
ARTICLE

Conceptualizing Woman-Centred Care in Midwifery

by Lisa Morgan, RM, BSc, BHSc, MA, PhD(c)

ABSTRACT

Feminist values conceptualize health care service as a social relationship, and they approach the sharing of information as a self-help activity rather than one between experts and naïve recipients. Woman-centred care embraces these ideas and is a fundamental concept in midwifery, straddling both the biomedical model and feminist health care aspirations. The definition of woman-centred care relies on a list of attributes that highlight choice and control, alluding to continuity of care and empowerment. The midwife/woman relationship is central to the provision of woman-centred care but is not without controversy. This relationship may not always be achievable due to external structures, a focus on “normal birth,” and concerns about work/life balance. Few formal evaluations exist. Regardless, women were dissatisfied with existing care and care providers, and exploring this model of care introduces the possibility for non-authoritarian, collaborative, and respectful care for women.

KEYWORDS

midwifery, woman-centred, continuity of care, empowerment, midwifery relationship, childbirth

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Conceptualisation des soins axés sur la femme en pratique sage-femme

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RÉSUMÉ

Les valeurs féministes conceptualisent les services de santé comme étant une relation sociale et elles abordent le partage de renseignements comme étant une activité d'auto-assistance (plutôt que comme une relation entre des spécialistes et des bénéficiaires naïves). Les soins axés sur la femme épousent ces idées et constituent un concept fondamental en pratique sage-femme, en jetant un pont entre le modèle biomédical et les aspirations féministes en santé. La définition des soins axés sur la femme repose sur une liste d'attributs qui attire l'attention sur le choix et le contrôle, tout en se rapportant à la continuité des soins et à l'autonomisation. Bien que la relation entre la sage-femme et la femme soit au cœur de l'offre de soins axés sur cette dernière, elle n'est pas exempte de controverses. La mise en œuvre d'une telle relation pourrait ne pas toujours être possible, et ce, en raison de structures externes, de la mise d'un accent sur l'« accouchement normal » et de préoccupations quant à l'équilibre travail / vie personnelle. Nous ne disposons que de peu d'évaluations menées en bonne et due forme. Quoi qu'il en soit, les femmes ont exprimé une insatisfaction envers les soins et les fournisseurs de soins existants; ainsi, l'exploration de ce modèle de soins laisse entrevoir la possibilité d'une approche non autoritaire, concertée et respectueuse envers les soins offerts aux femmes.

MOTS CLÉS

pratique sage-femme, soins axés sur la femme, continuité des soins, autonomisation, relation de pratique sage-femme, accouchement.

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INTRODUCTION

I am a midwife, and I have been using the term “woman-centred care” for more than a decade to describe the model of health care that I provide. At a recent presentation, I used this term to describe midwifery care and was then asked to define what I meant by “woman-centred care.” I was surprised at how this inquiry caught me off guard. I mumbled something about shared decision making, a non-authoritarian relationship, and informed choice. I then made a mental note to look into the accepted definition of woman-centred care.

An accepted definition of woman-centred care does not exist. I found three articles that examined the meaning of woman-centred care to midwives and to women and a fourth article that outlined the steps taken in attempting to conceptualize the term. I describe my research approach as “descriptive social theorizing” and present my findings for comment and review. This article attempts to arrive at a definition of woman-centred care by listing the attributes of such care. This is followed by a discussion of continuity of care and empowerment, two core attributes of midwifery as practiced in Canada. Finally, the controversies surrounding woman-centred care are discussed.

