the room, the nurse could have been trying to ‘make visible’ the elements of the situation that were outside of her control:
The husband is getting very stressed, because he can’t help, he can’t cope, he doesn’t know what to do – so he’s getting angry that the epidural hasn’t come, and the anger will go towards the nurse, because the nurse is the person who’s most present, actually, with the patient. So, I’m the nurse. I have to go back and say, ‘you know, that there’s a bit of a delay because the doctor is involved with something else, he’s doing a procedure – whatever it is – he’ll be here as soon as possible’. She’ll be saying ‘I need an epidural now, I need an epidural now, I’ve asked for one, so where is it?’ She’s quite distressed, and you’ve done the phone calls, you’ve got everything in place, the cart is waiting, ready to give the epidural… so, in that half an hour, I’m apologizing on behalf of the situation. I say there’s not much I can do about it… I’m just being really present in the room. I won’t leave that patient. I’ll just keep calling out ‘Can you call again? Can you call again?’ (Brenda)

Controlling the process

Some of the nurse’s narratives reflected inconsistencies in their understanding of the extent to which the unpredictable course of labour needed to be controlled. In these stories, control was ascribed at various times to the baby, the physician or to the labour itself and could be either shared or taken away. According to this participant, nurses had to know when to ‘let nature take its course’, a reference to situations where nurses could not control the outcome, as in an unplanned caesarean section. Within a moral-social environment, differently situated people will have different understandings of the costs and risks associated with particular situations (Walker, 1998). The nurse’s suggestion that women do not want to ‘hear’ about who is in control highlights an interpersonal disconnect in which the differing perspectives of the woman and the nurse are neither acknowledged nor heard:

The people that are hard are the people who are really, really want to be in control. And you’re trying to tell them the baby’s in control. They don’t want to hear that. They want to hear that they can do things on their own, and I find that hard…. you ask what people want, and you try to give them what they want, and at the same time make it really clear to the, that none of you is in control—that this is nature in control. (Joy)
Placing the baby ‘in control’ has the potential to silence the woman, who may feel that she is being selfish if she asserts her own needs and wishes ‘over’ those of her baby. This approach reflects a traditional understanding of autonomy and conflicting needs of two individuals – mother and baby – versus a feminist based relational approach in which maternal-fetal needs are seen as interrelated. Although we cannot know how a woman would respond to this approach, it reflects an understanding of the woman as not only passive, but standing in opposition to her baby, to ‘nature’ and ultimately to the process of birth itself.

Another nurse reasoned that nurses should give some control to women in order to preserve their sense of self. However, she added that it was sometimes necessary to take control or ‘convince’ women, especially in cases where they were fearful or in pain. Here it appears that the manner in which the nurse takes control – being polite and not bullying – is used to justify the action which could be viewed as coercive or manipulative:

I find with patients, generally, if they really need to do something, I will convince them to do it, and, do it without bullying them - just, say, it’s going to happen, just, by being polite with her and saying, ‘you need to do this, it’s needs to happen’. (Joy)

Experienced participants, many of whom had their early training undertaken with or influenced by midwives, expressed the least need to control the process of labour and birth, seeing themselves in guiding or supporting roles, allowing nature to ‘take its course’. These nurses had many aspects of shared narratives of moral identity. Narratives of moral identity constitute consistent values over time that reveal what a person responds to, cares for and takes care of, even in situations that include unpredictable demands that originate with others (Walker, 1998). In this case, nature ‘taking its course’ was equated with a positive outcome, leading towards a safe vaginal delivery. These nurses were also more likely to value working
with women who did not want an epidural, because it was ‘nice to have people who need you – all of your nursing skills’. The harmonizing of moral judgments and actions among people creates a ‘moral equilibrium’ (Walker, 1998). In these instances, shared moral understandings resulted in a kind of mutual satisfaction, whereby the nurse was able to foster feelings of confidence within the woman, while at the same time describing a ‘more interesting’ experience for herself.

These nurses also placed high value on vaginal birth as an outcome, as Caesarean sections were viewed as ‘major surgery’ requiring a lengthy recovery. For these nurses, labour ending in an unplanned Caesarean section was ‘physically, mentally and emotionally very demanding’ resulting in disappointment for the woman and a sense of failure that was often directed at the nurse. These experienced nurses tried to anticipate the trajectory of a woman’s labour, using a broad range of supportive measures, including positioning, emotional support and therapeutic touch to enable the woman to reach her goal. Within systems where expectations are mutual and understood, the imperfect nature of people and situations means that there will be disappointments in performance with concurrent remedies of accountability and blame (Walker, 1998). In spite of her best efforts, the inability to control the outcome and achieve the goal of vaginal birth left this nurse with a sense of ‘failure’:

If my patient ends up in the section room, I feel like a failure….I will try to pull every string I can to have a vaginal delivery because I think that’s the way it was meant to be, and I think that when a mother labours and she works hard, she reads the books about it and goes to the classes about vaginal deliveries and that’s the mindset she goes into the whole process with, and she ends up with a section, there’s also the failure aspect that she’s dealing with. Its maybe not a failure, but its ‘why’….why did it happen? (Carol)
One nurse described the nurse’s role as taking care of the essential nursing ‘tasks’ while supporting the couple to work as a team and enabling them to take control of the labour process and decision-making. This was accomplished through helping women to understand what was happening to them, staying with them, helping them to relax and to be more ‘in tune’ with their bodies. Another nurse described the importance of supporting a mother meet her goal of a non-interventionist birth by ‘helping without taking control’. Moral understanding that is expressive and collaborative gives priority to voicing and hearing and primacy to personal acknowledgment and communication (Walker, 2003). This nurse felt the giving over of control to the woman was especially needed in the case of women who were vulnerable, as reflected in her care of this young single mother with addictions:

It was challenging, but it was also rewarding, you know, to know that you were helping somebody who couldn’t necessarily help themselves, and allowing – respecting them for being a person, and going through this experience without taking control of everything and taking away their – their rights. Like I said, this is their labours. They have whatever ideals they’ve come into their labour with – and I have to respect whatever those ideals are…you know what I mean? What I have been through with my labours and what I have been through with my patients, I bring in to every case. But I can’t make people do what I want them to do, just because I feel that’s what’s best for them (Wendy)

According to one novice nurse, labour and birth is unpredictable and ‘beyond your control’ in that ‘you never know what you’re going to get’. This sense of ‘not knowing’ contributed to her anxiety and nervousness resulting in her heightened awareness of the need to anticipate what might happen and put measures in place that could help her to feel more ‘in control’. Although this nurse noted that she had to ‘let go’ of her desire to control the course of labour, she also identified factors that helped her to maintain this sense of control,
such as developing effective rapport with her patients so they would trust her judgment, and also being able to rely on her nursing ‘team’ to assist if the need arose.

Another nurse with relatively limited experience, expressed the sentiment that women’s expectations were not always in line with the unpredictable nature of birth. She found it ‘hard’ to work with these women. Her language of ‘demands’ and ‘refusals’ suggested a confrontational tone, reflecting a disconnect in values related to natural childbirth. The dualism illustrated within the narrative that there was a ‘good’ and a ‘bad’ course of action acts as a mechanism of oppression, where differences are polarized and thinking is narrowed (Sherwin, 1996).

Sometimes I get a patient who demands that she has a natural birth, and, y’know, refuses to have the pitocin when she’s not contracting, right? Or refuses to have her water broken, or, or doesn’t want the IV, or doesn’t want this, doesn’t want that …and just wants it all natural and sometimes, like, it’s really hard to be that nurse. I think sometimes, um…sometimes the more you want your labour to be natural the more unnatural it is. Sometimes I just think that people come in and they have unrealistic expectations - like they haven’t really been told that, y’know sometimes things don’t go the way that you want them to, right? (Andrea)

Some nurses tried to ‘control without being controlling’. This nurse participant directed the process of labour by anticipating the end point and devising strategies to have the woman ‘working with’ her:

The bottom line is you have to first know where you want to go. You have to have your direction where you want to end up - how you get there, it doesn’t matter…you want to be able to have her working with you not against you, because if she’s working against you it becomes a terrible delivery. There’s no sort of direction, there’s no consistency. It’s just that that you’re working against each other. You’re not trying to work with them and that’s a problem sometimes that happens, is that if you don’t try and work with them…sometimes if you work with them for a little ways then you can direct them to where you want to end up (which is) a nice delivery…where everybody’s happy. (Beth)
One nurse struggled with the knowledge that she may have tried – consciously or not, to control the process of labour. She acknowledged that at the time she may have ‘unintentionally’ taken over when a woman’s plan for birth interfered with her own work. She also described a situation during the pushing stage of labour – a time that is often more tightly managed, controlled and directed by physicians and nurses – where the woman took control of the situation. The nurse was impressed that the woman was able to exert that kind of power over the physician and others in the room, while at the same time teaching her (the nurse) a valuable lesson:

The doctor came in, and he went to examine her and she slapped him - she slapped his hand away, and so there’s quite a few people in the room at this point, so she basically sat up in an arm chair kind of position, and she allowed this baby’s head to come out very, very slowly. There’s no practitioner there at all, and we all just stood there in amazement as this baby just came out of her - vagina and the perineum just gently gave way. And the perineum remained intact…and so she had what she wanted, right, despite us telling her the opposite, y’know? She carried on with her plan, baby was born, baby was healthy, she was intact, she felt empowered because she did what she wanted to and I felt I’d learned a valuable lesson! (Esther)

Another nurse suggested that even in the face of unpredictability and unfavourable outcomes, the experience of the woman could be positively affected by the nurse’s response, which included helping women to anticipate what was going to take place:

I think that we as nurses have tremendous control over the perceptions that people are left with...I really believe that you can take a situation that just can be so difficult for a woman, and still have her come out feeling somewhat satisfied and intact, as opposed to attacked. I would never want a woman to feel manipulated or that she was unsafe in a situation, or that we took control away from her, and I really believe strongly that with time in and communication and face-on and listening, you can actually have emergency sections, you can have, you know, horrible vacuum extractions, that kind of thing...but you can still empower the woman with the way you structure the consent, the discussions about what’s going to happen, the anticipation, the planting the seeds, as you start to see things unfolding, right? (Veronica)
At times, ‘dependable responsiveness’, or being relied upon to take responsibility for actions (Walker, 1998) appeared to mitigate against the unpredictable nature of birth while at the same time providing reassurance to the woman:

When you tell them you’re going to be back, you’re back. You explain to them that even if you’re not in the room, that the monitor is at the desk, that somebody has seen it... when the doctor leaves, sometimes they’ll say, I’m not sure about this and so you talk to them about it and explain what the doctor said, and you also make sure the husband is there. (Beth)

Some nurses encouraged the active participation of women in order to decrease their anxiety and give them ‘a sense of control’. This was viewed as especially important given the ‘unknown’ related to childbirth and the potential fear that could result from this factor. Active participation was facilitated through gathering information about the woman’s knowledge and experience related to birth and integrating this into the plan of care. This nurse’s approach was to focus on the person in order to get her ‘into control’:

I try to focus on them you know what I mean? A lot of nurses come in and they get focused on the paper work, and they’re focused on the blood pressure and all the other things, and forgetting about the person in the bed having all this pain. She’s my first focus. I don’t care about the paper work, you know, I don’t care about doing her blood pressure. I need to get her listening to me and I need to get her into control because that’s what counts – that’s what matters, you know? (Wendy)

The way in which a nurse perceived the issue of control was also related to her own identity and personal experience. This nurse described how her own experience influenced her approach to control and alluded to a potential benefit derived for the nurse, who may be better able to work with a woman who is in control:

I don’t like sort of embarrassing painful procedures done on me that are not necessary, and I want people to respect my integrity as a person, not just when I come into the hospital. So, that’s always been my focus in nursing. Often when people come into the hospital, they lose their sense of self, and often if people are difficult
patients, they lose control and they tend to be much more difficult. If you give them back control, they tend to calm down. (Joy)

At other times, the fear of losing control was understood to be shared by both women and nurses. This nurse perceived a shared a narrative of identity with the woman and highlighted fears related to anticipating the unpredictable elements of birth:

I definitely think that, you know, this experience is their experience, and I think they carry this along with them for the rest of their lives, and that’s why there are experiences that I carry along with me the rest of my life...I think it stays with you – it’s a scar – um, its something you’d rather not think about…and I think it’s the same with these patients. I think its that fear? Of losing that control? Because labour is something that, really, you don’t know what’s coming around the corner - its the unpredictable. (Carol)

Ensuring safety

According to one nurse, during childbirth, things can go from ‘bad to horrible quickly, and horrible is catastrophic’. Many nurses expressed the sentiment that it was their responsibility to help women understand that sometimes things didn’t always go ‘as planned’ and that the top priority was the safety of mothers and babies. They expressed a willingness to ‘empower women, allow them to take control and to support their decisions’ as long as there were no ‘safety issues’. One nurse expressed the sentiment that while she considered her self to be an advocate for women, this could only occur ‘within the parameters of safety’ and when women had ‘legitimate’ concerns. Safety was most often cited as a justification for nurse vigilance in controlling and anticipating the process of labour and birth. Nurses understood that they should respect a woman’s expectations for birth and act as a guide to assist her in carrying out her plan ‘as long as there is a healthy outcome’. Commonly understood values, such as family centred maternity care, were encouraged ‘within safety
parameters’ where the extent of family involvement and inclusion was controlled by the nurse and restricted in ‘emergency’ situations.

Practices of responsibility can reproduce conforming behaviour by circulating understandings of what is required (Walker, 1998). This is achieved by “creating awareness of the sticks of blame and reprisals or the carrots of approval and reward” (p. 95). The nurses’ shared understandings of the need to ensure safety promoted conforming behaviour for them but also for the labouring women for whom they cared. One nurse explained that ‘for the baby’s protection’ she had to ensure that women had an ‘open mind’ and not too many expectations about ‘how’ the baby was going to come. She noted that as a nurse, she found it hard to realize that she couldn’t control everything that happened in labour, ‘especially when the baby’s in charge’. She also found it difficult to work with mothers who ‘read too much’ and focused on how they wanted their labour to proceed.

While some nurses relied on their ‘knowledge and experience’ in order to preserve patient safety, others felt that safety could be ensured as long as they ‘followed all the policies and procedures of the hospital. For these nurses, organization and preparedness was one way to mitigate against the unpredictability of labour where ‘anything can happen’. This nurse, who was not fully confident in her knowledge about the value of the particular intervention, still believed that a refusal to accept the offering was equated with risk. In this case, the value the nurse placed on the intervention supplanted the value of choice:

When it comes to baby care, I’ve had some mothers that have refused to have the vitamin K and the erythromycin ointment, and I find that really hard. I know it’s their choice and I know that researchers have shown that it’s not really necessary that you have to give these to the child... I haven’t really looked into that area, in that way. I just feel like why wouldn’t you give it to your baby, right? Like, these are prophylactic treatments, right? The vitamin K is good for your baby, right? It’s not like it’s going to harm your baby. I mean why would you put your baby at risk for
getting, like, an infection, or an eye infection when you can just put ointment in the eyes, right? (Andrea)

For another nurse, compliance was a key component of ensuring safety. Her goal was to establish connection with the woman in order to gain compliance for ‘the baby’s safety’. Rather than a shared understanding, compliance may be enforced by threat, putting into question the moral nature of practices where standards are reached through coercion or deception (Sherwin, 1992). According to this nurse, when a woman chose not to do what the nurse advised, she could ‘compromise the baby’. Women who were non-compliant ‘might not have been that smart’ or were ‘unable to follow directions’. This nurse also wondered whether or not these women ‘cared’ or if they were apathetic or depressed. Ultimately, the nurse concluded that compliance resulted in a win: win situation for the baby and the nurse, although the impact on the mother was not evident:

Usually people are very compliant, they want their babies out, they do everything you tell them…um, and they work with you. And those are very rewarding. (Ginette)

Some inconsistencies were apparent later in this nurse’s narrative, however, when she told a story of allowing the woman to ‘choose’ a repeat caesarean section rather than staying with the original plan of proceeding with a vaginal birth. She explained that although it wasn’t the nurse’s idea to go for the section, she felt it was the ‘best’ outcome, so “I followed her plan”. Given the nurse’s previously expressed value of compliance, I wondered if she would have been as willing to ‘follow the plan’ if the woman had chosen to proceed with the planned vaginal birth.

Ensuring safety often trumped the woman’s experience. Values such as ‘natural childbirth’ were sidelined when the well being of mother or baby was thought to be at risk:
…really what this is all about is getting out a healthy baby. It’s not about a huge birth experience… I want people to clearly understand that the process doesn’t matter. It doesn’t matter, y’know, it doesn’t matter. There’s really no such thing as natural child birth. Birth is natural, and sometimes it’s gotta come another way - because the process is, it’s fluid, y’know? We have so little control. All we’re doing is catching a baby—that’s all we’re doing. (Joy)

This narrative puts into question the role and responsibility of the nurse. In some ways, the fact that the process is unpredictable and that the nurse has no control is used as a justification for shedding responsibility for the outcome. However, the impact of the nurse’s approach and practices of care is rendered invisible – a critique nurses often level on others but, as illustrated in this case, also, unintentionally, turn on themselves.

**Summary of Responding to the Unpredictable**

Commitments and consequences may shift and change in light of the ‘complex synergies’ of choice and chance that are a part of everyday life (Walker, 1998). Nurses’ responses to the unpredictable highlighted the many dimensions of labour that were deemed to be outside of their control. While control was attributed at times to physicians, the baby and ‘nature’, the woman was rarely acknowledged as having control over the unpredictability of labour. Only one participant acknowledged that in her nursing role she might have unwittingly taken control of the labour process, either to get her ‘job done’ or because she felt she was in a better position to judge what was best. This nurse’s narrative was unique in that she expressed doubt about her actions and reflected on alternate courses of action, whereas the other participants expressed more certainty about the correctness of their actions and responses and were unaware of the ways in which they may have exerted control.
The unpredictability of labour pain and management of pain was a contested area in which understandings and expectations of women, nurses and physicians were often at odds. Nurses expressed strong and diverse opinions concerning the function and value of labour pain, stemming from their training and experience, which influenced their understanding of their responsibilities towards women in this area. The mismatch in what women expected and what they received for pain often resulted in anger and blame directed at the nurse. Training and professional socialization also influenced the degree to which nurses felt the process of labour needed to be controlled. Nurses who were trained under a midwifery model exhibited shared narratives of identity in which they valued supporting women through non-interventionist births. Other nurses, both experienced and novice, who were trained in a more North American obstetrical model, placed high value on compliance and the application of technology and medical interventions in order to control the unpredictable elements of labour and birth.

**Recognizing Limits to Responsibility**

Responsibility ethics, as articulated by Walker (1998) describes our obligation to “respond to particular others when circumstance or ongoing relationship renders them...dependent on us” (p. 107). Within this study, nurses’ stories described limits of their responsibilities to others and the need to preserve personal integrity. This was accomplished by responding to difficult situations or relationships that arose in everyday practice. The way in which a nurse responded was influenced by her ‘narratives of moral identity’, which were sprinkled throughout each participant’s interview. These narratives illustrated selective responses developed over time, and were based on priority setting among many competing
values (Walker, 1998). While particular responses were varied, they fell into three distinct groupings, including detachment, flexible resiliency and moral reparation. Those nurses who were able to remain flexible and to make and seek reparation described feeling more satisfied with their responses. Those nurses who responded with detachment felt that the experience had ‘taken its toll’ and were left with a ‘moral remainder’ that included lingering feelings of guilt, blame and anger.

**Detachment**

While some nurses described continuous reflection as a means used to understand difficult situations and maintain integrity, others preferred to ‘move on’ and bypass the debriefing process, both within themselves and with others. These nurses responded to ‘angry outbursts’ of women and colleagues with some form of detachment. Nurses described feeling less obliged to establish and maintain relationships with individuals who were on the unit for a limited period of time. For example, many nurses placed more value on their relationships with permanent staff physicians than with residents on a rotating schedule, even though the latter had more direct involvement with everyday decision-making. For some nurses, this also applied to their relationships with women.

