Exploring Respect During Childbirth among Nurses, Women and their Families

by

Leanne Chantrel Johnson

A thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Faculty of Nursing

University of Alberta

Abstract

Background: Childbirth is a transitional moment in a person's life. In Canada, most women give birth in a hospital supported by labour and birth nurses. Respectful maternity care have been revealed as a global concern, yet there is limited research on what respectful care means within the context of nursing practice.

Purpose: The purpose of this research is to explore the culture of respectful care as experienced by nurses, women who recently gave birth and their families within the context of patient and family centered care.

Method: A focused ethnography was conducted utilizing interviews, observations, and review of relevant documents. Semi-structured interviews with nine labour and birth nurses, thirteen perinatal women and one partner were completed.

Results: Four themes emerged: creating space for respectful relationships; shifting autonomy amid pain and vulnerability; navigating relationships with colleagues; and nursing in the middle of competing roles and responsibilities. Creating space involves building a collaborative relationship with a birthing person, supporting their family, and responding to diversity. Shifting autonomy reflects the changes in autonomy in both the birthing person during the birth process and in the nursing role. Navigating relationships among colleagues focuses on the importance of reciprocal respect. Lastly, nursing in the middle highlights how competing roles and responsibilities can impact the nurses ability to provide respectful care.

Conclusion: Providing respectful care during childbirth is essential to safe, high quality nursing care. Nursing care is influenced by other healthcare professionals, the culture of the unit, and the organization. Respectful interactions between all healthcare professionals is necessary to support respectful care for all.

Keywords: respect, nurse, childbirth

Preface

This thesis is an original work by Leanne Johnson. The research project, of which this thesis is a part of, received research ethics approval from the University of Alberta Research Ethics Board, Project Name: Exploring Respect During Childbirth among Nurses, Women, and their Families, Pro00085738, January 11, 2019.

Dedication

I would like to dedicate this thesis to my family. The journey to pursue my PhD coincided with raising children and fulfilling my career as a nurse. I could not have completed it without the unconditional support, encouragement and confidence of my husband. The birth of my own children influenced my understanding of respectful care and I am forever grateful for their love and snuggles throughout this journey.

Acknowledgments

Thank you to the participants of this study who took the time out of their busy lives to participate in this research. I am in awe of the nurse participants who demonstrated openness, commitment to high quality care and a passion for the nursing role during labour and birth. I am grateful to all of the parents who shared their birth stories, I recognize the honor it is to hear your stories and I thank you for choosing to share them with me. Thank you to my supervisors Dr. Beverley O'Brien and Dr. Solina Richter for your unwavering support and encouragement over the years. I will never forget your kindness and understanding throughout my program as I balanced my PhD studies with various family and career commitments. Thank you for your guidance and for sharing your expertise. I would like to thank my committee member Dr. Tanya Park for her encouragement and feedback; Dr. Anna Santos Salas for her thoughtful presence during my exam; and my external examiner Dr. Karen MacKinnon for sharing her insightful perspectives. I am grateful for the scholarships I received throughout my PhD program from Alberta Registered Nurses Education Trust (ARNET) and the Faculty of Nursing, University of Alberta.

Table of Contents

Chapter 1

The birth of a child is a significant event within a family unit. Childbirth is an experience that encompasses a woman's[1] [1]entire physical, psychological, emotional, spiritual, and cultural self. A woman will always remember her birth experience, and what she remembers can impact how she feels about herself as a mother and a woman (Simkin, 1991; Beck, 2004a). Many elements influence a woman's care in the hospital during labour and birth including the institutional policies, cultural context, available resources and the healthcare professionals themselves (Public Health Agency of Canada [PHAC], 2017). The way a woman is treated by healthcare professionals while in the process of childbirth may affect how she feels about her experience for the rest of her life (Simkin, 1991; Baker, Choi, Henshaw, & Tree, 2005). A woman's birth experience is enhanced when she feels respected, valued, and supported (Carlton, Callister, Christiaens, & Walker, 2009).

In Canada, nurses are in constant attendance on labour and birth units, assisting with almost every birth that occurs, and as such have the privilege of caring for women during this transitional moment. Perinatal nurses, who offer a variety of services across the childbearing continuum, recognize childbirth as a transformative process that is unique and life altering, with an emphasis on a relationship of mutual respect and trust (Canadian Nurses Association [CNA], 2017a). They collaborate with a variety of healthcare professionals including obstetricians, family physicians, and midwives, and care for labouring women at varying degrees of acuity. They have complex roles that require both technical and interpersonal skills as well as competency in assessing maternal and fetal well-being, and they spend more time at the bedside

[1] Throughout this paper, gender-specific language such as "woman", "women" and "mother" is used. While gender identity was not captured in the demographics of this research, it is important to acknowledge that any child-bearing person, regardless of gender identity deserves respectful maternity care.

than any other healthcare professional (Gagnon, Meier, & Waghorn, 2007; Hodnett, 1996). Their constant presence on the labour and birth units provides them with a unique understanding and overall knowledge of how care is provided by a group of multidisciplinary care providers to a diverse group of women. This situates nurses in a central and key position within the Canadian maternity care system, and in an influential role with the birthing experience of women and their families.

National guidelines for maternal and newborn care guide maternity care in Canada, with the most recent publication by the Public Health Agency of Canada in 2017. Family-centered maternity and newborn care (FCMNC) involves increasing women's and families' participation in the decision-making process throughout the pregnancy-birth-postpartum continuum in a collaborative and respectful relationship between women and their families, and health care providers (Public Health Agency of Canada, 2017). The FCMNC is based on 17 principles (see Appendix A). While national guidelines have been in place for decades, Chalmers (2017) argues that family-centered maternity care has yet to be fully realized and implemented throughout Canada.

While one overall aim of the care of women and their families during labour and birth is to foster a positive birth experience, the experience of childbirth is subjective and unique to each individual birthing person. Many aspects of the experience, such as control and pain, are perceived and conceptualized by birthing women in a variety of positive and negative ways thus contributing to the complexity of the experience (Larkin, Begley, Devane, 2007). A positive birth experience is attributed to the birth environment, interpersonal care from healthcare providers, and the degree of maternal involvement in decision making during the birthing process, regardless of the outcome (Rudman, El-Kouri, & Waldenstrom, 2007).

Women's feelings of empowerment are associated with the presence of a trustful relationship with their partner and healthcare professionals, and can impact their ability to have a positive birth experience (Nilsson, Thorsell, Hertfelt Wahn & Ekstrom, 2013). This feeling of empowerment results in an increased ability to feel control, strength of body, satisfaction, and reassurance in the birthing process, leading to an increased ability to manage pain (Nilsson, Thorsell, Hertfelt Wahn & Ekstrom, 2013). A sense of personal control and the ability to make informed choices contributes significantly to a woman's satisfaction with her childbirth experience (Knapp, 1996; Cook & Loomis, 2012).

The core concepts of patient- and family-centered care (PFCC) include providing dignity and respect, information sharing, participation, and collaboration (Institute of Patient and Family Centered Care [IPFCC], 2017). The focus of PFCC is working with patients and their families, placing an emphasis on collaboration at all levels of healthcare delivery, with the goal of promoting health and wellbeing (IPFCC, 2017). PFCC is an indicator of high-quality healthcare, leading to improved safety, greater satisfaction among patients, families and healthcare providers, and reduced costs (Alberta Health Services [AHS], 2015; IPFFC, 2017). Family-centered perinatal care is "care offered to the woman and her supportive family members that is evidence-based, psycho-socially sensitive, multi-culturally adapted, inter- and multi-dimensional and using only essential and appropriate technology" (Chalmers, 2017, p.10).

Alberta Health Services is committed to providing PFCC, and created the Patient First Strategy (AHS, 2014). Within this strategy, the plan of action includes promoting respect, enhancing communications, supporting a team-based approach to care, as well as improving transitions in care (AHS, 2014). The Patient First strategy is informed by the fundamental pieces of relationships and humanity (AHS, 2014).

Respect is a central concept within PFCC and in professional nursing practice (IPFCC, 2017; CNA, 2017b). Yet what respect means and how it is enacted in every day practice is not clear (Gallagher, 2007). As patient- and family-centered care provides the framework for healthcare within Alberta, it is important to explore women's (patients') and their families' perceptions of how they perceived and experienced respect during the births of their children.

Globally, respectful maternity care has become a topic of concern as reports of mistreatment of women have been identified in low, middle, and high-income countries (Bohren et al, 2015; Bowser & Hill, 2010). National news articles (Burns-Pieper, 2016a; Burns-Pieper, 2016b), as well a provincial report (Maternity Care Consumers of Alberta Network, 2014), suggest that how women are treated during labour and birth requires further exploration. Research on respectful maternity care is starting to emerge in Canada (Vedam, 2017; www.respcct.ca)

Personal Background

My nursing career has focused on supporting women and their families throughout pregnancy, birth, and parenting. Throughout my professional and personal experiences, I have witnessed births in hospital and at home, both within Canada and abroad. My first nursing position was as an obstetrical nurse in a tertiary hospital with approximately 250-300 births per month. I worked alongside obstetricians and family physicians, caring for both low- and high-risk women and their families during childbirth. I loved working on the labour and birth unit: witnessing the strength of women and the power of birth, supporting families during some of the best and worst moments of their lives, experiencing the rush of a "stat" caesarean section, and developing a strong bond between colleagues.

While I have not worked on the unit for well over a decade, my experience and passion for supporting women and their families during labour and birth has continued to inform my career. I have worked in a maternity clinic, facilitated prenatal classes to expectant families, and taught obstetrics and community health to undergraduate nursing students. In addition to my professional experiences, my personal experiences of pregnancy and the birth of my two sons significantly contribute to my understanding of the holistic needs of a woman and her family during childbirth.

I recall the moment I stepped back and began to analyze the experiences I had while working as an obstetrical nurse. I had recently become pregnant with my first child and was attending a weekend course on how to become a doula. I was teaching prenatal classes at the time and thought that this course would supplement my knowledge on teaching comfort measures to expectant women and the people who support them. The instructor told us to "Draw your ideal birth". I stared at the blank paper while immediately putting my hand on my stomach, and found myself drawing a bathtub in my house with my husband by my side. I felt shocked, chuckled to myself, and thought *you can't have a home birth, you're a labour and birth nurse*. I was familiar with the hospital environment, the expectations, the terminology used, and the meanings behind the looks and silences. While on one hand this provided me a source of comfort, it was also the exact reason why I was drawn to home birth. I found myself struggling between my ideal birth and my perceived reality of birth in the hospital, which caused me great distress. I did not want to be a patient in the same place I loved to work.

When reflecting further, I identified areas of practice that I was not proud of, and these experiences influenced my thinking around where I wanted to give birth, and informed my understanding of respectful nursing practice. I have been the nurse in the room when the

physician applied the vacuum ten minutes before shift change and I struggled to identify the medical indication on the delivery record. I have handed the amnihook to the physician with just a look of their eye, and witnessed them rupture a woman's membranes without seeking informed consent. I have told women to "check their modesty at the door" upon admission, and have said "let's just get this IV in place now so it's ready for when you want an epidural", rather than offering them encouraging words and non-pharmaceutical pain management options during their labour. I feel disheartened as I reflect on my involvement in these practices, and other limitations in my care: my limited knowledge of physiological birth, my lack of understanding of the historical influences on hospital birth, my inability to be a strong advocate for women, and the significance of these actions in contributing to the use of unnecessary medical interventions and the mistreatment of women in labour. As I grow in my awareness of respectful care, I can appreciate how these common practices of my past have contributed and influenced my current beliefs and values around respectful nursing care. While I have found new avenues in community practice, education, and research that fuel my passion for childbirth; I continue to find myself drawn towards obstetrical nurses, and understanding what informs their nursing practices and shapes their professional identity.

During my first pregnancy, I was also concerned with the idea of being the unknown patient. Being in labour is a profoundly vulnerable state of being, and I was not comfortable entering an environment where I did not know anyone. In my experience, the unknown patient is more likely to be treated as a number in the institution, filed into the standardized care plan, and more likely to be deemed non-compliant when they deviate from that plan. While I believe that nurses try their best to provide nursing care that meets their patient's needs, other factors such as staffing, institutional policies, and relationships with colleagues influence their practice. I know

that on occasion errors occur, assessments are missed, and the ability to go above and beyond is not always possible. In my experience, being known means being more than a patient in the system. It means being recognized as a person who is in a relationship with their healthcare providers, who is presented with choices, has autonomy in their care, and who receives respectful care.

My personal and professional experiences have left me with a desire to explore the concept of respect in nursing care as experienced during labour and birth. Respect is a tenant of professional nursing practice, but how is that enacted in everyday nursing practice? The culture of the unit, professional nursing culture, as well as how birth is culturally informed within society have all informed my clinical actions. Examining the day-to-day clinical experiences and perceptions that shape our understanding of respect is necessary to understand how to provide respectful care to all birthing persons and their families during this pivotal moment in their lives.

Chapter 2 Literature Review

Historical Context of Birth

Understanding the historical context of the evolution of maternity care within the Canadian healthcare system is crucial to understanding how women, families, and healthcare professionals understand and participate in birth today. In the early twentieth century, the majority of births took place in the home supported by midwives and family (Mason, 1988); however, by the 1950's approximately 80% of births were attended to in the hospital by physicians and nursing staff (Noel-Weiss, 2007). Physicians often promised "civilized" births in the name of science, and a higher status was attributed to women who had a "highly-medicalized birth" (Harper, 2005, p.33). This shift from home to hospital was heavily influenced by societal and cultural beliefs that birth was not natural and safe, but rather a medical event that required consistent monitoring and intervention (Mitchinson, 2002).

Midwives were not integrated into Canada's mainstream medical system and were pushed out by physicians and nurses (Mitchinson, 2002). Except for those living in rural and remote areas of Canada, the majority of women did not have access to midwifery care (Mitchinson 2002; Macdonald, 2006). While other countries such as the United Kingdom and the United States were utilizing nurse-midwives to replace traditional and lay midwives, Canada did not create this duel professional role. Midwives practiced only in rural and remote settings, not reemerging as a viable option for women until the second wave feminist movement in the 1970's (Macdonald, 2006). Canada and the United States are the only countries where obstetricians, rather than midwives, attend the majority of low-risk births (Wagner, 2001).

Robbie Davis-Floyd (2001) describes a technocratic model of care as the birth model prevalent in hospitals in industrialized countries. Influenced by the industrial revolution, this

model reflects the factory production style of society of that time, making the hospital the facility, the mother the machine, and the baby the product (Davis-Floyd, 2001). To ensure the production of birth runs efficiently and effectively, technology and tools are used during childbirth, the woman is viewed as an object, and the practitioner often remains distant and uninvolved. Hierarchical organization, and standardization of care is prevalent, and knowledge and authority are accorded to the practitioner rather than the birthing woman. Aggressive medical intervention is used and other ways of knowing are discouraged (Davis-Floyd, 2001).

Positive change within healthcare will occur as the patriarchal medical model of care is replaced by more holistic care models, such as patient- and family-centered care. As the technocratic model can be inferred to contradict the principles of patient- and family-centered care, a shift in healthcare professionals' practice is required.

Search Strategy

A literature review was conducted to inform this research proposal. Various combinations of key search terms were utilized: family-centered care OR patient- and family-centered care OR family-centered maternity care OR family-centered perinatal care; obstetrics OR maternity OR intrapartum OR perinatal; respect; and nurse or nursing. The University of Alberta's discovery system that searches the library catalogue was utilized, including over 300 databases (CINAHL and MEDLINE databases included). Grey literature was also explored from key healthcare organizations, news articles, and community reports. The search was limited to the English language. Individual titles and abstracts were scanned, and relevant articles were integrated throughout the literature review.

Limited research was found that examined respect within the nursing context on obstetrical units in Canada. For example, in 2018 a search within CINAHL database, using the

search terms nurse, respect, and obstetrics OR maternity OR intrapartum with publication limitation to the last ten years within Canada yielded zero results.

Care Models

Family-Centered Care

The term family-centered care stems from pediatrics where historically children were separated from their families during hospitalization in the middle years of the 20th century (Jolley & Shields, 2009). Key researchers, John Bolby and James Robertson among others, were instrumental in identifying the negative effects of separation on children, and change began to occur following World War II (Jolley & Shields, 2009). Key organizations were established including the Institute for Family Centered Care in 1992.

Family-centered care (FCC) has evolved and been studied since the consumer revolution of the 1960s, yet there are conflicting views in the literature on what FCC is, and how it is used and executed in practice (Peterson, Cohen, & Parsons, 2004). The term FCC has not yet been clearly defined in the literature despite its common use (Chalmers, 2017). Most of the research on FCC was conducted within pediatric and neonatal units, and difficulty in implementing this concept into daily practice has been identified (Butler, Copnell, & Willetts, 2013; Harrison, 2010; Peterson, Cohen, & Parson, 2004).

Two reviews of qualitative studies were retrieved. A review of eleven qualitative studies was conducted where the use of FCC in children's hospitals was described (Shields, Pratt, & Hunter, 2006). Themes that emerged include negotiation between parents and children and hospital staff are key to the success of interactions during hospitalization; and perceptions of both parents and staff roles influence the delivery of FCC. A subtheme of both financial and emotional costs was identified. In another systematic review, 15 articles on healthcare

professionals' and parental experiences of FCC for children in hospital were examined (Foster, Whitehead & Maybee, 2010). The four main themes that emerged were communication, healthcare professional and parent relationships, caring for parents, and available resources (Foster, Whitehead & Maybee, 2010). Perceptions among healthcare providers and parents on parental needs and FCC vary within the hospital setting (Foster, Whitehead & Maybee, 2010). Neonatal nurses' perspectives of family-centered care have been examined, identifying the need for ongoing organizational support, guidance, and further education to deliver FCC effectively (Trajkovski, Schmied, Vickers, & Jackson; 2012).

Patient- and Family-Centered Care

In 2010, the Institute of Family Centered Care changed its name to the Institute for Patient and Family Centered Care (IPFCC, 2010). This reflected a change to acknowledge that neither *family-centered* nor *patient-centered* care is sufficient, as both patients and their families are essential within healthcare. According to the IPFCC website (http://www.ipfcc.org/about/pfcc.html):

> Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control. (Adapted from Johnson, B. H. & Abraham, M. R., 2012)

It appears that PFCC is the term currently being utilized and adopted to all clinical areas in hospitals, ambulatory care settings and long-term care (Johnson & Abraham, 2012).

Rankin (2015) provides a critique of PFCC in a discussion paper derived from her research program on nurses' work in hospitals, stating that "PFCC is organized to be empty rhetoric; an idealized abstraction implemented inside standardizing technologies that are the ruling relations of the objectively organized health system" **(**p.533). She further states that nurses are socially organized to meet the hospital's agenda, in which they overlook the subjectivities of patients and families and align themselves with objectifying technologies that become the focus of their work.

Maternity Models of Care

The principles of patient- and family-centered care have been adapted and integrated into maternity care and the concept of family-centered maternity care has continued to evolve since its inception.

Family-Centered Maternity Care

As family-centered care infiltrated into healthcare, maternity units began to adopt guidelines to reflect family-centered maternity care (FCMC). Celeste Phillips, a nursing leader from the United States was a strong advocate for FMCM and developed the 10 principles of family-centered maternity care in1994 (Phillips, 1994). These principles are presented in Appendix B. Supportive care during labour, keeping families together during birth and postpartum, unrestricted visiting hours, and single room maternity care are some examples of FCMC (Public Health Agency of Canada, 2000; Tomlinson & Bryan, 1996). However, dysfunctional operating systems, poor leadership, and overwhelmed staff can negatively influence the ability to implement FCMC (Zwelling & Phillips, 2001). Implementation requires changing the entire

institutional culture to reflect FCMC, and a shift in attitudes of physicians and nurses. Movement from practitioner centricity towards partnerships with women and their family is needed (Zwelling & Phillips, 2001).

Patient- and Family-Centered Maternity Care

To reflect the integration of both patient and family in healthcare, the Institute of Patient and Family Centered Care (2010) created core concepts of patient- and family-centered care that apply specifically to maternity care. The concepts include respecting each childbearing woman and her family; identifying strengths; providing information to make choices about approaches to care; having flexible policies, procedures, and practices to individualize care; supporting, empowering and collaborating (IPFCC, 2010).

Family-Centered Perinatal Care

Further developing the concept of FCMC, Beverley Chalmers, a perinatal health consultant from Ontario, Canada offered the 10:10 principles of family-centered perinatal care (2017). These principles are both family centered and caregiver centered, giving insight on how to further implement FCC into practice (see Appendix C). The principles apply to women having either vaginal or caesarean birth as well as those experiencing optimal or adverse outcomes. Chalmers (2017) argues that, overall, we have much to do before we are truly family centred in our approach to maternity care; we have yet to implement evidence-based guidelines, integrate women and their families in care, and provide holistic care that extends behind the physical aspects of pregnancy, labour, and birth.