BACKGROUND

The idea of woman-centred care can be traced back to the women’s health movement of the 1960s and 1970s, when woman-centred models of health care that were based on feminist ethics emerged.¹ Reproductive health care became the health services area in which consumers were particularly vocal and litigious about the shortcomings of their current system.² A now-famous report entitled *Changing Childbirth*, commissioned by the United Kingdom Department of Health, stated that women who gave birth in public hospitals were particularly unhappy. Issues raised included a lack of continuity regarding care and caregivers, the lack of information and involvement in decision making, and a lack of respect and sensitivity among caregivers.³ Concerns about fragmented care and increasing medicalization were shared by women and midwives. Subsequent government policy changes gave rise to a new type of maternity care service, which “borrowed the terminology of woman-centred care” from the earlier feminist movements.³

Current approaches to health care have utilised frameworks for the delivery of public services that treat citizens more like customers, enabling them to hold public servants responsible for rendered services.⁴ These approaches

introduce accountability, market-style competition for patients, and a recognition of patients as consumers. The problem with this orientation is that the goals of health care may be at odds with the goals of business because the prime beneficiaries are intended to be the patients and not the owners.⁵ Standardized routines are part of the biomedical model characterized by the concentration of information and decision making in the hands of providers and not in the hands of women. The emphasis is often on technology. Women are labelled according to their diagnoses, without appropriate attention or responsiveness to their individual needs.⁴ The suggested alternative to the biomedical model is woman-centred care. Midwifery embraces both biomedical and feminist health care principles and therefore exists at the intersection of a mainstream health care ideology and an alternative woman-centred ideology.⁶ The ultimate goal for women is non-authoritarian (egalitarian) shared decision making. However, tensions continue to exist due to asymmetrical positions, diverging concerns and purposes, and the unavoidable presence of professional control within health care encounters.⁶

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DEFINING WOMAN-CENTRED CARE

The last decade has seen health policy increasingly focus on individual service users and their relationship with the service. The concept of woman-centred care has been used as a framework in a range of policy documents and standards related to midwifery, notably in the United Kingdom and Australia.¹ Reflecting on the meaning of woman-centred care requires an analysis of the language that is generated and used. The language or terms adopted play a role in constructing and perpetuating the culture of pregnancy and birth.⁷

In the United Kingdom, woman-centred care is a concept that was introduced in the *Changing Childbirth* report.⁸ An expert committee was convened in 1992 to review policy on National Health Service maternity care. The goal was to obtain, through interviews, the views of women who had given birth since 1989 and who were not

linked to any group or organization. The key components of these views were the following:

- The service should respond to women's unique needs and be respectful of ethnic, cultural, social, and family backgrounds.
- The woman should be closely involved in planning her own care and should be cared for by a known caregiver.
- The woman should be provided with adequate information with which to plan her care.
- The woman's psychological and physical needs should be understood and her autonomy respected.

The report concluded that maternity care must be woman-centred, concentrating on meeting the needs of the women for whom the service is intended.⁸ In Australia, researchers surveyed women to determine what women wanted from their midwives.⁹ Branches of the Australian College of Midwives and the Maternity Coalition in each state and territory were asked to distribute surveys among their patients. Telephone interviews were also conducted with 32 midwives randomly selected from around Australia. The survey found that for women and their midwives, providing woman-centred care was seen as a way of working rather than as a particular organizational model. Ensuring that women have control over their care, focusing on their needs, and being receptive to different approaches were part of this capacity to work in a woman-centred way. Being flexible in the caregiving role and supporting the family were components of this approach.⁹

The aim of a study by Berg, Olafsdottir, and Lundgren¹⁰ was to develop an evidence-based midwifery model of woman-centred care in Sweden and Iceland. Four intertwined requirements were identified, based on a synthesis of findings from 12 published qualitative studies conducted by the authors:

1. A reciprocal relationship is needed as the midwife gets to know the woman that she is caring for and the woman comes to understand her midwife.
2. The atmosphere should be calm in order to avoid distraction. The setting should inspire trust as opposed to fear, risk, and danger. Safe surroundings promote self-confidence and a sense of control, inspire strength and confidence, and support and guide women on their own terms. The environment should support normal birth, bearing in mind the limitations in cases of complicated birth.
3. The midwife should have the resources and skill

required to use her embodied, or "grounded" knowledge differently in response to each woman's needs.