When faced with ‘demanding’ patients, one nurse explained that while she was responsible for getting on with her job and being polite and respectful, she also had to ‘turn off the switch’ and not let it bother her. This nurse, like others, felt less responsible for meeting the usual expectation of a ‘therapeutic relationship’, because the situation occurred at the end of the shift. In this way, the nurse was able to justify that something less was owed, given their limited history:
So I just looked away - I was facing away from him anyhow, so I just continued facing away and took a deep breath…I just did what I had to do, and I was just – polite. I took a deep breath and just ignored what he had to say, and then just, you know, spoke politely to the woman and told her what I was going to do next, got on with my job. If it wasn’t the end of the shift and I was going to have to deal with him on an on-going basis I might have taken more time to talk to them? But I wasn’t – there was no need at that point in time to start trying to develop a therapeutic relationship because I wouldn’t be the one with them, so, at that point there was nothing I could do. I felt there was nothing I could do, let’s put it that way, but just to show respect for his wife, and just do what I had to do. (Heather)

Another nurse’s story described a situation in which she was frustrated with what she perceived to be the family’s intrusion into care, which included constant questioning of her actions and decisions. This nurse’s narrative of moral identity placed high value on compliance and trust as indicated by a woman’s acceptance of her suggestions. She decided ‘not to try’ to establish a relationship because she would not be seeing her again:

…I only had her for, not very long because I was at the end of my shift, but, I don’t know - with those cases, I just found it really hard to connect with her. It’s almost like my brain just shuts off and says like, okay, y’know what, I’ll just deal with this for two more hours, and even though I know that building a relationship is really important, and communicating is really important, like, I’m just too tired to deal with this right now. So I’ll just answer these questions, and then I’ll just leave you to the next nurse. I just really couldn’t cope with it, at the moment. And sometimes, I just don’t try to - not that I don’t want to, but I don’t have the energy to try and build that relationship with her, especially at the end of a shift. I know that I’m going off and I won’t be seeing her, right? (Andrea)

Certain circumstances – in this case a demanding family and a limited term of relationship - caused a reordering of responsibilities which can occur when existing responsibilities are no longer sustainable, causing a person to become ‘differently reliable’ (Walker, 1998). The nurse appeared to be struggling with what she would normally be relied upon to do, for example establishing a relationship and communicating, but alters her response by to the situation by not trying.
One novice nurse, who placed high value on ‘happy’ outcomes for herself, the women and families she looked after and the outcomes of birth, adjusted to her unmet expectations through withdrawal, stating she did not want to ‘be there’ when women and families could not relate to her on those terms:

Sometimes it can pose as a challenge – especially in labour and birth – just because you need to do a lot of interaction, a lot of working together between the patient and yourself - especially when you’re pushing with a patient, you know, you kind of have to have some sort of relationship in order to have a successful birth right? So when someone is not really receptive, it’s hard. Its almost just like she doesn’t want to be there, I don’t want to be there, and its just not meshing well. (Melanie)

Only one nurse spoke directly about personal limitations - independent of other contextual factors - that limited her capacity to respond to others. This nurse’s narrative reflects the disjuncture between maintaining integrity and enacting the kind of ‘open-ended responsiveness’ that is often associated with caring (Walker, 1998). People who are immersed “in complex, varied and changing relationships” can be compromised by an “unlimited demand for responsiveness” (p. 108). The fact that only one nurse would include this story as part of her narrative suggests that certain stereotypes persist among nurses themselves about what is expected of them and the stories that they are able to tell about falling short:

Well, I know for me personally, if it’s a night where I didn’t sleep very much and I just feel like everything, everything is more of an effort than usual to do, and then sometimes, I just don’t have the energy to be in the room all the time… I just don’t have the energy to give to the degree of what it seems this woman and her partner require. (Maggie)
This nurse also recognized that her personal limitations put restrictions on what she was able to accomplish for the couple she was looking after and the range of responses available to her:

I know that there have been in the last few months a few situations where I didn’t feel connected to them and therefore I didn’t feel like I was making a huge difference for them? And I was exhausted and it kind of just felt more mechanical and I felt like I tried and I wasn’t getting sort of real response from them. (Maggie)

**Flexible resiliency**

Reliable accountability enables people to maintain or re-establish important commitments in order to preserve integrity (Walker, 1998). To be able to respond in this way, ‘flexible resiliency’ or the ability to “exchange global wholeness for more local dependability” (p.106) is required. One nurse’s narrative included many references to the value she placed on remaining calm, being disciplined, professional and maintaining high standards. The ability to recognize that individuals cannot always choose or control all results for which they may be held accountable is a form of integrity or ‘dependable responsiveness’ that develops over time and within communities (Walker, 1998). Over her years as a labour and delivery nurse, this participant developed a strategy of turning inward in order to deflect the anger:

I’ve learned breathing techniques for myself to keep in that calm state and not be pulled in to her emotion. To be detached enough – one has to be – well, I’ve tried to learn to be detached enough so that I am compassionate and understanding, but at the same time I’m not going to get upset by her or his emotional outburst – because it’s not really me – it’s being directed at me, but it’s not me. They’re just angry with the situation. If I’d never had this, I wouldn’t know how to cope, and I’d probably go out and say ‘somebody else take over for me, ‘cause I can’t cope with this’. I do know, now, that I can be present, I can stay calm, and I won’t let them see any emotion from me. I won’t get pulled in, and I won’t lose my temper and I won’t get irritated or frustrated by them, because one has to maintain that professional stance and, uh, I think sometimes it’s very difficult. (Brenda)
Some nurses found a way to remain present and managed to maintain connection with the woman, even in the face of personal costs, such as exhaustion. Stories within this participant’s interview, which reflected her extensive experience as a labour nurse and woman who had given birth, reflected a strong belief that proper support in labour resulted in enhanced self-confidence and feelings of accomplishment for labouring women. Through her professional and life experiences, this nurse developed selective responses that allowed her to pay special attention to certain things and people and to put up with behaviour that others, without the same valuation, may not have tolerated:

I mean there’s patients who exhaust you because they’re demanding, or because they’re just – they’re, um, they want so much, you know what I mean? I try and just take that with a grain of salt and realize, you know sometimes you realize – you know what? This is the only attention these women are getting - the attention I’m giving them. And you know what? It’s really no skin off my nose to have to do some of these things for some of these people. (Wendy)

Although nurses usually described relationships with women in which they gave of themselves physically and emotionally, they also found ways to alter their response to women in cases that were intense and highly charged in order to be able to provide some degree of effective care while preserving integrity:

It can be traumatic sometimes. I’ve had a patient where CAS (Children’s Aid Services) has come to the unit - which is unusual because usually our patients are in the postpartum unit - and apprehended the child right there in the room...so that was stressful for me and the woman was crying and upset and you feel like crying...’cause, you know, the emotions are there. The woman is crying, and you have to contain your emotions – it’s ok to show them a bit – but, then you have to be capable of helping her to deal with the pain of losing the child. It is emotionally tiring because you have to bring your self in check and say ‘ok – I’ve got to support her through this, and listen to her. (Heather)

Moral reparation
The term ‘moral repair’ is used to describe steps taken to stabilize moral relationships when commitments and expectations have not been met (Walker, 2006). Some nurses felt it was important to follow-up and try to make reparation – for themselves or others – when situations had not gone well. The notion of moral repair implies shared terms for responsible conduct that are set and understood within communities and revealed in responses, feelings, attitudes and beliefs of the people within those communities (Walker, 2006). For example, when this nurse felt she was the unfair target of anger and blame, she made a point of speaking with the woman afterwards to explain her feelings and to clarify the extent of her responsibilities and what she considered to be reasonable expectations:

… she was directing her anger at the nurses during the labour, which I don’t think was fair because it made her labour rougher - it didn’t need to be like that. Because she was angry, she wasn’t working with the nurse. She was angry because the nurse wouldn’t watch her son, y’know, and I said to her, ‘y’know, our job is not to watch your other child our job is to take care of you and to take care of the baby you’re going to have’. (Beth)

A number of nurses commented that regardless of the type of birth, they valued the opportunity to meet with women after the birth. This was especially true when things hadn’t gone as expected, as these visits allowed the nurse to release some of the ‘weight’ of responsibility for the outcome. There were structural limits imposed on the nurses’ ability to debrief in this way, as they did not always have the time or opportunity to visit women in the postpartum area. This nurse’s attempt at reparation addresses the needs of both the woman and the nurse. Helping the woman to ‘understand’ is an acknowledgement that expectations were not met, while taking the ‘weight’ off speaks to the nurse’s need to forgive herself, which involves “overcoming a bad feeling” (Walker, 2006, p.161):
I think it’s also important to visit them postpartum… I’ve sat down with them if it hasn’t gone maybe the way that they wanted it… I didn’t want it that way either – we all didn’t want it that way…. And they then understand why things were done in a particular way – and that sort of takes the weight off you as well – that they understand and accept the fact that this is something beyond their control. (Carol)

The nurse’s responsibility was also limited by the responses of management, physician colleagues and the institution to the concerns brought forward, including stories of negligent care. One nurse described how her documented concerns about a particular situation ‘disappeared into a black hole’. Another nurse explained that sometimes her ‘hands were tied’ by the woman and her decisions and by the decisions and actions of the other members of the health care team.

Busy units’ inflexible rules and being pulled in different directions made it hard for one novice nurse to be ‘the nurse you want to be’. When the unit was busy, the range of responses for nurses were limited to responsibilities such as providing physical care, trying to ‘get some emotional support in there’ and directing the family to help the labouring woman. Nurses valued an environment in which they were acknowledged for the work they do by physicians, patients and the institution. Institutional recognition was linked to moral reparations of sorts through the physical work environment. Nurses perceived that the physical environment in which they worked could place limits on their ability to provide care. This nurse described her understanding of the link between ‘happy’ nurses and patient care:

If the nurses are happy, then we’re going to do a better job. So to say that it’s not important that you have a, satisfactory lounge or changing area, or a decent break time - that’s not the priority, the priority is ‘this’. Yes that is a priority, because we need to be fed and watered just like everybody else. If you give us these things it shows us that you value what we have to provide - you value us as people, we’re gonna stay longer - you’re going to retain us… you’re going to give women more
than the basic care. You’re going to be happy - you’re going to be happy to work there, you’re going to provide better service. (Esther)

Intra-professional relationships between physicians also placed limits on the extent to which nurses felt responsible for enacting some form of moral reparation. While one nurse expressed her frustration that that professional decisions made by physicians, such as anesthetists and obstetricians were sometimes based on professional friendship versus patient need, most nurses who addressed this in their narratives spoke of the impact of conflict between physicians on the labouring woman. In cases where physician to physician conflict was mentioned, nurses expressed feelings of powerlessness and frustration with the result being that neither the nurse nor her patient was seen or heard:

I was just incensed because this particular surgeon and this anesthetist are always bickering over something, and I thought it was a personal thing and the people had forgotten there was a patient there, and what she’s going through…I felt I couldn’t be her advocate. I could only watch this, going on before me. And this has happened to me so many times in nursing where you feel like you want to speak up, you want to stop it but you feel, because of the power imbalance that you can’t do it. And afterwards you’re kicking yourself because you feel guilty because, y’know, if only I’d said something, if only I’d walked out, if only I’d done something, y’know? (Esther)

The guilt associated with being unable to act ‘in the moment’ reflects an understanding of the need to act correctly in every instance, which cannot be a reasonable expectation. Integrity may be applied not only to those people who act from a ‘standing position’ but also to those who ‘own-up’ and attempt to “clean up messes, their own and others” (Walker, 1998, p. 118). What is left unclear are the ways in which responsibilities for ‘cleaning and owning up’ would be made transparent and fair among the doctors and nurses involved in particular circumstances.
Moral remainders

When moral demands are left unfulfilled, moral residue or ‘remainders’ ensued, reflecting the reality that choices must often be made from a selection of imperfect responses (Walker, 2003). Although the complexities of some circumstances which limited the enactment of moral responsibilities were evident to this nurse, the resultant feeling of not being able to fulfill expectations left her with lingering negative feelings about her performance:

I had to trust that what was happening at the desk was what was needing to happen, while I was in the room doing what I needed to do. Once I got the physical sort of tasky things done, once I got her settled in that way, that’s when I felt like I could direct my attention to what was happening out there… I don’t know, I guess I sort of went from the desk to being in the room, checking on her as a labouring patient to see how she’s doing, and to give her suggestions of how to manage a little bit of her pain and what was happening - still trying to so that, but feeling icky and then going out to the desk and feeling icky. (Maggie)

Moral repair was not always possible. Some nurses described carrying a burden of guilt for their actions (or inactions) when caring for labouring women. Although they recognized, on one hand, the limits of their responsibilities to these women, these memories endured and took an emotional toll, even years later. One experienced nurse reflected on how she felt ‘stupid’, ‘cowardly’ and ‘guilty’ for her inability to intervene effectively between two feuding physicians in order to have her patient’s needs met. Her story revealed relations of authority that allowed some understandings to prevail and limited the way she was able to respond.

Nurses expressed strong opinions about what they valued in their relationships with women. When those values were not evident, there were limits placed on the extent to which the nurse felt she could meet her responsibilities to that woman and family. The fact that a
person’s life includes more than one cherished value, means that the demands of some responsibilities may condition the fulfillment of others (Walker, 1998). This novice nurse placed high value on being ‘trusted, noticed and wanted’ as this was tied into her feelings of confidence and competence as a relatively new labour nurse. She described how she was able to tolerate other aspects of stress in her working environment, as long as the relationship was going well. If this was not happening, it ‘takes its toll’:

Basically I felt that I wasn’t wanted. So, despite my attempts to, kind of correct things, and to try to be, you know, on her good side, it seemed like it was pretty hopeless. And the fact that, you know, you’re running around, and it kind of takes a toll on you, you know, you’re running around and you’re stressed out with the workload from the actual unit itself, and then you’re not really jiving with the patient as well as you’d like to be. Because sometimes if its really really busy and if its, you know, you can’t even remember the last time that you ate, because its so busy. But, having a great patient makes it all worthwhile, its almost like time is going by fast - its like you’re enjoying your time despite the fact that you can’t even feel your legs from running around. (Melanie)

Another more experienced nurse described a situation in which she wasn’t wanted by the woman. Although there was evidence of hurt and anger in her story, the nurse was not willing or able to lay blame on either the woman or herself and reasoned that there was nothing else she could do:

I guess she perceived me not being, either caring enough or not giving her enough attention, and she blew up at me, and told me to get out. She was very angry and agitated at the time. I was upset and I was ticked off and I just said, you know, sometimes you’ve just got to bite the bullet. And I said, you know what? This isn’t about me - its about her, and if that’s her wishes, I’m not here to fight and argue with anybody. I think the bottom line was I thought, well, she’s, you know, maybe she had other issues – I have no idea, and, to tell you the truth, I wasn’t in the mood to find out... for whatever reason, we both rubbed each other the wrong way...like I might have been kinda upset for a day, or half of the day – whatever. It’s not worth it, because in my mind, I didn’t do anything wrong - it was just a clash of personalities which happens in life (Patricia)
Stress associated with the work environment was perceived by this nurse to limit her ability to respond fully to the needs of women and families and also took a personal toll on the nurse herself:

The thing I fear the most is becoming…like some more experienced nurses… a lot of them stop really caring? So, I fear that I would become that - and I don’t want to become that type of nurse. That’s the main reason why I chose labour and delivery, just because from when I started, from when I first got my first experience in labour and delivery, I felt that ‘wow – this is a very warm and comforting environment - this is somewhere that I could really work, you know, and do for quite some time. But I’m starting to notice that sometimes I’m not as patient as what I would be normally, especially when I'm juggling, you know, two patients, and then a triage patient, and a really heavy patient. I’m seeing it more now just because, you know, we’re so busy in the unit, there’s not a while lot of staffing. Someone could easily just, you know, burn out and not enjoy it as you once were. (Melanie)

Moral understandings create meaning by reproducing social arrangements (Walker, 2003). These understandings can sustain pride and trust or mobilize resentment towards those who undermine them. Through her narrative, this novice nurse indicated an acceptance that burn out was ‘just the nature of the job’ and a passive resignation to accepting the limits to being able to care:

What you learn in school is to be caring, to act caring, and you kind of just question: why are they not doing this? Whereas now, working as a nurse, I’m kind of - better understanding why that could happen. And I think that's what a lot of nurses are experiencing – its just the nature of the job…you know, you give so much, and sometimes you don’t get back in return. (Melanie)

**Summary of Recognizing Limits to Responsibility**

Nurses who responded to difficult situations with detachment and avoidance expressed lingering feelings of guilt and anger. Their stories carried a tone of resignation. When nurses tried to fulfill expectations of commitment and trust in situations in which their range of response was limited – either by their own values or interpersonal and structural
power relations – they attempted to find a balance between maintaining integrity and providing care. When this balance was not attainable, as was often the case, nurses carried a moral ‘remainder’ which influenced their capacity to meet their previously understood moral responsibilities to their colleagues as well as women and their families.

These findings suggest that the ‘self’ of the nurse must be viewed in terms of history of relationships and valuation, and within the context of changing circumstances that affect the range of responses available. Given the interplay between our social and moral worlds, Walker suggests that moral residues and carryovers should be considered more the rule than the exception (2003). If that is the case, it makes sense that there would be limits to nurses’ responsibilities to others and also important to recognize that choices regarding how to act will be selected from a range of imperfect responses.

**Negotiating Care with Women and Families**

Nurses used many approaches in this study to negotiate care practices and choices with childbearing women. The extent to which care was negotiated and ‘matched’ the initial expectations and choices of women was shaped by the values underlying each nurse’s approach to organizing and coordinating care, her responses to the unpredictability of birth and the degree to which she experienced limits on her responsibilities to others. In addition, the negotiated understandings and expectations arising out of each encounter between the nurse and a labouring woman influenced the nurse’s subsequent approach to care. While there were many intricacies involved in negotiating care with women and families, three main components were identified, including: establishing rapport with women and families, responding to difficult patients, recognition and response to choices.
Establishing rapport with women and families.

Several nurses highlighted the importance of mutuality in establishing effective relationships with labouring woman. There was an assumption that women would recognize when the nurse was being ‘respectful’ and therefore an expectation that women would respond in kind. Although nurses were cautious about the amount of personal information exchanged with women, they appreciated when women asked questions about how they were doing, which suggested to the nurse that she was ‘noticed’ as a person.

While the nurse could ‘set the stage’ for the initial patient encounter, the response of the woman to the nurse’s overture had a strong impact on the degree to which rapport would be established. Although one might expect labouring women to naturally exhibit signs of distress, anxiety and pain, many nurses expected that women would be ‘smiling and welcoming’. Establishing expectations regarding how a person should behave is a form of “culturally normative prejudice” (Walker, 1998, p. 178). Assumptions are made that specific people, in this case labouring women, will exhibit certain behavioural or physical characteristics. Through these representational practices, social identities are constructed leading to assumptions and expectations for certain norms of behaviour and response (Walker). Labouring women, who recognized and conformed to these norms, were regarded as ‘good’ or ‘easy’ patients. For this nurse, when culturally established expectations were not met, she felt ‘down’ and expressed doubt about her ability to have a ‘nice’ relationship:

If the mother seems really miserable, even before she’s contracting, um, I feel a bit down…if she’s not smiling when I come into the room, and um, she’s very reluctant to give eye contact…or she doesn’t talk to me at all, and then I have to, um, converse with the relatives. If she’s open to me and she’s smiling, and she’s welcoming then you know it’s more uplifting - more hopeful that we’re going to have a nice relationship. (Esther)
The notion of ‘intuition’ was commonly expressed as a way of knowing by nurses. This experienced nurse relied on ‘nursing intuition’ to establish rapport and ‘get involved’ with women. Intuition required both experience and wisdom and was a key component of being a ‘good’ nurse:

I guess I’ve learned in nursing, always go by that little feeling in your stomach – its an intuition that I think you learn over the years (with) wisdom, experience - everything you’ve seen and learned through the whole process. I think it’s a gift. To be honest with you, all the nurses that I’ve worked with always had that feeling….You can pick up pretty easily, like if the mom’s really anxious or scared. And if I see that I give a lot of reassurance, like you know, sometimes just hold somebody’s hand, or give them a little rub and that adds up to being a good nurse – getting involved with your mom. (Patricia)

Intuition, which reflects the way the way in which we pay attention or notice certain things, depends on a number of factors. In order to tell what others are experiencing, we rely on “whole familiar patterns of clusters and features in certain characteristic settings and sequences” (Walker, 1998, p. 183). In other words, these are learned understandings gained by nurses through their experiences and interactions. As these understandings reflect personal as well as institutionally dominant values, there is as much potential to get it ‘right’ as there is to make the ‘wrong’ interpretation, resulting in misrecognition or misunderstanding.