While the term PFCC has evolved over the years and has been adapted to maternity settings, similar concepts remain. Birth is viewed as a normal healthy event that requires an

holistic approach that encompasses women's individual needs and includes their families into the care (Phillips 1994; IPFMC 2010; Chalmers, 2017).

National and Provincial Documents

The *Canadian National Guidelines for Family Centered Maternal and Newborn Care* (Public Health Agency of Canada, 2017), as well as the Alberta Health Services' *Patient First Strategy* (2014), reflect the importance of integrating both patient and family into care, and influence how healthcare providers take care of childbearing women.

Canadian Family Centered Maternal and Newborn Care: National guidelines

The *Family Centered Maternal and Newborn Care: National Guidelines* (2017) focus on the care of women and their families during preconception, pregnancy, labour and birth, and the postpartum period (Public Health Agency of Canada, 2017). In this document, family-centered maternity and newborn care (FCMNC) is described as a "complex, multidimensional, dynamic process of providing safe, skilled, and individualized care. It responds to the physical, emotional, psycho-social and spiritual needs of the woman, the newborn, and the family" **(**Public Health Agency of Canada, 2017). The guidelines are based on seventeen principles (Appendix A).

Patient First Strategy

Alberta Health Services (AHS) committed to providing patient- and family-centered care and created the Patient First Strategy (2014a) with the assistance of 24 consultations with stakeholder groups including patients, families, clinicians, service providers, various councils, and community partners. Four themes were generated from the consultations including: promote respect, enhance communications, support a team-based approach to care, and improve transitions in care. The AHS PFCC Resource Kit provides healthcare professionals with strategies that address the themes and improve the patient experience at the point of care (AHS,

2014b). The Patient First Strategy also focused on AHS employees with the goal of having a safe, healthy, and valued workplace, which in turn improves patient and family experiences, quality of care, and safety (AHS, 2014c).

Respect

Respect is a core concept of patient- and family-centered care, a key principle within family-centered perinatal care, and a subtheme within the AHS Patient First Strategy (IPFCC, 2017; Chalmers, 2017; AHS, 2014). While definitions of respect vary slightly between organizations, partnering with patients and their families to provide holistic care that honors the individual and family needs is a common thread. Within PFCC, respect and dignity mean honoring patient and family perspectives and choices as well as incorporating their knowledge, values, beliefs, and cultural backgrounds into the planning and delivery of care (IPFCC, 2017). Within family-centered perinatal care, caring for families with respect and concern for their dignity includes recognizing the psychosocial aspects of perinatal care, incorporating cultural, religious, or ethical needs, and providing evidence-based individualized care (Chalmers, 2017). According to the AHS, promoting respect includes honoring the patient's desire to be treated as an individual and a whole person (AHS, 2014). Respect is also a fundamental value within nursing and is integrated throughout professional ethical statements (Beauchamp & Childress, 2001; CNA, 2017b). Nurses have an ethical responsibility to "relate to all persons receiving care with respect and to maintain their dignity and integrity" (CNA, 2017b, p.12).

Respect is significant to human beings, enacted in our day-to-day lives and central to our relationships with others, yet is complex to understand and define. The word *respect* comes from the Latin word *respicere*, meaning to 'look back at' or 'look again at' (Dillon, 1992). Philosophers such as Kant, Downie and Telfer, and Donegan and Gautier have deliberated the

ethics of respect for persons (Frankena, 1986). However, it was Immanuel Kant, arguably the most influential moral philosopher, who defined respect, claiming that all human beings are owed respect, and that it is morally and unconditionally required (Dillon, 2016). Respect is about recognizing the inherent worth of every human being who is encountered.

Respect can be conceptualized in various ways: "show respect (consideration), give respect (honor esteem), be respectful (deference), have self-respect (a felt self-worthiness), provide respectful acknowledgment (regard, love), give respectful distance (allow personal space and privacy), or stand in silent respect (honoring the dead)" (Bergum & Dossetor, 2005, p. 68). An attitude of respect is the relation between a subject and an object, in which the subject responds to the object from a certain perspective in some appropriate way (Dillon, 2016). Respect can be viewed as object orientated in that it is called from us, commanded from the other (Dillon, 1992; Dillon, 2016).

As respect is a responsive relation, key elements of the response include attention, acknowledgment, valuing, and behavior (Dillon, 2016). Central to the concept of respect is worthiness, of perceiving something, of deeming it worthy and recognizing its value (Dillon, 1992; Bergum & Dossetor, 2005). People can be the recipient of various forms of respect including directive respect, institutional respect, evaluative respect, obstacle respect, and care respect (Dillon, 2016). Particularly applicable to nursing, care respect calls us to see the individual by identifying the *me-ness* of a person, respecting their uniqueness and our shared humanity (Dillon, 1992).

Nursing Practice

The concept of respect is used throughout professional nursing ethics (CNA, 2017b). The idea of the 'subject' and 'object' relationship exists within professional ethical statements, as

there are often a variety of objects that the nurse must respect, such as "individuality, autonomy, dignity, worth, uniqueness, privacy, persons, policy, human rights, cultural rights, and the values and responsibilities within the codes" (Gallagher, 2007, p.362).

Only a few studies were found where the concept of respect within nursing was analyzed (Browne, 1993, McGee, 1994; Browne, 1997). Browne (1997) examined conceptual, behavioral, and operational indicators of respect and developed the following conceptual definition:

> Respect is a basic moral principle and human right that is accountable to the values of status equality among persons, human dignity, inherent worthiness, and self-determination. As a guiding principle for actions towards others, respect is conveyed through the recognition and acknowledgment of the above values in all persons. As a primary ethic of nursing, respect forms the basis of our attitudinal, cognitive, and behavioral orientation toward all persons, and is most obviously demonstrated in the manner with which one person treats another during direct interactions. (p.777)

Gallagher (2007) goes beyond recognizing respect as a duty or right within nursing practice and looks beyond the objects of respect. She views respect as a virtue and discusses three components of being a respectful nurse: acknowledgement, preservation of what is valuable, and an active engagement with others. Respect is an active value that requires meaningful engagement, authenticity, and a disposition to do and to be respectful (Gallagher, 2007).

Human dignity, which is often linked and explored with respect as noted in the above definition by Browne, has been further examined (Coventry, 2006; Baillie, Ford, Gallagher, & Wainwright., 2009; Wainwright & Gallagher, 2008a and 2008b); yet is not widely understood (Wainright & Gallagher, 2008a). However, it is argued that a focus on respect, rather than

dignity, is needed in healthcare since most people have a sense of what is meant by the term respect and being respectful (Wainright & Gallagher, 2008b).

What respect means in day-to-day nursing practice is unclear (Gallagher, 2007). The concept of respect has been explored among health professionals practicing in various settings such as the Intensive Care Unit (ICU) (Geller et al, 2015) with an older adult population (Koskenniemi, Leino-Kilpi, & Suhonen, 2012), and in forensic psychiatry (Rose, Peter, Gallop, Angus, & Liaschenko, 2011). While respect transcends all areas of nursing practice, the context of care influences the interpretation of its meaning (Rose et al., 2011). Quantitative researchers, Carrese, et al (2017), attempted to measure respect and dignity in the ICU clinical setting by developing a direct observation checklist of 29 items to assess clinician behavior and demeanor, the patient's room environment, patient status and mood, and the activity observed; they concluded with plans to assess the external validity of this checklist in other settings.

Patient Perspective

It is important to explore patients' perceptions of what respect means to them, as nurses' and patients' perceptions of respect can vary. A multi-centered descriptive and correlational study with patients (n=1565) and nurses (n=1148) from 88 general surgery units across 34 hospitals in six different European countries found that nurses and patients differed in their perceived frequency of respectful behaviors and human presence, with nurses reporting more behaviors than patients perceived (Papastavrou et al., 2012). However, there is little research into the patient's perspective related to respectful treatment (Dickert & Kass, 2009; Papastavrou et al., 2012).

One qualitative study with 18 survivors of cardiac arrest found that respect is a multifaceted task, and that it includes autonomy, empathy, care, provision of information, as well

as recognition of individuality, dignity, and attention to needs (Dickert & Kass, 2009). Another descriptive qualitative study explored respect as experienced by older adults (n=10) and their next of kin (n=10) in an acute hospital in Finland (Koskenniemi, Leino- Kilpi, & Suhonen, 2012). It concluded that patients identified polite behaviour, the patience to listen, reassurance, response to information needs, assistance in basic needs, provision of pain relief, response to wishes and time management as respectful nursing actions. According to another study**,** patients who perceive that they are respected by being treated with dignity, and by being involved in decision making experience greater satisfaction with their care (Beach, Sugarman, Johnson, Arbelaez, Duggan, & Cooper, 2005).

Childbearing women's (n=20) perceptions of nursing care that promotes dignity was investigated using descriptive qualitative research by asking the research question "what is important for nurses to do to help women feel respected" **(**Matthews & Callister, 2003, p.499). Themes that emerged included: nurses play a pivotal role in preserving dignity, women appreciate feeling valued and respected, and dignity is enhanced by care that gives women their preferred sense of control. Participatory decision making and fostering a sense of control through shared power can contribute to respect and dignity for childbearing women.

DeLellis (2000) argues that when pregnant women are cared for by their family and other women, respect occurs spontaneously and naturally. According to DeLellis (2000), the perinatal experience is a life-transforming object of respect, but "instead of flowing in natural spontaneity among all the participating strangers, expressions of respect must now be sought, demanded, rehearsed, institutionalized, nurtured, and protected" (p. viii)**.** He also argues that the vast majority of patients aspire to demonstrate respect, yet many patients continue to feel disrespected. Observable behaviour that conveys respect should be fundamental among

healthcare professionals who accompany women through the childbearing experience (DeLellis, 2000).

Respectful Maternity Care

Since 2010, respect during childbirth has received global attention. A comprehensive global report on the mistreatment of women during labour and birth revealed that mistreatment occurs in a variety of forms (physical and verbal abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention), and is found at all levels of care (Bowser & Hill, 2010). In a mixed methods systematic review of the global mistreatment of women during childbirth, 65 studies from 34 countries were examined, and it was found that mistreatment of women during childbirth occurs in many settings within low-, middle- and high-income countries (Bohren et al., 2015). The review developed a typology of mistreatment of women during childbirth with first order, second order, and third order themes that highlight activities related to physical, sexual, and verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women and providers; and health system conditions and constraints. While mistreatment can occur at the provider level, systemic failures at the levels of the health facility and health system contribute to its occurrence. Only two Canadian studies were included within this systematic review (Chalmers & Hashi, 2000; Chalmers & Omer-Hashi, 2002), both focused on Somali women's birth experiences in Canada.

It is argued that mistreatment should be analyzed within the larger context, as violence within healthcare settings often reflects dynamics found within society and can be viewed as a subset of the violence and abuse that occurs more broadly against women in society (d'Oliveira, Dinix, & Schraiber, 2002**;** Jewkes & Penn-Kekana, 2015). The paternalistic influence of power

and control over women during childbirth parallels the dominance of men that continues to exist within many societies. Healthcare professionals and staff who engage in mistreatment of women may often feel disempowered themselves, and experience forms of structural violence such as heavy workload, long hours and inadequate facilities (d'Oliveira, Dinix, & Schraiber, 2002; Jewkes, Abrahams, & Mvo, 1998).

International organizations have responded by raising awareness of the rights of childbearing women. The White Ribbon Alliance (2011) created the Universal Rights of Childbearing Women in response to a report by Bowser & Hill (2010) identifying the rights of childbearing women as: freedom from harm; right to information, informed consent and refusal, and respect for choices; right to confidentiality and privacy; right to dignity and respect; equality and freedom from discrimination; access to the highest attainable level of health; and the right to autonomy and freedom from coercion. The Respectful Maternity Care movement (Hastings, 2015), spearheaded by a working group convened to formulate the universal rights of childbearing women, involves multi-sectoral collaboration between healthcare providers, maternal health implementers, global institutions, and human rights advocates to promote and support respectful maternity care (RMC) around the world. RMC focuses on the interpersonal interactions during labour and birth, and advocates for positive and supportive staff attitudes and behaviours (Hastings, 2015). The World Health Organization drew further attention to this issue in 2014, calling for greater action, research, advocacy, and dialogue on the mistreatment of women during childbirth. Respecting women during childbirth is vital to ensuring that their experiences while giving birth are both fulfilling and empowering (Wagner, 2001). The World Health Organization (2015a) acknowledges that all women deserve dignified and respectful care.

While abuse and disrespect of women during childbirth is often cited in low- to middle-income countries, the mistreatment of women in high-income countries may appear in subtler forms. Hodges (2009), a birth activist from the United States, claims that those who work on labour and birth units have heard of, or witnessed, examples of verbal and physical abuse in the hospital setting despite the presence of many caring and supportive healthcare professionals. Goer (2010) identifies and describes modern day mistreatment of women during childbirth in her article, Cruelty in Maternity Wards: Fifty Years Later, in which excerpts from online blogs and research articles were used to exemplify abuse during childbirth in the United States. Goer (2010) paralleled domestic abuse with abuse during childbirth, expanding the definition to include four additional categories of abuse that are unique to childbearing women: denial of the right to informed choice; elective primary cesarean section initiated by the physician; denial of the right to refuse invasive medical procedures; and the legal system where fetal rights supersede the rights of the woman. Issues related to informed consent and women's choice are prevalent within the traditional hierarchal medical model of care, as is the use of unnecessary medical interventions and lack of evidence-based care (Chalmers et al., 2009; Klein, 2009; Simmonds, 2008; Miller et al., 2016). In a maternal health series printed in *The Lancet* (2016), respectful maternity care was examined globally. It was noted that too much too soon (TMTS), meaning the number of medical interventions used during childbirth, leads to the over-medicalization of normal pregnancy and birth (Miller et al, 2016). TMTS causes harm, increases costs, and often concentrates disrespect and abuse. The authors conclude that healthcare providers and health systems must ensure that all women receive high-quality, evidence-based, equitable, and respectful care that protects and promotes human rights.

Research on respect in maternity care continues to be published globally with emerging research from high-income countries like the United States and Canada. An online cross-sectional survey on experiences of maternity care in the US, completed by 2138 women, found that 17.3% of women reported experiencing one or more types of mistreatments such as being shouted at, ignored, or having a loss of autonomy (Vedam et al., 2019). Findings suggested that mistreatment is experienced more frequently when birth occurs in a hospital, among women of color, and among women with social, economic or health concerns. In Canada, the Mothers on Respect Inde*x* (MOR) was developed to measure women's experiences of respect and self-determination (Vedam et al., 2017), and research is underway for a Canadian Institute Health Research (CIHR) funded study on women's birth experiences led by Dr. S. Vedam and the Birth Place Lab at the University of British Columbia. (https://www.respcct.ca).

Hospital Birth Environment

The medicalization of childbirth has influenced how birth is viewed and supported in the hospital, impacting the way nurses understand and participate in birth today, and influencing their ability to provide respectful care. Increased use of medical interventions, lack of informed choice, and loss of autonomy are some of the influences linked to mistreatment and disrespect of women. Within a brief span of time, the medical system has become the expert on childbirth, and healthcare professionals have taken over the care-giving duties that were once the responsibility of family and friends (Smith & Nickel, 1999)**.** Throughout this transition, nurses have had a strong need to be recognized by the medical profession and have often been found to be proponents of medical management of birth in the hospitals where they are employed (Task Force on the Implementation of Midwifery, 1987). In Canada, approximately 96% of births occur in the hospital **(**Canadian Institute of Health Information [CIHI], 2017). Childbirth remains

the most common reason for hospital admission, and a caesarean section is the most common inpatient surgery (CIHI, 2017).

Inherent in the prevalence of hospital births compared to home births is the belief that birth is safer in the hospital, yet research supports positive outcomes for women and their infants in midwifery-attended home births that occur within a well-developed system (Janssen et al., 2009). Globally, Canada and the United States are the only nations where obstetricians, as opposed to midwives, attend the majority of low-risk births (Wagner, 2001). This has implications for women in that practitioners practicing under the medical model of care tend to utilize interventions at a higher rate when compared to those practicing under the midwifery model of care (Gaskin, 2011; Kitzinger, 2012). The birth environment can either support or hinder a woman's ability to have a physiologic birth (Stark, Remynes, & Zwelling, 2016).

When used appropriately and in a timely manner, medical interventions can save the lives of both the mother and infant; however, routine use without medical indication can disrupt normal physiological birth and lead to negative maternal and newborn outcomes (American College of Nurse-Midwives et al., 2012; Jansen, Gibson, Bowles, & Leach, 2013). The use of routine interventions was explored in the Canadian Maternity Experiences Survey (MES), conducted in 2006, and the largest set of data where women's experiences with maternity care were examined. Of the 8244 randomly selected eligible women in Canada (those who had given birth between February and May 2006, living with their infant and over the age of 15), 6421 women (78%) agreed to participate (Public Health Agency of Canada, 2009). The MES found that the rate of interventions varied across provinces and territories. Two-thirds of women reported having continuous electronic fetal monitoring during labor, although intermittent auscultation is the best-practice recommendation (Chalmers et al, 2009). An epidural was used

by 57.3% of women, yet the World Health Organization does not recommend its routine use for pain management in labor (Chalmers et al, 2009).

The primary cesarean rate in Canada in 2015-2016 for women under the age of 35 was 17.8%, while the rate for women over the age of 35 was 23.6%. (CIHI, 2017). In 2015, the WHO released a statement based on systematic reviews of ecological studies indicating that, at a population level, caesarean section rates higher than 10% are not associated with reductions in maternal or newborn mortality (Betran, Torloni, Zhang, 2015; WHO, 2015b; Ye, Zhang, Mikolajczyk et al, 2015). Unfortunately, outdated policies regarding routine medical interventions remain the norm in many Canadian hospitals as identified by the Canadian Hospitals Maternity Policies and Practices Survey (Public Health Agency of Canada, 2012).

High levels of interventions have been associated with negative psychological outcomes as women can feel "disempowered by a medical model of childbirth that entails obstetric management, physical immobilization, lack of emotional support, frequent interventions, rigid timing, and an operative delivery" (Kitzinger, 2012, p.304). A growing number of women are unhappy following their childbirth experience. Approximately half of women in the MES rated their experience as very positive, leaving approximately 25% of women somewhat satisfied, 10% indifferent, and 10% having a somewhat negative or very negative experience (Chalmers et al., 2009). It is acknowledged that it is difficult to measure satisfaction related to a woman's birth experience due to the various factors that can impact her ratings (Chalmers, Dzakpascu, Heaman, & Kaczorowski, 2008). Some reports caution against using ratings as a reflection of the quality of care being provided as women may rate whatever experience they have as positive and may be unaware of the other options that exist (Van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003).

Approximately 1.5% to 6% of women experience post-traumatic stress disorder, and up to 30% of women experience trauma symptoms related to labour and delivery. (Beck, 2004a; Soet, Brack, & Dilorio, 2003). Ten qualitative studies were included in a mega-ethnography of women's perceptions and experiences of traumatic birth (Elmir, Schmied, Wilkes & Jackson, 2010). The themes identified were: feeling invisible and out of control; the need to be treated humanely; feeling trapped; the reoccurring nightmare of childhood experience; a rollercoaster of emotions; disrupted relationship; and strength of purpose as a way to succeed as a mother. Healthcare providers appear to be unaware of the women's traumatic experience as they focus only on clinical outcomes and a live healthy baby (Beck, 2004b). Healthcare providers must recognize that women need to be fully involved in the decision-making process to increase their sense of control (Elmir, Schmied, Wilkes & Jackson, 2010).

As most childbearing women are healthy and capable of making decisions about giving birth, informed choice is highly valued in maternity care; however, the ability of a woman to make a choice depends upon the information that is presented to her, the birthing environment, and her healthcare providers (Simmons, 2008). A questionnaire was completed by 1318 low risk nulliparous pregnant women in Canada to understand their attitudes related to birth technology and their roles in childbirth (Klein et al., 2011). A significant number were uncertain of the risks and benefits of common procedures such as epidurals, episiotomy, and caesarean sections (Klein et al., 2011). A mixed method study conducted in the United States examined the factors influencing women's decisions regarding their birth (n=49) (Regan, McElroy, & Moore, 2013). Women, particularly those who wanted to access medical intervention and birth in the hospital, did not appear to actively pursue information about the risks and benefits of their choices, nor could they articulate the risks associated with their choices (Regan, McElroy, & Moore, 2013).

Furthermore, healthcare providers themselves have limited knowledge about current evidence-based research in maternity care (Klein, 2009). A survey conducted with 549 obstetricians providing intrapartum care in Canada compared attitudes and beliefs between obstetricians over 40 to those under 40 years of age (Klein et al., 2011). The younger cohort of obstetricians was found to strongly oppose home birth, be more concerned about the safety of vaginal birth, and be more comfortable with Cesarean section and the routine use of epidural analgesia. Despite evidence that is available, attitude drives practice (Klein et al., 2011).