4. The cultural context, which consists of norms which can hinder or promote optimal care, should include a model of care that places the midwife at the woman's side, providing continuous support throughout labour. However, there can be a cultural clash between the values held by the woman, the provider, the institution, and the overall health care system. Other requirements of the institution and the system may make it necessary for the midwife to complete competing tasks.¹⁰

Maputle and Donavon⁴ conducted a concept analysis to define woman-centred care. The qualitative, exploratory, descriptive study involved 24 mothers and 12 attending midwives, who participated in comprehensive interviews and participant observations. The characteristics that were indicated by the analysis occurred frequently, were deemed necessary, and gave a holistic overview. The authors arrived at the following list of defining attributes: responsibility sharing, empowerment, interdependence and collaboration, participative decision making, open communication and listening, respect and accommodative midwifery actions (i.e., recognition and honouring of cultural sensitivity and the support of choices), self-determination, and self-reliance.⁴

The aforementioned four requirements allow a definition of "woman-centred care" as consisting of the following characteristics:

- Individual focus
- Shared responsibility, reciprocity, open communication, and receptiveness
- Empowerment
- Information sharing, interdependence, and collaboration
- Participative decision making with a known caregiver
- Autonomy, self-determination, and self-reliance
- Respect: honouring culture, ethnicity, and social and family background
- Holistic care
- An atmosphere of calmness and safety

CONTINUITY OF CARE

Woman-centred care is closely tied to continuity of care, which satisfies the woman's needs, realizes her aspirations, and enables the social context to be addressed

within the midwife-client relationship.¹ One of the most commonly expressed wishes of expectant women is that they be attended to in pregnancy, labour, and the postnatal period by a midwife with whom they have an established relationship.² Research into social support in pregnancy and birth indicates that supported women feel less anxious, more in control, and more satisfied with their care, and this translates into better physical and psychological outcomes for women and their infants.¹¹ Associated benefits include less clinical intervention in labour, a shorter second stage of labour, less use of analgesia, fewer cesarean sections, and fewer episiotomies.²

A midwife who is consistently sensitive to the mother's needs must be present, or a lack of participation and informed decision making can result.⁵ A survey of women in Australia with respect to continuity, choice, control, and satisfaction in regard to their midwifery care revealed that there is overwhelming support from women, irrespective of the level of intervention, for a continuous primary caregiver.¹² Women at high obstetric risk (in the medical sense) benefit as much if not more from continuity in midwifery care.²

There is some conflicting evidence that indicates that continuity does not necessarily equate with good care. Although it matters to most women, a focus on continuity may neglect other aspects of care that are equally important.² It has become clear to me that woman-centred care requires continuity of care, as the relationship with the caregiver is of great importance. However, continuity of care does not ensure woman-centred care; a known caregiver will not necessarily engage in the level of mutual participation demanded by woman-centred care. There are also indications that continuity of care is a part of midwife-centred care (as a result of midwives using this element to regain the professional autonomy lost by working in a hierarchical setting dominated by medicine) and that job satisfaction among midwives has increased.² The critical attributes of woman-centred care as both process and product have to be identified and distinguished from midwife-centred care.⁵ It may be that greater choice and control for women is contingent upon midwives' having occupational autonomy. Midwives claim a discrete sphere of knowledge and expertise legitimated by a more equal partnership with women in an area in which medical care has been criticized.² There is also evidence of increased stress in midwifery when midwives have autonomous roles. Job satisfaction often increases, yet there is greater intrusion into midwives' personal lives because of the demand

for continuous availability.² Midwifery has been called a "greedy" profession, one in which great commitment, loyalty, time, and energy are required, but the rewards are great as well.² Finally, it seems that although women want consistent care from people they trust, what matters most is the philosophy of care, including the sharing of information and involvement in decision making.³