A number of the participants linked the ability to establish rapport and connection to a personality ‘fit’ between nurses and the women for whom they cared. The ‘fit’ was often stemmed from an understanding or knowing that was based on finding common ground. This novice nurse explained that she could determine from the first few minutes of the encounter with a woman, whether or not it was going to be a ‘good’ shift:
The first few moments of introducing yourself is very, very crucial because that’s when you know whether or not it’s going to be a good night with that patient, or it’s not going to be…what I’ve noticed is that sometimes when they – they can sometimes sense whether or not you’re nervous or you are going to be not the attentive nurse, or they already have some sort of idea when you present yourself, so by presenting yourself, I don’t know, it’s this weird kind of connection… almost instantaneously. Once she feels that ‘Oh – maybe this nurse is actually not bad’, she starts to warm up and then, when they start bringing up stuff, you know, and then they start asking, ‘Oh – so how are you doing today?’ They start to ask when they feel comfortable enough, they start to ask you not just so much about the work, but about you - and that’s when you know that ‘Oh, its ok’. (Melanie)

For this nurse, the ‘connection’ was based on sharing, including the woman acknowledging the nurse as a person as by enquiring about the nurse’s well-being.

Interpersonal trust involves being able to predict or plan on a certain outcome based on certain expectations of behaviour and response being met (Walker, 2006). This form of recognition relies on a presumption of familiarity and coherent and mutually recognizable modes of expression. The notion that ‘good’ relationships were dependent on the fit between the nurse’s ‘style and approach’ and the woman’s expectations was prevalent among the nurse participants. This nurse described personal and professional benefits that resulted from being connected to a woman, including feeling positive ‘energy’ and knowing that she’s making a difference:

I think my style and approach fit with their expectations - that’s how it seemed, ’cause there were times when my style and approach does not fit and I have to change things and ask them questions about it. They wanted hands on, keeping them abreast of what’s happening, asking them questions about their own personal birthing experiences, showing that I care… it happened almost right away - you get that feeling from them, and they’re responding to what you’re doing in a positive way. It didn’t feel like work. (Maggie)
Another nurse who was midwifery trained placed high value on the woman’s experience of birth, and described an orientation to the woman versus her nursing ‘tasks’, as an essential element in the establishment of rapport:

…from the moment you walk in the room, with a smile on your face, appearing to be unhurried, so that you, you establish that their time – your time with them is going to be very special? And, if you go in as a nurse and say ‘I’m just going to do you vital signs, and I need to do this, this and this and, oh by the way, my name is so-and-so’ and you’re already into your tasks, then, from my perspective, that patient won’t develop as good a rapport as if you wander in and say ‘hello, my name is so-and-so’ um, and you introduce yourself to the partner, and you ask how are they (Brenda)

Her colleague echoed a similar sentiment of focusing on the person, not the ‘paper work’. In both cases, their stories focus more on expectations around their own behaviour versus expectations of woman and their partners:

I try to focus on them you know what I mean? A lot of people come in and they get focused on the paper work, and they’re focused on the blood pressure and all the other things, and forgetting about the person in the bed having all this pain. She’s my first focus. I don’t care about the paper work, you know, I don’t care about doing her blood pressure. I need to get her listening to me and I need to get her into control because that’s what counts – that’s what matters, you know? (Wendy)

**Responding to ‘difficult’ patients**

The characteristics ascribed to ‘difficult’ patients varied from nurse to nurse, although most of the difficult situations described included elements of power struggles between nurses and demanding women who wanted to be ‘in control’. Within a feminist approach to ethics, it is suggested that most patients recognize their relative vulnerability and respond by offering a ‘cheerful disposition’, listening attentively and apologizing for requiring attention (Sherwin, 1992). Therefore, those women who ask questions and ‘demand’ attention would trouble cultural norms and expectations for behaviour and engender a different response from nurses. Nurses who valued a high level of control over the birth process expected women to
listen, to comply, have ‘reasonable expectations’ for birth and be open to the nurse’s suggestions. These nurses equated being questioned by women and their partners as interference and signs of mistrust.

The ability to acknowledge and respond in moral terms is learned through a process of continual negotiation, in which new situations are “mapped onto past understandings and projected into future possibilities” (Walker, 1998, p. 65). Novice nurses had limited experience to draw upon when contemplating responses to changing circumstances and challenging relationships. This junior nurse felt that she lacked the tools to cope with difficult patients, even though she appeared to understand the source of the difficulty. Her feelings of anxiety and tension worked to undermine her confidence and the establishment of trust:

A lot of patients are more or less primips, so a lot of them are very fearful. When you walk into the room, especially with a tense client, and the husband or the partner are tense, there’s just this weird energy in the room that, it’s kind of like, sucking you in….not only are they really anxious, I get anxious too, just because, you know, this room is tense and now I feel like I’m tense. And they have 20 million questions and sometimes I feel like I’m not providing them with sufficient answers? Because they keep asking more questions, so I feel like I have failed because they keep asking more questions. Nothing is reassuring them and so it makes me really anxious, and sometimes I can’t really do much about it. (Melanie)

Nurses had more difficulty establishing relationships when there was not a good fit of personality, described by one nurse as not being able to ‘see eye to eye’. This moral misrecognition can result from result from unfamiliarity, temporary inattention or a habitual tendency to notice only certain things (Walker, 1998). Women and families who were recipients of care in these cases where often referred to as challenging or demanding. In these cases, nurses continued to try to forge connection, checked in to see how the woman was
doing, tried to be ‘helpful therapeutically’ while not letting the woman know, verbally or non-verbally, that the nurse was angry or stressed. One nurse described a situation in which she felt manipulated by a woman who was challenging the nurse’s sense of being ‘in control’:

I was definitely intimidated by her and I had to keep working in my mind to say ‘ok, now, I’m a labour and delivery nurse, you’re not. And she even said herself, once or twice, ‘ok ok, yes, you’re in control, I’m not, so do as you need to do’ And I’m thinking, ‘ok, you’re saying that, but you’re not actually doing that, so I just kept on doing what I needed to do, and I almost felt like I had to keep proving myself? Just feeling uncomfortable, feeling intimidated and just kinda feeling yucky, but just carrying on, and not able to connect with her, in any kind of way, really. (Maggie)

Expressions of resentment and indignation can signal violations of shared understandings and are meant to bring about corrections of unacceptable behaviour (Walker, 2006). Through her internal dialogue, the nurse reinforces the normative expectation of how a labouring woman should behave and who is ‘in control’. Even though the woman ‘corrects’ her behaviour (‘ok – you’re in control’) in an attempt to re-establish the relationship, she is not believed. Within this climate of mistrust, the nurse is not able to forge a connection.

Negative or reduced moral recognition and response can occur when people are identified with groups that are devalued or feared (Walker, 1998). Some nurses described feeling fearful or apprehensive when working with women whose life history diverged from their own. Other nurses responded by attempting to find a link between themselves and the women for whom they cared as a means of establishing rapport. These ‘sense-making’ connections, are one way of enacting practices of responsibility by determining and acknowledging separate but mutual histories (Walker, 1998). One nurse described her initial
fear when faced with looking after a homeless woman who was infected with HIV. While on one hand the nurse worried about placing her family at risk for infection, imagining a myriad of possibilities given the woman’s living situation, she was also fearful about the extent to which this ‘difficult and belligerent’ woman would be receptive and responsive to her care. This nurse was the mother of a young child, whose stories illustrated the high value she placed on the well being of babies while the needs of the mother were often obscured. The nurse described that she was able to overcome her initial fear once the woman in her care began to talk about her unborn child. For example, when the woman shared that she had a name picked out for her baby, the nurse understood that they shared a common value – caring and concern for the child – regardless of the disparity in their life circumstances. From the nurse’s perspective, this formed the basis for the establishment of rapport.

The degree to which an individual recognizes or identifies with another’s vulnerability depends in part on the person’s sense of self as well as their tendency to “affiliate or differentiate from others” (Walker, 2003, p.160). For one experienced nurse, a theme that ran throughout her narrative was that ‘everybody deserves respect’. In the case of vulnerable women and families, this nurse explained that a respectful approach was especially important ‘no matter how far away they are at the present time from humanity’. The establishment of a trusting and respectful relationship was accomplished by hearing their point of view or ‘seeing where they’re at’, and explaining what was being done and why and providing information so that they didn’t feel ‘coerced’ into making decisions.

While some nurses found it challenging to negotiate care with women who were marginalized in some way, others sought out these women as patients and described intense satisfaction from working with them. This nurse explained how knowing more about the
person helped to lessen the fear and judgment associated with caring for women from backgrounds that were different from hers:

I think that has really made a difference, in working with our homeless population and our teen population. I think a lot of people are just really scared to work with this population because they don’t know what to say to them, and they don’t know what to do. They’re scared to, y’know, call the social worker, they’re scared to ask the social questions. I don’t know how I always get these patients, but somehow, like, I get a lot of these patients assigned to me, and time after time I learn from them, and I learn what to say and I learn how to support them and, learn to be non-judgmental when I’m talking to them, and then now it’s just become a lot easier. I think it went from being a really scary situation to something that I’m really comfortable with and that part, I think, has been really significant to me (Andrea)

Resentment is a social emotion that can prompt individuals to recognize and negotiate the shared norms and expectations within their relationships and communities (Walker, 2006). For some nurses, finding a way to identify with ‘difficult’ patients helped them to overcome resentment and establish a ‘bond’ with the woman. In this case, the nurse identified as a woman who had given birth herself, and was able to recognize and respect the woman’s strength and persistence. Once she was able to work with the woman instead of ‘fighting her’, an effective relationship was established in which the woman was receptive and appreciative of her care and the nurse experienced ‘good’ feelings:

I was looking after this woman who was a very strong, positive woman. She had strong ideas about what she wanted. I remember at the time feeling resentful…she didn’t want to push and she explained that she wasn’t going to push because she’d read that the longer the baby’s head stayed in the perineum, the more the perineum would stretch out and remain intact. So, basically every type of intervention I suggested she wasn’t for it. I thought, you know what? This is ridiculous. I’m going to stop fighting her and work with her, right? Because at one point I thought to myself, my goodness how can this woman, who has not had an epidural, hold back from pushing? ‘Cause I’m thinking of my own personal experience, it was just automatic - and she didn’t want push - at all! So I said ‘You must be very uncomfortable down below, can I maybe apply a hot compress?’ And she says ‘Yes, yes you could try that’, and so I did, and she says, ‘Oh that feels wonderful, thank you very much!’ And so we bonded - we bonded, and so I thought okay I’m going to
work with this - this feels good. And I really started to respect her, and I really felt that she was a very, very strong woman. (Esther)

The nurse quoted above also acknowledged that a possible source of resentment was that the woman, in resisting the proposed interventions of the nurse, was not allowing her to ‘do her work’. On reflection, the nurse was able to consider the source of her resentment and identified the gap between the espoused philosophy of patient-centred care with actual practices. Through her story, she also reaffirmed her narrative of moral identity and her priority valuing of the woman directing her experience of birth versus the nurse ‘taking over’:

We’re also learning all the time, and we’re learning from them. They’re supposed to be the primary health care givers for their own management - we’re only supposed to be assisting them. So basically we’re assisting them in their birth - we’re not taking over, and sometimes I feel that I don’t take over, but maybe I have been taking over all this time because I felt resentful that she wasn’t allowing me to do my work. I think my initial reaction was, ‘how dare she tell me what to do and tell me about my own job, I’ve been doing this for years and years, and this is her first baby, and she’s telling me what to do’ kind of thing. And then I realized, eventually (laughs), after many hours, as you can imagine, that y’know, I’m honoured to be apart of her birth experience, but it’s her birth experience (Esther)

Sometimes, nurses felt connected to women because they identified with them by virtue of their age. This nurse was critical of what she perceived to be the judgmental approach of her older colleagues towards the young woman in her care, and felt she was better positioned to understand her because of their closeness in age. She described a mutual understanding she had with young women that included treating them as responsible mothers in exchange for them treating her respectfully as a nurse:

I just felt it was really important to connect with them, ‘cause I work with a lot of older nurses, and I just didn’t think it was very fair, sometimes when I watched them, that they would – judge them because of their age, or treat them differently, y’know,
treat them as if, like, they were - they were their child…saying like, ‘don’t talk to me like that’ or ‘you shouldn’t be doing that’ or, y’know, saying things that were really disrespectful…but like I think because I’m the same age as them, or they’re like, younger than me, I don’t really feel that I have that role as a parent, right? So I see them almost as like my peer… I don’t really ever have a problem with them, like they never disrespect me as a nurse and I don’t ever treat them as if they’re irresponsible mothers right? (Andrea)

Moral understandings, when shared and understood, sustain trust and confidence (Walker, 2003). In situations where social and cultural differences precluded initial shared understandings, constant negotiation regarding expectations was often required in order to establish trust. This nurse described caring for a demanding and uncooperative woman with a history of chronic drug abuse. She used continuous negotiation to establish reasonable expectations within the relationship and, as a result, was able to build a level of trust with the woman. Her approach and response reflected an understanding of the woman’s behaviour as a normal response to labour. As a result, the woman was not blamed or chastised, but understood:

And then she’s saying ‘can’t you see I’m in pain?’ And I said ‘yes I do know, but yelling at me, and screaming isn’t going to help.. .. I said ‘first of all, we’ve got to draw blood, and I said ‘it’s gotta be, y’know, a fair amount’ So I draw blood, and she says, ‘I’m only giving so much’. I said ‘fine - at this point, I will accept that, however, we will be taking it later, because it’s important to know for the baby’s sake’. Then she said ‘Everything’s for the baby what about me?’ I said ‘for you, right now, the important thing is to get you through this, and it’s not going to be easy, but we will make it through…I think people take things too personally, y’know? Like when somebody’s in labour they don’t always mean to be where they are. Because afterward she had this baby, she was totally different. She was apologetic for her behaviour (Beth)

Expectations regarding what we should and should not anticipate from particular others in trusting relationships are learned over time and within shared communities of understanding and vary according to personal history and identity (Walker, 1998). One nurse
was able to empathize with the woman’s perspective, reflecting on her own negative experiences with hospitals and medicine and acknowledging that ‘hospitals are scary places’. Her understanding, born out of personal experience, was that non-compliant women were usually anxious and fearful. Her response was to activate the ‘mother gene’ in order to help the woman overcome her fear and become part of the ‘process’ of labour and birth:

When people are afraid you have to activate the mother gene- you encourage her, you say you’re breathing well, you’re pushing well. There’s no point in shouting at the person - to just shout at them only makes people angry…or afraid. So, the most important thing is to have a tone that is sort of loud enough so that you can be heard, but is, is not to like a child. You want to get their attention; you’re not wanting to brow beat them down, you know, because they have to be part of the process in labour and delivery. (Joy)

Although nurses understood that it was important to be ‘non-judgmental’ especially when people behaved in ways that were foreign to them, inconsistencies were evident in their stories. One nurse who valued her non-judgmental approach to working with young, socially isolated women, reserved harsh criticism for well educated women and their families who ‘interfered’ with her management of labour. For many nurses, the desire to be non-judgmental was rooted in their professional socialization, although one nurse explained that because she came from a judgmental home, she was more attuned to avoiding making judgments of others:

I came from a very judgmental home. When I left that home and I started working as a nurse…and I saw so many situations where you would – you could make a judgment and then it would completely change the way you approach the parent or the care that you were going to give, because you – you would get a mindset around the type of person you were nursing, and that could direct your actions, your communication, …and then you’re missing – you could be missing some key pieces. (Veronica)
The priority valuing of each nurse was evident in the range of responses to difficult situations. One nurse responded by attempting to remain ‘present’, even in the face of personal exhaustion, in order to have a ‘happy’ outcome:

I stay present in the room. I stay in the room – but of course you don’t stay there minute for minute, right? I’m in the room probably more to sort of try to gain their trust, and to reassure them… I guess you don’t realize that they’re feeding on you more than you realize that by the end you’re so exhausted, but so relieved. And, you’re sort of very happy at the end of it, that all has gone well - baby’s well, mommy’s well, partner’s happy…its like ‘thank God everything has gone well’, for me, and the patient, and the baby and the husband… (Carol)

Another nurse described the need to build connection and ‘get past the wall’ in difficult situations by working with the woman and her partner, asking questions in order to understand their perspective and providing reassurance:

Well, normally, when you walk in, people would be just like ‘Oh, someone is here’ kind of thing, whereas in this room, you walk in and they’re just like – it’s almost like they didn’t see me. So right there, you kind of just get this feeling of not being wanted… normally, if I’m getting some sort of closed connection like that I try to ask more questions - I try to probe, you know, to see what’s happening – try to better understand them… then she started to tell me her story, and she told me she’s getting kind of tired of being in bed, and since it was such a busy night, the doctor who told her that she would come and break her water in an hour or so, you know, 5 hours ago, hasn’t come in to see her. She’s not really trusting what’s going on there. Yeah, it’s almost like she felt, um, unnoticed? So she kinda started building this wall … and here I am trying to, kind of get past the wall… (Melanie)

This nurse’s description of ‘getting past the wall’ resonates with other nurses’ stories of overcoming resentment. Resentment and anger can occur when there is a belief that that someone has gone ‘out of bounds’ by ignoring rules of expected behaviour (Walker, 2006). In this case, the source of the nurse’s resentment was linked to her normative expectation that she would be seen and ‘wanted’ by the woman and her partner. By trying to learn more about the woman’s experience, the nurse was able to identify with the break in trust of what the
woman expected from her caregivers. The nurse’s response to this difficult encounter generated a new shared understanding whereby the nurse could relate her own feeling of not being seen with the woman’s experience of feeling ‘unnoticed’.

Some nurses were unwilling or unable to break through the wall of resentment. Their experiences with difficult women and challenging situations were framed in terms of compliance. Compliance rests on the notion of trust – or at times ‘blind’ trust – whereby the patient is expected assume a relatively passive stance and have full confidence and trust in the effectiveness of their caregiver (Sherwin, 1992). This nurse, whose stories illustrated high value placed on adhering to standards and policies, was very clear about her expectations about how women should behave:

I don’t find people that are challenging, because they’re cocaine addicts or because of their nationality or because of their socio-economic status. I would find them challenging if they are not compliant. Like even if it was somebody that was poor if she would do what I said, um, I would do the best for her. I would do the best for anybody, but if they’re not compliant I find it frustrating…I mean the odd time you get a cocaine addict who is non-compliant, because they’re stoned - so then you just, be sympathetic. (Ginette)

When resentment is felt, there is often an assumption of ‘malice of indifference’ whereby it is believed that the person could have chosen to behave properly but instead disregarded the ‘rules’(Walker, 2006). The implication from the nurse’s story was that women were culpable for bad behaviour and ‘excused’ only if they could not reasonably be held accountable, as in cases where women were under the influence of drugs. In this story, the range of responses open to women was very limited based on the nurse’s expectations of how they should behave. The understanding of trust as an interpersonal attitude or relation
where understandings and expectations are negotiated (Walker, 2006) was not reflected in this nurse’s approach.