Hierarchical power imbalances, dominating medical models of practice and the emphasis on authoritative knowledge, the focus on efficiency, economy, and technology, and the discourse surrounding risk and safety in obstetrics impact a woman's ability to choose what she believes is right for her during childbirth (Lothian, 2008; Simmonds, 2008). It has long been acknowledged that a power differential exists among health care providers and their patients, and this imbalance is exaggerated when differences in gender, class, and race are present (Goldberg, 2009).

Furthermore, choice does not exist in isolation nor is it limited to the hospital setting as choice is also influenced by greater social and political factors (McAra-Couper, Jones, & Smythe, 2011). Many women use a birth guide to outline their choices during labour and birth and to gain a sense of control. However, when 22 women from southern Alberta who had a baby within the previous three years (n=22) were interviewed, it was found that their experiences differed significantly from their expectations (Malacrida, & Boulton, 2014). The women's accounts "reveal that the decision to undergo medical interventions was not a free choice but a constrained decision made within the context of an unpredictable and disempowering event, where medical advice and intervention often led to escalating medicalization and undermined women's birthing efforts" (Malacrida, & Boulton, 2014, p.56).

Healthcare providers can struggle with the ideal of informed choice, and the realities of their practice (Simmonds, 2008). Nurses who work in labour and birth need to be acutely aware of the extremely vulnerable nature of the woman during labour and birth, and their role as her advocate (Simmonds, 2008). However, nurses' ability to advocate for their clients is influenced by their practice environment, their relationships with their colleagues, as well as their own personal characteristics (Penticuff & Walden, 2000; Sleutel, 2000; Simmonds, 2008).

In 2014 Maternity Care Consumers of Alberta Network (MCAN) conducted a listening campaign with almost 1400 Albertans, including both consumers and a variety of maternity healthcare professionals. In their final report, Maternity care: Priorities in Alberta, three themes were explored including place of birth, approaches used in maternity care, and primary care providers and other health professionals. The report revealed that the desire to move from the technocratic model was identified but was not fully implemented into practice. Women's autonomy and choices were not always respected. Participants identified rude and inappropriate behaviour (e.g. bullying) in the hospital by physicians and other healthcare professionals, even while "the need for respect was repeatedly stated" (MCAN, 2014, p.20). Birth trauma was identified as a primary theme, yet participants thought few healthcare providers were aware of any incidences that were perceived to be traumatic. It was reported that there is a need for "greater appreciation for how birth experiences impact women, babies, and breastfeeding outcomes" (MCAN, 2014, p.24). In addition, restrictive hospital policies, shortage of resources, and a disconnect between administration and policies were also identified as issues affecting healthcare providers.

Additionally, the mistreatment of women during childbirth in Canada was reported in a national news segment on the Canadian Broadcast Company (CBC), both online and during

national and local news-hours (Burns-Piper, 2016a). It was reported that hundreds of complaints related to quality of care and disrespect have been submitted to health authorities across the country. The provinces of Alberta and British Columbia received a combined total of 763 complaints about treatment in maternity care over the previous six years. A labour and delivery nurse was quoted, "There is no doubt in my mind that there are practices that can be seen as abusive and disrespectful and disempowering to women happening in Canadian hospitals" (Burns-Peiper, 2016a). As well, the president of the Association for Safe Alternatives in Childbirth in Edmonton said the organization has heard thousands of stories of mistreatment. Nine stories from women about mistreatment in hospitals by nurses and physicians were highlighted in an additional CBC News article (Burns-Pieper, 2016b).

Summary

A focus on patient- and family-centered care can change the hospital birth experience for women and impact the way nurses provide care. Respect is key to both PFCC and the nursing profession, yet limited research was found that examines respect from the perspectives of nurses, women, and their families during childbirth. While the global community has focused on respectful maternity care, there is a lack of understanding of what respect looks like in the Canadian maternity context. It is vital to explore the perspectives and experiences of the nurses, the healthcare providers who spend the most time with patients during childbirth, about what respectful care means to them, and what they experience within the hospital environment.

While nurses can certainly provide insights into practice, the culture of respectful nursing care requires a holistic lens. It is important to understand how respect is perceived in order to know how to provide respectful care in practice. As patient- and family-centered care is embraced, it is vital to understand the perspective and experience of the birthing person, as well

as their family members, on what respect means to them during labour and birth. Considering the recent focus on mistreatment in the MCAN report and on CBC news, exploring respectful care is certainly needed in this context.

Purpose

The purpose of this study is to explore the culture of respectful care during labour and birth as experienced by nurses, women, and their families. It is important to understand the views of nurses since they are in attendance during almost all births that occur in the hospital setting. As patient- and family-centered care becomes integrated throughout AHS, it is important to also explore respectful care as perceived and experienced by women and the family members who accompany them during childbirth (e.g., their partner and/or support people). This can also provide an opportunity to compare the understanding of respect between nurses, women, and their families.

Research Questions

1. How do nurses, women, and their families perceive and experience respect during labour and birth?
2. What is the culture surrounding respectful care during labour and birth? What factors contribute to, or hinder, a culture of providing respectful nursing care during childbirth?

Chapter 3 Methodology

Focused Ethnography

A focused ethnography is the appropriate qualitative method to answer the research questions. Ethnographic researchers explore the shared and learned patterns of values, behaviours, and language, and the meaning of behaviours and interactions among members of the culture-sharing group (Creswell, 2013). Patterns of social organization and worldviews are then explored by the researcher (Wolcott, 2008). The participants' emic (insider) perspectives are explored and filtered through the researcher's etic (outsider) perspective to develop a 'cultural interpretation' (Creswell, 2013). In turn, this interpretation offers a new understanding of how the culture-sharing group functions. To do so, researchers can ask the following questions: "What is going on here?" (Wolcott, 1999, p.69) and "What do people in this setting have to know and do to make this system work?" (Wolcott, 2010, p.70). Ethnography has gained recognition among a variety of disciplines, and researchers are asking questions to understand cultural experiences relevant to their specific discipline (Erickson, 2011).

Focused ethnography (FE) is an applied research method that limits the exploration to a smaller element of society, rather than a broad cultural group (Knoblauch, 2005). Researchers focus on an issue, situation, or problem within a small subgroup of people. Nurses who practice on a labour and birth unit are their own subculture within the broader profession and culture of nursing, and relate to their own set of values, beliefs, and ideas.

The act of giving birth itself is culturally informed, as social, cultural, and political factors influence a woman's birthing options and outcomes, and socio-cultural values and beliefs towards birth affect the practice of the healthcare providers who care for them (Jordan & Davis-

Floyd, 1993). In addition, each woman and her family have their own culture, which informs their understanding of respect.

Exploring perceptions of respectful nursing care from the perspective of the woman and her family (partner/support person) enhances and expands our understanding of the concept of respect. This research leads to an in-depth understanding of the values, beliefs, and ideas that inform nursing practice in maternity care, and how nurses convey respectful care to their patients and families. This also allows the opportunity to further explore any actions that may be perceived as disrespectful, and to investigate the broader context affecting nursing actions. Exploring patient- and family-centered care as well as examining the historical lens of hospital culture is needed to understand the context in which nurses' work.

FE is well suited for healthcare research as topics important to clinicians or clinical specialities can be explored, and ways to improve care and care processes can be described (Higginbottom, Pillay, & Boadu, 2013). It can be used in nursing research to discover how people from various cultures integrate health beliefs and practices into their lives, understand the meaning that members of a subculture or group assign to their experiences, or study the practice of nursing as a cultural phenomenon (Roper & Shapira, 2000). This method helps to better understand the nurses' experiences of daily work, the context of that work, and the various processes that occur in the clinical setting (Fry & Stainton, 2005). FE is a popular methodology in nursing research. For example, in conducting an extensive literature search, 40 focused ethnography studies were found that included nurses within the authorship, 11 of which were conducted within Canada (Keen & de Chesnay, 2014). Most of these studies were conducted in inpatient and community settings.

Sample

Registered nurses, women, and their families were the appropriate sample to be recruited into the study to answer the research questions, and to understand how respect is experienced and perceived in nursing practice. The experiences of these individuals were situated in labour and birth units to explore the culture of nursing practice.

Registered Nurses

The sample included registered nurses who were, at the time of the study, working on a labour and birth unit in a hospital in Alberta and who were able and willing to complete the research requirements. It was optional for the nurses to maintain a research diary or notes in between two planned interviews as a way to capture their reflections.

Women and their Families

English speaking women who had given birth at a hospital within the 12 months prior to the data collection period were included in this study. It was anticipated that women between six months to one year postpartum would be more interested and available to participate in the study due to the overwhelming nature of the immediate postpartum period and the intensity of caring for an infant. Research suggests that views of women may become more balanced and reflective as time goes by compared to the initial postpartum period that tends to focus on the excitement of birth (Waldenstrom, 2003). It was the woman's choice if she would like to invite and include the family members who accompanied her during labour and birth to participate alongside her in the study. Women could choose to participate in the study with or without their family present. It was not the purpose of this research to link the nurses in the study to the women they attended during childbirth, but rather to gain deeper insight into the nursing behaviors and attitudes that were perceived and interpreted as respectful, or perhaps as disrespectful.

Labour and Birth Units

Initially, two labour and birth units in Alberta were to be observed, but due to factors beyond the researcher's control only one site was used for observations. However, it was possible to recruit nurses from the two labour and birth units from different hospitals. The use of multisite ethnography is gaining popularity and is based on the understanding that culture can exist beyond geographical boundaries (Molloy, Walker, & Lakeman, 2017). Exploring respect through the lens of multisite ethnography lends itself to a broad understanding, across practice sites, of the phenomenon of interest. It also allows for a focused understanding of specific hospital units and individual nursing practice. This is applicable, as the environment in which labour and birth nurses' work can influence their own attitudes and beliefs about birth (Liva, Hall, Klein, & Wong, 2012). This in turn contributes to the culture of nursing practice.

Sample Size

Sample size cannot be predetermined within qualitative research, but rather depends on when a rich and comprehensive understanding of the phenomenon of interest is attained (Creswell, 2013). To have a comprehensive understanding of the phenomenon, it is important to collect extensive details about the participants and sites involved in the research. However, in other focused ethnographies conducted within unit-specific inpatient settings, between 7-15 nurses were included in their samples (Rose et al., 2011; Smallwood, 2009). Therefore, it was anticipated that a sample size of 8-10 nurses, and 8-10 women with or without their family members would be appropriate for the study.

In this study, nine nurses from two hospitals participated in two interviews each. In addition, 13 women who had had a baby in 2019, and one partner participated in a single interview. The women ranged in age from 24-40 years; eight had given birth to one child

previously, 3 to two children, and one to 4 children. All identified at least one person who accompanied them in labour (i.e., partner, mother, doula). All women gave birth at one of the participating hospitals.

Recruitment

Following institutional approval, the executive director of the facility, and managers of the units were contacted, and liaison was made with a hospital research nurse. Nurses were recruited by placing posters in the staff room on the labour and birth units, notice via email in unit-specific newsletters, and by placing a research poster in clinic mailboxes (Appendix D). Women and their support persons were recruited via posters at community health centers and announcements at New Moms Network at specific public health centers (Appendix E). These centers were chosen for their proximity to the chosen hospitals. The recruitment of both nurses and women (with or without their family members) occurred simultaneously as the information gleaned from each group helped further define the interview guide and observation period.

A purposeful sampling technique was utilized to ensure that the participants were able and willing to discuss respect. It was also used to ensure that a wide range of people with varying experiences had been included, which can ensure a more complete understanding of the phenomenon of interest (Roper & Shapira, 2000). Snowball sampling was also utilized as participants often are able to identify other people who would be 'information rich' and appropriate for the study (Creswell, 2013).

Data Collection Methods

In focused ethnography, data collection tools may include observations, formal and informal interviews, and review of available written materials (Fetterman, 2010). For this study,

semistructured interviews and non-participant observations were conducted, and relevant documents including research diaries were reviewed.

Interviews

Interviews are used to explore participants' perspectives and experiences as described in their own words, and to understand how they make meaning of their everyday world (Kvale, 2007). Semistructured interviews were used to explore how participants describe the phenomena of interest within the context of their daily lives (Kvale, 2007). While semistructured interviews can provide direction, they remain fluid and open to change.

Interviews were conducted between April to November 2019. As planned, open-ended questions using a semistructured interview guide was conducted with the nurses and women/family (see Appendix F and G). The guides continued to shift, change, and develop throughout the research process as ideas emerged from the data-collection methods. Examples of additional questions posed to the nurses included: how do you facilitate a respectful relationship to the partner/family, how would you describe the culture of the unit, when is it challenging to provide respectful care, and how do relationships with colleagues influence your ability to provide respectful care? The nurses completed two interviews approximately two months apart. Between the interviews, they were invited to reflect on respect within their practice in a research diary or through voice memos that they were willing to share with the investigator. In the final interview, their diary entries or voice memos were explored by providing an opportunity to discuss the data collected. The interviews were audio recorded and transcribed verbatim.

Non-Participant Observation

Observation is another data-collection method often used within ethnographic research. Observation provides an opportunity to gather data about a phenomenon in the real-world

context, free of interpretation from others (Caldwell & Atwal, 2005). In focused ethnography, participant observation is episodic, conducted within specific timeframes, and may even be deleted (Morse, 2007). When participant observation is deleted, it may be replaced by hypothetical scenarios or structured vignettes to elicit views within interviews (Higginbottom, 2006).

The act of giving birth is a very private and transitional moment, so directly observing childbirth within individual patient rooms was not included in the conduct of this research. However, observation of the dynamics of labour and birth units may uncover additional knowledge related to the culture of nursing practice. The nurses involved in the study were not directly observed in practice, as it was the labour and birth unit that was the focus. Episodic non-participant observation sessions were utilized throughout the research process to gain further insights into the concept of respect.

It was anticipated that the data-collection period would be approximately three to six months with six to eight observation sessions per clinical unit. As events occurred that were beyond the researcher's control, observation became available at only one of the clinical sites and was limited to five sessions over a one-month period. The observations occurred in the open spaces on the unit such as the hallways and at the nursing desk. Patients' rooms, meeting rooms, and offices were not included because of confidentiality and privacy reasons, and as such only limited data were gleaned. Observations did contribute to the interview guide, and enhanced conversations with the nurses. The nurses were able to articulate the nursing culture of the unit, and thus respond to the research question.

While I am an outsider to the hospital units, I do understand obstetrical nursing practice, including the labour and birth process, common terminology used, and best practice guidelines.

This prior knowledge assisted me during my observations, and provided justification for a shorter, more focused observation period. As it was not the intent of this research to quantify respect, a checklist was not used, but rather descriptions of the setting and interactions that occurred were collected and examined. These descriptions included observations about the unit layout, conversations among colleagues at the nursing desk, and any interactions that occurred with patients and their families outside of their rooms while in the public space. The information gleaned from the interview process informed the observational sessions and vice versa. Minimal informal conversations were conducted with staff during the observation periods. Observational field notes were taken, including both descriptive and reflective notes.

Relevant Documents

A wide variety of documents may be analyzed within FE, including "policies, procedural documents, epidemiological and census data, maps, photographs, patient records, test results, and biographical methods" (Higginbottom, Pillay, Boadu, 2013, p. 5). Written material available in the public space on the unit and relevant material related to respect within Alberta Health Services public website was reviewed. Patient charts were not examined throughout the conduct of this research as the focus of the research was nurse and patient perception and experience.

Due to the complex nature of respect, it was anticipated that some nurses might have difficulty articulating their thoughts around respect within their nursing practice; therefore, the nurses were invited to keep a research diary between interviews one and two. The purpose of the diary was to provide an opportunity to self-reflect on how the concept of respect is incorporated into their day-to-day clinical practice with women and their families. Research-driven diaries or solicited diaries that individuals are asked to keep for research purposes and are often focused on a particular subject provide an alternative form of self-expression in the research process (Elliot,

1997). Reflective journaling has been identified as an effective data collection tool in ethnographic research (Clayton & Thorne, 2000), and is strongly recommended as part of a multiple-method approach (Meth, 2003). It also provides a temporal aspect, offering longitudinal insight written in the moment, representing a recent account of an experience (Meth, 2003). Solicited diaries can increase the visibility of the routine and everyday experience and are an appropriate method to explore sensitive data (Kenten, 2010). Diaries can be a substitute for observation in settings where the researcher is absent (Elliot, 1997), as in the labour and birthing clinical room. The diary approach can include the participant as both an observer and informant, and can be used in conjunction with a diary interview as an approximation to the method of participant observations (Zimmerman & Weider, 1977). However, the use of a diary does require commitment from the participant and an ability to articulate their experiences.

Reflection and interpretation are crucial to learning, enhancing judgement, and decision making in the nursing world (McKinnon, 2016). Developing a therapeutic relationship with others involves self-awareness; knowing how our behaviour and actions affect others is important (Wilson & Crowe, 2008). This is particularly relevant within the context of this research investigation of the experience of respect. Nurses were instructed to reflect on the concept of respect as provided towards women and their families in their daily practice within 24 hours of working a shift.

The timeframe for keeping a diary varies in the literature from 7 to 14 days, 3 to 6 weeks, to 6 months (Elliot, 1997; Kenten, 2010; Meth, 2003; Skott & Eriksson, 2004; Valimaki, Vehvilainen-Juljunen, & Pietila, 2007; Zimmerman & Weider, 1977). In this research, the nurses were asked to record their reflections for approximately ten shifts, which varied in time depending on employment status. It was anticipated that this timeframe would be sufficient to

obtain data on the subject, but not too time consuming and onerous for the nurses. They had the option to either write their thoughts down or speak their thoughts into their personal smart phone or other recording device, which would be transcribed for analysis. Anything the nurses felt would relate to the concept of respect (or lack of) towards women and their families as experienced in their practice was included. This could take on the form of words, stories, thoughts, or questions, and was used to guide their second interview as well as contribute to the data analysis. Four nurses provided a written document with clinical stories as well as reflections on respectful care, while three others wrote down key words to trigger their memory during the second interview. This diary interview allowed the researcher to expand on the written material and seek further understanding of the experience (Zimmerman & Weider, 1977; Kenten, 2010). The other nurses used their memory recall to discuss recent clinical stories.

Data Analysis

It was anticipated that a large amount of data would be collected during the study period from the various data collection methods (interviews, observation periods, documents, diaries). The data collected was transcribed into words, which was "at first grouped into meaningful segments and then organized to compare, contrast, and identify patterns that shed light on beliefs and practices of the people in (the) study" (Roper & Shapira, 2000, p. 94). It was important to identify and follow a data analysis process which helped organize and understand the data so it could be analyzed concurrently with data collection (Roper & Shapira, 2000). Data analysis began at the start of the research process, was driven by the data and informed what additional data was then collected throughout the study (Roper & Shapira, 2000).

The steps described by Roper & Shapria (2000) were followed alongside the use of NVivo, a computer analysis program. The steps included coding field notes and interviews,

sorting data to identify patterns, generalizing constructs and theories, and memo-ing to note personal reflections and insights. These steps are not linear but iterative as one moves back and forth between steps throughout the process. During coding, key words were identified and words that were repeated several times were noted; patterns that emerged were identified, leading to a broader understanding of why things happen. Once the data were coded and patterns emerged, greater understanding was gained from both the emic (insider) and etic (outsider) perspectives, which led to the development of theoretical constructs to explain the study findings. Personal reflections were used throughout the research process in order to understand my etic perspectives related to the phenomenon (Roper & Shapira, 2000).

In qualitative research, an inductive understanding of the participant's world leads to an analytic understanding of how they view themselves and the world around them (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014). Qualitative research uses inductive reasoning to pose questions to explore a phenomenon, and then generates a theory from the data collected. While inductive logic infers a building up of themes from the data collected from the participants, researchers also use deductive logic, that is the themes are constantly being examined against the data that were collected (Creswell, 2013).

Rigor

It is important to conduct a research study that is both valid and reliable to ensure rigor. In qualitative research, the term trustworthiness was developed by Lincoln & Guba (1985) and is commonly used to describe rigor, yet the use of the term is heavily debated among researchers (Morse, Barratt, Mayan, Olson, & Spiers, 2002). Trustworthiness is explored through the following questions: "How can an inquirer persuade his or her audiences (including self) that the

findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue?" (Lincoln & Guba, 1985, p. 290). To support trustworthiness, the following criteria were operationalized: credibility, confirmability, transferability, dependability (Lincoln & Guba, 1985). A critique of Lincoln and Guba's (1985) work is that they are too focused on employing trustworthiness at the end of the study rather than integrating processes throughout the research (Morse et al., 2002). Therefore, it is necessary to ensure that rigorous processes are in place during the research process and not just post hoc evaluative assessments (Morse et al., 2002). This can be achieved through the following strategies: investigator responsiveness, methodological coherence, sampling adequacy, saturation, and an active analytic stance (Morse et al., 2002). These strategies were used to support the conduct of a rigorous research study.