WOMAN-CENTRED CARE AND EMPOWERMENT

It is often claimed that the increased availability of medical information (primarily owing to the Internet) has diminished the asymmetry between physicians and their patients in regard to knowledge, equalizing their power; this is termed "patient empowerment." Empowerment is defined as "the process by which people, organizations, and communities gain mastery over their lives."¹³ Accepting this requires the following assumptions: (1) it is valuable to increase the responsibility of patients and consumers, (2) patients want to be empowered, and (3) power is a commodity that can be acquired and possessed. Veinot (2010) suggests that empowerment-based health discourses conceal a policy of health resource rationing that shifts the burden of care, transforming self-care into a civic obligation.¹³ The focus on "participative decision making," "self-determination," and "self-reliance" within the definition of woman-centred care may be perceived by some as shifting the burden of care onto women as clients and patients.

Literature on woman-centred care and midwifery acknowledges that when care is concentrated on individual women, there is the potential to create situations in which the woman herself can become personally empowered, which also serves to strengthen family, community, and society.¹ This is termed the "ripple effect" and is a core community development principle. However, one person cannot empower another; rather, an individual can be involved in facilitating situations that enable power to be taken on by another person.¹ We need to avoid talking about midwives empowering women and focus on the potential of midwives to facilitate situations in which women can feel empowered. The key is to distinguish between "power-over" interpretations of empowerment and those in which intrapersonal, interpersonal, and community empowerment result from the creation of opportunities and resources that facilitate autonomy.¹⁴ Empowerment is the outcome of woman-centred care, but it must be clear that the empowerment is achieved by the woman who is being served and that woman-centred care is intended to create the conditions in which women empower themselves.

IS WOMAN-CENTRED CARE ACHIEVABLE OR DESIRABLE?

With the emphasis on intimacy, women's empowerment, and individually tailored and engaged care, a review of the rhetoric raises some questions, including the questions of whether this kind of relationship is always achievable and whether it is what all (or even most) women want from their midwives.³ It has been assumed that because midwifery is a female-dominated profession, midwives will guard the rights and interests of women and provide a more holistic, empathetic, and egalitarian style of care, thus ensuring choice and control for women. There is little evidence to support this view, as external structures influence professional behaviour regardless of gender and because organizational factors can curtail the provision of woman-centred care.² Neither midwives nor women are homogeneous groups about which generalizations can be made. Other concerns involve work-life balance and have resulted in arrangements for sharing the care of a woman

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among colleagues, potentially compromising continuity of care. Midwives justify these conditions with the assertion that a woman will receive better care if her midwife's needs are met first.¹⁵

Carolan and Hodnett question the value of woman-centred care, as there have been few formal evaluations.³ The midwife/woman relationship is portrayed as going beyond other professional relationships in health care in terms of importance, intimacy, and intensity.³ The findings from a three-year project in New Zealand revealed that although midwives felt that they were providing care that was distinct from medical services, many women chose midwifery care for the convenience of home visits and reported that their care from a midwife was similar to the obstetric care they had received during their last or previous pregnancy. The women did not feel they needed emotional support from their midwives.³ Some women prefer a more formal contractual form of relationship and prefer to leave

the decision making to the experts. These women may be called "reluctant collaborators."³

The dominant view is that normal birth is the ideal and that any other type of birth is a source of disappointment, guilt, and failure.³ There is concern that woman-centred care is exclusively linked to normal birth and to midwifery-led care and that this focus, in a culture of escalating intervention and rates of surgical birth, may detract from the experiences of women who do not give birth "normally".¹ Midwives may be practicing a new form of authoritarianism, persuading women to give birth in a certain way and perpetuating an adversarial culture of midwives versus obstetricians. It is difficult to determine whether women who are deemed at risk for pregnancy complications are particularly interested in giving "normal" birth or achieving empowerment, given the increasing demand for cesarean sections.³ It has been suggested that a contest exists between medical intervention, paternalism, and control on the one hand, and the midwife's providing woman-centred care and acting as the woman's advocate on the other hand. The struggle for hegemony is a legitimate concern, as it affects interprofessional care and the provision of quality maternity care.³