Nurses had varying responses to family involvement and participation in the birth, with some viewing them as an integral part of their responsibility in establishing relationships with women, while others regarding family members as an unwelcome interference. Nurses who welcomed family involvement regarded family members as resources in helping them to understand and interpret the woman’s needs. One nurse explained that trust of the family had to be earned by the nurse and was usually accomplished by inclusion, such as asking lots of questions about their experiences and showing them different strategies for helping the woman to cope with labour. By asking questions and including the family, the nurse explored narratives of relationship within the family, which includes understanding the history, commitments and expectations of one another (Walker, 1998). This required time and diplomacy on the part of the nurse, and the ability to anticipate – based on past experiences – how to avoid conflict in the room:

> I was a little apprehensive at first, because I knew I had to kind of in addition to taking care of this woman and offering her support…I need to work with these other women in a way so that we can work together to help this woman and not have any kind of negative dynamics going on in the room. It’s kind of like you just sit back and get the feel of their relationship - what are they going to do if … if things aren’t going well, or she’s really having a hard time? I mean, how are they going to react to that, and how am I going to be in the middle of this? And so I kind of think in my mind things I’ve experienced in the past where it can go that’s not good and kind of keep it away from that and just kind of keep things going positively. (Maggie)

For this nurse, having an effective relationship with the family was a valued aspect of her work which she was not always able to experience due to the busy environment of the unit:
I just felt so apart of that family, and that’s really what gives me a lot of the energy and motivation to continue on in this work... for me it was a very powerful time. I also, like, I guess for me it was knowing that because the rest of the unit wasn’t busy I was able to stay in the room and work with her. If it was really busy in the rest of the unit, I wouldn’t have been able to stay, I wouldn’t have been able to get to know them as well as I did, and sort of have the working relationships that we did because of the trust building. (Maggie)

Negotiating care with families required some flexibility on the part of the nurse. The extent to which families were involved and included depended in part on the nurse’s previous experience and resultant values related to the benefit of family involvement. Variations noted between nurse participants were based in part on the ways in which they interpreted and enacted institutional policies:

I came from a really family-centred facility, that, um, you know what, you go through cycles...you go through a cycle where every Tom, Dick and Harry could be in there, and the dog and the cat – you know what I mean? ...Different places have different rules...but, we’re allowed two, and two only, and you have to stick with that. But sometimes you kind of bend the rules a little bit, like you know, you can come in for a few minutes, because I still believe that the family and friends are important. I don’t want to live by a dictatorship and I mean, you know, it is her labour - you have to be flexible. (Patricia)

For another nurse, family was viewed as an interference, standing in the way of her relationship with the labouring woman. This nurse placed high value on having her patients ‘trust’ her, and was exasperated by the constant questioning of family members, which she interpreted as demanding and mistrustful. Responses such as resentment and indignation can signal violations of shared understandings and send a clear message regarding the need to correct behaviour (Walker, 2006). Although the nurse acknowledged the importance of wanting to ‘do’ family centred care, her response left little room for negotiation of care with the family and the establishment of rapport with the woman:
The patient’s mother is in there, and is very…um, like, interruptive…she needs this, or why aren’t you doing this?’ and it sort of, like, disrupts the whole interaction between you and the patient, right? So it’s more or less when there’s other family members there that are like, disrupting your interaction, or not trusting you, or questioning what you’re doing all the time…I try and, be, obviously, to include, because we want to do family centred care and then, explain to her, y’know, everything that we’re doing…but I just find, like, in those situations its really hard as the nurse, because you’re always having someone, like, questioning you. (Andrea)

**Recognition and response to choice**

Expected norms of behaviours within communities embody attitudes that are both “giving and demanding” (Walker, 2006, p. 80). In other words, people – in this case labouring women - are presumed to be responsible and responsive as long as expectations for what they ‘should’ do are met. As one nurse put it, responding to women’s expectations and negotiating care was a form of ‘bartering’, in which women were given options and the freedom to make their own choices while still allowing the nurse to ‘do what she needs to do’. Another nurse described achieving the woman’s goals for birth as a mutual responsibility, whereby the nurse advocated for the woman’s choices and the woman agreed to work with the nurse in order to achieve her goals. Nurses had to do ‘their best’ to give women what they wanted but also needed to help them to understand when there is a need to change their goals.

Narratives of relationships tell the story of expectations developed within the relationship and the possibilities for continuation (Walker, 1998). Negotiated care practices were viewed by nurses as reciprocal in nature, where trust was established through a shared understanding of mutual expectations. One nurse relied upon the woman’s plans and knowledge of herself to provide a basis for negotiating care and choices. She explained that a
woman would have more confidence in the nurse and be more open to her suggestions if the nurse demonstrated a willingness to follow the woman’s plan:

You go from the time they come in with the birthing plan - so they’ve set their criteria, and so you go along with it, because when you reach a point when that doesn’t work any more, you have to be able to have - they have to have enough confidence in you that you can say to them, ‘you know what? We’ve done everything that you wanted, however, this is taking longer than it should. Can you - we change the plan?’ (Beth)

One nurse, who initially paid limited attention to a woman’s plans for birth, acknowledged afterwards that some of the tensions in their relationship could have been reduced if she had understood more about why those plans were important to the woman in question. Her story suggested a cultural difference in moral identity between the nurse and the woman, whereby they set different priorities among the values of modesty and having a vaginal birth:

I think I was doing things that she didn’t want me to do. I felt I should have had a conversation with her and asked How do you see this unfolding? What do you want me to do? - that kind of stuff - given her some power. I just thought I knew better, y’know, I went into the room and I thought, ooh, yeah I can see this, and maybe if we try doing this, this might work. But I didn’t give her the chance to say, ‘no I don’t want to do that. I don’t want to push, I want a C-section.’ And that’s what she wanted - she wanted a C-section, right? I wanted to stop her from going into the C-section room, but she didn’t want to push, she felt too tired. And she didn’t want to expose herself to her husband, so, by pushing he’s going to be seeing, where she doesn’t want him to see. (Esther)

The nurse’s initial attitude and response indicated that she failed to morally ‘recognize’ the woman’s request, as this was a departure from her commonly understood norm of what was ‘best’. Incomprehension and imperfect understandings can create opportunities to reconsider and search for “reconciling procedures” within relationships and communities (Walker, 1998, p. 71). Once she was able, on reflection, to understand the basis
of the woman’s choice, the nurse could use this new understanding to consider an alternate response ‘next time’:

I just thought to myself, well okay, that went wrong - how could I have done that better? I failed there and I hate failing, and I, I let her down. I thought I could have done things a lot better and differently. The next time I’ll have that conversation to find out what does she want to do, and, um, make sure it’s an informed decision and help her to get there. (Esther)

The correspondence between choice and action is mediated by multifaceted social understandings and can, therefore, be conditional and inexact (Walker, 2003). While many nurses expressed the desire to meet women’s expectations for birth, they had to anticipate obstacles with physicians and administrative policies and actively work to circumvent these:

I think the more senior you get as a nurse, the more experience you have under your belt, you’re anticipating as you speak with patients and find out what they want and who they are, right? And then you know – oh my goodness, when this such-and-such physician is on call this afternoon, or and I can see there’s going to be a clash, right, then you do everything you can to not let the clash happen, because you know all the players. (Veronica)

Management of labour pain was one area in which a nurse’s understanding and response was often at odds with the woman’s expectations. For some nurses, pain was seen as a benefit, to ‘help the process towards an outcome’. These nurses would go to the ‘nth degree’ to help a woman avoid an epidural if she didn’t want one. For these participants, epidurals had negative effects on the nurse as well, acting to restrict her role. There was a shared understanding among experienced nurses who were midwifery trained that for their nursing colleagues without training in supportive care, it was ‘easier’ to give a woman an epidural than to coach them through natural childbirth.
While nurses were consistent in their assertion that women could choose how they wanted to manage their pain, their approach was often streamlined so that only a limited array of choices was made available to the woman. Ideas about autonomous choice presume “voluntary bargaining relations of non-intimate equals or contractual and institutional relations among peers in contexts of impersonal or public interaction” (Walker, 1998, p. 51). This presumption obscures and ignores the ‘discretionary’ responsibilities of those who care for relatively vulnerable others in intimate contexts. The relationship between labouring women and their nurse was neither equal nor impersonal, but instead involves a high level of intimacy, putting into question the degree to which expectations and choices of women could be adequately met.

Nurses’ responses to labour pain were influenced by their personal and professional experience and training. For example, this nurse told several stories that reflected consistently negative personal experiences with pain, especially when pain was deemed to be ‘unnecessary’. Although the nurse understood that choice regarding pain management was an expected norm, her analogy of pain and death suggested that she might not have been able to recognize and respond effectively to a woman’s expectations which were different from her own:

I hate pain myself...I just feel people need to be able to say, I don’t want it any more, y’know... it’s like death; some people want to go kicking and screaming the way they come into life; other people want to go nice and soft. And so, I feel people should have that choice, y’know? But, in labour and birth, if a patient is crying because she can’t handle the pain, and you’ve tried all the stuff that they say to try, and none of it’s working, you give her an epidural….because, to me, pain is something people feel and some people have low pain tolerance and some people have high pain tolerance….it’s their experience, and pain is a very personal thing, and y’know, we don’t have the right to say to somebody, ‘your pain is not bad’ (Joy)
Another nurse had a completely different response to a labour pain, seeing pain as a helpful and important facet of birth. Her response reflected her normative assumptions about pain and birth that she attributed to her midwifery training:

Labour and birth nurses can be restricted in many ways with epidurals, so, you follow a format to help them through the labour process with an epidural. If someone comes in and wants natural childbirth, as a former midwife, I really enjoy that challenge, because I would consider it a challenge nowadays...um, so many people don’t understand how pain can help, in fact, with the process towards an outcome, so, and its how one can cope with that pain as to whether it can be helpful for them, or, um, a real disadvantage for them and they end up needing an awful lot of pain relief. So, if someone’s asking for a natural childbirth, I will really help them with all the techniques that I know, to get them through that time (Brenda)

While the next nurse shared a similar approach to pain management, her motivation was different, in that she valued helping labouring women to build confidence and self-esteem. She felt that many women were not given the opportunity to believe that they could labour without an epidural:

I think a lot of women can do it. They just haven’t been given the option to believe in themselves - that they can, do you know what I mean? Like now with epidurals and everything else, and I mean they go into their doctor’s office and ‘oh yeah – if you’re going to want something for pain we’ll give you an epidural’. They’re never given the opportunity to entertain the fact that maybe they could do it...and I just think there are women out there who need to know that they can do it, and need to see that they can do it...I like to give women the opportunity. I like to put it in their heads that they can do it. Women have done it for years without an epidural, because they knew that there wasn’t the option – we had to do it. I think it helps with self confidence and self esteem - there’s a lot of women out there who lack that - and for you to be able to say, at the end of their labour, ‘Look what you did! Look what a strong person you are!’ (Wendy)

Although this nurse also placed high value on supporting a woman through birth without an epidural, she understood that in the end, the woman must make the decision about how to manage her pain:
I have a friend who had a 45 minute labour, but she still talks about the fact that she didn’t get an epidural, you know what I mean? The birth process is something that stays with women forever. It’s a memory that you have for the rest of your life, and if you make it a negative memory, that’s a negative thing you’re carrying around with you. (Wendy)

Another experienced nurse with similar background and training, explained that for her, helping women to birth without epidurals was mutually beneficial, in that it built up the woman’s confidence while also heightening the intimacy of the relationship with the nurse and hence the nurse’s satisfaction with her work:

It’s nice when women feel confidence in themselves, that they can do this. And this is not for everybody, and I’m not saying that this is a universal value, but for women who can do that, its nice because its a much more intimate relationship with someone who really is needing your professional assistance in every sense of the way - both emotionally and, obviously as I said, we always have the physical and physiological responses where we have to make sure that you’re monitored as per hospital standard. But its all the other things, helping the couple working together, you know, teaching them different things... you can help them to experience what they’re feeling for the different stages of labour – more in tune with their own bodies as to what’s actually happening. (Heather)

Underlying recognition and response to choice is the notion of informed decision-making, a hallmark of what nurses understand to be patient centred care. However, nurse’s responses to women’s choices often reflected the understanding that due to the exertions of labour and their unfamiliarity with the process, women were not able to make good decisions for themselves. A feminist perspective challenges the dominant assumption that fear combined with the physical and emotional aspects of illness render the decision-making abilities of patients unreliable (Sherwin, 1992). While nurses understood their responsibility to give information so that women could make informed decisions, their narratives suggested some inconsistencies in this area. There was some evidence that while nurses believed in
enabling women to make informed decisions, they also made determinations about what information was shared in particular contexts. For example, the process of information sharing was described by one nurse as giving the women all the information you could give, answering their questions, assessing their fears, their environment, what they know and what they should know.

Nurses’ stories reflected the understanding that listening to women and hearing their story was an important component of informed decision making. Although nurses understood they were expected to listen and incorporate the woman’s perspective into care, in practice this wasn’t consistently applied as reflected in one nurse’s comment that you should listen but that nurses ‘don’t necessarily have to go along with what they’re saying’. For example, when a woman was given the information and chose not to follow the nurse’s suggestion, there was often a presumption that the woman didn’t properly hear or understand, negating the possibility that women, armed with relevant information, might make a choice that was different from that of the nurse. This nurse was careful to distance herself from the spectre of ‘force’ or coercion, recognizing that this was something she ought not to do:

It’s our job to give - to give them the information. And sometimes, alright, sometimes, they’re going to say no, and you’re thinking, well maybe I could explain it a different way. Maybe they didn’t quite understand it. It’s not that you are necessarily trying to force it on them… (Esther)

Some nurses explained that negotiating care with women involved articulating what the nurse thought should be done and then giving the woman the option to change the plan. Even when a nurse asserted her wishes over that of the woman, she explained that she acted to ensure that the mother was not ‘damaged or negatively affected in any way’. In this excerpt, the nurse describes a situation in which she made a decision to hold a dying
premature twin, contrary to the mother’s original wishes, while waiting for the second twin to be born:

So, I just asked her, I said, you know, what do you think? I said my feeling is that I feel like I’d like to provide some extra comfort for your (dying baby) while I’m still helping you, and if you change your mind at any point, we can change what we’re doing….I think that’s how I said it….we can change what we’re doing – ‘cause it was so important to me not to make her feel guilty - I was trying to empower her - that she was ok in her space, even though I was doing what I wanted to. (Veronica)

Whether or not she was successful in her efforts is unclear, as we do not have the voice of the woman to corroborate the nurse’s story. The essential point is that the nurse felt justified in asserting her wishes, as long as the impact on the woman was not detrimental. Although the nurse insisted that she put herself on the same level as the woman and avoided ‘hierarchies’, the concern here is that, due to their relative vulnerability, the women may not be able to express their dissatisfaction directly to the nurses who are responsible for their care and well being, and that of their unborn child.

**Summary of Negotiating Care**

Nurses’ narratives revealed that they were often unaware of the power they yielded over women – sometimes through insistence on compliance, or more often by limiting options, using persuasion or rewarding women who chose to do what the nurse believed was the ‘right’ thing. While the desire for mutual understanding and human connection is understandable, our interconnected moral and social worlds are based on unequal power and asymmetrical relations of dependency that do not resemble reciprocal exchanges (Walker, 2003). When the power differential is denied or obscured, the unequal power relations become invisible and the potential for oppression, intentional or otherwise, exists.
The finding that many nurses shared similar understandings regarding how labouring women should behave and respond negates the fact that individuals have different personalities, hopes and desires. This is especially applicable in the arena of birth, where no two women give birth in the same way. When these aspects of people’s lives are erased, reasonable expectations for interpersonal respect and engagement may not prevail (Walker, 1998). In the findings, ‘reasonable expectations’ were based on normative or dominant understandings of how birthing women should behave, which included being responsive and open to the nurse’s suggestions and varied according to the nurse’s training and underlying philosophy of birth.

I was particularly interested in the finding related to nurses’ stories of working with ‘difficult’ women and families. I had assumed that difficulties would be encountered when nurses attempted to negotiate care with women who were considered to be marginalized for a variety of circumstances including age, history of drug addiction, or having English as a second language. In fact, few nurses identified these women as ‘difficult’ to work with as there was an expectation on the part of the nurse these women and their families would present certain challenges and behave in certain ways. For example, expressions of anger, resistance and fear were expected from these women and seen as ‘normative’. However, women and families who came with clear plans for birth, asked questions and articulated their preferences for birth and pain management were often viewed as demanding and difficult. They were often judged as being non-compliant, irrational, lacking in knowledge or unconcerned about the health and well being of the fetus.

Finally, the ways in which nurses recognized and responded to choice was influenced by what Walker refers to as narratives of moral value, which reflects the relative importance
of certain kinds of relationships, commitments and things (1998). While many nurses valued the establishment of close relationships with women and appeared to want to acknowledge women’s choices, their narratives revealed a general lack of trust and confidence that the woman would be able to choose appropriately. Approaches to informed decision making included helping a woman to understand why certain options were preferable to others, and continuing to ‘explain’ until a woman agreed to adapt her plan in accordance with the nurse’s suggestion. Being ‘open’ and ‘flexible’ were shared expectations of all of the nurses in this study which puts into question the practice of encouraging women to make plans for birth and the expectations for choice and decision-making that are associated with those plans.

Chapter Summary

Although nurse participants enacted their responsibilities in ways that they believed would ensure healthy outcomes, their perceptions of a ‘healthy outcome’, or in moral terms, the ‘good’ or desirable outcome, and the decisions and care practices that stemmed from this understanding varied significantly among nurses and also within each particular nurse’s narrative. Walker’s ‘ethics of responsibility’ (1998) attempts to capture the depth and breadth of what people take responsibility for and care about in a way that accommodates the spectrum of different lives people lead – either through choice or necessity. The findings indicated that nurses’ understanding of their moral responsibilities to women in childbirth had some common dimensions but were enacted in a variety of ways depending on the circumstances, the people involved and context of care. A key influencing factor within each theme was the degree to which understandings and expectations were deemed to be
reasonable and mutually agreed upon among and between care providers, women and their families.

Shared understandings were more prevalent among and between nurses and physicians who shared a common history of relationship, had clear and agreed upon roles and responsibilities and demonstrated an appreciation for differing approaches to care reflecting a range of clinical and experiential knowledge. These morally coherent relationships facilitated the organization and coordination of care and contributed to the development and maintenance of a morally inhabitable environment. In addition, relationships within the nursing team were influenced by mentoring and orientation, specifically the way in which birth and birthing women were modeled within the training milieu. These early training experiences established normative expectations for the extent to which birth and birthing women should be managed and controlled.

Contested understandings of the unpredictable nature of birth and how to ensure ‘safe’ outcomes underscored the mixed responses of nurses to labouring women and their families. While some nurses described having trust and confidence in allowing the process of birth to unfold, others felt that safety could be ensured by attempting to control the process and limit the choices available to birthing women. In the absence of a history of relationship, conflicts arose between nurses and labouring women when expectations differed on the need to control birth or manage labour pain. In those situations, nurses attempted to bring women ‘onside’ through a process of negotiation or insistence on compliance. Although power differentials were evident in these struggles, only one nurse reflected on the power she might have inadvertently yielded in order to maintain control and get her ‘job done’. In all of the other cases, power was ascribed to ‘nature’, the baby, and the process of birth itself.
Embedded within the participants’ narratives was the consistent finding that nurses needed to recognize and set limits on their responsibilities to others, including their nursing and physician colleagues and the women and families in their care in order to preserve integrity. The nurse’s choice of response, ranging from detachment to flexible resiliency and finally moral reparation, was often imperfect, leaving a moral remainder. While some nurses developed effective strategies over time to address and resolve feelings such as guilt and anger associated with moral remainders, other nurses described the burn out and dissatisfaction with their work that stemmed from the accumulation of these experiences.

Through the process of analysis, I worked on a conceptual drawing (figure 6.1) that helped me to ‘see’ how the themes fit together and to consider contextual influences on the moral nature of intrapartum nursing practice. In this model the nurse is represented centrally as a prism. Within the prism of the nurse lie her personal history, her professional training and experience and the underlying values that make up her unique identity. The nurse’s responsibility to organize and coordinate care as well as her response to the ‘unpredictable’, represented by the first two thematic categories, is influenced by institutional roles, relationships and expectations. The influence is shown to be bi-directional as moral choices and understandings are continuously “acquired, refined, revised, displaced and replaced” both by communities and the individuals within them (Walker, 1998, p.113). The interplay between these elements affects the way in which the nurse enacts and understands her moral responsibilities towards women and families.