To ensure investigator responsiveness, ongoing analysis was conducted, congruent with the analytic procedures used in focused ethnography. I kept a reflective journal which encouraged continuous self-critique throughout the research process. While I have prior experience as a labour and delivery nurse, I am no longer practicing in that clinical setting, and I am aware that my previous experience may not apply to the current context. I do possess some insider (emic) knowledge related to the process of labour and birth, and obstetrical nursing practice, but I remained an outsider (etic) to the current clinical experience. Obtaining reflexivity through a reflective journal allowed me to identify any biases that existed and examine their potential influence on the data and the interpretation of the data (Roper & Shipera, 2000).

This research endeavored to ensure methodological coherence between the research question and the method being used. An audit trail, a detailed record of the data analysis that included information regarding how the researcher came to her conclusions, was maintained

(Wolf, 2003). The supervisory committee and I remained in close and consistent contact throughout the entire research process.

Within focused ethnography, one does not spend a prolonged period in the field, but the data-collection period continues until an understanding of the phenomenon is reached and sufficient data are collected. This occurred by achieving an appropriate sample to discuss the concept of respect. Two semi-formal interviews were conducted with the nurses to ensure adequate understanding of their experience and the consistency of their perceptions over time. In addition, interviews were conducted with women who gave birth within one year and the research continued until no new themes were generated. Data were analyzed during the collection period to inform the research process.

Triangulation is when researchers use a variety of sources to develop a theme or perspective (Creswell, 2013). There are four different types of triangulation: the use of multiple sources, methods, investigators, and theories (Denzin, 1978; Lincoln & Guba, 1985). In this research, a variety of data collection methods (observation, document analysis and interviews) from multiple sources (nurses, women, families) were used, which contributed to triangulation. Investigator triangulation was applied through independent readings of selected transcripts by me and the supervisory committee, and subsequent discussion of how themes emerged.

Ethical Considerations

Ethical, Operational and Site Approval

The following ethical considerations were made in this research to protect the participants, maximize their benefits, and minimize their exposure to harm. The Tri Council Policy Statement 2: Ethical Conduct for Research Involving Humans (2014) was used as a resource to develop the research proposal, and as a guide throughout the research process. Prior

to initiating data collection, ethical approval was obtained through the Human Research Ethics Board Health Panel (Study ID: Pro00085738). Once ethical approval was granted, operational approval was obtained through Northern Alberta Clinical Trials + Research Centre (NACTRC) for the hospital units and the public health centers. The executive director of the hospital and the unit managers of all participating labour and birth units and public health centers were contacted.

Informed Consent

Nurses and women/family members who were interested in the research contacted the researcher via email or research phone number. The participant information letter that included the contact information of the research team, purpose of the study, benefits and potential risks was reviewed with each participant to ensure that they had the required information to make an informed choice (see Appendices J, K, L). If the individual chose to provide consent, their signature along with that of the researcher was obtained, and they were given a copy of the signed documents. It was made explicit to these individuals that their consent was voluntary, and that the last point that participant data could be withdrawn was within two weeks after transcription of the interview notes. At that point, identifiers were removed, and the data were no longer linked to the participant.

Limited nonparticipant observation was conducted in this study which included observing public spaces within the labour and birth units, such as the nursing station and the unit hallways. Observations were not conducted in individual patient rooms and no personal information was collected. An information letter about the purpose of the observations was placed in the staff room and emailed to the staff by the manager prior to the observation period (See Appendix H). During the observational periods, a poster stating observation was being conducted was placed on the nursing desk (See Appendix I). According to article 10.3 in Chapter 10 of the Tri Council

Policy Statement 2: Ethical Conduct for Research Involving Humans (2014), consent was not required as this research activity is considered minimal risk and no personal information was collected during the observation period. Further, the number of individuals on a clinical unit would make it impractical to obtain formal consent from everyone.

Confidentiality and Privacy

To protect the privacy of participants, the interviews were conducted away from the hospital setting at a location mutually agreed upon by the researcher and participant. All data (audio files, transcripts) were uploaded to the University of Alberta Health Research Data Repository (HRDR). All audio files were transcribed verbatim and all identifying information, including names, were removed. A professional transcription service was utilized after signing a confidentiality form. All contact information was kept in a locked cabinet at the University of Alberta, any computer used was password protected, and any USB stick was encrypted. The nurses who kept a research diary were instructed to remove any identifying information. They had the option to keep their diary, or consent for it to be stored in a locked drawer at the University of Alberta for a period of five years. While nurses had the option to record their thoughts on their own personal recording device (e.g., smart phones), no nurse chose this option.

Conclusion

A focused ethnography was the appropriate method to answer the research questions: how do nurses, women, and their families perceive and experience respect during labour and birth; and what is the culture of respectful care during labour and birth? This research led to an in-depth understanding of the complexities surrounding respectful nursing care on the unit. The sample included nurses working on two labour and birth units, women who had given birth within the 12 months prior to data collection, along with one accompanying partner, and one

labour and birth unit. Data were collected by conducting semi-structured interviews, non-participant observations, and a review of relevant documents including research diaries maintained by the nurse participants. Data analysis was completed using NVivo, following the steps outlined by Roper & Shapria (2000). Rigorous strategies were used throughout the research process, including triangulation, investigator responsiveness, methodological coherence, sampling adequacy, and an audit trail. The appropriate ethical and institutional approvals were obtained.

Chapter 4 Findings

The findings are derived from data collected through interviews, observations, and document reviews. While all three methods were utilized, data were principally obtained through interviews with labour and birth nurses, and women who had given birth within the previous year. These interviews informed each other and provided a deeper understanding of the concept of respect in nursing practice. Observation was used to orientate the investigator to the space and general activity of the unit while the interviews were conducted to provide the context and clinical vignettes. All nurse participants were invited to record their observations and thoughts in between two interviews. Data from all sources were analyzed and woven throughout the findings.

In this research, the meaning of respect was explored, specifically what it means for nursing practice within the context of patient- and family-centered care, and what is the culture of care surrounding respect. The nurse participants were able to identify what contributed to their ability to provide respectful nursing care and what made it challenging to do so. While the focus was on the relationship between the nurse and the childbearing person, it quickly became apparent that this relationship was impacted by the environment in which the nurses work, including relationships held with other healthcare professionals. The experiences that the women participants (plus one partner) shared were congruent with the information shared by many of the nurses, and provided insights into how nurses provide respectful care, as well as suggestions for improvement. The women were able to identify the actions that made them feel respected as well as those that that made them feel disrespected.

Having both perspectives provided a comprehensive understanding of the phenomenon and allowed for verification and triangulation of the research findings. Stories from the nurses

and women, as well as data from observations and written materials is interwoven throughout the findings. In analyzing the data, the following general themes emerged: creating space; shifting autonomy; navigating relationships with colleagues; and nursing in the middle.

Creating Space for Respectful Relationships

The theme creating space refers to the elements that foster a respectful birth environment. Within this space, it is important for the nurse and woman in labour to develop a supportive and collaborative relationship, ensuring that privacy, seeking permission, and preserving dignity exists to foster respectful care. In this space, it is necessary for nurses to support those accompanying the woman in labour (i.e., partner, family, friends, doula) and to accommodate diversity. While providing respectful care is key to creating an optimal space for the transformational experience of birth to occur, there were also times disrespect occurred, which will be elaborated on further in the findings.

Building A Collaborative Relationship

Building a collaborative relationship with the labouring person was identified as critical to fostering respectful nursing care. Being able to spend time with a woman and her family, and being able to understand her as a person, helps nurses to enter an in-depth relationship that fosters respectful interactions. This is illustrated in the following excerpts from interviews:

> You don't know how that patient is going to respond to that until you get to know them as an individual. And we have very limited time to do that, but I think that that's really an important component of respectful care, is recognizing where your people are coming from. (NURSE 3)

> I feel like that's a huge part of respect like developing a connection because then it makes them less likely to feel like they're just a number that's just like being pushed through the room. It makes it feel like they're being treated as a person. (NURSE 1)

As identified by some nurses, respect goes beyond listening, but rather is enacting and actively partnering with the labouring woman and her family. It also involves the nurse in being fully present in order to create this birthing space and, as noted by one nurse, emotional, mental, and physical presence is very important in creating a respectful birthing relationship and experience. A few of the nurses identified that respect starts with professional obligation, and needs to be provided regardless of whether or not it is reciprocated. As one nurse stated:

> I feel like as a nurse it's our obligation. It is part of who we are as nurses to respect our patients, respect their families, respect our colleagues and stuff, but at least when it comes to the patients and their families there isn't always that respect back. (NURSE 4)

The participants identified the nurse as a key person in their birth experience. One woman was able to describe how the nurses' involvement, and in turn their relationship with their patients can affect their experience:

> The nurse is going to be the one that's kind of guiding you through a lot of it and it makes a big difference in your experience and whether they're actually present or if they're just hanging out at the nursing desk and checking on you in intervals. (PARTICIPANT 13)

Attending to the needs of the birthing woman was important in developing a relationship, whether it was assisting with comfort measures, coaching during contractions, or using soothing and reassuring tone. The nurse was often remembered by the women:

> When I think about labour happening, the two people I remember are my midwife and the nurse like being right there at my side. And I remember my husband too, but he was almost like secondary to those two. (PARTICIPANT 7)

The idea of a mutual relationship was emphasized by the women, as several described respect as being about treating others how you wish to be treated. One woman voiced her perspective, "If you're a good patient then you're going to have a good nurse" (PARTICIPANT 8). When probed further, this participant described a good patient as someone that does not yell at or argue with the staff. While treating others as you want to be treated was identified as a basic tenant of respect, a few women acknowledged that being respectful to patients was integral to the role of the nurse. One participant mentioned that it is expected of those who are in a position of authority, such as a nurse.

The nurses expressed their belief that showing respect and holding space for women and their families by meeting them where they are at physically, emotionally, and intellectually are essential to provide patient-centered care. A few nurses recognized the importance of acknowledging and minimizing the power differential between nurses and patients in order to create a safe space.:

> I know as nurses we need to remember that our patients are probably going to see us higher than they are, almost not as equal and we need to come down and remember even simply things like trying to be at the same eye level as them so grabbing a chair and sitting down, instead of standing above and talking to them. (NURSE 4)

Another nurse discussed assessing and matching the body language exhibited from the family as a way to be respectful:

> …and then what is the body language you are looking at, [be]cause you can say things like ya open, open, open but if a person has closed body language you can meet them at that, and they should be ok with it, or you can try either way or go back a little bit and if they are like no, then open up more. It's the ability to assess that. (NURSE 7)

Embedded within meeting people where they are is a sense of empathy by the nurse to be able to understand and respond to their needs:

> Respect to me is being empathic to the other person and trying to understand where they're coming from, trying to understand their situation, and trying to reflect whatever emotions, I guess they're showing me, back to them and just showing that I understand. (NURSE 1)

Lastly, one nurse also identified the importance of speaking to the patient at the appropriate health literacy level, therefore using language that the patient and family can understand.

As labour and birth is continually progressing, it is important for the nurse to continually reassess a woman's needs throughout her labour process and be able to adjust accordingly. One nurse described a situation where a woman was "out of control" during labour. This nurse discussed the various actions that could have taken place including yelling at the patient or forcing her to do something, all things she has witnessed in the past. In this moment she knew what was the most appropriate, and in turn, showed what she regarded as respectful and compassionate nursing care:

> So, I just sat down beside her and I took her hand and I said I'm just going to sit with you until you are ready to have your baby. And when you're ready just let me know. And she just, like, looked at me like what? And then I kept repeating myself. I'm not going to

> force you to do something so when you are ready, just let me know. But I did this for, like an hour and a half …until she was delivered and repaired. (NURSE 9)

Being in tune with and meeting women where they were in their labour was also important to the women participants. One participant described boundaries as important to her understanding of respect, including recognizing and providing physical and emotional space. Another participant recalled her nurse being in tune, being able to read her body language, knowing when she was ready to begin pushing. Showing empathy was important and was integrated into respectful care according to several women. One participant recalls being required to walk to the labour and birth unit because there were no wheelchairs and the nurse was saying, "I know this is hard. Take as many breaks as you need to" (PARTICIPANT 6). This was in contrast to another woman participant who discussed how she was forced to walk to the labour and birth unit after she told the nurse she could not walk. She felt that she was not listened to and in turn was disrespected. When talking about the link between respect and empathy, a woman said, "I feel like maybe, they don't respect you as much because they're not trying to empathize with the situation, especially when it's a harder situation" (PARTICIPANT 6).

The experience of labour and birth is riddled with moments of vulnerability. Providing privacy and asking permission for any procedure is identified as an important part of respectful care and in creating a safe birth space. Nurses work with many women in labour, and it can be easy to get into a routine and not realize how each intervention can impact a woman. As one nurse shared:

> Not uncovering them…without asking them, respecting their privacy, not just throwing monitors on without asking. I think we are so use to working with women that sometimes we think it is ok to just go in and be 'hands on' but I think it is important to remember

> that not everyone is use to that. Remembering to explain to them I am going to uncover them if that is ok with you, I am going to examine you if that ok, and explaining to them I am going to touch your leg first and things like that because I think way too often we go in and say, 'I'm going to check you' and they just do it before the patient probably knows what is going on. (NURSE 8)

Another nurse stated:

> Even something as easy as just making sure the doors are closed when the patient is being exposed or like, making sure the curtains are pulled or those little simple things that can make it better, right? (NURSE 5)

Maintaining dignity is important for women during labour. One woman participant discussed how she appreciated the comforting and respectful manner of the nurse who helped her get cleaned up during labour.

Supporting The Family

Supporting the individuals that the labouring women brought with them was identified as important to providing respectful care and in creating a comfortable space for the birthing woman. The family may include the woman's partner, other children, extended family and friends, as well as members of the birth team such as a doula or birth photographer. The nurse participants acknowledged the importance of including the family, as defined by the birthing woman, in the care of a labouring woman by involving them in the plan of care, seeking their thoughts, and answering their questions:

> Typically, I think of respect as being an equal thing, but there are many times particularly in a birth setting where not every voice within that group is going to be equal because obviously certain people are not going to be making the decisions for the laboring woman.

> She needs to ultimately be the one who makes her own decisions, but I think it is important that her partner or the people she wants feedback from have the opportunity as well to be heard. (NURSE 4)

It was also deemed important to keep in mind that the family is the unit that will support the woman and child when they go home, therefore necessary to involve during this life transition:

> When you are talking to the patient you are not just talking to the patient, you have to be talking to everyone in the room. So, you have to get the eye contact, you gotta listen to what their concerns, answer those concerns, address those concerns cause although it may not be important for the patient, the questions they are asking, it is important for the family members to feel that comfort during certain processes, whether we are worried about the fetal heart rate, or they are wondering about some type of pain management and the effect on the baby. . . or the patient. (NURSE 6)

For these nurses the importance of family-centred care was evident:

> I think you just need to keep in mind …that the family is including them and explaining to them also and teaching them things they can do to help, cause really, I think they are just worried about who they are with, like their person. I think especially in labour and delivery family centered care is huge. (NURSE 8)

Including the family in the care meant having everyone the woman wants to accompany her present in the room. One nurse stated, "Respecting that the family is involved as well, not just the patient. You know, families are never asked to leave the room, never" (NURSE 4).

There were times when nurses wondered if the family was being a burden to the patient, but unless the patient directly told the nurse to interject with the family, the nurse continue to support everyone in the room:

> I could tell at times the patient was a little frustrated with her and the patient upon occasion asked the mom to you know, go take a break or whatever, but you know it was never my role to ask her to leave in this situation. I needed to take my cues from the patient and see where she was at. (NURSE 4)

Another nurse said that she really disliked visiting hours and felt that the family should always be with the patient. The participating nurses acknowledged that while most of them do support whomever the patient wants, not all nurses practice the same way, and at times unit culture can make this challenging. This issue will be discussed further in the theme of navigating relationships. One nurse described, as an example of respecting the patient's request, a situation where a birth photographer was allowed in the operating room, but such accommodations are not always possible. One woman participant also described how important it was for her to be able to have her birth photographer attend her caesarean section, how she cherishes her pictures, and how grateful she is to the staff for accommodating her request.

When asked specifically about how they show respect to the partner and involve them in their care, some nurses noted that they encouraged the partner to support the woman's legs during pushing or asked them to get water or ice chips. One nurse described the importance of guiding the partner to support a woman:

> I said, 'do you mind if I put my hands on your back and I would like to show your husband something', so it wasn't so much I am going to take over, 'I am going to show your husband a way to alleviate this pain but if you don't like it, it's your body you can say don't touch me'. It's not taken personally and then when I put pressure on her back it was immediately like, 'ahh', and then I just handed that over to her husband and the power was back to them. (NURSE 7)

This demonstrated respect for the woman, her partner, and their relationship. A few women commented on how their partner was involved in the birth by holding their legs or helping count during pushing, while others recalled their partner being more on the sidelines of the experience. Only one partner participated in this research, so it is not possible to glean information on the families' experiences of being involved in the birth experience.

The nurses also discussed how they nursed the family by extending their nursing practice to include the woman's family members. They attended to the needs of the family members and tried to ensure that they were taking care of themselves during the labour and birth process, "Also trying to make sure that they're taking care of themselves, so you know go get something to eat, maybe lay down and have a little rest it's okay" (NURSE 4). Another nurse said, "It's also paying attention and making sure they are not overwhelmed with that task. I do find that giving them that small task gives them something to focus on and gives them something to do in the delivery" (NURSE 2). Just as the nurse recognized and attended to the needs of a woman in labour, the nurse also attended to her partner and family members, recognizing if they needed a break, a warm blanket, or something to eat.

Lastly, in order to provide family-centered care, nurses reflected on their role to provide nursing care, respect the wishes of the patient and family, and be present for the experience:

> I find for labour and birth nurses, to ultimately respect patients and their families and the whole transition to becoming a mom is knowing that this is not about them. It is selfless, it is about our care, but it is not about us. You have to give that up. (NURSE 7)

For this nurse it was important to acknowledge that the experience was about what the patient needed and wanted, rather than attending to their own wants and needs.

Responding to Diversity

The nurses on the unit care for a large number of women from diverse cultural and ethnic backgrounds, including a large proportion of Indigenous and newcomer populations. When sharing a story about supporting an Indigenous woman in labour, one nurse highlighted the importance of mitigating structural barriers, and working with the family members in order to meet the patient needs. By collaborating with family and colleagues, the nurse was able to integrate cultural components of care by providing nursing care such as fetal monitoring around the needs of the woman, and developing a partnership with the family:

> That was like, probably my, like most respectful birth I've even had and it's really because rather than seeing the family and the patient as barriers to the outcome that we want, they were really, like part of…an integral part of the care that was being delivered. (NURSE 3)

Working with people from backgrounds and ethnicities that were different from their own was identified as challenging by participating nurses. They commented on how respect can be subjective, while actions that one person perceives as respectful can be perceived differently by another depending on their cultural background and personal preferences. Such activities included providing touch for labour support, or exposing certain areas of the skin. At times it was difficult to know the appropriate action to take or the words to speak, which can lead to hurtful and unintended moments of disrespect. One nurse described a time when she thought she made an innocent comment, but a family member took offence:

> I felt quite badly about it cause you know you don't want to be offensive to someone or disrespectful to someone but sometimes there is an ever changing set of rules we are all trying to function under, its hard sometime to know where the boundary [is)]. (NURSE 9)

The nurses identified that labour and birth can be expressed differently depending on the persons' experiences and backgrounds, which can be challenging if it is outside the expected norm of behaviour. One nurse said:

> Again, with cultural differences, we have some women who are extremely well at managing their pain and very good at internalizing it. . . So those patients get stuck in the assessment room or the emergency or in the triage room for hours through their whole labour because we can't see that they are feeling [pain]. So, there are times when they are so internalized about it that they end up getting to 10 cm and deliver in our poor little assessment room. (NURSE 2)

Perhaps as a result, women who express labour in a way that is unexpected or divergent from the 'norm' may not receive timely or high-quality care. Written documentation from one of the nurses demonstrated that this nurse struggled to understand respectful care and felt that respect in childbirth is always at risk for patients who do not fall in line with the standard patient model (i.e., takes prenatal classes, brings in only her partner, has an epidural, delivers a healthy baby who breastfeeds well). Patients who differed from this were more likely to experience disrespect for a number of reasons; they required more work, more tolerance of ambiguity, and more time from the staff.