Participation in decisions about care requires knowledge of health care, the ability to process medical information, and an understanding of the potential repercussions of choices.⁵ The notion of choice implies a comprehensive set of options from which informed women are free to choose. The truth is that within health care systems, this level of choice seldom exists, and the available choices may not be left up to the childbearing women themselves.³ The pregnant woman is positioned in a web of surveillance, monitoring, measurement, and expert advice that requires constant work on her part. There is also an assumption that women will embrace the surveillance in order to maximize their infants' health.³ Institutional power within the hospital, through its resistance to change, denies women choice; this is related to power relations between care providers, management and health care consumers within the hierarchical and bureaucratic organization in which they exist. Denials of maternal requests are couched in the language of what is best for a woman and her infant.³

Midwifery regulators across Canada have adopted many of the core concepts of woman-centred care and have incorporated them into their standards of practice. For example, the College of Midwives of Ontario (CMO), as part of its standard of practice presented in The Ontario Midwifery Model of Care, lists the following statements

under the heading “Philosophy of Midwifery Care”:¹⁶

- Midwives respect and support their clients so that those clients may give birth safely, with power and dignity.
- Midwives respect the diversity of women’s needs and the variety of personal and cultural meanings that individuals, families, and communities bring to pregnancy and birth.
- Midwives encourage women to actively participate in their care and to choose the manner in which their care is provided.
- Midwives provide education and counselling to support women making informed choices.
- Midwives promote shared decision making between the client, her family, and her caregivers; the client is the primary decision maker.
- Midwives provide care that is continuous, personalized, and non-authoritarian.
- Midwives provide care that is responsive to women’s social, emotional, cultural, and physical needs.
- Midwives respect the woman’s right to choose her caregiver and birthplace.

Although continuity is important to women, philosophy and consistency of care appear to be of greater importance.

In the CMOs model of care standard of practice, special mention is made of “continuity of care” and the need for midwives to make the time commitment necessary for developing a relationship of trust in order to provide safe and individualized care; to protect this aspect of care, the CMO limits the number of midwives caring for any one woman to four.¹⁶ Similar statements underpin the philosophy of midwifery care in the six other provinces and two territories that have recognized and regulated the profession, and without exception, the standards of practice serve to make woman-centred care the accepted model of care.

CONCLUSION

The concept of woman-centred care emerged from feminist critiques of women’s health care encounters. The Changing Childbirth report borrowed the term and applied it to maternity care specifically after consulting women about their desired reproductive health care. Researchers in Australia, Sweden, Iceland, and South Africa conducted similar investigations specific to midwifery in order to find the most important elements of the midwife/woman clinical encounter. The combination of these four inquiries allowed me to create a list of attributes that form a definition of woman-centred care. The “known caregiver”, called “continuity of care” in midwifery circles, is part of the definition. Although continuity is important to women, philosophy and consistency of care appear to be of greater importance. Woman-centred care is intended to create the conditions under which women can empower themselves. The definition of woman-centred care assumes that it is valuable to increase the responsibility of women and that women want empowerment. Woman-centred care is not without controversy. Evidence that outcomes are improved strictly owing to this model is lacking. Whether woman-centred care is meeting the needs of women, the needs of midwives, or both, is still being debated, and further investigations may be warranted. Within institutional power structures, choice may be limited, and attempts towards advocacy may be met with resistance. This model of care was reintroduced because of women’s dissatisfaction with existing care and care providers. The guiding principles of woman-centred care have been adopted and embraced by midwifery regulators, but stressors within the maternity care system and issues around work-life balance threaten to weaken the commitment of midwives to a woman-centred approach. Let us honour the voices of women and be clear about providing care that is truly woman-centred, meaning that the care is non-authoritarian, collaborative, and respectful.

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