The third theme addresses the limits of the nurse’s responsibilities to others. This includes responsibilities to women and families as well as to colleagues and the institution. Although the pressure to exert limits may exist outside of the nurse, limits are individualized
to each nurse, attached to particular situations and circumstances and are linked to her personal history, professional socialization and experience.
Figure 4.1 Moral Responsibilities of Intrapartum Nurses
The nurse’s understanding of the limits of her responsibilities to others acted as a kind of refractive filter or lens, ultimately affecting the degree to which a nurse was able to enact her responsibility for negotiating care and choices with childbearing women and their families, as illustrated by the fourth theme. As with the first two themes, there is a mutual influence between the nurse and the labouring woman, as indicated by the two way arrow in the drawing. As the nurse negotiates care with each woman and family, she encounters new experiences and understandings which can either reinforce what was already known and practiced, or challenge and shift previously understood values resulting in new responses and approaches to care.

I chose the image of a ‘prism’ because although the prism appears to be the same from the outside, the internal composition between and within prisms can change, just as with intrapartum nurses. As the findings reveal, even nurses with similar training and experience have unique personal histories that affect the way they are ‘put together’. This impacts the ways in which they understand and negotiate their moral responsibilities towards labouring women. As with a ray of sunlight, the angle and strength of the arrow representing coordination of care and responding to the unpredictable will continuously change, depending on the expectations and understandings of the people involved and environmental issues such as staffing and unit acuity. These changes ‘filter’ through the prism of the nurse and ultimately impact the way in which she negotiates care with women and families.

In my initial conceptual drawings, I struggled with where to place the labouring woman and her family in relation to all of the other parts. My inclination was to position her centrally, as she is generally understood to be in the conventional sense of woman-focused maternity care. Ideally, the shared and reciprocal understandings of women and their nurses
would be clearly visible in any project attempting to illustrate the social-moral nature of intrapartum nursing practice. However, the focus of this study was limited to the narratives and experiences of the nurses themselves, as a full exploration of the perspectives of both women and nurses was deemed to be beyond the scope of this study. In this conceptual drawing, the labouring woman is positioned at the ‘end point’ of care, after the nurse’s response has been filtered through the ‘prism’ of her personal history, professional experience and on-going interactions with the people and the environment in which she works. Although we cannot ‘hear’ the woman’s voice in these findings, the drawing illustrates the potential for a disjuncture between what the woman initially envisions about the way she would like her birth to proceed, and the actual care practices that are negotiated with her nurse.
Chapter 6 - Discussion

In this chapter I will give consideration to three main components of the findings. These content areas, including informed decision making and control, establishing collaborative relationships and limits to responsibility were identified for discussion as they underlie many of the situations, responses and reflections in the participants’ narratives. I will draw on Walker’s theoretical perspective as well as related literature to enhance my understanding of the meaning and relevance of these issues for intrapartum nursing practice.

Informed Decision-Making and Control

Contested knowledge and underlying assumptions.

Typically the hospital setting is an environment in which individuals who are ill come to avail themselves of expert, skilled and highly specialized knowledge (Liaschenko, 2002). However, childbirth is different. Within the intrapartum unit, nurses, birthing women, their families and support people as well as physicians encounter one another in a type of moral community in which values and knowledge are deeply contested. All of these individuals arrive at the place of care with their own narrative of moral identity and understandings of birth that allows them to set priorities in addition to shaping and controlling their responses and approach to care during childbirth. While situations do arise in which labouring women require medical intervention and support, birth is not an illness and therefore the specialized knowledge regarding treatment and cure is not always applicable. This creates an environment in which the moral knowledge underlying decision-making is also diverse. As every birth is unique, health care professionals cannot ‘know’ or predict with any certainty—
as they might with a medical treatment or surgical intervention - how a particular woman will move through the process of birth.

It would seem that caring for women during childbirth requires a shifting of priorities and a different understanding and enactment of roles and responsibilities. However, within North American hospital settings, intrapartum units function according to a risk oriented approach, whereby risk frames medical childbirth protocols, beliefs and practices (Hausmann, 2005). The findings of this study suggest that the dominant ideology within this hospital birthing environment was also one of risk, whereby nurses felt varying degrees of responsibility for managing and controlling the process in order to ensure a safe and ‘happy’ outcome. At the extreme end, some nurses accomplished this by insisting on compliance and negating the woman’s wishes entirely. Other nurses believed that women who wanted to make decisions and be ‘in control’ did not have the knowledge to understand the inherent medical risks surrounding birth. These participants ostensibly took a middle road, whereby they acknowledged the woman’s desire to be involved and make decisions, but then effectively excluded them by explaining that labour was ‘uncontrollable’ and by providing a limited ‘menu’ of choices, encouraging women to be ‘flexible’ and ‘open minded’.

These narratives illustrated the way in which socially enforced dominance, in this case medical ideology, can make ‘coerced vulnerabilities and dependabilities’ seem inevitable (Walker, 2003, p.105). There was also a sub-set of nurses within the study, many of whom were trained in a midwifery model and had many years of experience, who reasoned that nature should be able to ‘take its course’. These nurses saw themselves in guiding and supportive roles and valued the woman’s knowledge and experience as an essential component of their work as intrapartum nurses.
These findings resonate with those of Regan and Liaschenko (2007) who found that nurses had different ways of cognitively framing birth, ranging from understanding birth as a natural process to inherently risky process that influenced trajectories of nursing care. My study supports their findings, but looks through a different lens. These findings indicate that nurses’ beliefs influenced their capacity for moral recognition and response. In other words, the degree to which the nurse associated the unpredictability of birth with safety and risk determined how she understood and ‘recognized’ her responsibility to control the process and the extent to which she was able to include the authoritative knowledge of the woman and family.

Within Walker’s model of morality, moral understandings are produced through social arrangements (1998). While differently situated people will have different understandings of the costs and risks associated with particular situations within a social-moral environment, it is important to consider whose knowledge and understandings dominate and why. If relationships between nurses and women within the hospital birthing environment were ones of equal power and reciprocity, a space could potentially be opened for the woman’s knowledge of herself, including her desires, needs and expectations, to be fore-fronted during labour and birth. This would create possibilities for negotiating a shared understanding and foundation for developing confidence in one another and maintaining a trusting relationship. However the findings support the notion that medical knowledge is still privileged over the woman’s authoritative knowledge of herself. For example, although one nurse acknowledged that the woman had ‘read the research’ on administration of Vitamin K while she, the nurse, was uninformed, the nurse still asserted that what was offered must be ‘best’. Even in situations where nurses were inclined to listen to and accommodate the
woman’s preferences and plans, the powerful ideology of technology and intervention within the environment impeded or limited the extent to which women and families were included in decision-making.

**Choices and expectations**

Differing understandings of the experience and value of labour pain were common themes woven throughout the nurse’s narratives and often were a source of conflict or site of moral misrecognition within relationships between nurses and labouring women. These findings reflect those of an earlier study in which conflicts arose between nurses and labouring women when each person attempted to assert their own frame of reference when entering discussions about pain management and control (Beaton, 1990). Although both women and their nurses entered the relationship with certain expectations regarding labour pain, the links between choice and action are conditional and inexact as they are mediated by many-sided social understandings (Walker, 2003).

The culturally normative understanding of many pregnant women within the Canadian context is that there are a range of ‘choices in childbirth’. This understanding is partly mediated through the popular press, on the internet and through prenatal classes, many of which operate within the hospital setting where education about ‘options’ is integrated with socializing women to hospital routines (Torres & De Vries, 2009). While women’s choices related to labour pain may range from having a fully medicated birth to the exclusive use of supportive care measures, the point is that women do have expectations, hopes and preferences.
Once they enter the hospital birthing environment, women encounter their nurses who also have personal preferences related to pain as well as clinical knowledge and professional experience that shape their responses to a woman’s expectations for care. Nurses’ narratives reflected a broad range of understandings related to pain, from seeing pain as an integral and beneficial aspect of childbirth to viewing pain as an unnecessary and unwelcome obstruction to the process and outcome of birth. Nurses also linked the use of epidural to satisfaction with their work. For example, nurses who perceived pain as a beneficial felt that the predominant use of epidural restricted their role and deprived them of the satisfaction they gained from supporting women through ‘natural’ childbirth.

Although most nurses in this study asserted that it was up to women to choose how to manage their labour pain, their narratives suggested that nurses acted to steer women in the direction they themselves thought was best and appeared to be unaware of the power they had to shape the woman’s choices. In order to understand why women “go along with this stuff” Kitzinger (Roundtable discussion, Birth, 2006) suggested that because birth is managed in a culture of fear, women will do almost anything if there is a suggestion that their babies’ lives may be in danger. Concern has also been expressed that with the current trends towards biomedicine, the concept of ‘choice’ in women’s health is being transformed into ‘risks to well-being’ (Lippman, 1999). The findings of this study suggest that the cultural norm of framing ‘choices in childbirth’ as an expression of individualism ignores the relational and structural constraints on women’s ability to choose (Lippman, 1999).

It is important to question the extent to which some nurses, especially those with strongly held views, are able to ‘recognize’ morally a woman’s preferences and experiences of pain when they differ from her own. Within Walker’s model of morality, moral
recognition stems from culturally-based assumptions that are not experienced as problematic by those who hold them, given that those individuals are usually in a relative position of power (1998). However, as cultural norms regarding childbirth and labour pain vary not only between nurses and labouring women, but also among individuals within each of those groups, it follows that nurses’ understandings of their moral responsibilities towards women with regard to labour pain will be contingent and variable. I am left wondering the extent to which women and their nurses can establish reasonable expectations of each other in this domain and what can be done, both for nurses and labouring women, to enable them to come to the relationship with a common language that will foster shared understandings, mutual respect and trust.

A final dimension to consider when discussing expectations related to labour pain is that decisions and responses must be made in the context of an unpredictable intrapartum birthing environment. For example, one nurse’s story described the tensions that arose when a woman and her partner’s expectations regarding the epidural were at odds with what the nurse understood to be normative on the unit – that is, people often had to wait for the anesthetist. The fact that anesthetists could not be ‘reliably accountable’ for being present in particular times of need contributed to the spectre of unmet expectations and damaged trust between nurses, labouring women and their families.

**Representations of birthing women**

Some of the nurses within this study had clear expectations of how labouring women should behave. The extent to which these expectations were met influenced the nature of the relationship. For example, many nurses expected that women would be ‘happy’ to see them,
be flexible and ‘open minded’, and would willingly engage with the nurse and follow her suggestions. This finding was especially true for novice nurses, who described that form of acknowledgement as an important factor influencing confidence in their abilities to provide care. Women and families who were not receptive to the nurse, who questioned her suggestions and tried to assert themselves were often viewed as controlling, demanding and ‘difficult’. The assumption underlying this finding is that there are ‘normative’ expectations for how women should behave during labour and birth. These social constructions and understandings of birthing women as “nice, polite, kind and selfless” have been identified in other studies (Martin, 2003), where it was suggested that gender played a role in women disciplining their bodies in order to meet the perceived expectation of behaviour. However, by holding these expectations, nurses limit their ability to acknowledge the separate and mutual histories that would allow them to understand what is owed to whom and why. In other words, having these preset ideas of how women should behave effectively limits the nurse’s ability to understand and negotiate their moral responsibilities to labouring women.

Some nurses also had shared expectations of how women who were perceived to be marginalized in some way, for example because of their social circumstances or history of addiction, would behave. In these situations, nurses expected women to be non-compliant and ‘challenging’ to work with and many embraced the opportunity to care for them, describing various strategies they used to establish relationships and gain the confidence of these women. These women were not considered to be ‘difficult’, because within the nurses’ stories, women’s behaviours matched the expectations or culturally normative views that nurses had of women with addictions. Some nurses also described the satisfaction they felt when working with women whose language and culture differed from their own, explaining
that they perceived that these women and families were often ‘easier’ to work with and more appreciative of the nurse’s knowledge, skills and presence than women from the culturally dominant group – in this case white, middle class women.

Women’s reproductive functions, including birth, have historically been subjected to control and domination of powerful and often invisible structures (Sherwin, 1992). Therefore, it is important to consider the origin of these behavioural expectations, mirrored in other studies (Sinivaara et al, 2004; Beaton, 1990) that seem to be at odds with what we might reasonably expect given what we know about the intense physical and emotional demands of labour combined with the anxiety that can accompany giving birth in an unfamiliar hospital environment. There is some evidence that while women want to be treated as individuals, they are also aware of societal expectations regarding ‘acceptable’ behaviour during labour (Bowers, 2002).

While some expectations, for example in the cases of marginalized women, appeared to enhance the establishment of trustful relationships, in the absence of these women’s voices, we cannot know how they experienced the relationship and what, if any, accommodations they might have had to make to engender the regard and hoped for response of the nurse. The unexamined assumptions of some nurses that women should behave in predetermined ways can have a detrimental effect on childbearing women who want to have their identities, needs and preferences acknowledged. This is especially crucial, given that birth is not ‘just another day’ in the lives of women and that the experience and memory of birth has potential to impact the way women see themselves as well as their capacity to become confident and competent mothers (Simkin, 1991).
Walker suggests that practices of responsibility, when mutually coherent and transparent, can “exert pressure towards the production or prevention of outcomes” (1998, p. 94) while also shaping and correcting the common fabric of trust. However, childbirth is fraught with multiple, competing and colliding moral understandings. There were no single shared, agreed upon culturally normative understandings both within and between physicians, nurses, labouring women and their families. It seems that Walker’s theoretical conception of negotiated understandings and the attainment of mutual recognition may be more easily applied in situations and within communities where there is at least some identifiable common ground and where the values underlying what is known are less at issue. Given the complexities surrounding clinical and moral knowledge within the birthing context, it is not surprising that nurses in this study by and large held on to one moral viewpoint, for example the need to control the process of labour and the nature of decision-making, versus remaining open to competing and on-going expectations. This leaves open the question of the extent to which it is reasonable or possible for nurses to morally recognize multiple viewpoints and still have the capacity for action and response.

An additional element of complexity is the unpredictable nature of birth, or as one nurse noted “you never know what you’re going to get”. Unlike other realms of routinized health care practices within the hospital setting, such as tending to a wound or completing a surgical intervention, caregivers cannot, with any certainty, predict the trajectory of each labour and birth or anticipate the woman’s response. Within Walker’s model of morality, moral understanding that is expressive and collaborative gives priority to voicing and hearing and primacy to personal acknowledgment and communication (2003). While all of these elements are possible within the realm of hospital-based childbirth, the lack of predictability
coupled with multiple understandings of what is ‘normal’ can conceivably constrain the
capacity of caregivers and labouring women to negotiate shared understandings. Given the
nature of birth and the present realities of the hospital intrapartum birthing environment, a
key consideration is how to create a moral community that best serves the needs of
childbearing women and families while also creating morally inhabitable spaces for their
caregivers.

**Establishing Collaborative Relationships with Nursing and Physician Colleagues**

**Nurse to nurse relationships**

The establishment of effective collaborative relationships between nurses and their
nursing and physician colleagues was an important determinant of the way in which nurse
were able to negotiate and enact their responsibilities for labouring women. Narratives of
nurse-nurse collaborative relationships centred on issues related to reliability while respect
and recognition and struggles for control were fore-grounded in interprofessional narratives.
Unmet expectations within these relationships resulted in a loss of trust and feelings of
resentment, invisibility and decreased worth. Nurses’ stories suggested that expectations
within these relationships were not something people talked about, they just ‘knew’ – or did
not know. Both positive and negative feelings resulting from met or unmet expectations were
experienced by the nurse in isolation and rarely shared with the individual responsible for a
particular act or omission.

Nurses within this study worked in distinct teams. Those who had worked together
for extended periods of time had developed a ‘narrative of relationship’ whereby they had
clear expectations of one another and also shared an understanding of roles, or who had
particular strengths and could be called upon in specific situations. Novice nurses faced some challenges when trying to integrate into the new team. As they lacked the shared history, they were not ‘known’ and had to ‘hope’ that they would receive the support, information and acknowledgement they needed in order to build their confidence and have a sense of belonging. As hope can be given and created, it can also be destroyed, either wilfully or unintentionally, through repeated experiences or feelings of injustice and loss (Walker, 2006, p.41). For example, while one novice nurse spoke about her hopeful feelings when she experienced high levels of support and acceptance from her team on one of her first busy and challenging shifts, another relatively junior nurse did not receive the support she hoped for and experienced feelings of resentment and anger. Unmet expectations ran both ways, with one senior nurse lamenting what she perceived to be a diminished work ethic and lack of interest and reliability among some of the newer nurses which she attributed to a ‘generational gap’.

The findings suggest that within their teams, not every nurse has a shared understanding of what is expected and what is owed. This finding was echoed by Downe et al (2006) in their review of ‘expert’ nursing practices within maternity care in which the diversity of education and experience as well as the reflective capacity of the practitioner were identified as factors that influenced the way in which care was provided. In addition to the tensions between novice and experienced nurses, there were differing expectations among the nurses about how intra-nurse conflicts should be managed. For example, one nurse expected nurses to speak directly with one another about perceived slights or wrongdoings, instead of speaking with other nurses or management. Another nurse explained that nurses
could be their ‘own worst enemies’ by discussing their dissatisfaction with their nursing colleagues directly with physicians instead of ‘sticking together’.

In order to be reliably accountable, individuals within communities do not have to all be one way, but they do have to be reliable in matters involving important commitments (Walker, 1998) What is not clear is how nurses establish what those important commitments include and the means by which that understanding is made transparent to new and existing team members. One important finding was the role of the mentor in establishing cultural and practice norms for new nurses. In other words, novice nurses were highly influenced and learned what to ‘expect’ by their mentors through their formative experiences on the unit. This highlights the importance of giving full consideration to how orientation is conducted, what practices and philosophies are included and the emphasis they are given, as well as who might be the most appropriate person to take on the mentor/preceptor role.

Walker suggests that the sustenance of moral relationships requires that individuals have confidence in shared standards (2006). As far as establishing cultural norms for nurse to nurse communication among and between nurses it would appear that few formal processes exist or, if they do, they are not uniformly understood or transparent. This may have contributed to the additional difficulties one nurse described that were associated with having casual nursing staff fill in for permanent members of the team. While in other realms of nursing practice, concerns related to casualization of nursing have focused on continuity of care, the issues in childbirth are somewhat different. Because labouring women have a very limited length of stay on the unit, continuity of care is less about having the same nurse responsible for care on a day to day basis and more about ensuring that the practices and
understandings of the casual nurse have some connection to those of the intrapartum community at large.

**Interprofessional relationships**

Some of the participants indicated that they were able to develop trusting relationships with their physician colleagues over time. However, time and relational history were not the only criteria for establishing respectful relationships. Nurses described a kind of sensitivity or ‘emotional intelligence’ that allowed physicians to understand what the nurse was trying to achieve when caring for a woman and to move in and out of the situation as the required. From the nurses’ descriptions, this was not something that could be learned, but just ‘happened’ and was usually mutual. The ability to pay attention and communicate knowledge is a key factor in resolving moral problems (Walker, 2003). This finding suggests that there may be more to learn about the personal, professional and environmental factors that allow physicians to ‘pay attention’ to the nurse-patient relationship and what characteristics or knowledge on the part of the nurse enable this to happen.

When confronted with conflicts with their physician colleagues, nurses expressed strong feelings of frustration, anger and resentment. Conflict was most evident where power and control was at issue and included situations in which nurses described not having their knowledge respected (even though they were ‘right’), or when physicians ‘took over’ without acknowledging their work, which most often occurred in the second stage or pushing phase of labour. Disrespect has emotional and moral costs that can be difficult or impossible to bear (Walker, 2006) When damages to trust occur within communities where reasonable expectations are not met, people deserve help in restoring what was lost in order to regain
self-respect, avoid self-blaming and to re-establish trust and moral equilibrium (2006). Although some of the nurses turned to each other to ‘debrief’ and find support, they rarely identified effective avenues for directly addressing the person or processes that were implicated in the situation described. Reasons for choosing not to respond and to just ‘let it go’ were usually to protect the woman from disruption or added stress that could result from interprofessional conflict. One nurse who did attempt to address processes she deemed to be unfair through established channels of formal communication saw her documented concerns disappear into a ‘black hole’.