Another example provided by a nurse included women who appeared to the healthcare team to be exaggerating their pain. One nurse overheard the use of the term "ethnic drama" by another healthcare professional, which she interpreted as overreacting or showing too much emotion in order to get attention that is associated with people of certain cultural backgrounds. The nurse participant was appalled by the use and interpretation of this term.

People whose first language was not English provided a challenge to nurses concerned with providing respectful care as the nurses wondered if the patient understood enough to be fully informed and was receiving the care they wanted or needed. One nurse commented:

> There are times where you question whether, especially if the woman does not speak English, that what you are being told by the family is actually what the woman feels or is it what the family has decided is right for the woman. (NURSE 4)

While nurses spoke about using the phone translation service or google translate it was not always the most effective tool with a woman who is experiencing labour and birth; therefore, they often used the family for interpretation services, which is not ideal. One nurse described a situation when a partner delayed telling the nurse what the woman was saying because he thought she was "just being hysterical" but the situation turned out to be an emergency (NURSE 9). This patient safety concern impacted the nurse's ability to create a safe and supportive birth space. On the unit, epidural patient information sheets were translated into five languages (Somali, Vietnamese, Chinese, Japanese and Spanish) and were available near the epidural cart but all other visible unit material was written in English.

Ethnic diversity was not collected as demographic information and was not a specific focus of this research. English was the first language of all participants in this study. Further research is needed to examine newcomer and immigrant experiences with respectful care. It is also vital to seek experiences of Black, Indigenous, and People of Color (BIPOC). One woman participant self-identified as Indigenous during the interview. She participated in smudging as a cultural practice while in the hospital and had a physician who advocated for her wants and needs. She did not identify any specific concerns with her labour and birth experience; however, she did express some concerns with how she was treated during her postpartum experience.

Shifting Autonomy Amid Pain and Vulnerability

Honouring a woman's autonomy during labour and birth and engaging in positive communication strategies were identified as respectful actions by both the nurses and the women. Listening, being open, and trying to understand where a patient is coming from was identified by several nurses: *"*To me, respect is acknowledging the autonomy, dignity, and capacity of every human being" (NURSE 3); *"*Respect to me is people are autonomous in their views. It's doing little actions as well, putting yourself in someone else's shoes, if you were in that position what would you want" (NURSE 2); *"*I think that one of the most respectful things that we can do for a patient is actually listen to them" (NURSE 6). Positive non-verbal communication was also identified as important to being respectful and to being aware of how cues such as eye rolling, impatient sighs, or showing disgust can impact a patient.

Though deemed important by the nurses in this study, the idea of autonomy seemed to be fluid; at times during the process of labour a woman's level of autonomy could shift with the unpredictable nature of birth. The ability of the nurse to fully honour a woman's autonomy also seemed to shift. This may be easy for a nurse to do when the woman's wants and needs align with the needs of the provider and institution yet may be difficult to do when they do not. This seemed especially true when the woman refused an intervention or went against medical advice, and during emergency situations. Shifting autonomy may also be related to a woman's self-confidence and awareness as labour progresses, and the result of changing dynamics in the nurse-patient relationship.

Engaging in Positive Communication

Birth plans were identified as a tool that could be used for open communication with a birthing woman to provide guidance on what the family expected and wanted out of the labour

and birth experience. A birthing plan may include the woman's preferences for pain management and interventions, as well as their beliefs surrounding childbirth. Discussing within the birth plan what can be done, and what may not be possible and why was identified as a respectful nursing action. While the birth plan is a way to explore the wishes of the family, the nurses identified it as a strategy to understand the underlying beliefs, values, fears, and experiences that inform the family's understanding of birth:

> Ya, I try my very best to try and understand where they are coming from and why that birth plan is so important to them because I think a lot of the time it's from past experiences or experiences from people they know. (NURSE 8)

Another nurse said:

> I read their birth plan through very carefully to get a sense of what is it they are trying to avoid. And some of these birth plans are really very extreme, which is fine but there tends to be some common thread in their birth plan, if they have a million things about the moment of birth, then typically they have some issues with connection and bonding with their baby. (NURSE 9)

The nurses who participated in this research all valued a birth plan yet acknowledged that this was not typical among their colleagues. There was a perception that when a woman brings in a birth plan she sets up herself up for failure. Another nurse described a saying that is commonly used that implies a long birth plan is associated with a caesarean section, which is detrimental to forming a respectful relationship. This same nurse commented that having that perception can influence that woman's birth experience and outcomes. Some nurses also expressed apprehension about caring for women who bring in long detailed plans as this can signal that the labouring woman does not trust the medical system making it difficult to build a relationship.

However, another nurse commented that a detailed birth plan provides the nurse the opportunity to explore issues of control, and the underlying thoughts and feelings behind the long birth plan in order to develop a respectful and therapeutic relationship. Being unable to fulfill expectations and requests presented in the birth plan was another concern. One nurse participant estimated that only 50% of birth plans were actually followed through.

Some nurses expressed frustration that patients often did not seem to critically think about their plan, but rather obtained copies from the internet that were not necessarily applicable to the woman's individual situation, or did not incorporate evidence-based requests such as refusal of the Vitamin K injection. The nurses commented that they had witnessed their colleagues ridicule, and at times mockingly disregard a woman's birth plan:

> When people come in with birth plans I think it is really easy for people to sit there and be like "oh gosh look at this this is so ridiculous" but I think it is really important to know where they are coming from in the birth plan and why it is so important to them. (NURSE 8)

One nurse commented how using strong language on what they do not want done may offend nurses, and that using more positive or polite wording was suggested. In addition, having a more open versus strict plan was supported.

The women participants also voiced their belief that autonomy and effective communication were important components of respectful care. Being heard and supported in a non-judgemental way were identified by several women:

> You want to feel part of the decision-making process. If you're going in there and you feel like you've prepared yourself and informed to the extent in understanding that things

> happen during birth that you don't have control over, but still there are some things that you can control. (PARTICIPANT 11)

As well as being informed and supported, women voiced that they appreciated not being criticized or judged, and being able to make an informed choice and provide informed consent was considered an integral part of respectful communication. As one woman stated:

> So that's kind of huge to me, being given the information about whatever's happening so that I can make an informed decision and be my own advocate because I mean as much as I respect and can trust medical professionals, I feel like at the end of the day I also know my own body. (PARTICIPANT 7)

Another woman identified how communicating with, and having the healthcare team advocate for her wishes contributed to her positive experience, despite the outcome:

> They did a really good job of levelling with us and explaining, no we've got to move things along…most people would probably look back at our experience and say it was traumatic or negative or whatever, but that definitely made it, I would say a positive experience. (PARTICIPANT 8)

While being informed was identified as important, it appeared that consent was not always provided for all procedures. While she had a positive experience, one woman stated, "I don't know what other consent was really required, aside from my epidural, which I obviously gave consent for" (PARTICIPANT 10). Other women did not report positive experiences. *"*They were very forceful. Like they didn't really take what I was saying, or how I was feeling into account is where the respect comes in. Like I just didn't feel listened to at all" (PARTICIPANT 2).

Several women prepared a birth guide and identified this as a tool to open communication and identify their needs. One woman recalled sitting down and reviewing her birth plan with her nurse and talking through any questions. Another woman who prepared a birth plan was explicit about her preferences for pain management, and yet was asked repeatedly if she would like a certain intervention. This, in turn, made her feel that she was not listened to, and that her needs were disregarded. Integrating birth plans was deemed to be important to women participants. One participant noted:

> It's respecting something I wanted, something I did, took time to do to make their job easier. Everything was so clearly written and stuff. And it wasn't like small fonts. Like I made it larger fonts and like bullet point not even paragraphs. Like super easy to read. (PARTICIPANT 2)

It is interesting how this comment notes that the birth plan was written in part to make the healthcare team's job easier. Even though the plan was written so that it would be easy for the healthcare team to read, it was not utilized.

A few of the women were discouraged by healthcare professionals from writing a birth plan. One woman said her doctor discouraged her because of what happens when it doesn't go according to plan, and another said that she was told in her prenatal class that a birth plan would set her up to be disappointed. Several participants decided that they did not want or need a birth plan. The use of birth plans will be further explored in the discussion section.

Dealing with Challenging Decisions

Some nurses identified that it is challenging to work with families when they are going against medical advice and appear to disregard the opinions of the healthcare professionals. As one nurse commented:

> You know they are arguing with patients about whether or not they can smoke or not, that is very disrespectful, like we can't support the position as nurses, which is what I always say, "I'm a nurse, your pregnant, what do you think I have to say to you", but I am also not running a prison, but there are nurses that will make you sign an Against Medical Advice for every little misdemeanour you have. . . she doesn't need to be berated over and over. (NURSE 9)

Another nurse commented on how she could lose respect for a patient or family if they are refusing something that she feels is not evidence based:

> So like I feel like if you don't have a valid reason for rejecting that care then maybe I'm less likely to respect you. I can respect women who don't want epidurals because there is research behind that, but if you're rejecting Vitamin K, I don't understand why. (NURSE 1).

Nurses identified that it was challenging for them when a fetal demise occurred, but especially when they perceived that the death was the result of the patient and family refusing medical care, and that the newborn's life would likely have been saved if the care had been completed. One nurse commented that it was during a particularly different birth that she realized that the fetus does not have rights over the mother. Several nurses described situations where patients refuse care such as an emergency caesarean section or assisted birth, and identified the difficulty that situation creates in providing non-judgemental and respectful care. When this happens, the nurses may feel a lack of respect by the patient and the family toward the healthcare team, which may further rupture the relationship:

> That was one where I didn't feel like there was a lot of respect for the medical professionals. She wasn't even open to even hearing what we had to say because even

> when I tried to explain to her why we (medical intervention), no, she just shut right down. Like she didn't even want to talk about that. (NURSE 4)

Another nurse commented on a different situation:

> I definitely felt disrespected, I think everyone in the room felt disrespected. The patient didn't trust us to do what is best for her and the baby…she didn't trust the healthcare system to do things safely for her and her baby. (NURSE 2)

The nurse continued to comment on how disregarding the medical procedures and policies that are in place for patient safety is disrespectful:

> We have these protocols for a reason, they are done with lots of research, lots of thought put into them, lots of case studies to explain why these protocols are the best thing. . . and to have this patient come in a say I don't want any of this, could be constructed as disrespectful because it is kinda saying like yes you have done all this research and all this planning and looking into it but I don't believe you. I am going to do it my own way because I am special. (NURSE 2)

In this case, nurses who did not feel heard, or felt that their knowledge was meaningless to the patient felt disrespected themselves, and took the actions of the woman and the family personally. However, other nurse participants acknowledged that in the end the patient is in control, and that it is important to remember that the patient is making the right choice for her and her family. "Yeah, like there's only so much you can do. So, and you have to just say well, she's making that decision for herself and her baby and her family and nothing more than I can do" (NURSE 4). Another nurse said:

> … the nurses always say to me, well, what if that baby dies, and I am like it's not my problem actually she knows what she is deciding, she is asking for certain things and the risks have been explained to her so many times you could call is coercion. (NURSE 9)

As a result of caring for patients who are going against medical advice, nurses identified actions by the team that could be perceived as disrespectful. These actions also appeared to negatively affect the nurses and may have contributed to moral distress:

> If there's one thing as a nurse that feels gross is when you have to force somebody to do something. And if your baby' heart rate was 60 I would force you because I had no choice. But if I have a choice I know from previous experience, you get into some sort of physical tussle when you're physically restraining and pushing a patient around, or they're trying to run up the bed and you're pulling them back down the bed, you'll leave that destroyed. Like that is not what you want to be doing. Right? And it's really, really hard on the people who have to do it. (NURSE 9)

Another nurse commented:

> I've seen more than once, physician's orders that I think are punishing patients for not acting the way we think… I feel like there are both overt and covert ways that we seek to, not only like, dissuade that behaviour, but actually punish people for making their own decisions that we don't necessarily agree [with]. (NURSE 3)

This can also contribute to nurses feeling trauma themselves, perhaps contributing to burnout and fatigue. A few nurses who previously had traumatizing experiences commented on how that experience continued to affect the care that they were able to provide. One nurse who was involved in a case where the women refused a medical treatment, found herself feeling reserved and tense when she encountered a similar situation:

> I still have a voice in the back of my head, maybe they will refuse again. Maybe I will have to go through that case again. I don't think anytime I go through a traumatizing delivery you carry that through with you for a long time. And it's hard to take it as a learning experience because you are traumatised from it. So, I think a lot of time it makes us more guarded in those areas. (NURSE 2)

Another nurse commented on how she wondered if patients ever considered how their decisions impacted the healthcare professionals:

> I don't know that the patients and families even consider how that impacts us as professionals and as individuals and what we might carry home with us when we've had to deal with their decisions. And especially in labour and delivery people assume it's this wonderful, happy, great place and sometimes it truly is and sometimes it's not and sometimes its rather traumatic for us and I don't know that they ever consider that that's the case. (NURSE 6)

Moral distress and secondary trauma will be further explored in the discussion chapter.

Communicating During An Emergency

Nurses expressed concern with the challenges in showing respect to patients and their families when an emergency was happening, such as a fetal bradycardia (slowing of the fetal heart rate), or an emergency caesarean section. It can be difficult to keep everyone truly informed during an emergency. For example, obtaining permission may not occur and informed choice can be difficult. When discussing asking permission for a pelvic exam in an emergency, one nurse stated, *"*Most people are pretty good about asking and things like that but when we get into those emergency situations that goes out the door and we can all be more mindful of taking that extra second" (NURSE 8).

In an emergency seconds matter, and nurses acknowledged that they may not have the time to engage in conversation or obtain consent for procedures:

> And then of course there's those times where you don't get permission or you just pushed through, I just need to do this. This can be challenging in emergency situations where you're needing to draw blood quickly, you need to get another IV going, you need to run for the OR. There are times where you just don't have the opportunity to sit down and say, 'so this is what's going on and they ask why we are doing it'. (NURSE 4)

One nurse identified an emergency caesarean section where communication with the patient was maintained and another where it was not:

> I have seen ones go really well where one person focuses on the patient and telling them what is going on and I have seen ones where we kinda forget and before you know it we are in the OR and the patient is probably like, 'what is happening?'. (NURSE 8)

Obtaining informed consent was identified as a concern. Although it is within the scope of practice for physicians to obtain consent for a procedure that they are going to perform, the nurse is often a witness in emergency situations. When discussing forceps, one nurse mentioned:

> I don't feel they're consented well enough for the risk of say, perineal injury or incontinence or even just to your baby. Those kinds of things. I don't feel that a lot of people are consented well enough. But there also, maybe isn't time. So, it's hard to say. (NURSE 5)

Lastly, one nurse commented on the internal struggle between wanting to be able to be there for her patient and the family and explain things but having to deal with the reality of needing to complete urgent procedures, deal with colleagues, and write detailed chart notes. This led to frustration for the nurses, and likely for their patients and families:

> Like I can't do this right now. Everything fine. . . my brain is only working on emergency mode right now, and helping you understand that this is okay, is not in my capacity right now. Like I'm desperately trying to chase down the cord blood that got thrown into the garbage and I have to go dumpster diving so we don't have to poke this baby". (NURSE 3)

Dealing with multiple complex needs at once can be difficult for nurses.

Emergency situations, particularly caesarean sections, were also described by the women participants. Often the partners were left alone in the room or forgotten during the situation. One woman said she was already in the surgery when she had to ask if someone was going to get her husband. Another woman commented that it was common to see the mother taken away for surgery while the partner was left not knowing if their baby or their partner was going to die. She felt that even during emergencies it was important to explain the situation in a respectful way, and that there should be some support for the partners. This is similar to written comments provided by another nurse who felt that doing small things like closing curtains and doors, explaining procedures using lay language, and updating family members frequently can contribute to respectful care during emergency situations.

Navigating Relationships with Colleagues

The nurses identified that their relationships with their colleagues impacted their ability to provide respectful care to their patients. Relationships between nurses, as well as the interactions and relationships between nurses and physicians, midwives, student learners, and other healthcare professionals were identified and explored in the interviews. Within these relationships were complex variables of power and hierarchy that was influenced by the unit culture and the institutional setting in which the nurses worked. As one nurse stated:

> And you can't have high quality care where people aren't respecting each other…disrespect trickles down to the patients because you know, people are flawed and those emotions, like you can't just hide them away and make them go away and you have to live with them; and you can't just abandon your shift. (NURSE 3)

Nurse to Nurse

The nurses all stated that the nursing atmosphere and culture on the unit influenced their ability to provide respectful care. Nurse to nurse relationships reflected the interactions between nurses, and could be extended to include the patient, adding further complexity to the situation. Reporting at the end of a shift or during a patient exchange was identified as a key time when the nurse to nurse interaction impacted how the patient was perceived and treated. As one nurse said:

> If somebody has a perception of a patient, whether it is the charge nurse or the nurse at the bedside that is giving you report, if it is negative or positive it is reflected in how you perceive that patient before you even walk into that room. (NURSE 6)

That, in turn, influenced how the patient was perceived, and impacted the nurse's ability to provide respectful care. If patients and their families were discussed using positive language, then they were perceived a certain way versus if they were discussed using negative comments. Nurses inserting their own beliefs or biases about a patient and her family during report influenced how the next nurse perceived them, and subsequently provided care to them. As one nurse said:

> If you come out of every room like oh my gosh, they said this, or this husband is useless…it definitely makes you think less of your patients and you are less likely to

respect them or give adequate care, cause it puts them at a lower level than you. (NURSE 2)

One nurse commented when she is told positive comments about a patient, she finds herself trying to be more friendly and have a higher level of tolerance.

In the written document, one nurse talked about how she was told in report that the patient was being very difficult and was possibly drug seeking. This nurse tried to maintain an open and nonjudgmental demeanor, and later felt that she had a positive interaction with the patient. She felt that having an open mind was crucial to creating a positive and respectful relationship. Another nurse identified that being told that a patient was wonderful also tainted her care because she was then going into the patient's room excited to meet her and may be more willing to talk to her and her family, and to try and meet their wishes. This nurse commented that she did not want her judgement to be affected by what others say, "I think that's better way to set myself up to be like respectful to them because then otherwise I'm going to judge them straight off the bat because then my first impression of them is just not as great" (NURSE 1).

Nurses talking in a negative manner about patients to other nurses during their shift impacted the care a patient received. One nurse recalled a time where there was one room that no one wanted to go into because the nurse at the desk was making fun of a patient. Another nurse recalled a nursing colleague complaining about how loud her patient was in labour, and said, *"*They should get an epidural, they clearly need it" (NURSE 1). This demonstrated the nurse's bias towards an epidural, rather than appreciating how some women can be vocal during labour. The nurses commented on how snide comments about a patient or family, and body language such as eye rolling were disrespectful.

How nurse colleagues treat each other also impacted their provision of patient care. Having a 'gossipy' unit, where nurses were talking about patients and care provided by nursing colleagues contributed to the overall culture of the unit. It also impacted whether nurses felt they could trust their colleagues or ask them for assistance when needed. One nurse said that she worried about what her colleagues said and thought about her, to the extent that if she was ever pregnant, she would not want to give birth in the hospital where she worked. She would feel worried about what they would think if she was too vocal during labour or if her room smelled. It appeared that this nurse feared being vulnerable in front of her colleagues, people who she should have been able to trust to guide her through her labour and birth.

The nurse in charge of the unit has a complex role and is responsible to the nursing team, unit, and various primary care providers. Nurses described feeling disrespected by their charge nurse when they perceived they were being treated unfairly, or when they felt alone in caring for their patients. A few nurses described how the allocation of patient load by the charge nurse, and limited assistance by colleagues impacted how they felt about their colleagues:

> You have your typical cliques that like to disappear and go do their banking or whatever, then you have the new nurses that are just kind of stuck in their rooms because they are terrified of something happening, and then you have the other nurses…they're fast, efficient, but because the charge nurse has to overcompensate for the nurses who like to do their banking, those nurses are disrespected. (NURSE 7)

This nurse continued to discuss how respect from the charge nurse, her colleagues, and the unit decreased and led her to a breaking point. Another nurse described how she had a very busy day at work and did not feel like she was part of a team with her colleagues. She was assigned numerous new admissions to the unit while other nurses were not assigned a patient. She

commented that the difference between her and the other nurses was that they had more seniority on the unit than she did, and she wondered if that was why she was continually assigned new patients. This nurse also described a time when she felt she was rude to a patient because of the lack of support she was receiving from her colleagues.

Another nurse described a time when there were numerous confrontations between a physician and the charge nurse during a shift. This nurse brought a concern about a patient to the charge nurse, who then reprimanded her and told her to "comply with the doctor's orders because that was my job" (NURSE 3). She felt unsupported by the charge nurse but also acknowledged the difficulty the charge nurse was having with the physician during that shift. Disrespectful interactions between healthcare providers in the patient room also impacted the patient experience. "I do think when there is any kind of tension in the room even if it is not between the patient and the staff, but staff to staff, the patient is still affected by it." (NURSE 2).

Nurse to Physician

The nurses commented that, overall, they had good working relationships with their physician colleagues. Several comments were made about knowing each other on a first name basis, sharing personal stories and attending social events together as positive aspects of their relationship:

> …you know their first name, you know what they're doing on vacation, you know what they ate for dinner. you have those relationships. It's a lot different than many units and I think because we work so closely one on one with these patients and stuff like that, that we get a closer relationship where it's not just a doctor comes in, writes orders, and then leaves. We're all invested in something. (NURSE 6)

The nurses felt trusted by the physicians, in that the physicians trusted their assessments and nursing judgements; however, this trust had to be earned over time:

> When I first started…the doctors didn't trust you, you hadn't established that you actually know what you are doing. They would always triple check or then a patient would end up having two exams because they wouldn't trust what the nurse was saying. (NURSE 5)

While all new healthcare providers require time and clinical experience to become accurate at their assessments, double checking a nurse's assessment when the nurse was sure of her result lead to unnecessary interventions and implied disrespect towards the nurse. The hierarchy and power differential between nurse and physician appeared to have affected the nurses' ability to be assertive and confident in their assessments.

While the nurses acknowledged positive relationships with the physicians, the hierarchy between the healthcare providers was evident and impacted nurses' roles and their ability to provide respectful care. Improving teamwork was identified as a need. A few nurse participants reported that they felt like the physicians seemed to perceive themselves as their boss rather than their colleague. One nurse said, "I have to work with these doctors in this really awkward paternalistic hierarchy . . . and I am not anywhere near the top" (NURSE 3). During the second interview, this same nurse noticed that this hierarchy was very evident in her clinical practice and was reinforced by those around her, "giving a lot of power to people who are the decision-makers but are not necessarily informed enough to make a decision for individualized care" (NURSE 3). She was involved in a situation where a physician came on shift and completely changed the plan of care for a patient without regard for what the patient wanted, and what the nurse felt was best. This nurse supported the patient's wish to refuse care but did not feel supported by her nursing colleagues during this time.

All the nurses identified that it was difficult, if not impossible, to stand up to the physician if they were concerned about the care being provided, or if the physician was being disrespectful to their patient. The hierarchy and lack of support for speaking up with a concern made this difficult to do, especially for newer graduates, but also for experienced nurses. As previously reported, when concerns were brought to management, nurses were frequently told to go back and discuss the situation with the primary provider, but the nurse may not have felt safe to do so. Many nurses expressed that they were unable to speak up and this tension will be further described in the theme 'Nursing In the Middle'.

As the nurse participants worked with a variety of care providers, they were able to gain a sense of how each person handled certain situations and treated staff and patients. Depending on who was working, they would be prepared for a positive day or a negative day:

> There are some days that some stuff is going down on the unit that if it was one doctor we would tell them immediately but if it's another one, we're going to kind of wait and see if it's like a really serious problem because its worse not only for us but for the patients. (NURSE 3)

In the written documentation one nurse noted that each shift's capacity for respect was defined by the team lead, and this capacity could change drastically at physician shift change. This certainly impacted patient safety, teamwork and work satisfaction.

Nurse to Midwife

There appears to be some tension in the relationship between nurses and midwives, perhaps because they have not worked together as long as nurses and physicians**.** While a few nurses described positive relationships and respect for the midwives, some nurses reported that they felt hesitant and leery of the midwifery role. While the nurses worked consistently with

patients when a physician was the primary provider, they were not always integrated into the care when a midwife was the primary provider. Some of this was attributed to the characteristics of the midwifery model of care, as the majority of births attended by midwives happened in the home setting where nurses were not present.

> I don't think they necessarily understand truly what a midwife's role is and how they work with their patients and because in this area at least, so many of the midwives end up doing home births and a lot of them are perfectly healthy, no complications. A lot of our nurses never see or hear that. (NURSE 4)

Another nurse acknowledged that "There's a big bias against the midwives because the only deliveries we see of theirs tend to be the ones that are not going well, whereas like 95 percent of them we would just never see" (NURSE 3). Some nurses acknowledged that midwives provided the space for women to choose what they wanted, and supported their decision:

> . . . they've chosen to have a midwife and it's not that the midwife is trying to pressure the patient to not do anything medical, it's more the opposite way. It's the patient who is refusing things and they've chosen a midwife because they know that the midwives are going to be more willing to respect and . . . midwives will educate their patients and then if the patient says no, I'm not doing that, the midwife will be like, 'okay', that's your choice. I've given you the information. They're not going to try and pressure them the way that a doctor might. (NURSE 4)

This same nurse acknowledged that, as a result, some nurses blamed the midwife when there was a bad birth outcome; however, she knew that the midwife gave the responsibility to the woman who then made the decision that led to the outcome.

When midwives work within the hospital system, they remain independent practitioners unless they transfer care to the obstetrician on call due to patient complications. Nurses did not have many opportunities to work with midwives during low-risk births, and seemed to become more integrated once the patient was transferred to the obstetrical team. The limited ability to work together led to the nurses feeling uncertain of their role, knowledge base, and model of care. This led to lack of understanding about how nurses and midwives could work together. In some cases, it led to concerns about the quality of midwifery care, patient safety, and disrespect to their colleagues.

When a midwifery patient was admitted to the hospital, a nurse was assigned to the room as well, yet there was confusion about the roles of the nurse and midwife:

> They (midwives) come to the desk if they need something, maybe once as hour you say 'Hi', But you don't have a lot of interaction with them. Those are the ones that scare me a little bit because I'm still the nurse assigned to that [patient], but I don't know anything about that patient. So, what if something happened or went wrong? Am I going to be held responsible in that case? Because if we're in the room we're over-stepping our boundaries, but at the same time we're the nurse assigned to that room. (NURSE 6)

One nurse commented how, at times, the nurse may not agree with the midwife:

> …and so there have been times where I've had to try and intervene and report what's going on in- and then whether or not, it's a good outcome or not, is sometimes really challenging. Unfortunately, there's a lot of that that happens. (NURSE 5)

This transfer of care provided some challenges within the nurse and midwife relationship:

> . . . the midwives don't chart the best. Sometimes they don't chart at all or they chart in very odd ways. So, when there is a sudden transfer when they're in the hospital, as a

> nurse you're handed this binder and you're like, 'where is the information I need? Where is this? Where's that?' Because we are expected to know, right? And it's like well, 'I don't know because it's not charted', you know. Or it's in five different places that you wouldn't expect to look. So yeah. So that can be very challenging then. (NURSE 4)

At times, the midwife continued to support the patient during a transfer of care, taking on roles such as patient education, which would usually be a nursing responsibility, further challenging their relationship with the nurse, and confusing the roles. This differs from a transfer of care from a family physician to an obstetrician as, in most cases, the family physician leaves the patient's side, leaving the obstetrician fully in charge. One nurse wondered how it was possible to change from a primary care provider to a support person. A few nurses also expressed concern about how the transfer of care from midwife to an obstetrician impacted their relationship with the patient:

> It can be really hard because your just getting the patient, your kinda responsible for getting them through the toughest part of all this when things have gone wrong and this is not what they want but you don't have that rapport because you haven't been with them for their labour but I think you kinda just talk to them about how their feelings and respect that sometimes its ok to be upset cause things didn't go your way and just let them be upset. (NURSE 8)

One nurse commented on how building a relationship with a patient during a transfer of care is difficult because,

> …they don't trust hospital staff. The reason that they had a midwife is because they didn't want to deliver in the hospital, and then something happens that they end up there, or something goes wrong that they need medical intervention, and then you're walking

into someone who already doesn't want you there. So, it's very hard sometimes to break that barrier. (NURSE 5)

A few of the women interviewed had midwifery care in the hospital setting and required a transfer to the obstetrical team. One woman commented on the relationship between the nurse and the midwife. She noticed that the provider roles overlapped at times:

> It is kind of interesting because my midwife was there. She actually maybe kind of took over a little bit of the role of the nurse in a few situations. Because she was also like explaining and I kind of maybe got the vibe that the nurses especially that. . . maybe took like kind of a . . . backseat to her. (PARTICIPANT 7)

She also wondered about territory within the hospital setting:

> I remember her (midwife) sitting down in the nurse's chair. The was one of those moments where I was like oh, I feel like that could be awkward, but the nurse was super cool about it and she just started going over all the charts. (PARTICIPANT 7)

This same woman commented on how even though the midwife was no longer in charge because her care was transferred, she really appreciated how involved the midwife stayed in her care. *"*Honestly, I feel like the way they were the most respectful was that when my midwife was present, they seemed to kind of let her drive the show, which I appreciated because I had the relationship with her" (PARTICIPANT 7).

Nurse to Student Learner

While student learners are important for the continued development of healthcare professionals' knowledge and experience in the area of labour and birth, working with students posed some challenges to nurses' practice. Showing respect to the woman in labour included asking permission and receiving consent for the student to be part of their care. It also involved

introducing them and making sure everyone understood their roles, whether it was a nursing student or a medical student. It was important for the nurses to ensure that all student learners spent some time with their patient, and that their patient was comfortable with the team:

> Like if you have a student nurse, making sure that the student has been present for a lot of the care, make sure that student is part of the experience with the patient, so the patient is comfortable with them. And medical students too, a lot of time they meet them once in the assessment room and then they come back for the delivery, it's like no, you have to do some work here. (NURSE 8)

When paired with a nursing student, the nurses identified that having a student with them distracted them and took some of their attention away from the woman experiencing labour and birth.

> It makes you stop thinking about the patient or the person who is having a very important life stage happening to them, an important memory they are going to hold with them for a long time and makes it a medical experience. If I have a student it can distract me from the patient, I am worried about the student; Are they having a good experience, are they feeling ok, are they stressed out, do they have any questions? I am less able to focus on one person when I have multiple people. (NURSE 2)

In order to address this, this nurse talked about how she tried to complete the teaching outside of the room so they could focus on patient care in the room. However, another nurse identified that she felt it was nice for the patients to hear the additional teaching provided when a student was integrated into the care plan. She also discussed that it was important to let the student do what was within their scope to care for the patient, "Because it is so easy to come and do it yourself

and that is not really fair and that kinda undermines them in front of the patient and that is not very respectful" (NURSE 8).

One woman participant recalled having a student nurse assisting with her care and it became obvious to her that the nurse did not want to have a student. She observed the nurse ignoring the student, eye-rolling at their comments, and generally not integrating the student into her care. The woman then felt a need to interact with the student to try and make the experience better for them by asking questions and asking for ice chips. This put unnecessary pressure onto the woman. It was important to recognize that student nurses had an effect on a woman's birth experience, which could be influenced by the nurse mentor.

Nurses also observed physicians working with residents and medical students and found that they were also distracted by their teaching, and not focused on the patient. One nurse provided an example of an interaction during a stillbirth, when the medical team was talking about what they would do if the fetus was born alive. They were reminded by the nurse in this scenario that the conversation was not appropriate to be discussing in front of the patient. The nurses recognized, as well, that talking about patients in front of another patient was a breech of confidentiality and privacy.

Finally, disrespectful care was observed when members of the medical team talked to each other about anything other than the patient when she was pushing and about to birth her baby. In her written reflection, one nurse acknowledged that the large number of learners that go through the unit was a possible contributor to disrespect as they distracted the team from the patient. Learners also added to the number of people in attendance at a birth, and if they were talking or asking questions at inappropriate times patients could be overwhelming.

Nurses worked closely with medical students and residents on the unit and had begun to notice an increase in positive interdisciplinary relationships. They attributed this to a few recent changes in the program and management. One nurse commented that, in the past, residents felt like "they are being overridden by nursing staff…but as they progress in the program, they get much more skilled and we trust them a lot more" (NURSE 6).

It was noted by the nurse participants that respectful language between the providers contributed to a team approach and learning from each other. For example, instead of saying "'We don't do that here', saying 'Oh we would usually do this, is that something you're interested in?'" (NURSE 8). This nurse commented that when telling someone to do something, there are polite and respectful ways to ask for something, and that over time, the medical students, residents, and nurses were communicating better and respecting each other's boundaries and expertise. Another nurse recalled a time where two residents were talking and one resident "brought up that when (they) were in first year, (they) didn't realize it, it's the nurses that run the show. And (the other resident) laughed and (they) were like no, I'm absolutely serious" (NURSE 6).

It appeared that nurses were able to exert more power over the medical students or residents as perhaps they were more receptive to learning from the nurses. One nurse stated that she was able to guide them in their care. She commented, "Oh should you be breaking that water if the head is so high? Maybe we should wait or maybe let someone a little more experienced do it" (NURSE 5).

Nursing in the Middle of Competing Roles and Responsibilities

The nurses identified times when the limitations of the nursing role and their scope of practice impacted their ability to provide respectful care to their patients and families. They often

found themselves “in the middle”, referring to the in-between work of trying to balance the various roles and responsibilities they have of being an advocate for their patient while practicing family centered care, adhering to hospital policies, and collaborating with colleagues. This was influenced by a real or perceived lack of power accorded to the nurses by other providers and their patients, and reflective of a hierarchy present within the system. As nurses are the healthcare providers who are constantly present on the unit, and work with a variety of other healthcare providers, they found themselves in the middle of conflicts between providers, management, and the broader hospital environment. If there was any discrepancy or disagreement between any or all of these situations, it impacted nurses and their ability to provide respectful care. It also placed the nurses in ethical dilemmas or created confrontation with colleagues or management. Within this theme, nursing in the middle can be between the patient and her family, between the patient and the primary care provider, and between the nursing role and the organization. These subthemes inform and impact each other, and as such there may be overlap present between them.

Between Patient and their Family

It was evident that the nurses frequently found themselves in the middle of family conflict, negotiating the wants and needs of patients and their families. While the family was supporting the patient the majority of times, dealing with family dynamics was challenging. For example, when witnessing what they perceived to be gender inequity expressed within a family unit, it was difficult for nurses to provide respectful care to the family. The family was seen as limiting the ability of the healthcare team to understand the labouring woman’s wants and needs by giving lower status to the woman and minimizing her voice while speaking on her behalf. This was especially challenging when the family was refusing procedures:

> That is really hard, I think that is probably the most difficult. You just want to do what is best for the patient but when you are being yelled at by the family that makes it so hard. I want to know what the patient wants you to do, but they can't tell you because their family is in their face and you feel like sometimes, they are trying to be like 'kick them out' you know what I mean, you just wish you could read their mind. (NURSE 8)

If the partner appeared to be controlling or confrontational it was difficult to provide the patient what she wanted.:

> I would say if the husband is very challenging or if he's googling things on the side and thinks that its more knowledge than what you had. Or for example, if he's saying she can't have a c-section (caesarean section) or she can't have an epidural, then that's really frustrating because she is the patient and we have to treat her. And epidurals are big as well, for, say, husbands not wanting patients to get epidurals (NURSE 5).

One nurse recounted a situation where the partner refused a procedure, and the patient did consent to a procedure until her partner left the room. In some instances, family members were asked to leave if there was a safety concern for the patient or staff. Through experience in dealing with these family conflicts, one nurse identified that she had learned how to demonstrate respectful care during these disputes. "I think now it's educating them and as politely as you can telling the family that it is not their decision and that I have to respect the patient wishes if they want something and the family does not" (NURSE 8).

It was challenging and stressful for nurses when there was a discrepancy between the clinical picture and what the family was saying. This was exacerbated when the woman also did not speak English:

> When you see that the patient is so uncomfortable or in so[much] pain you feel like giving them pain medication…you can tell they are just not coping well at all. But due to their cultural expectations or due to the expectations of their partner or family you are unable to provide that for them. It's just very, in those cases it just feels hard to care for the patient. (NURSE 2)

This also placed the nurses in conflict with their obligation to advocate for their patient, and to know where the patient's capacity for consent lies:

> I feel that nurses have a general bias towards certain individuals where say, their autonomy has been taken away by certain family members, they like to speak for them or they want[to] give them the option for pain management or things like that and it is really hard for a nurse that is supposed to advocate for their patient are in a position where a woman should have compete autonomy over this body;. . . umm it is hard to always support the other family members in the room, which may provide a toxic atmosphere as well. (NURSE 6)

Another nurse commented:

> I find it very difficult because often the patient will not speak for herself after that point, the family will speak for her. And I have a hard time understanding here [if] the capacity for consent is there. If I'm you know, like they'll ask me for a bottle for a baby. Well, I know that baby is breastfeeding and (name of organization) requires me to actually get you to sign a consent form for me to even hand you this bottle of formula. I have to get that from Mom. Mom is sleeping and doesn't want to talk to me and is outright saying, like whatever my family says. (NURSE 3)

One nurse voiced concern that structural barriers in the unit, such as visiting hours, limit the family involvement in the room:

> Nobody wants families at the hospital anymore and it's so frustrating because like those people have to go home eventually and their families are going to be the ones taking care of them and their baby. You don't want to separate people from their support networks and we make it so hard for them (NURSE 3).

Another nurse commented that having any additional family in the room actually impeded her care:

> I had a patient here that had a sister, a husband, a mother and a grandmother all in the room for support and I find that super hard to deal with. Try and respect that but it's really hard because I feel like it impedes on my care because I feel like there's so many people in the room to please…You know, just like two people, the person in labour and their partner because that would be easier. (NURSE 1)

During the observation period, it was noted that there was a small patient lounge in the middle of the unit with a sign that said *This lounge is for patients only, family must go to the visiting area*. This was a clear message that family was not able to accompany patients to all areas and could only be in the designated areas. In this same lounge there was a small poster with the letters *RESPECT*, stating that everyone wants it, everyone deserves it, so take action; respect each other and report abuse.

It also appeared that, at times, policies were created, but not necessarily written. These constituted understood rules that supported the healthcare team rather than the patient or family and could be enacted by the team when convenient. Nurses seemed to be uncertain of which rules were bona fide policies. One example that was engrained in practice was that only two

support people could accompany a woman in labour. Depending on the context, enacting this understood rule could be seen as respectful if it came as a result of the patient's request, but could be disrespectful if enacted for the convenience of the staff. One nurse attributed this limitation on the number of support people allowed as *"*a structural thing; how families are seen as a barrier to what we have to do" (NURSE 3).

While the nurses believed it was a written policy to have only one support person in the operating room, at times, additional people such as doulas or birth photographers were allowed. When these exceptions were granted depended on the providers in the operating room and presented inconsistencies in practice. Unintentional biases by the team may have influenced the decision to allow more than one support person and may have demonstrated disrespect to those to whom it was not granted. One nurse commented that she believed doulas, for example, should always be allowed in the operating rooms because they were hired by the patient for support, and not including them would be disrespectful. Another inconsistency in practice involved mother and baby recovery after caesarean section. Some nurses kept mother and baby together for skin-to-skin contact during recovery following a caesarean section, while others took the baby away to complete the necessary assessments as per policy. It was necessary to decipher between what was actually a policy, and what was being stated for the convenience of the staff rather than for patient- and family-centered care.

Between Patient and the Primary Care Provider

When obtaining informed consent for a procedure that is to be completed by the physician, it is the physician's responsibility to describe the risks and benefits, and obtain informed consent. Yet the nurses in this study found themselves re-explaining what the physician

had said and verifying the woman's level of understanding. This was often done after informed consent was received by the physician:

> Like when doctors come in they are often rushed, or when they say something really fast, you can kinda see that it doesn't quite click in the patient's eyes. So, its sticking around afterwards and making sure they actually understood what the physician said and that it is ok with them, and kinda making sure there is that connection between what the physician said and what the patient heard or what the patient said and what the physician heard NURSE 2.

Another nurse noted that once the doctor left the room, she would clarify with the woman what she had been told, asking:

> Did you fully understand that? Do you need clarification? Is there something I can do to help you fully understand that? Or do you need me to call them back to talk about something (NURSE 5).

While it was recognized by the nurses that it was prudent to ensure patients understand all aspects of care, they also understood that it called into question the validity of an informed consent if the nurse has to continue the conversation once the physician has received consent and left the patient room.

Nurses were placed in a difficult situation when they were witnesses to primary care providers who tried to persuade or convince patients to agree to certain procedures:

> There are times where medical professionals will say things in such a way that makes it seem more severe or dire than what it really is because for their own reasons, whatever that may be so it always my hope to be able to balance that… "[primary care providers] will- sometimes . . . they'll try and pull out stats or well, you know, 50 percent of babies

> died when we didn't do this and that. Like there will be scare tactics by some. I won't say all. Physicians more have this mentality that well, you should listen to me, I'm the expert here… (NURSE 4).

In this moment, it was difficult to correct the information the physician provided.

Nurses could act on the wishes of their patients only if the primary care provider also agreed. As an example, depending on the primary care provider who was on duty, women may or may not have had the option for a vaginal breech birth. In that situation, the nurse is unable to advocate for her patient:

> Someone wants a vaginal breech delivery and the physician is not willing to do it then it's like, 'well humpf,' then you have no option basically, the patient has no option. I think there are definitely situations where their wishes do not get respected (NURSE 8).