Much of the literature examining intrapartum interprofessional relationships focuses on the negative encounter and power imbalances within these relationships (James et al., 2003; Sleutal, 2000). Walker notes that although oppressed individuals can be seen to have lives that are not their own, either because their limited control impinges on their ability to ‘set their own course’ or because they are subjected to the persistent demands or control of others (Walker, 1998), maintaining integrity is more a matter of how we respond to circumstances than the circumstances themselves. This perspective is hopeful, in part, because it suggests that while some circumstances may be out of our control, individuals and communities could potentially choose another way and adapt habitual responses in order to create a more positive environment of care. Walker cautions that the ability of individuals who feel exploited or overlooked to change or to even believe that change is possible depends their potential or actual power as well as “their awareness that it is not so good to live as they live” (1998, P. 220).

If our moral and social lives are interconnected, it would be reasonable to conclude that moral recognition will be unequal and asymmetrical, prompting responses that embody
different attitudes towards different types of people (Walker, 2003). Although many nurses admitted that they were dissatisfied with the lack of recognition of many of their physician colleagues, they expressed feelings of intimidation and were concerned about the consequences to themselves and especially their patients if conflicts were brought out into the open. These feelings and responses act to “entrench and propagate unequal…moral standings that reflect social ones” (p.143). It is impossible to know if the nurses’ fears related to direct confrontation would come to pass if they were able to directly address perceived injustices with physicians. In addition, without the voices of the physicians, we cannot know if they are aware of the way in which lack of recognition or acknowledgment impacts nurses and, if they were aware, would this be of any concern to them. We also do not know the extent to which physicians experience either a coherent sense of who is responsible for what or resentment and frustration when their expectations of nursing colleagues are met or not met.

One area receiving considerable attention in education, practice and research is a move towards an interprofessional approach to care. While in theory this type of approach holds the potential to improve practice environments and the quality of care provision, measurable success has been elusive, due in large part to the ‘variable and complicated’ relationships between service providers that are characterized by conflict rather than cooperation (Irvine, Kerridge, McPhee & Freeman, 2002). It is thought that there needs to be a better appreciation of the subject positions between and within health care professions in order to fully understand how to enact effective inter-professional care.

Recently, a project was undertaken to develop a “multidisciplinary collaborative primary maternity care model” in order to increase access and quality of maternity services
for Canadian women (Multidisciplinary collaborative primary maternity care project, 2006). Within this project, the definition of a collaborative maternity care model included “the active participation of each discipline in providing quality care. It is women-centred, respects the goals and values of women and their families, and provides mechanisms for continuous communication among caregivers.” (2006, p. 4). While it is beyond the scope of this discussion to go into extensive detail on the structures and processes identified within this project that would lead to a collaborative model, there is an assumption stated at the outset of the executive summary that true collaborative practice has ‘no hierarchy’. This idealistic notion is difficult to accept, given what is known about the impact of practice boundaries and the particularities of knowledge and values underlying professional practice (Irvine et al., 2002).

Although there are obvious challenges with attempting to build shared understandings among caregivers in the intrapartum setting, it is important to pursue strategies that facilitate mutually respectful relationships while also acknowledging varied perspectives and values. As moral life requires participation and collaboration within a system of accountability that is marked by differentiated social positioning, it may be that health care providers need to learn specific skills in order to understand the perspectives that they bring to their work and appreciate the value of alternate approaches (Verkerk et al, 2004). Nurses within this study noted that in cases of interprofessional conflict, not only did they feel invisible but they perceived that the needs and experiences of the labouring woman were also obscured. Conversely, when interprofessional relationships went well, nurses perceived positive outcomes for themselves, their physician colleagues and women, in which they were able to share a sense of accomplishment and pride in what was understood to be a mutually
satisfying outcome. Therefore, an important impetus for continuing to strive for improved interprofessional relationships is to create climates of care that promote positive outcomes for labouring women and their caregivers.

**Limits of Responsibility**

Within the discourse of nursing, limits to practice and responsibility are often framed in terms of the environmental, structural and social barriers that render nursing work undervalued and invisible (Chambliss, 1996; Liashenko, 1997; Peter, MacFarlane & O’Brien-Pallas 2004; 1997 Rodney, Varcoe, Storch et al, 2002; Weiss, Malone, Merighi & Benner, 2002;). In many instances, these institutional and relational constraints are mediated by dominant ideologies and power imbalances. The end result is that nurses experience moral suffering when they are unable to meet the ethical and practice standards to which they are held accountable (Maben, Latter & Clark, 2007). The findings of this study revealed another dimension of limits to responsibility which was influenced by the environment of care but arose from within the nurse, based on individual values stemming from her personal and professional experience. The nurses’ choice of response to circumstances in which practice was constrained fell into three broad categories, including detachment, flexible resiliency and moral reparation. These responses departed from the idealized and ‘expert’ practices often reflected in professional practice standards and codes of ethics and instead were often imperfect and contingent.

By embracing particular ethical standards of practice, which are reinforced through education training and practice, the nursing profession sets clear expectations of how nurses should behave (Doane, 2002; Thompson, 2002, CNA, 2008). The prescriptive nature of
codes presupposes that there will be “uniformity in judgment and action both across cases and across agents” (Walker, 1998). However, abstract universal principles and normative theory, which form the basis of professional codes of ethics, obscure the character of the moral agent and the particularity of context. Moreover, these codes because they are most commonly an extension of the theoretical-juridical model, can reflect those in positions of moral authority as opposed to the real life moral experience of nurses in practice. Some nurses in this study told stories of being too mentally and physically exhausted to enact a ‘therapeutic relationship’ with labouring women, even though they knew this was a professional expectation. Other nurses needed to ‘turn away’ when they identified a bad ‘fit’ with the labouring woman or family or lacked support from nursing colleagues. For these nurses, the tension between the ideal expectations of practice and what was actually attainable resulted in a loss of integrity, or the nurse’s ability to see herself (and others) as reliable and dependable.

Our national Code of Ethics describes detachment as a form of ‘moral disengagement’ which results in nurses becoming “unkind, non-compassionate or even cruel” (CNA, 2008, p. 7) to both colleagues and recipients of care. Walker refers to the language we use to make moral judgments as the ‘moral medium’ (1998, p. 55) but cautions that the use and interpretation of these resources, such as the Code of Ethics, differs based on social power and positions of authority. She advises that we question whom these representations claim to represent, what communicative strategies they support and who is in a position to use them. Nurses in this study who chose to detach recognized that their actions were ‘imperfect’ but were unable to envision or enact any other response. Although they shared their stories as participants in this study, these are not the stories that nurses are
encouraged to tell, both in the practice and educational settings. By closing off this
discussion, practices that are less than ideal remain hidden, potentially compromising care
and leaving nurses to bear the moral remainder of guilt, resentment and detachment in
isolation.

Some nurses responded with ‘flexible resiliency’ in that they had the capacity to be
‘reliably’ accountable, recognizing that while they could not control every reaction and
response, they were able to identify the essential commitments or what was owed, in
particular situations. For example, one experienced nurse was able to maintain a
‘professional stance’ in the face of repeated angry outbursts directed at her from the woman’s
partner, because her primary commitment was to remain present with the woman. Some
nurses who had not been able to fully meet their responsibilities to women ‘in the moment’
were able to build understandings afterwards through a process of moral reparation that
helped to lessen the moral remainder and re-establish a basis of trust within the relationship.
These nurses made special arrangements to seek out women in the postpartum period when
those nurses felt they had been the unfair target of blame or had feelings of guilt associated
with feeling that they had not adequately met the woman’s expectations. These situations
occurred most often when nurses were unable to meet a woman’s request for pain
management in a timely manner or they felt like a ‘failure’ for not being able to support a
woman through the kind of birth she had hoped for.

As moral reparation requires shared understanding of terms for responsible contact, it
was perhaps not surprising that nurses who were able to respond in this way had extensive
intrapartum experience. However, not all experienced nurses sought to resolve these
lingering moral issues and not all nurses who wished to regain this sort of moral equilibrium
were able to do so. This leaves open the question of what personal, professional and structural factors enable nurses to pursue this course of action, which can contribute towards building moral understandings and trust within communities and between nurses and labouring women.

Chapter Summary

While the discussion topics covered a range of issues including decision making and control, professional relationships and limits of nursing practice and responsibility, the common thread tying all of these areas together was the impact on individuals and communities – including caregivers, women and their families – when expectations regarding care, communication or personal regard were met or unmet. Walker notes that trust is created when individuals recognize shared moral standards and develop practices and that support them (2006). While it is unreasonable to expect a Utopian state in which there will be complete agreement on what constitutes a ‘good’ birth and the practices and responses that support this, thinking in terms of ‘shared understandings’ opens a space for learning more about what we care about, what we hope for and how we might achieve our goals.
Chapter 7 - Conclusions: Strengths, Limitations, Implications and Recommendations

In this chapter I will describe the significant strengths and limitations of the study and discuss the implications of this research for nursing practice research and education. I will conclude with a final statement which highlights the unique contribution of this work in furthering our understanding of the moral nature of intrapartum nursing practice.

Limitations and Strengths of the Study

Considerable tension exists concerning the degree to which we can use stories to understand experience due to possible inconsistencies between what people say happened and what actually did happen. The use of narratives in research has also been critiqued because narratives are constructed interpersonally in contexts where dominant public narratives predominate (Miller, 2000). As there are risks associated with disclosure of experiences that stray from cultural norms and expectations, nurses participating in this study might have felt constrained by the need to tell only ‘acceptable’ stories and might have avoided personal narratives that did not resonate with the expectations of those around them or stories that might have left a negative impression of the nurse as a competent social actor.

However, Kitzenger (2007) argues that attempting to confirm the accuracy of what people say is inappropriate, as all experience is “embedded in a social web of interpretation and re-interpretation” (p. 117). In addition, I believe a narrative approach is appropriate for this study as it aligns with Walker’s expressive and collaborative model of understanding morality and provides a mechanism for giving ‘voice’ to the stories and experiences of intrapartum nurses that have had minimal representation in the public domain in general and within the nursing profession in particular.
There was a restricted amount of demographic information collected on the study participants. This can be seen as a limitation in critically-based research, where social, cultural and historical factors can influence who we are, what we know and what we believe. This decision was made in order to preserve anonymity of the nurses, as there was an expectation that I present my findings to the study site following completion of the research. In retrospect, I believe that demographic information normally sought at the outset of data collection was revealed indirectly through the nurses stories, in which they linked factors related to their personal and cultural history – for example respect for authority – to the ability to establish relationships with people in positions of power and ultimately to meet their responsibility to organize and coordinate care.

Traditionally, the usefulness of any research is measured by its ability to provide some practical answers to the questions under consideration (Ange, 2000). While these findings offer a new way to understand the moral nature of relationships between intrapartum nurses, their environments, colleagues and the women and families with whom they work, the understandings are necessarily imperfect and contingent based on the fluid nature of our relationships, and our situatedness and temporality. In this way, it is not be possible to know, at the conclusion of this project, the degree to which the study will have relevance to intrapartum nursing practice in general and ultimately if it will have an impact on the care provided to childbearing women. However, while imperfect understandings can be seen by some as problematic, Walker argues that “moral incompleteness” (1998, p. 79) is necessary to promote open dialogue and to prevent the authoritative knowing and depersonalizing attitudes that may occur when what is known becomes closed off for discussion and exploration.
Finally, a study examining negotiated understandings within nurse-woman relationships would ideally include the perspectives of everyone involved. As this was a study involving only nurses, we cannot know whether or not women and their partners interpreted the actions and responses of the nurse participants as supportive and morally adequate or obstructive. While it was recognized that it would have been desirable to include the stories and perspectives of women as well as other health care professionals, it was believed that a study of that magnitude would be beyond the scope of a doctoral thesis. Although the missing voices represent a limitation in what we know, the findings from this study can be used to inform future studies that include the perspectives of all involved.

Implications for Nursing Practice

This research has implications for the way in which nurses are oriented to intrapartum nursing practice. It is apparent that cultural norms regarding what to expect of labouring women as well as nursing and physician colleagues are communicated to new nurses through the orientation process. This suggests that there is an opportunity for specific units and the professionals within them to consider what their shared understandings might be and the particular philosophy they would like to promote within their environment.

This discussion would have to go further than a statement of missions and values. Those individuals responsible for the development and implementation of nursing orientation programs should be mindful of the messages they are conveying in how these programs are structured and who is responsible for their delivery. In addition to consideration of content and structure of orientation programs, educators and managers should be mindful of the potential for generational ‘mis-recognition’ between senior and novice nurses. Without
attention to this dimension of practice and education, there is potential for the experiences and feelings of both experienced and junior nurses to be lost in translation, leaving lingering feelings of resentment and lack of value that were experienced by some of the nurses within this study.

The need for careful consideration of orientation practices should extend to medical practitioners as well, particularly medical residents, who are placed on intrapartum units for limited time periods but are charged with the responsibility of managing a majority of the obstetrical care and establishing collaborative relationships with nurses in order to coordinate and implement care. If nurses are not directly involved in the orientation of new residents, this may be a worthwhile consideration in order to enhance understandings of one another’s role and responsibilities.

Another consideration for practice is the structural environment of labour and birth units and how these add or detract from the ability for nurses to recognize and respond to their moral responsibilities for labouring women. For example, one of the findings of this study was that nurses found it beneficial to be able to ‘debrief’ with women following their birth, either to share in the joy of the experience or to explore and resolve negative feelings that resulted from unmet expectations. However the structure of the unit and the ways in which the unit was staffed worked against these practices. Although this intrapartum unit included ‘Labour, Birth, Recovery and Postpartum (LDRP) rooms, where women could be cared for from admission to discharge in one space to promote continuity of care, it appears as though these rooms were not functionally integrated into the practice setting. This can occur when nurses are unwilling to ‘cross-train’ to perinatal areas, for example, ante partum, intrapartum and postpartum care, as they have strong preferences for particular areas of
practice. In addition, there can be cost implications for the institutions, as the LDRP room is considered to be a private room and therefore a more costly way to provide care than semi-private or ward accommodations. Given that many institutions which provide intrapartum care have the structural capacity to deliver continuity of care and facilitate the development and maintenance of trusting relationships between nurses and birthing women, it would be worthwhile to re-examine how these facilities might be put to better use to enhance the provision and receiving of maternity care.

Finally, some consideration should be given to the structure and content of prenatal classes, especially those taught by nurses in hospital and community settings. This should include an exploration of what information is being given and the forms of knowledge that are being privileged. Nurses should be mindful of the ways in which notions of ‘choice’ are propagated and understood and work along with women and their support people to develop strategies for making their expectations known to their caregivers during labour and birth. Specifically, the concept of the birth plan may need to be reconfigured and perhaps renamed as a birth ‘story’, as the notion of a ‘plan’ may act to highlight the process of labour and birth versus the people involved. By encouraging prospective parents to tell the story of who they are and what they value, prenatal educators can help to set the stage for establishing shared and negotiated understandings between women and their intrapartum nurses.

**Implications for Nursing Research**

While there are indications that interprofessional care within hospital labour and birth settings has potential to improve access and care for women and families, more research needs to be done to determine how these practices can be effectively implemented, given the
multiple and competing perspectives that guide and inform practice. Although guidelines have been developed to support the development of interprofessional relationships within maternity care, they do not describe the processes for addressing the structural and relational factors that influence the establishment and maintenance of those relationships.

Verkerk and Lindemann (2009) have advanced the concept of using moral ‘reflection’ as a framework for mapping and understanding interprofessional responsibilities. They propose that by attending to the core values and beliefs underlying their actions and coming to understand the social norms and consequences of certain responses, practitioners can develop a type of moral ‘competence’ or sensitivity to the vulnerabilities and responsibilities they encounter in their everyday practice. Future research could explore possibilities for adapting the framework of moral reflection to the intrapartum setting in order to promote a more coherent and transparent understanding of responsibilities and examine the ways in which this may contribute to the creation of a morally inhabitable work environment.

Based on my review of current literature and experience with this study, I believe that future investigations into the moral practices of nurses should avoid asking nurse participants about their practice in ‘ethical’ terms. Framing questions in this way has the potential to elicit stories that illustrate heroic deeds that may not reflect the realities of practice and also perpetuates the understanding among nurses that ‘ethics’ involves the resolution of ‘dilemmas’ which are often the purview of cure and treatment oriented medical practice (Nelson & McGillion, 2004; Liaschenko & Fisher, 1999). Research into ethics in nursing must account for the moral-social dimensions of practice and knowledge and work to make visible the way in which nurses understand their work and attempt to meet their moral
responsibilities to their clients, their colleagues, their institutions and themselves. To this end, I believe that asking about ‘everyday practices’ is one way to uncover more about what nurses know, what they notice and care about and why.

**Implications for Nursing Education**

Within the profession of nursing, there is a need to pursue new ways of thinking and talking about ethics that reflect the social-moral realities of nursing practice. Although nurses must understand standards of practice and ethical guidelines, we need to broaden our thinking beyond ‘ideal’ ethical practices to application in everyday situations. This discussion could include an exploration of the range of moral responses available to nurses, by introducing the notion of ‘flexible resiliency’ or responsiveness. Careful consideration needs to be given to the costs and benefits for nurses, both as individuals and collectively, if we continue to teach and propagate the expectation that nurses provide limitless compassion and caring, regardless of individual circumstances and contexts of care. As Nodding notes in her examination of the construction of the ideal of ‘caring’ within nursing, we cannot do ‘everything’; instead, we should “construct an attainable ideal so that we will plan ahead and focus our efforts on what can in fact be done” (1984, p.112)

Another area of consideration is the way in which we encourage nursing students to enact ‘patient centred care’, through enabling and advocating for individuals and families to be able to make full and informed decisions regarding their care. The findings of this study suggest that although nurses enthusiastically endorsed a woman’s right to ‘have the birth she wants’, they were unaware of the way in which their environment, beliefs and practices shaped and restricted the choices available to women and families in the intrapartrum
context. Teaching and learning in ethics should include case studies from everyday nursing practice that challenge the ways in which we think about and see ourselves as ‘advocates’ for informed choice and decision making by illuminating the complexities of the practice environment and asking nurses and nursing students to consider the assumptions underlying some of our taken-for-granted notions of who we are and how we practice as nurses.

Finally, I believe that nursing researchers and educators have a responsibility to more fully understand the experiences of nursing students and early practitioners as they attempt to reconcile the ideals and expectations of nursing with the realities of practice. This requires the development and integration of educational activities into undergraduate curricula to support students and assist them in identifying strategies for self renewal. I was especially disturbed by the comments of one of the participants in this study who had initially been drawn to intrapartum nursing because of the positive experiences and feelings she associated with her work in the area as a student. After only a short time in practice, she explained that she was coming to understand how nurses could become ‘uncaring’ and ‘burnt out’ and was fearful that she might become that way as well. While some of the experienced nurses had developed self-care strategies over time to cope with the inevitable limits of their responsibilities, newer nurses are given neither the understanding nor the tools to help preserve integrity in the face of complex and continuous demands on their personal and professional selves.

**Final Statement**

Striving to accommodate women’s choice and informed decision-making so that they may have ‘the birth they want’ has traditionally been understood to be a basic moral
responsibility for nurses and an integral part of ethical intrapartum nursing practice. While previous studies have identified the gap between the so-called ideal and actual practice with respect to supporting and enabling women’s choices, this study reveals some of the complexities inherent in nurses’ enactment of a fuller sense of their moral responsibilities towards women during childbirth, including the way in which personal and professional histories influence nurses’ responses to women’s expressed needs and expectations as well as consideration of the importance of networks of relationships and organizational structure in enabling moral recognition and response.

Normative assumptions related to the provision of family centred care, choice and informed decision making must be challenged when we consider the contested nature of childbirth and the lack of shared understandings of what is ‘best’ among and between nurses, women and their families as well as other caregivers. The findings also highlight the importance of teaching and talking about the relational work of nursing in a way that moves us beyond moral obligations. This would include creating an ‘expressive and collaborative’ space in which nurses can openly acknowledge the limits of their responsibility to others and address the range of moral responses available.
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Appendix A: Participant Recruitment Flyer

Date:______ REB# _____

Invitation to Participate in a Nursing Research Study

Title: Understanding the Everyday Nature of Intrapartum Nursing Practice: Identities, Relationships and Values

Investigator: Anne Simmonds, RN, MN, Doctoral Candidate
Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Faculty Supervisor: Dr. Elizabeth Peter, RN, PhD. Thesis Supervisor
Associate Professor & Associate Dean, Academic Programs
Lawrence Bloomberg Faculty of Nursing, University of Toronto

On Staff Investigator: Lianne Jeffs, RN, MsC, PhD (c)
Director, Nursing/Clinical Research
Scientist, Keenan Research Centre
St. Michael's Hospital

Purpose: The purpose of this study is to understand the everyday practices of labour and delivery nurses through stories. Your stories and descriptions of your practice, specific situations as well as interactions with people you encounter in the course of your daily work, will provide the basis for more fully understanding the nature of intrapartum nursing practice.

Eligibility: RNs currently employed on the labour and delivery unit and who have been practicing on the unit for a minimum of 6 months

Participation involves: One 60-90 minute audio recorded interview with the investigator, Anne Simmonds. Interviews will be conducted privately and at a time and place that are convenient for you.

Contact Information: Anne Simmonds: anne.simmonds@utoronto.ca; (416) 946-8749

Please Note: If you contact Anne Simmonds for more information regarding the study, it does not mean that you have consented to participate in the study.
Appendix B: Field Note Template

Pre-Interview Comments:

Location of Interview:

Description of Environment:

Non verbal behaviour (e.g. tone of voice, facial expressions, body movements, hand gestures)

Content of Interview (e.g. use of key words, topics, focus, words or phrases that stand out)
Researcher Impressions (e.g. discomfort of participant and researcher with certain topics, emotional responses of self and respondent to people, events or objects)

Interpretations (e.g. researcher’s questions, tentative hunches, trends in data and emerging patterns)

Technological problems (e.g. time lapses when tape turned)

General Post-Interview Comments:

Referral Source:
Appendix C – Interview Guide

I am interested in hearing stories from your practice as a labour and delivery room nurse. In particular, I want to be able to understand how your everyday practice is influenced by: a) the setting in which you work, and b) your relationships with your nursing and physician colleagues as well as the women and families in your care.

Introductory Question:

Please begin by telling me a story from your everyday practice on this unit that you would like to share. This story could be (prompts)

- Your most recent experience on this unit or about the last patient you took care
- A story that has stayed with you, for some reason; one that you have told others about
- A story that you think is important to tell
- This could be a story that you have thought about in either a good or bad way
- It could be a story about dealing with pain in childbirth.

Possible Probes

Narrative of Relationships

- Who were the people involved? What was their role?
- What were your expectations of those people?
- What were they expecting of you and how did you come to know this?
- Did you have a relationship ‘history’ with any of the individuals involved?
- How would you describe your relationship with the individuals in your story?
- What factors influenced the nature and quality of your relationships?

Narratives of Identity

- How did you decide what needed to be done in the situation described?
- What was your priority?
- Did you feel torn or conflicted about how you should respond?
- How powerful did you feel?
- What did this situation tell you about yourself – i.e. what you care about?

Narratives of Value (Individual and Collective)

- What meaning did this story and the situation you describe have for you?
- In retrospect, how do you feel about your actions and responses and the actions and responses of the other people involved?
- How did you feel about the outcome?
- If you could relive this story, is there anything you would change?
- What did this tell you about your workplace or team?
- Is this story consistent with previous situations you have encountered? If so, what does this tell you?
Appendix D: Participant Information Sheet

Please provide the following information about yourself by filling in the appropriate responses or by placing a (✓) beside the appropriate choice.

PARTICIPANT # ________

1. What is your age? _____ years

2. What is your sex? _____ female   _____ male

3. Were you born in Canada? __ yes  __ no;
   a. If ‘no’ please indicate country of origin. _______________
   b. # years living in Canada rs

4. What is your highest level of education?
   _____ Diploma
   _____ Bachelor Degree
   _____ Master Degree
   _____ PhD Degree

5. How many years have you practiced as a labour and delivery room nurse?
   _____ years

6. How many years have you practiced as a nurse?
   _____ years

Thank you for taking the time to answer these questions!
Appendix E: Consent Form and Information Sheet

Title of Study
Understanding the Everyday Nature of Intrapartum Nursing Practice: Identities, Relationships and Values

Investigator
Anne Simmonds, RN, MN, Doctoral candidate
Lawrence S. Bloomberg Faculty of Nursing
University of Toronto
(416) 946-8749

Faculty Supervisor
Dr. Elizabeth Peter
Associate Professor & Associate Dean, Academic
Lawrence Bloomberg Faculty of Nursing
Member, Joint Centre for Bioethics
University of Toronto
(416) 946-3437

On Staff Investigator
Lianne Jeffs, RN, M.Sc, PhD(c)
Director, Nursing/Clinical Research
Scientist, Keenan Research Centre
St. Michael’s Hospital
Phone: (416) 864-6060 Ext. 3547

Introduction
You are invited to participate in a research study conducted by Anne Simmonds, a doctoral candidate at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. Anne is working under the direct supervision of Dr. Elizabeth Peter in the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. Lianne Jeffs, the Director of Nursing and Clinical Research at St. Michael’s Hospital, will be the on staff investigator for this study. Ms Simmonds is conducting this research study as the dissertation component of her PhD requirements.

Before agreeing to take part in this research study, it is important that you read the information in this research consent form. You should not sign this form until you are sure you understand all of the information. If you have any questions, please ask the investigator.

Purpose of the Research:
The purpose of this study is to understand the identities, relationships and values that shape intrapartum (labour and delivery) nursing practice from the perspective of nurses who work in this area. Your stories and descriptions of everyday practice, specific situations as well as interactions with people you encounter in the course of your daily work will provide the basis for more fully understanding the nature of intrapartum nursing practice.
Description of the Research:
In order to participate, you must be a registered nurse who has been employed on the labour and delivery unit for a minimum of six months. Your interview will last approximately 60-90 minutes. You will be asked to give permission for your interview to be tape recorded. The interview will take place in a private room in a location and at a time that are convenient for you. If you feel that more time is required to complete the interview, a subsequent time can be scheduled with the investigator at your convenience. You will be asked a few questions about your background, including your age, training and years of experience in nursing. Then you will be asked to talk about your everyday practice as a labour and delivery room nurse. As you tell your story or stories, the investigator may ask you questions in order to more fully understand the circumstances and specific details of the situations and encounters you describe.

Potential Harm
There are no known risks for participating in this study. However, you may become uncomfortable if sensitive issues related to work life on the unit arise during interviews. If this does occur, you may choose to end the interview or request that the topic of discussion be changed.

Potential Benefits
While there are no direct benefits from participation, you may find that the interview provides a space that is removed from the clinical setting to talk openly and honestly about your everyday practice. Additionally, participation in this study may help you to think about individual and collective strategies that can enhance your daily practice, the environment in which you work and the delivery of quality, family-centred maternity care.

Protecting Personal Information
In order to protect your privacy, you will be assigned a code number that will replace your name and your name will not appear in typed transcripts. Any information that is collected will have all identifying information removed. In addition, in order to protect the privacy of others, you will be asked to use pseudonyms only when referring to individuals that are featured in your stories about nursing practice.

Any information that you provide will be kept confidential and anonymous and only the investigator will know which responses belong to specific respondents. It should be noted, however, that privacy and confidentiality can only be maintained to the extent permissible by law. Any evidence of professional misconduct will be reported to your unit manager and the College of Nurses. In addition, in rare cases, research data can be subpoenaed.

During the study, data will be kept on a secure server at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. Tape recordings, field notes and typed transcripts will be stored in a secure, locked cabinet at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. Tapes will be erased after transcription is completed. When the study is completed, computer data will be transferred to a compact disc and erased from the computer. All data on the compact disc as well as the printed copies of interviews will be
stored in a secure, locked filing cabinet for seven years at the Faculty of Nursing, University of Toronto. At the end of seven years, the data will be destroyed/shredded.

Your name will not appear in any publication about the study. All identifying or potentially identifying information (i.e. name of unit/facility) from your statements will be removed before they are used for any presentation, publication or viewing by the investigator’s thesis committee.

**Study Results**
Once the study is completed, you will be invited to a presentation of the study results that will take place at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto.

**Reimbursement to Participant**
Upon completion of the interview, you will be offered a $20 gift card as a token of appreciation for your participation in the study.

**Participation and Withdrawal**
Participation in this study is voluntary. You are free to refuse to answer specific questions and/or to stop the interview at any time for whatever reason. Following the completion of the interview, you will have one month to withdraw from the study. Upon withdrawal, the investigator will ask you if any data collected from your interview could still be included in the study. Data will be erased upon request.

**Research Ethics Board Contact**
If you have any questions regarding your rights as a research participant, you may contact Dr. Julie Spence, Chair; research Ethics Board at (416) 864-6060 ext. 2557 during business hours.
Signature
The research study has been explained to me, and my questions have been answered to my satisfaction. I understand that my participation is voluntary and that I have the right to withdraw from the study. As well, the potential harms and benefits of participating in this research study have been explained to me. I know that I may ask now, or in the future, any questions I have about the study. I have been told that records relating to me will be kept confidential and that no information will be disclosed without my permission unless required by law. I have been given sufficient time to read the above information.

I consent to participate. I have been told that I will be given a signed copy of this consent form.