Another example of this was provided: the nurse and patient wanted to birth in the hands and knees position during the pushing stage of labour, but in the end the nurse was required to assist the women into lithotomy position in case of a shoulder dystocia or other emergency concerns. A similar situation was also identified by a woman participant who, when asked if she could push in a certain position, was told by the nurse that she would need to change position when the physician came in as the physician did not like that position. She also recalled her nurse removing the birthing bar because she did not think the physician would like it.

If a nurse decided to advocate for a patient for something that was against what the primary care provider had ordered, it placed the nurse in a difficult position. As one nurse stated:

> You want to advocate for the patient, but then you're also then risking your professional relationships, so what do you do? You have to work with that person again, it's not like you're not going to see them again, so it can make work tricky (NURSE 5).

Another nurse discussed the challenge and struggle of being in the middle between the resident and primary care provider, “If I feel that the resident isn’t appropriately reporting to the primary attending physician, or that they’re not making the best decisions possible you do have to override them” (NURSE 8). Although challenging, the nurse felt that it was her responsibility to override the resident, but it was much more difficult to challenge a primary care provider. When describing advocating for the patient against the care providers wishes another nurse stated, “I just accept that I’m going to get screamed at for not making the patient do the ‘right’ thing” (NURSE 3). The right thing was what the primary care provider wanted the patient to do, rather than doing what the patient wanted. If the nurses disagreed with the primary care providers, they often found it very challenging to confront or address this directly with their colleague. One nurse commented on how it was embedded in the nursing role that nurses defer to the doctor, and that it was evident that “you can’t make the doctor look bad in front of the patient” (NURSE 9). This nurse acknowledged that when she had a concern about a primary care provider, she was told to talk directly to the provider yet she felt that her concerns needed to come from someone with more power. The hierarchy among healthcare providers accorded nurses a lower status than physicians and others, which impacted how nurses responded to concerns of disrespectful care provided by primary care providers, or those with perceived higher status and power.

One nurse recalled a time when she felt disrespected in front of the patient by how the physician spoke to her. The physician proceeded to sit at the end of the bed, with their arms crossed, appearing to be pouting while awaiting the woman to birth. To compensate for the physician’s behaviour, the nurse found herself trying to cover up the physician’s disrespectful behaviour, and do what she could to bring the attention back to the birth experience. This was also observed by the patients as one woman interviewed recalled a situation where she noticed

that the physician was snapping at, and was rude in interactions with the nurse. Once this physician left, the woman observed the nurse apologize for the physician's behaviour. "I just felt like she was trying to smooth over the situation" (PARTICIPANT 10). These interactions created a negative work environment and impacted the woman's birth experience.

Within this middle place behind the scenes, nurses worked to maintain the status quo, and balance the various personalities and needs of both patients and colleagues, perhaps at their own expense. Lower status within the hierarchy, and the power of the physician was maintained in part by the activities of the nursing role. A very poignant comment reflected the paternalistic culture felt by one nurse, where she describes being is nurse is like "having 20 husbands and you have to figure out which way he wants it today, how he likes it…and then the next doctor comes, and you have to change your dance steps to please that guy" (NURSE 9). She continued to describe the rituals in preparing for a birth, and addressing the needs of the primary care provider by outlining all the details the nurses needed to know:

> …how (they) like (their) gloves, what temperature it is in the OR- like we do all this- all the behaviours and some of that's just to keep down the chaos that gets created when they're wielding the power they have, and they have lots of power (NURSE 9).

While the nurses were required to anticipate the needs and wants of the primary care providers, this was not reciprocal. When nurses existed in this middle space between the patient and the primary provider, they also needed to know which physician was more likely to label a bleed as a postpartum hemorrhage, call a shoulder dystocia, or require additional nursing staff at birth. Nurses needed to know who wanted to be called early for birth and to stay informed about the unit, and who did not:

> There are some days that some stuff is going down on the unit that if it was one doctor we would tell them immediately but if it's another one, we're going to wait and see if it's like a really serious problem because its worse not only for us but for the patients (NURSE 3).

To maintain the status quo while working in the middle, one nurse recognized the emotional labour required for her role. For example, she put effort into understanding the emotional tenor of the physician and her nurse colleagues during her shift to "know what their buttons are and how to stay off them that night" (NURSE 3). Again, this was not reciprocal as she described "the high amount of emotional support that I provide to doctors who I would never expect but I would definitely never receive in return" (NURSE 3).

Another nurse described a situation where she recognized another nurse was having a difficult time with a patient who needed additional care that the primary nurse was not willing to provide. This nurse, by recognizing the barriers in place, went behind the scenes to ensure the patient was taken care of without the knowledge of the primary nurse. This same nurse mentioned offering food or drink to an anesthetist as a way to calm them down. While this can represent teamwork, in the larger work environment these strategies appeared to be coping mechanisms used by the nurses 'in the middle' to try and minimize negative interactions with colleagues in the hope of fostering a positive work culture. This emotional labour provided by nurses to accommodate their colleagues will be explored further in the discussion chapter.

A concerning finding is that nurses felt that they were always to blame when a situation went wrong. One nurse provided an example of a communication breakdown with a physician where she took the initiative to seek this person out and apologize rather than having a mutual discussion on what had happened. Another nurse provided an example:

> Like if there's a baby that turns blue on the mom, well, it's the nurse's fault, she wasn't watching the baby…or if a count is wrong [sponges during a surgery], it's the nurse's fault because she didn't count or keep track of things, but the surgeon put them in the abdomen and it's their fault too" (NURSE 5).

This nurse continued to describe how this was also significant when discussing fetal heart tracings. If the nurse was concerned and showed the primary care provider, they might be listened to, or told not to worry. Yet if a baby was born acidotic, it would be blamed on the nurses as they did not show the graph to the provider early enough. Nurses then continued to be stuck in the middle, between their nursing role and responsibility to their patient and their relationship with the primary care provider--a time of feeling powerless to act on their own volition. As one nurse stated, "there's always going to be a power struggle between who has the patient's best interest, and who has the say" (NURSE 6).

Another nurse talked about the structures in place that support the existing hierarchy and the behaviours exhibited from physicians that reinforce their power. She described a situation where a physician was able to come in and change the course of care for a patient without taking the patient wishes, or the nurse's recommendations into consideration. This nurse found it isolating to challenge the physician in such a case and did not receive the support needed from her nurse colleagues.

Between the Nursing Role and the Organization

The nurses in this study discussed how they were often in the middle between organizational structures and their nursing role, which posed challenges when providing respectful care. The hierarchical structure of the institution, unit layout, staffing, and polices were some of the identified organizational challenges. All of the nurses voiced concern that a

lack of time, being busy on the unit and being short staffed led to disrespectful care as they were unable to spend the time that they needed to understand the patient's needs and wishes, nor did they feel they had the capacity to act to change the situation. This led to nurses feeling frustrated and being limited in their ability to adequately care for their patient:

> One thing that goes a long way is having rested nurses. I find that when we are really busy and we are tired and hungry we are not as respectful. We are racing around like crazy and you just want to get through whatever it is your trying to get through, it can be really hard to stop, sit down and try to explain something when you know you need to get back to the other room over there or whatever (NURSE 4).

Feeling overworked limited a nurse's ability to provide high quality, safe and respectful care. One nurse noted in her documentation that feeling distracted impacted her ability to be present with her patient and in turn to develop a relationship. Distractions included interactions with co-workers and personal conversations, cellphone and technology, charting demands, acute situations that pulled them from their patients, and fatigue (NURSE 8).

A few nurses commented that perceiving to be assigned an uneven or overwhelming caseload led to them feeling overworked and under supported by their colleagues and impacted patient care. One nurse expressed frustration when, during a shift, she felt she was continually being assigned the new admissions to the unit while some of the other nurses had not been assigned patients yet. Another nurse commented how it felt to have an overwhelming caseload. "I feel horrible, I try my best, but I'm like man, I'm not as invested as I feel like I would be maybe with my first patient." (NURSE 1).

One nurse noticed that uneven caseloads assigned by the charge nurses seemed to be reflective of the nurse's seniority on the unit; the new nurses were given reasonable assignments,

those with the most seniority were often given a reduced assignment, and those 'in the middle' were often overworked, given multiple assignments throughout a shift. This led to frustration and burnout for the nurses who felt that they always received an unfair patient assignment.

Nurses trained in the operating room for caesarean sections also expressed some frustration as the unit was limited in nurses with this training, and they were frequently asked to go to the operating room, or to leave their labouring patients to tend to another. This impacted continuity of care and the relationship they had with a labouring woman and left another nurse to cover multiple patients at once.

Some women identified when the nurse was busy or pre-occupied, and how it impacted their experience. "Like she was getting the numbers like my temperature, and my blood pressure and things like that, but then if I said something she would be like okay, yeah, yeah and to not really hear what I said" (PARTICIPANT 2). Another woman identified how it was important to have more staff during busy times because "ladies probably need someone to be a bit nicer and sympathetic to them during that experience. Instead of just being like Oh I am busy, the doctors are on break" (PARTICIPANT 6). Yet another woman commented how it was a busy time of the year and when she asked for a blanket, the nurse responded that she would like to go on her break (PARTICIPANT 8). What was happening on the unit affected the staff and in turn affected patient care. Respectful interactions were affected when time is limited, and the staff were busy.

What is interesting is that several nurses commented that they preferred the unit at night, despite the night shift being lower staffed. Booked caesarean sections, additional monitoring such as NSTs, student learners, and the presence of management and staff increased the business of the unit during the day shift. While patients labour during the day and night, one nurse commented that she felt the nursing staff "has a lot more capacity to give individualized family-

centered care on nights" (NURSE 3). Furthermore, the physicians are not on the unit as much during night shifts, so "you need to have a lot more trust in your night staff to handle it because you are fighting fatigue at that point and you need to work together" (NURSE 3). Some nurses felt a greater sense of control and autonomy to provide the type of care they desired during night shift, rather than contending with the competing demands for their attention that are the norm for day shifts. The focus at night was on labouring patients rather than booked procedures, the presence of extra staff and learners, or management meetings.

The nurses also identified the assessment/triage room as an area of limitations and frustrations in their role. As the unit was often very busy, they found themselves "in the middle" when a patient was waiting to see the primary care giver, or in some cases waiting for a bed or transfer to another unit such as labour and birth. When women and families came to the unit with minor complaints such as cold symptoms, nurses felt that they were limited in their ability to refer them to their primary care physician, thus freeing unit space. In addition, if the nurses completed a labour assessment and confirmed that the patient was in early labour and not ready to be admitted, they were still required to contact the primary care provider and sometimes wait long periods of time before the patient could be discharged. They felt stuck in the middle between their nursing assessment that the patient was safe to be discharged home and the limitation of the nursing role rendering them unable to provide the diagnosis. This placed nurses in the middle of frustrated patients who just wanted to go home, an assessment unit that did not have enough beds, and busy primary care providers who were trying to see multiple patients: This then put a strain on the nurse and impacted her ability to provide respectful care to patients:

> In the assessment room especially, it can get very challenging because there are long wait times often and trying to explain to people why they are sitting in a bed for hours not

> being seen by the physician creates a lot of challenges with that whole respect thing. People can get quite frustrated, impatient, and demanding. So yeah, trying to maintain that because you know you get frustrated then, because their frustrated that the doctors have not come, you're feeling for your patient but at the same time you're feeling frustrated because they're coming down on you now because they want to know when they are coming and why can't I leave now (NURSE 4).

The nurses identified that at times they are unable to fully inform the patient about their condition or plan. "Sometimes we know things we can't necessarily communicate to the patient or can't confirm with the patient" (NURSE 4). Being unable to be fully truthful in the moment with the patient and the family placed a strain on the trust between nurse and patient.

One nurse suggested the development of a policy to support nurses' ability to inform women who are assessed as having a low priority (i.e. cold symptoms) in the assessment unit so that they could leave and follow up with their primary care provider. She identified that while she did not feel comfortable doing so without a policy, some nurses did inform the patient in such an instance. The conflict among nurses working under policies for their own protection and for patient safety, in addition to their limitations to enact on their clinical judgement was evident.

One nurse expressed her thoughts that respect included having equal opportunities. This was challenging in the assessment unit when multiple patients arrived at the same time in a similar stage of labour, but there was only one room available on the labour and birth unit. It was frustrating and stressful to make the decision about who would be admitted to the unit, where the woman had access to an epidural and other supports. Several of the women participants also commented on the assessment unit, as most were required to wait long periods of time either to be seen in assessment by the physician or to be transferred to the labour and birth unit.

Another nurse expressed significant frustration with the overall system, especially the limitation within her nursing role to actually use her nursing knowledge and judgement. She felt a lack of power to be able to effectively advocate, respect the needs of her patients and provide quality care. She identified how protocols limited her ability to enact her nursing judgment and complete care based on her clinical assessment. One example involved breastfeeding. The protocol to offer formula did not provide the space for the nurse to decide whether or not the baby needed more time and support for latching before offering formula feeding. While policies have a place to support patient safety, they may also impede nursing judgement and were sometimes in conflict with patient centered care:

> I hate feeling like someone's mother when I'm telling them like you can't…I always say I am supposed to tell you, not that you can't…but I am supposed to tell you that you cannot eat right now because your 'VBACing' [Vaginal Birth After Caesarean Section], the tracings gorgeous and you know I could support your decision to eat right now if want to. I just tell you all the risks and that but there's an order and I hate doing that. I feel like we should just give people the information and they can make their choice about whether or not they're going to eat. (NURSE 3)

The perceived that lack of power and ability to provide high quality care played a role in a nurse's wellbeing and led to feelings of moral distress and burnout, which will be further explored in the discussion chapter.

Two nurses acknowledged that the system appeared to change the relationships and dynamics between providers over time. For example, one nurse shared an experience where she had a positive working relationship with a resident, yet this relationship changed when this resident became a physician. Another nurse recalls hearing practice stories from other nurses on

what physicians would do. “They can recall behaviours from physicians that would just completely boggle my mind with how cool they were being of something” (NURSE 3). She suspected that they wouldn’t do the same things now, and that the physicians were impacted by a high caseload and systematic barriers that also led to feeling burnt out. This same nurse recalled a situation when she was able to communicate well with a certain care provider, advocate for a patient, overcome barriers as a team member, and in turn respect all a woman’s wishes in labour. However, she attributed the support in part to that of the provider being a new physician and wondered if that would change over time as the physician became more experienced:

> …and I don’t think it’s their fault, I think that it’s a structural hierarchy that does something to them, the way that it does to us and everybody who works in it…and being disrespectful is not necessarily going to get you sued or fired, whereas not approaching something in a way that, like is going to achieve a good outcome, that is the most important thing to them by virtue of our work organization and the way that we practice medicine. (NURSE 3)

Another nurse made a similar comparison to nurses that over time get use to how things are supposed to go, indoctrinated to the way of the unit which speaks to the nursing culture.

> It’s like a woman will come in. They need an epidural, like they’re going to do this, everything is like, planned out. So, instead of following a birth plan, the nurses follow their own plan…So I find that respect is lost there because now we’re not thinking of the patient as an individual, we’re thinking of the patient as just a process that should be carried out”. (NURSE 1)

Conclusion

The process of labour and birth is a unique life experience that requires healthcare professionals to attend to the physical, emotional, social, and spiritual aspects of a patient, often in a very acute timeframe. As one nurse described:

> Birth is so personalized. It's not like you go in for an appendectomy or get your tonsils out or something. Those are just cut and dry. There's the emotions. There's building of a family. There's so much more to it. It's not just a procedure. (NURSE 4)

While many birthing experiences are positive and demonstrate respectful relationships, some experiences can leave lasting negative impressions for both nurses and women. Two nurses spoke openly about their experience with burnout. When experiencing burnout, one nurse found herself minimally engaged at work, not able to enter into meaningful interactions to build relationships with her patients and her colleagues and felt indifferent to what was going on. She recalled one of the final triggers was during a difficult case she felt that all the blame went to the nurses. She concluded that "the space in which she works can impact respect: is our environment safe? Is our environment allowing us the space to be compassionate… the environment is respect" (NURSE 7). Another nurse commented, "I'm just feeling a lot more powerless to really provide the kind of care that I want to" (NURSE 3). She expressed many experiences where she felt she was not getting the support she needed from colleagues and was aware of structural barriers that influenced her ability to care for her patients. In her written documentation, she wrote, "I am so convinced of my limited capacity to show and experience respect in my workplace that I am planning on leaving in about a year." While how respect is perceived between nurse and patient was the focus on this research, it was evident that the dynamics within

interprofessional relationships impacted respectful care to patients and affected the mental wellbeing of nurses.

Nurses and women participants in this study provided similar accounts of respectful care. Respectful care involves creating a space in which a relationship between patient and nurse is formed, where dignity and privacy are maintained, consent is received, and family are included. Caring for families from diverse backgrounds provided challenges for nurses who wanted to ensure their actions remained respectful to all people. While autonomy was highly valued, it appeared to be fluid depending on the context. It was challenging to show respect, especially when a patient did not accept medical advice, or during an emergency. Navigating relationships with family members placed nurses in the middle between a patient and their loved ones. Both nurses and women participants identified that nurses' professional relationships with other nurses, physicians, midwives, and student learners trickled down to adversely affect patient care. At times, this placed nurses in the middle of conflict between providers.

Lastly, the organization provided the structure in which nurses work and impacted their ability to provide the patient-centered and respectful care for which they strived. The culture of the unit, which was informed by the organization and societal influences on birth, influenced how nurses provided respectful care to patients and their families.

Chapter 5: Discussion and Limitations

The purpose of this chapter is to discuss the meaning of the findings and their implications for what is known about respectful care from the perspective of nurses and women who have recently given birth. Focused ethnography provided a way to examine the culture of respectful care. Several important and interconnected themes emerged. The first theme, creating space for respectful relationships, explored how respect is supported in the birthing room between the nurse, the labouring woman, and the family. It quickly became evident during the research that understanding the nursing role in respectful care cannot occur in isolation, but rather is influenced by a team of colleagues and the institution in which the care occurs. This is the theme of navigating relationships. The ebb and flow of a woman's autonomy is influenced not only by the labour process but also by the nurses' autonomy and the hospital environment. This is discussed in the theme of shifting autonomy amid pain and increasing vulnerability. Finally, nurses may find themselves "in the middle" between the wants and needs of the patient and their family, their colleagues, the hospital administration, and their professional role. Implications for the findings that emerged from this study contribute to the understanding of respectful care. While the themes are separated for clarity, they are all interconnected and affect nurses' ability to provide respectful care. Finally, limitations of the study will be addressed.

Creating Space

The participants described elements that created a respectful birth space, including the importance of building relationships between nurses and birthing families. Interaction with the birth environment was an opportunity to show respectful actions such as shutting doors and providing drapes for privacy as well as asking permission to come into the room. Supporting the family and accommodating the diversity of the birthing families contributed to a respectful

space. These are similar to concepts discussed within the Family Centered Maternity Care: National Guidelines (PHAC, 2017). Building a relationship with the birthing woman involves getting to know her on a more intimate level, developing a connection, and attending to her individual needs and wants during her childbirth experience. This is also highlighted in the AHS definition of respect where the patients' individual needs are attended to in a holistic manner.

The elements of creating space found in this study are also similar to the topology of respectful maternity care that was developed through a synthesis of qualitative research studies (67 studies from 32 countries) on respectful care during childbirth in health facilities globally (Shakibazadeh et al., 2017):

> Twelve domains of respectful maternity care include being free from harm and mistreatment; maintaining privacy and confidentiality; preserving women's dignity; prospective provision of information and seeking informed consent; ensuring continuous access to family and community support; enhancing quality of physical environment and resources; providing equitable maternity care; engaging effective communication; respecting woman's choices that strengthens their capabilities to give birth; availability of competent and motivated human resources; provisions of efficient and effective care; and continuity of care (p.935).

The findings from this research support many of the domains presented in the metasynthesis.

Respectful maternity care that is free of discrimination applies to all individuals, yet accommodating diversity and caring for ethnically diverse populations presented challenges for the nurses in this study. Some nurses expressed their concerns on how a patient's ethnicity may impact the care they receive and their access to timely high-quality care. They also had concerns

about their ability to integrate culturally appropriate care and communicate effectivity with women who did not have English as their primary language.