__________________________________
Signature of Participant
__________________________________
Signature of Investigator

____________________
Date

____________________
Date
## Appendix F: Qualitative Research Studies

<table>
<thead>
<tr>
<th>Author/Date</th>
<th>Purpose</th>
<th>Design/Sampling</th>
<th>Analysis</th>
<th>Findings/Relevance</th>
<th>Quality Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baker, Choi, Henshaw &amp; Tree, 2005</td>
<td>To explore the impact of maternity care staff on women’s experiences and feelings associated with childbirth</td>
<td>Qualitative</td>
<td>Open and axial coding used to distill themes: perceived control, staff attitudes and behaviours, resource issues</td>
<td>Feelings of control linked to inadequate provision of information, poor communication and limited opportunity to influence decision making</td>
<td>Findings and data supported original theoretical assumptions; no mention of deviant data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Semi-structured interviews</td>
<td>Data used to support interpretation</td>
<td>Womens’ negative feelings accompanied feelings of decreased control</td>
<td>Title “I felt as though I had been in jail” reflects bias</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 women</td>
<td>Importance of reflexivity noted but no elaboration</td>
<td>Highlights influence of nurse:patient relationship in control/satisfaction and the importance of considering environmental factors</td>
<td>Participants taken from cohort who had developed postpartum blues - ? transferability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiparas and primiparas from cohort (99) of previous study</td>
<td></td>
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<td></td>
<td></td>
<td>United Kingdom</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Linguistic and conversational analysis</td>
<td>Caregiver ‘birth talk’ directed towards forced or physiologic bearing down were equally effective</td>
<td>Old data, small sample size with no demographic information</td>
</tr>
<tr>
<td>Bergstrom, Richards, Morse &amp; Roberts, 2010</td>
<td>To determine what constitutes successful care to women experiencing pain or distress during 2nd stage of labour</td>
<td>Secondary qualitative analysis of videotapes from previous study</td>
<td>‘birth talk register’ used as foundation of analysis</td>
<td>In presence of severe pain or distress, ordinary birth talk was ineffective requiring caregiver to alter their usual response</td>
<td>Theoretical underpinnings of analysis not described in this article</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convenience sample – 23 labouring women (no access to original demographic data)</td>
<td>Analysis details included in a second article</td>
<td>Identified need to research the impact of caregivers on woman’s sense of control</td>
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3 Analysis and appraisal of qualitative studies guided primarily by summary criteria developed by Walsh & Downe, 2006
<table>
<thead>
<tr>
<th>Author/Date</th>
<th>Purpose</th>
<th>Design/Sampling</th>
<th>Analysis</th>
<th>Findings/Relevance</th>
<th>Quality Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaton, 1990</td>
<td>To investigate the influence of nurse-patient verbal interaction on the social construction of the childbirth experience</td>
<td>Not explicitly stated; qual with attempt to quantify results</td>
<td>Observations based on ‘pre-specified behavioural events’; Hewthorne effect not accounted for</td>
<td>Significant differences found in role dimensions - attentiveness, acquiescence, &amp; presumptuousness - for nurses and women in labour Nurses controlled social context of CB through verbal interactions in these 3 dimensions Nurses and labouring women interact from their own perspective – limited understanding of the ‘other’</td>
<td>Validity of quantifying data is questionable; however, displaying patterns can ↑ clarity &amp; confidence in results limited rationale for choosing events to observe; may be missing key elements of relationship/care</td>
</tr>
<tr>
<td>Blackford &amp; Street, 2002</td>
<td>To engage nurses in understanding and improving care for migrant women</td>
<td>Qualitative &lt;br&gt;‘Feminist praxis study’ &lt;br&gt;5 collaborative research groups of 4-6 nurses meeting over 7 months &lt;br&gt;Purposive sampling: Nurses self-identified as ‘liberal feminist’; equality-focused &lt;br&gt;Australia</td>
<td>Little detail given concerning analysis &lt;br&gt;Analysis was ‘thematic’, interactive and collaborative bet. researchers and participants</td>
<td>Treating all people ‘the same’ meant that women from different cultural backgrounds did not always receive equity in care Nurses uncovered contradictions in their practice and identified ways to meet the gendered and racially constructed needs of women from different cultural backgrounds</td>
<td>Analytic approach not made explicit Use of ‘small surveys, questionnaires, individual and focused group interviews, narrative accounts’ noted, but no details re: development or content given</td>
</tr>
<tr>
<td>Brown, Beckhoff, Bickford, Stewart, Freeman &amp; Kasperski (2009)</td>
<td>Examine role of L&amp;D nurse from perspective of both women and partners</td>
<td>Descriptive, qualitative &lt;br&gt;Interview &lt;br&gt;Purposive; 10 heterosexual couples (Ontario)</td>
<td>‘Iterative and interpretive’ &lt;br&gt;Coding and NVivo used</td>
<td>4 roles of L&amp;D nurse: providing continuity, support, education and advocacy</td>
<td>Part of larger study ‘reported elsewhere’ (not indicated elsewhere) Limited description of the sample and process of analysis</td>
</tr>
<tr>
<td>Author/Date</td>
<td>Purpose</td>
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<tr>
<td>Clark Callister, Khalaf, Semenic, Kartchner &amp; Vehvilainen-Julkumen 2003</td>
<td>To report on the perceptions of culturally diverse women regarding the experience of pain in childbirth</td>
<td>Data gathered from 8 phenomenological studies focused on cultural meanings of CB</td>
<td>Secondary analysis of previous studies</td>
<td>A sense of personal control is increased if women have choices in pain management, are supported by professionals, allowed to use personal coping strategies and participate in decision-making</td>
<td>Secondary analysis; inclusion and exclusion criteria unclear; Process of analysis to arrive at findings not described</td>
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<tr>
<td>Carlton, Callister, Christiaens &amp; Walker 2009</td>
<td>Identify perceptions of nurses caring for birthing women in high-tech nurse-managed birthing environments</td>
<td>Purposive, maximum variation sampling 18 nurses working in 4 nurse-managed labour units interviews</td>
<td>limited description of analysis; ‘simultaneous data collection and analysis’ themes, categories and member checks</td>
<td>nurses may not be willing to share power and enact women’s choices in L&amp;D nurses sought predictability and efficiency in provision of care disparity bet. nurses and physicians re: how positive outcomes are achieved</td>
<td>study limitations not identified; process of analysis unclear; ? methodological coherence</td>
</tr>
<tr>
<td>Downne, Simpson &amp; Trafford 2006</td>
<td>Explore accounts of maternity care practitioners (nurses and mw) that are termed ‘expert, excellent, exemplary or experienced’</td>
<td>Metasynthesis – 7 studies 5 mw; 2 nurses 5 in USA; 2 sweden</td>
<td>Stages of analysis listed but not described in detail 10 initial themes synthesized to arrive at the 3 domains of expert practice</td>
<td>Domains of expert practice included: wisdom, skilled domain and enacted vocation Care may be compromised when ‘maternity systems’ limit ability of caregivers to perform in those domains</td>
<td>Search methods and criteria or inclusion, exclusion identified Studies included are described and ranked according to established criteria</td>
</tr>
<tr>
<td>Goldberg, 2003</td>
<td>To understand the intrapartum nursing relationship</td>
<td>Interviews Participant observation Feminist, interpretive phenomenology 8 L&amp;D nurses &amp; 8 PP women</td>
<td>Analytic approach specified and linked to phenomenology Subjective meanings of participants were portrayed</td>
<td>Relationships between nurses &amp; birthing women is marked by ‘introductory engagement’ Involves respect of the particular person, their values and relationships, creating a space for relationship</td>
<td>Findings grounded in relevant explanatory literature New insights into the intrapartum relationship</td>
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<td>Hallgren, Kihlgren &amp; Olsson, 2005</td>
<td>To describe prospective mothers’ &amp; fathers’ and their midwives’ ways of relating using a relational ethics perspective</td>
<td>Qualitative content analysis, Observation (video-recorded sessions) and interviews, 4 nulliparous couples, 9 MWs, Sweeden</td>
<td>Reflexive stance of researchers explained, Basis of content analysis outlined, Data compared and discussed within Logstrup’s framework of relational ethics</td>
<td>MWs strongly influenced different ways of relating during childbirth, Ethical ways of relating included openness to uniqueness, attentive companionship and providing space for a caring relationship, Unethical relations included prescribing what had to be done, neglecting the non-technical aspects of caring</td>
<td>No description of sample, other than ‘4 couples’ – their situatedness can help reader interpret relevance to other populations, Limitations noted by authors, New insights into MW-pt relationships revealed</td>
</tr>
<tr>
<td>Hauck, Fenwick, Downie &amp; Butt 2006</td>
<td>To explore influence of CB expectations on women’s perceptions of birth experience</td>
<td>Explanatory descriptive, Purposeful sample related to themes from previous study, Interviews; 20 women, multips and primips</td>
<td>Audit trail incorporated into analysis, Constant comparative method used</td>
<td>In order to perceive birth as positive, a woman had to achieve her priority expectations for birth, Women adapted expectations after a first birth when expectations were unmet</td>
<td>Themes from first phase of the study; not clear how those themes were arrived at.., Specifics of constant comparative method unclear</td>
</tr>
<tr>
<td>Hindley &amp; Thomson, 2005</td>
<td>To investigate midwives’ attitudes, values and beliefs on the use of intrapartum electronic fetal monitoring (EFM)</td>
<td>Qualitative, Semi-structured interviews, Purposive sample of 58 MW experienced in use of EFMs, England</td>
<td>‘general thematic analysis’ used to establish categories, Due to time constraints, transcription, coding and interpretation of data was done summatively</td>
<td>The ideal of informed choice for labouring women was not translated into MW practice, Competing health service agendas and medically driven protocols identified as barriers to enhancing pt autonomy, women have the choice MW wants them to have</td>
<td>interview guide ‘derived from the literature’ but relationships not explained, deviant data not accounted for</td>
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<td>Hyde &amp; Roche-Reid, 2003</td>
<td>To understand midwives’ perceptions of their role in maternity services</td>
<td>Semi-structured interviews</td>
<td>Constant comparative analysis used to distill themes and categories of data</td>
<td>MWs value women’s autonomous choices but use ‘expert’ knowledge used to maintain control over L&amp;D</td>
<td>Method of data analysis consistent with stated framework</td>
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<td>Analysis based on Habermas’ theory of communicative action</td>
<td></td>
<td>Obstetrician preference, convenience, staff shortages and status of pt (private vs public) influenced use of unnecessary technological intervention</td>
<td>Use of 3 sites for comparison, inc. implications of private versus public hospitals, beyond the scope of method used &amp; sample size</td>
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<td>12 experienced midwives, &gt; 4 years exp. Ireland</td>
<td></td>
<td>Orientation of OBS towards success, power &amp; money conflict with MW values of communicative action and understanding.</td>
<td>Unclear who researchers are, relationships to participants and reflexive stance</td>
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<tr>
<td>James, Simpson &amp; Knox, 2003</td>
<td>To examine how expert L&amp;D nurses in a nurse-managed labour model view their roles in caring for mothers during childbirth</td>
<td>‘focus group methodology’</td>
<td>Analyzed using inductive coding to identify categories and themes</td>
<td>Described importance of ‘being with’ women, attuning to her responses, let woman guide the birth</td>
<td>Not clearly designated as qualitative research; no evidence of epistemological orientation to guide analysis</td>
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<td>54 expert L&amp;D RNs; criteria &gt; 5 yrs experience</td>
<td></td>
<td>Advocacy discussed in context of safety and avoidance of adverse outcomes –acting in ‘best interests’ of women</td>
<td>Part of larger study</td>
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<td>4 large medical centres with higher than average intervention rates United States</td>
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<td>Autonomy = nurse decision-making vs MD</td>
<td>Focus groups - RNs who worked tog.? only dominant views</td>
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<td>Nurses’ descriptions of supportive nature of care not consistent with setting data on high rates of medical interventions</td>
<td>Assumptions “the autonomous nature of nursing…was reflected in spirited discussions”</td>
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<td>Kennedy, Shannon, Chuahorm at al., 2004</td>
<td>To expand knowledge on the process and outcomes of ‘exemplary’ midwifery care</td>
<td>Videotaped interviews, Interpretive narrative analysis, Theoretical sampling, Stories/vignettes of 14 MWs &amp; 4 recipients of care, 6-40 years of practice, United States</td>
<td>Role and reflexive stance of researchers identified, Analytic process described in detail: software used for organization of data and identification of conceptual relationships, Narratives coded and interpreted in face to face sessions</td>
<td>Processes of care included: Relationship founded on mutuality, Orchestration of an environment of care, inc. respect for choices, advocacy, shifting control from MW → woman, creating physical &amp; emotional space Outcomes of care Family centred, trust in ability to give birth, sense of accomplishment for MW and women</td>
<td>Lack of ethnic diversity, What is an ‘exemplary’ midwife? Recruited from previous Delphi study – dated narratives, links between processes of care and outcomes cannot be accurately established using this research methodology</td>
</tr>
<tr>
<td>Liaschenko, 1997</td>
<td>To understand the ethical concerns experienced and articulated by nurses</td>
<td>Narrative analysis using geographic framework, 19 home care and psychiatric RNs, United States</td>
<td>Assumptions guiding analysis: narrative rationality and contextualized view of ethics, Clear links established between author’s interpretations and conclusions</td>
<td>Relationship emerged as vital aspect of nurses’ ethical concerns, Pts and nurses inhabit vulnerable space, Hospitals geared to economy and homogenization → identity, Nurses ‘fill the gap’ to meet particular pt needs at their own expense</td>
<td>Participants addressed issues apart from current practice – large range of settings and contexts, Limited detail of analytic process included in this article</td>
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- 6 postpartum women relating their birth experiences  
- Canada | - Epistemology informed analysis of audiotaped transcripts  
- Results grounded in comprehensive review of related literature | - Nursing ‘presence’ an important part of womens’ experiences  
- Nurse’s presence cannot be understood apart from structures and processes of workplace; more research needed in this area | - Research a ‘work in progress’; from quality perspective this is a fair outcome of this type of research  
- May be used to inform the work of others |
| Mabin, Latter & MacLeod Clark, 2007 | To explore whether the current nursing mandate (del’y of pt. centred, high quality, holistic and evidence-based care) is sustainable | - Interpretive research design based on collection of longitudinal qualitative data  
- 3 phases of study: questionnaire and interviews pre graduation and questionnaire 3 yrs post | ‘content analyzed’ | Organizational constraints impact capacity of newly qualified nurses to enact nursing ideals and values  
Unattainable expectations may be source of dissatisfaction and poor morale among nurses | - No information provided re: process of analysis or theoretical underpinnings  
- Information on questions asked limited; demographics of participants not included. |
| Machin & Scamell, 1997 | To understand womens’ expectations and experiences of pregnancy and childbirth | - Ethnography  
- Participant and non-participant observation; Pre and post-natal interviews  
- 40 primiparas Purposive and snowball sampling  
- England | Detailed analysis using ritual theory consistent with purpose of study  
- Explanations sought for deviant data  
- research technique of ‘hanging out’ sounds intriguing but is not described | Thrust for ‘informed choice’ may not be culturally appropriate for all women  
- Women with strongly expressed needs for control and autonomy can be traumatized by experiences that do not meet this ideal  
- Differences birth expectations blurred with the onset of labour | Comparative element sought by researchers (women attending NHS vs NCT) questionable using the methods described; no demographics on women included, therefore difficult to draw conclusions about comparisons |
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<td>Maher, J (2008)</td>
<td>● explore the conflict between ‘medical’ and ‘birthing’ time and implications for birthing women</td>
<td>● 10 women&lt;br&gt; ● Australia&lt;br&gt; ● Semi-structured interviews; narrative-based approach</td>
<td>● Limited explanation given for process of analysis or guiding theoretical perspective</td>
<td>● Women develop their own form of process time when telling birth stories; conflict not expressed</td>
<td>● Interpretations stem from related literature; unclear what process guided analysis</td>
</tr>
<tr>
<td>Matthews &amp; Callister, 2004</td>
<td>● To understand the perspectives of childbearing women about the maintenance of dignity during childbirth</td>
<td>● Qualitative&lt;br&gt; ● Semi-structured interviews&lt;br&gt; ● 20 low risk primiparous women&lt;br&gt; ● United States</td>
<td>● Details of process of analysis included&lt;br&gt; ● Themes related to authors’ understanding of ‘dignity’ emerged from data</td>
<td>● Nurses play pivotal role in preserving dignity in CB&lt;br&gt; ● Dignity was enhanced by nursing care that gave women their preferred level of control</td>
<td>● Sample: Married student housing unit at private university; relevance to diverse populations</td>
</tr>
<tr>
<td>Peter, E. &amp; MacFarlane, A. &amp; O’Brien-Pallas, L. 2004</td>
<td>Analysis of the moral habitability of the nursing work environment</td>
<td>● Secondary analysis of report synthesizing published research examining the impact of work environments on nurses’ health&lt;br&gt; ● Canada</td>
<td>● Theoretical framing of analysis (Walker) explicitly stated &amp; described&lt;br&gt; ● Process of analysis described, inc. development of codes and themes</td>
<td>● Moral hospitality of nurses’ work environments are influenced by: Oppressive work environments; Incoherent moral understandings; Moral suffering; Moral resistance&lt;br&gt; ● Proximity to patients r/t moral accountability</td>
<td>● Original study used approach consistent with qualitative description&lt;br&gt; ● Quality issues within secondary analysis addressed, i.e. similarity between primary and secondary question</td>
</tr>
<tr>
<td>Regan &amp; Liaschenko, 2007</td>
<td>● To examine relationships between L&amp;D nurses’ cognitive framing of childbirth and cesarean section (C/S) rates</td>
<td>● Qualitative&lt;br&gt; ● Purposive sample&lt;br&gt; ● 51 L&amp;D nurses&lt;br&gt; ● United States</td>
<td>● Projective analysis - assumption that cognitive framing informs action&lt;br&gt; ● Theory used to organize and explain findings</td>
<td>● L&amp;D nurses cognitively frame childbirth as: a natural process, a lurking risk, a risky process&lt;br&gt; ● Suggests causal relationship between cognitive framing of birth and trajectories of action that follow</td>
<td>● Criteria for identifying expertise in narratives unclear</td>
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| Rodney, Varcoe, Storch, McPherson, Mahoney et al (2002) | ▪ To describe nurses’ ethical practice; the role of APN in ethical practice; ethical content in nursing curricula | ▪ Constructivist  
▪ Focus groups  
▪ Theoretical sampling;  
▪ 87 participants (RN, SN, APN)  
▪ Canada | ▪ Individual and group analysis of transcripts to establish relationships amongst emerging themes  
▪ Use of ‘moral horizon’ as a framework to interpret findings | ▪ Nurses work ‘in-between’ values of others  
▪ Ethical decisions are processual, contextual and negotiated  
▪ Negotiation constrained by privileging of biomedicine, & corporate values; facilitated by supportive colleagues, professional standards and education | ▪ Detailed description of theoretical framing and links to methods of data collection and analysis contribute to quality  
▪ Specific suggestions for practice environment pulled from analysis |
| Sleutal, 2000 | ▪ To describe labour support techniques used by an expert intrapartum nurse to enhance labour progress and prevent C/S | ▪ Pilot study  
▪ Interpretive interactionism  
▪ Interview and observation  
▪ 1 ‘expert’ RN | ▪ Process of analysis not described in detail  
▪ Reflexive stance of researcher identified | ▪ Nurse’s approach to labour involves both ‘following the mother’s body’ and ‘hastening and controlling labour’  
▪ Nursing care limited by constraints of medical practice | ▪ Definition of expert (ie nurturing & caring) not justified or fully explained  
▪ unable to draw conclusions based on sample size |
| Sleutal, Schultz, Wyble et al., 2007 | ▪ To explore L&D nurses’ views of intrapartum care and factors that affect provision of supportive care in labour | ▪ Questionnaire – on-line and paper surveys  
▪ Convenience and snowball sampling  
▪ 416 RNs | ▪ Content analysis of narrative comments on questionnaire  
▪ Roundtable discussions and triangulation used to achieve consensus on categories, themes | ▪ RN/MD attitudes influence practice  
▪ Barriers to SC: MD practice ( routine inductions and epidural); untrained and unsupportive RNs; evidence-based care; mothers’ knowledge, preparation; ESL, high-risk  
▪ Facilitators: teamwork, collaboration, belief in mothers’ ability to birth | Questionnaires distributed at AWHONN conference (Phase 1) and online via professional electronic mailing lists (Phase 2) – skewed sample limits interpretation of findings |
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<tbody>
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<td>Thompson, 2003</td>
<td>To consider the lived experiences of mothers and midwives from an ethical perspective</td>
<td>Qualitative: narrative enquiry; interview; Snowball sampling; 8 women &amp; 8 MW; Australia</td>
<td>Analysis informed by feminist virtue ethics framework; theoretical underpinnings described; initial interpretation of narratives by both researcher and participant; second level of analysis with rel. literature</td>
<td>Use/abuse of power in relationships; Values conflict between midwives and organizations; Preferred ethical response – supporting the woman – not always possible; Midwife’s primary relationship was with mother while mother’s primary relationship was with baby</td>
<td>Study limitations acknowledged; Relevance to practice and future research described</td>
</tr>
<tr>
<td>VandeVusse, 1999</td>
<td>To clarify how decisions are made in labour through analysis of women’s birth stories</td>
<td>Exploratory, descriptive; Convenience sample; 8 primiparas &amp; 7 multiparas; 33 birth stories</td>
<td>Content and thematic reanalysis of previous qualitative study; Coders from different disciplines used to uncover new interpretations</td>
<td>Decisions are made on a continuum from unilateral to joint models; Movement from unilateral to joint decision-making associated with ↑ confidence &amp; positive maternal emotions</td>
<td>purpose of original study (meanings of control) supports this subsequent analysis (examining patterns of decision-making); selection bias - Caregivers suggested women informants;</td>
</tr>
<tr>
<td>Varcoe, Rodney &amp; McCormick, 2003</td>
<td>to further understanding of health care relationships in context</td>
<td>Meta-analysis of 3 studies</td>
<td>Analysis informed by Noblit &amp; Hare; identification of common metaphors and concepts</td>
<td>Moral judgments and decision making in health care are relational and contextual; Nurses’ actions may inadvertently support dominant ideologies and oppressive practices</td>
<td>Tracking of thought processes and process of analysis made clear</td>
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| Watson, Murtagh, Lally, Thomson & McPhail, 2007 | – To consider complexities of place, maternity care and pain relief  
– Examine construction of ‘flexibility’ in healthcare | ▪ Focus group; part of larger study  
▪ Parent educators, midwives, health visitors, anesthetists and obstetricians | ▪ No explanation of process of analysis; however, concepts related to place and flexible pain relief articulated and integrated throughout the study | ▪ Flexibility in pain relief influenced by health professionals pre-constituted sense of place and relationships within those spaces | ▪ Limited information related to process of the study (i.e. content of focus groups) |
| Weiss, Malone, Merighi & Benner, 2002 | To examine the influence of institutional economic ideology (moral ecology) on maintaining moral practices and standards of nursing care | ▪ Interpretive phenomenology  
▪ Interview, observation, field notes  
▪ 75 RNs  
▪ Critical care focus  
▪ United States | ▪ Theoretical underpinning and aims guiding analysis described  
▪ Process of arriving at thematic categories not described in detail | ▪ Interaction between nurses and institutional environments directly affects nursing practice and pt well being.  
▪ Efficiency model has neg. effect on social-moral environment | ▪ Critical care focus not specifically r/t intrapartum nursing  
▪ ‘Moral ecology’ framework used to interpret findings; deviant data and alternate explanations not fully explored |
## Quantitative Research Studies

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<th>Author/Date</th>
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<th>Findings</th>
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| Davies & Hodnett, 2002       | ▪ To develop a questionnaire to assess nurses’ self-efficacy for labour support (LS)  
▪ Describe nurses’ perceptions of factors assisting and preventing provision of LS | survey            | 55 & 152 maternity nurses in phase 1 & 2 respectively  
▪ 5 Canadian hospitals | ▪ Nurses’ self efficacy re: provision of LS was high but not actualized in practice.  
▪ RNs identified factors in the workplace that ↑ or ↓ provision of LS  
▪ Attention needs to be paid to organizational factors related to provision of LS | ▪ Steps taken to ensure construct validity during development of self-efficacy scale, enhancing reliability of evidence  
▪ Difficult to determine validity and accuracy of self-reports |
| Gagnon, Meier & Waghorn, 2007 | ▪ To identify and describe indicators of continuity of nursing care during L&D  
▪ determine if there was any association between continuity of nursing care during L&D and risk of cesarean birth | retrospective study  
▪ data collection by medical record review | 467 primiparous, full term, low risk women  
▪ University hospital, Canada | ▪ An association was found between # nurses caring for a woman and risk of C/S  
▪ Unable to draw conclusions re: association of other aspects of nursing care and C/S | ▪ Logistic regression appropriate for study design  
▪ Continuity of care itself could not be generated from the data – no record of what care occurred between signatures  
▪ Important findings to direct future research |
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<td>Green &amp; Baston, 2003</td>
<td>To understand the relationships between internal and external control in CB</td>
<td>Exploratory study questionnaires (3); 2 antenatal and 6 wks post partum</td>
<td>women scheduled to give birth in Apr/May 2000 in 1 of 8 maternity units in England (1279)</td>
<td>parity associated with feeling in control; feeling in control of staff, one’s behaviour and during contractions contributed to pt. satisfaction</td>
<td>Insufficient explanation of theoretical basis for questions used in questionnaire</td>
</tr>
<tr>
<td>Hodnett et al 2003</td>
<td>To assess the maternal and neonatal effects of continuous 1:1 intrapartum support (SC) and compare to usual care</td>
<td>Meta-analysis of 15 RCTs comparing continuous support with usual care</td>
<td>12,791 women; Hospitals in 11 countries with diverse conditions, policies, resources</td>
<td>Women who had SC were more likely to have SVD, ↓ likely to have IP analgesia, ↑ satisfaction with birth experiences; ↑ benefits of SC when provider not member of hospital staff, when it began early in labour and in settings where routine epidural was not available; Effectiveness of SC may be influenced by policies in the birth setting</td>
<td>Methodological quality established, using well defined guidelines, consistent with Cochrane reviews</td>
</tr>
<tr>
<td>Hodnett, 2002</td>
<td>To summarize what is known about satisfaction with childbirth, especially related to pain relief.</td>
<td>A systematic review of 137 studies, inc. Descriptive, RCTs, systematic reviews.</td>
<td>137 reports of factors influencing women’s evaluations of their childbirth experiences</td>
<td>Attitudes and behaviors of the caregivers influence satisfaction, more so than pain relief</td>
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| Pauly, Varcoe, Storch & Newton, 2009 | ▪ To describe the level of moral distress experienced by nurses, their perceptions of the ethical climate and the relationship between the two | ▪ Quantitative cross-sectional survey using refined Corley’s Moral Distress Scale (MDS) and Olson’s Hospital Ethical Climate Survey | ▪ 374 nurses working in acute care hospital settings in BC (22% response rate) | ▪ Ethical climate and moral distress were significantly correlated | ▪ Low response rate; generalizations cannot be made  
▪ Scales used had been previously assessed for construct validity  
▪ MDS based on definition of moral distress that does not account for individual constraints |
| Payant, Davies, Graham, Peterson & Clinch, 2008 | ▪ To examine determinants of nurses’ intentions to practice labour support | ▪ Descriptive survey                          | ▪ 97 RNs  
▪ Large urban Canadian hospital | ▪ Organizational barriers and social pressures on unit influenced ability to provide supportive care | ▪ Provided detailed explanation of survey development  
▪ Unable to examine relationships between intentions and actual provision of LS |
| Penticuff & Walden, 2000     | ▪ To explore influence of practice environment and nurse characteristics on capacity for ethical response | ▪ Descriptive correlation design  
▪ 3 quantitative instruments – demographics, intrapartum values (PVQ), nsg ethical involvement scale | ▪ 127 L&D, NICU nurses (80% staff nurses; 20% admin nurses and APNs)  
▪ 5 hospitals  
▪ United States | ▪ Environment and personal characteristics influence nurse activism with latter accounting for greatest variance in nurse activism | ▪ Cause-effect relationships cannot be inferred  
▪ Self-reports  
▪ No power analysis to determine sample size req’d |
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<td>Radin, Harmon &amp; Hanson, 1993</td>
<td>to determine the influence of nurses’ care during L&amp;D the C/S rate</td>
<td>retrospective L&amp;D nurses grouped according to C/S birth rates; low (0-6%) and high C/S (11-37.5%)</td>
<td>216 low risk nulliparous women in spontaneous labour with vertex fetus private tertiary care hospital in United States, 6700 births per year</td>
<td>large differences in C/S birth rates for nurses when controlling for other variables, including physician practice &amp; possible maternal/fetal factors</td>
<td>Multivariate analysis used to control for confounding variables</td>
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<tr>
<td>Sinivaara, Suominen, Routasalo &amp; Hupli, 2004</td>
<td>Describe MW opinions about exercise of power over women in communication</td>
<td>Questionnaire No study design described – survey?</td>
<td>Convenience sample 112 MWs and RNs 43 head nurses and LPNs 4 hospitals in Finland</td>
<td>power was exercised over labouring women in a) giving of information, b) decision-making, c) relational interactions Decisions were more often made on behalf of women who were frightened, quite, of different ethnic background Aggressive women were given limited information Nurses with less experience thought power was exercised over different women in various situations</td>
<td>Theoretical exploration of power ‘over’ in communication Likert scale used; – construct validity not described leading to concern re: accuracy of what is being measured Reliability coefficient &lt; 80 except for 1 item Confusion re: nurses and MW – midwifery context but research question focused on nurses – not explained</td>
</tr>
<tr>
<td>Author/Date</td>
<td>Purpose</td>
<td>Design</td>
<td>Sample/Location</td>
<td>Findings</td>
<td>Appraisal</td>
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<tr>
<td>Sorenson &amp; Tschetter, 2009</td>
<td>• To document relationship between women’s negative birth perceptions, provider disaffirmation, perinatal trauma and PP depression</td>
<td>• exploratory investigation questionnaires comprised of scales measuring birth perception (BPR), quality of provider interaction (QPI), perinatal trauma (PTCS) and Beck depression inventory (BDI)</td>
<td>• 71 English speaking S Dakota Names from archived birth announcements; of 134, (36.7% total pool of births) 71 returned questionnaires</td>
<td>• New case prevalence of negative birth perceptions, perinatal trauma symptoms, provider disaffirmation and depression were greater than other prominent disease burdens • Supports need for detection and screening of women requiring support</td>
<td>• Sample not representative of population • BPR not tested (1 item scale); BDI not specifically designed for PPD</td>
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