A meta-ethnography (22 papers) of immigrant women's experiences of maternity services in Canada identified many concepts that impacted their experiences, concluding with the need to consider how their social positioning impacted their ability to receive high quality care, as well as the need to integrate customs and beliefs into care (Higginbottom et al., 2014). These findings were supported by the concerns that the nurses in the current study had in providing culturally appropriate care. A systematic review that examined Indigenous women's perspectives of maternal health and health care services found that factors impacting their experience included limited local healthcare resources, healthcare services consideration of socio-economic or lifestyle barriers to health, and impact of colonization on the relationships between providers and Indigenous women (Kolahdooz, 2016). Respectful care is ensuring that care is equitable and free from discrimination (White Ribbon Alliance, 2011) and as such, any elements of discrimination must be addressed. Although it is not within the scope of this research, increasing awareness of systemic racism across healthcare in Canada (Canadian Public Health Association, 2018; Canadian Nurses Association,2020; Turpel-Lafond,2020) demands examination of this in relation to the care of birthing women and their families. This will be further discussed in the recommendations chapter.

Shifting Autonomy

While recognizing a woman's autonomy was identified as a respectful action, nurses' support for autonomy was fluid. Needing or according autonomy changed and shifted along with a woman's labour experience, and was also influenced by the nurse-patient relationship as well as the relationships with the other healthcare professionals on the unit. Women described

listening and being listened to as respectful actions, and having their needs or wants ignored was perceived as disrespectful. The nurses also expressed listening and responding to a woman's needs as respectful actions, but this was challenging when the patients' needs and wants conflicted with unit policies, the physician's orders, or the nurse's scope of practice. For example, while a nurse may agree with and support a woman's desire to use a variety of positions for active pushing in the second stage of labour, a practice supported by national guidelines (PHAC, 2018), the primary care provider has the ability and power to decide something different at the time of birth. As another example, a plan of care that was agreed upon by the patient, physician, and nurse may be dismantled at shift change when another physician takes over care. Women's autonomy is challenged in labour and birth when patient- (woman) and family-centered care in a team-based approach is not provided.

It was common for the nurses to express distress when a woman decided to follow a course of care that was different than what was recommended by the primary care provider. This was especially true if the decision a woman was making was believed to have resulted in a negative outcome for her fetus or newborn. Under the Criminal Code of Canada, fetuses do not have legal rights as they are not defined as persons, and do not become a human being until born alive (Government of Canada, 1985, C-46). It is, therefore, the laboring woman who ultimately decides what is the best course of action for herself and her fetus. The autonomy of a woman to decide what is best for her overrides that of a healthcare provider (Kotaska, 2017). According to the universal rights of childbearing women, every woman has the right to information, informed consent and refusal, and respect for her choices and preferences (The White Ribbon Alliance, 2011).

Experiences in the labour and birth unit can be intense and stressful, involve life and death situations, and leave a long-lasting effect on families and healthcare professionals. It appeared that many of the nurse participants took it personally when a woman refused medical care, or their recommendations. The sense of personal responsibility felt by a healthcare professional for the choices a woman makes appears to be conflict with respecting the woman's autonomy. This is reflective of the historical patriarchal context of obstetrics, and emphasis on authoritative knowledge that assumes that healthcare providers know more about what is right or necessary for a laboring person than the person herself. It can be difficult to accept patient refusal for procedures, and the need to intervene is often felt by the nurses and the healthcare team. A relational ethics perspective can provide guidance, as fostering autonomy in others is seen as fostering relational power, that is finding space to discover and enact one's personal power (Bergum & Dossetor, 2005). Therefore "in a relational view of mutual respect, patient, family, physicians, nurses, and others share decision making [also] share the ethical exploration of what is the right thing to do" (Bergum & Dossetor, 2005, p.93).

The WHO definition of respectful care supports informed choice, and while some of the women participants reflected on their ability to choose during labour, others were not sure what choices were available to them. The idea of a being a "good patient" as one who does not argue or yell to the staff, infers that agreeing with what the healthcare team is presenting is necessary. While informed choice suggests there are options in care, and the patient makes an informed choice on what is best for them, concern about informed consent for procedures was discussed by the nurse participants. When decisions were being made, women were required to either provide informed consent or informed refusal to any healthcare intervention. Informed consent between a healthcare provider and a patient involves the sharing of information that is evidence-

based, includes the risks and benefits of the proposed intervention, and provides available alternatives (Evans, 2016). The sharing of information occurs when the patient, in turn, informs the care providers of their values, circumstances, and preferences. From this discussion, a recommendation is made by the provider, and the patient can choose to accept or decline the course of action (Kotaska, 2017). Consent from a patient must be voluntary (Evans, 2016). Implicit in the right to consent to a procedure or treatment is the right to refuse. Attempting to change the mind of a woman is coercion, and can include exaggerating benefits or withholding risks, demeaning a woman for putting her baby at risk, or threatening to withdraw care (Kotaska, 2017).

Nurse participants in the study described witnessing elements of coercion, including hearing providers continually repeating the risks after a patient had made a decision, or elaborating on statistics to persuade a patient to make a certain choice. Some nurses witnessed procedures by care providers that did not include full informed consent. This finding supports data found in The Maternity Support Survey showing that two thirds of doulas' and nurses from Canada and the United States (n=2781) reported occasionally or often witnessing providers engaging in procedures without informed consent or, although less often, proceeding despite a woman's refusal (Morton, Henley, Seacrist, & Roth, 2018).

A paternalistic model of care persists, and nurses, as part of the healthcare system, need to challenge care that does not respect childbearing women (Goldberg & Shorten, 2014). That a paternalistic model of care can affect the ability of nurses to provide respectful care was supported in this study. Promoting and respecting informed decision making is one of the seven primary nursing values in the Canadian Nurses Association Code of Ethics (CNA, 2017b). Within this value, nurses have an ethical responsibility to respect the wishes of capable people to

decline information about their health condition, recognize a person's right to refuse or withdraw consent, and recognize that people may choose to defer to "family, cultural expectations, or community values in decision-making while complying with the law of consent" (CNA, 2017b, p.11). It is the responsibility of the nurse to work with the family to help them understand why the patient made the decision they did (CNA, 2017b). It is critical that nurses understand the social, cultural, and political factors that may be influencing women's choices in childbirth. According to the CNA Code of Ethics, nurses have the responsibility to speak up when others fail to respect the dignity of a person they are caring for, "recognizing that to be silent and passive is to condone behaviour" (2017b, p.12). However, this can certainly be difficult to do and will be discussed further in the section on supporting a just culture.

Findings from this study support the promotion of a birth plan as an opportunity to open communication between a woman and healthcare professionals, and when used throughout labour and birth, a way to provide respectful care. Other terms such as a birth guide or birth preferences have been used to describe a birth plan, but the term 'birth plan' will be used in this discussion as it was the most used term throughout the interview process. A birth plan is a written document that outlines a person's preferences for pain management, medical interventions, and support during the labour and birth process. It is developed to help women to clarify their wishes for their labour and birth care, and communicate these wishes to their care team (Lothian, 2006). The concept was developed by childbirth educators in response to the medicalization of the birth process, in an attempt to help women avoid interventions, and make informed choices (Kitzinger, 1999; Lothian, 2006). When created in collaboration with healthcare providers during prenatal care, it can be a way for healthcare providers to learn about

a woman's preferences, build trust, and identify opportunities for education (Public Health Agency of Canada, 2018).

In this research study, birth plans encouraged open communication with some nurses and healthcare providers, and caused tension or mockery from others. These findings are consistent with what has been reported previously. A Canadian quantitative study examined the perspectives of birth plans held by women (n=112) and care providers (n=110) (Aragon, Chhoa, Dayan, Fluftinger, Lohn, & Buhler, 2013). The benefits of a birth plan were found to include its use as a communication and educational tool, increasing informed decision making, and increasing mothers' feelings of control and empowerment. The disadvantages of a birth plan included the potential for negative emotions arising if the plan is not followed, is unrealistic or too rigid.

Common critiques of birth plans include the concern that parents-to-be may be inflexible to making recommended changes within the plan, and the plan may include out-dated or defensive sounding information (Kaufman, 2007). This is also supported by findings in this study. While the birth plan was used and encouraged by some participants in the study, other women were discouraged to create a birth plan by healthcare professionals because of perceived negative consequences they may experience if labour deviated from the plan.

A birth plan may create tension between care providers and women when there are conflicting beliefs about birth, and power imbalances (Lothian, 2006). Mockery of a woman's birth plan or the use of phrases that imply a long birth plan is associated with caesarean section or other adverse outcomes shows disregard and disrespect for a woman's thoughts, feelings and preferences, and belittles her attempt to have a sense of control over her own birth. Perhaps it is the underlying emotions and thoughts of the woman, the beliefs and attitudes of the team, and the

work environment that influence the outcomes rather than the birth plan itself. A focus group with labour nurses concluded that nurses perceive that they have an influence on whether or not a woman has a caesarean section (Simpson & Lyndon, 2017). While the nurses voiced that they actively tried to support women from requiring a caesarean section, it is important to acknowledge that influence can go either way. In a qualitative study that examined the perceptions of nurses (n=73), new mothers (n=23) and physicians (n=7), the researchers concluded that nurses' support and advocacy for women have an important effect on birth outcomes, and that caesarean rates and breastfeeding rates are likely nurse-sensitive (Lyndon, Simpson, Spetz, 2017). Research that measures the influence of the nursing role on patient outcomes is needed.

While effect on birth experience and satisfaction remains unclear (Mirghafourvand et al., 2019), participants reported that the birth plan can be used as a tool to open communication between women and care providers, and as an educational opportunity about the labour process and postpartum experience. This finding is consistent with the assertion that the process of creating a birth plan can help parents learn about birth, explore their choices, and assist in identifying their concerns or questions for their care providers (Kaufman, 2007). Rather than a rigid documentation of what the birthing family does or does not want, the birth plan can be viewed as a living document that reflects changing circumstances, ongoing communication, and new information (Lothian, 2006). Listening to women, obtaining consent, and including them in the decision-making matters, is part of providing respectful care, and has an impact on their birth experience. Not doing so may lead to traumatic birth experiences.

In a study that included women who had a traumatic birth experience four themes emerged: having a lack of information and consent, feeling excluded from the decision-making

process, feeling distant from the event and experience, and inconsistency in a woman's expectation versus their reality (Koster et al., 2019). While it was not the scope of this research to explore traumatic birth experiences, disrespectful care may contribute to a woman experiencing negative feelings, which may impact their mood, and ability to effectively transition into parenthood. The healthcare team needs to be aware of the impact of their actions, and ensure they contribute to a positive, respectful birth space for women to have a positive birth experience.

Providing respectful care in an emergency was identified as a challenge for the nurses, and a concern for women who found themselves in an obstetrical emergency. Obstetrical emergencies are often life threatening for birthing women, their fetus, or both, and often results in an immediate birth, frequently by caesarean section. Several nurse and women participants felt that the family was often ignored during an emergency, not included in the discussion, or made aware of the birth progress, and at times being left in the hospital room alone and worried for the safety of their family member. Findings from this study are consistent with those reported in studies where the partners experiences during an obstetrical emergency were examined; partners may feel forgotten and powerless, and communication with them is critical during an emergency (Hinton, Locock, & Knight, 2014; Snowden, Elbourne, Forsey, Alfirevic, 2012). The nurses in this study identified the importance of having one nurse designated as the support person for the woman and family during an emergency, responsible for the ongoing communication as a way to ensure everybody remains informed and involved in the process. As inclusion and communication with the family was identified as an aspect of respectful care, it is important to improve the care provided to families during an obstetrical emergency.

Navigating Relationships

Respect is also a key component of relationships among all members of the healthcare team. It quickly became evident in the research that all relationships in which the nurses engaged impacted the important nurse-patient relationship, and their ability to provide respectful care. Unsupportive relationships among nurses, disrespectful conversations between colleagues about patients, conflicts between colleagues, lack of understanding and trust among team members, inability to speak up against disrespectful or unsafe care, and the additional workload of student learners were all identified as factors that impacted the ability to provide high quality, respectful care. The historical context of birth within Canada, and the hierarchical and patriarchal influences within healthcare continued to impact professionals' relationships, and the care provided to women and their families.

These findings support the complexity of the nurse-physician relationship that has been debated and scrutinized over many years and continues to evolve (Stein, 1967; Stein, Watts and Howell, 1990; Svensson, 1996; Rosenstein, 2002; Kramer & Schmalenberg, 2003; Holyoake, 2011). The dynamics within this relationship impact high quality care and patient outcomes. A collaborative and positive working relationship has been found to lead to improved patient and organizational outcomes, and increased satisfaction among nurses and physicians (Baggs et al., 1992; Kramer & Schmalenberg, 2004). On the other hand, perceived lower quality of care can be partly explained by poor nurse-physician relationships (Kenaszchuk, Wilkins, Reeves, Zwarenstein & Russell, 2010). A focused ethnography examined nurses' perceptions of interprofessional teamwork in labour and delivery and found that time, trust and respect, credibility, and social connection were the facilitators of positive relationships between nurses and physicians (Gleddie, Stahlke, Paul, 2018).

The nurse-midwife relationship is another that presented challenges to respectful care in this study. In Canada, midwifery is a profession distinct from nursing. Nurses have practiced under the medical model of care with physicians much longer than they have collaborated with midwives under the midwifery model of care. While some nurse participants expressed positive working relationships with midwives, others expressed concern around the safety of midwifery care, a lack of understanding by the midwives of the scope of nursing practice, and a lack of clarity of the nurses' role when assigned a midwifery patient. Nurses felt this threatened their ability to provide respectful care as they were unable to develop a strong relationship with their patient and felt uncertain about their role within the birth space. These findings were consistent with those reported in a focused ethnography examining the nurse-midwife relationship that found philosophic tensions surrounding labour and birth, safety, communication and respect, and pain management (Kennedy & Lyndon, 2008). A systematic review which included five articles examined the experiences of midwives and nurses collaborating to provide birth care, and found that negative experiences were influenced by distrust, lack of clear role, or unprofessional and inconsistent behaviour (MacDonald et al., 2015). This is congruent with the experiences the nurse participants shared.

The importance of student learners was acknowledged by the nurse participants, but they voiced concern about the difficulty in providing patient-centered care while also being responsible for meeting students' learning needs. Some nurses worried that mentoring a student detracted from the woman's birth experiences, while others acknowledged that the extra teaching and education provided to the student would benefit the patient. The challenge of balancing the needs of both a patient and a learner is cited in the literature (Cucsak et al., 2020). Limited research was found on preceptoring nursing students in a busy intrapartum setting, and its impact

on patient experiences or outcomes. Nurses in this study frequently witnessed physicians interacting with students and residents, and found it disrespectful when they focused their conversation towards each other rather than to the birthing person and their family.

Interprofessional collaborative patient-centered practice can positively impact care and health service delivery, and is supported by the Canadian Nurses Association (CNA, 2011). The Multidisciplinary Collaborative Primary Maternity Care Project was initiated in 2002 with the purpose of promoting women-centered quality care and improving communication between providers, and in turn fostering mutual respect for the contributions made by the professionals (Peterson, Medves, Davies, & Graham, 2007). In a qualitative study where 25 representatives from Canadian healthcare associations were interviewed about the project, interdisciplinary rivalry, characterized by turf protection (competitiveness) and a lack of mutual respect between maternity care providers, was identified as a significant barrier to collaborative care (Peterson, Medves, Davies, & Graham, 2007). Findings in this study support those elements of interdisciplinary rivalry that still remain evident in the relationship's nurses have with their colleagues.

Findings from this study also indicated that navigating relationships with colleagues involves attending to the emotional space in the workplace. Emotional labour is a term coined by sociologist Hochschild (1983) to describe managing personal feelings in the work setting. It is invisible, and requires one to either induce or suppress their own feelings to produce a sense of wellbeing in others. Emotional labour is inherent in the role of nurse, whose job it is to support patients who are in vulnerable positions during intense life experiences, such as birth and death. It is argued that the term 'emotional work' expands the concept of emotional labour by capturing

the complex emotional work response behaviours enacted by nurses in the workplace (McClure & Murphy, 2007).

While attending to the emotional needs of patients is often described as part of the nursing role, some nurses described their frustration in the unspoken requirement of tending to the emotional needs of their colleagues. Nurses provided examples of when they felt it was part of their role to be peacekeepers on the unit in order to minimize tensions or conflicts between colleagues. Others discussed situations where they went out of their way to put their physician colleagues in a positive mood in an effort to limit the number of negative interactions they may have during a shift. This reinforces the subservient role of the nurse to tend to the physician needs, as well as any real or perceived power imbalances among the healthcare team, and does not foster an environment in which mutual respect occurs. While attending to the emotional needs of colleagues may be important, it must also be reciprocal, with the intent to support team members rather than from a place of self-preservation in a negative work environment.

Mutual respect was not consistently felt by the nurses in this study, yet respect is important in interprofessional relationships with colleagues as well as relationships with patients. Relational ethics provides the space to explore mutual respect among relationships in healthcare, recognizing that mutual respect occurs in an environment of interdependence, with a focus on connection, and how we treat each other (Bergum & Dossetor, 2005). Relationships between care providers have been shown to contribute to or hinder patient safety initiatives, and the need to create a culture of respect is essential to a safe high-quality organization (Leape, Shore, Dienstag, et al., 2012a; Leape, Shore, Dienstag, 2012b).

A secondary analysis to evaluate the Interprofessional Model of Patient Care (IPMPC) was completed by measuring collaboration, respect, inter-professional conflict, and patient safety

climate (Manojlovich, Kerr, Davies, Squires, Mallick, & Rodger, 2014). The authors concluded that collaboration and respect were significant independent predictors of the patient safety climate. Unresolved conflict contributes to a lack of respect, and disrespect can inhibit collaboration and compliance with practices that promote patient safety (Leape, Shore, Dienstag, et al., 2012a; Leape, Shore, Dienstag, 2012b)

Quality and safety improvement "will occur when those who work in healthcare feel respected by their co-workers and safe to 'speak up' if they have a concern about patient care" (Health Quality Council of Alberta, 2013, p. 2). The nurses in this study did not feel comfortable speaking up when they witnessed disrespectful care, nor did they consistently feel supported by those in a charge nurse or management position. This is congruent with the US study in maternity care where half of nurses reported feeling free to question the decisions of those in authority (Clarke & Lake, 2020).

Nurse participants in this study also expressed the concern that the nurse is always to blame if something goes wrong, or when an oversight occurs. This suggests that other members of the healthcare team may not be engaging in self-reflection, or recognizing their contribution to problems. Clearly, this approach does not reflect a culture of mutual respect. Creating a Just Culture, as Alberta Health Services has committed to do, will work towards creating a safe space where healthcare workers, "are treated with respect and feel supported when something goes wrong or nearly goes wrong in patient care" (accessed October 3, 2020, from justculture.hqca.ca). Just Culture focuses on system factors, and the larger context in which an unsafe situation may occur, recognizing the many complex factors that can impact healthcare providers' actions and patient safety. A focus on respectful care related to quality improvement

and patient safety is an important outcome of this research and will be discussed further in this chapter.

Nursing in the Middle

Nurses have a responsibility to patients and their families, colleagues, and the institutional policies under which they work. This often places them in a middle space, leaving them to navigate through familial disagreements, disputes with colleagues about courses of care, and challenging or accepting a unit policy. The interactions that occur within this space, whether respectful or disrespectful, influence the unit culture, and patient encounters. Nurses were challenged in providing care when they found themselves between being able to respect the patients requests and conflicting physician orders or unit policies. It was distressing for nurses to know what the patient needed, but to be limited in their ability to address that need, whether hindered by time, unit policies, family members, or care provider orders. When providing care to individuals against medical advice, some nurses in this study expressed frustration, sadness, and anger, and felt challenged in their ability to provide respectful care in the moment. It was difficult for these nurses when family members spoke for the patient and appeared to refuse procedures, such as an epidural, on her behalf. While patients may defer to their partner or family to make their decisions, it is important to ensure that each patient has the ability to make their own decisions, free from coercion or abuse. Distress for nurses occurs when they are unable to ensure that the patient is making such a decision; for example, when there is a language barrier, or the presence of a controlling partner. Conflicts between colleagues and primary care providers about the course of care for a patient also contribute to distress.

Some of the nurse participants spoke openly about their distress in the workplace, distress significant enough to cause resignation from work, or contemplation of resignation. Lack of

power to address system change, limited support by colleagues and management, and the lack of ability to provide consistent respectful and high-quality care contributed to their feelings of distress. Feeling conflicted by internal and external factors, and by not being able to provide the care that the patient needs can cause nurses to experience moral distress (Austin et al., 2005; Austin, 2012).

Moral distress involves knowing the morally right thing to do but being unable to act due to personal or systemic structures (Rodney, 2017). Factors that lead to moral distress have been categorized as internal, such as fear or lack of knowledge, and external, such as system characteristics, team conflicts, and resource allocation (Austin, 2016; Huffman & Rittenmeyer, 2012). While research on moral distress has been explored in acute settings including intensive care and critical care units (Huffman & Rittenmeyer, 2012; Oh & Gastmans, 2015; Wall, Austin, & Garros, 2016; McAndrew, Leske, & Schroeter, 2018), limited research exists in the experience of moral distress among labour and birth nurses (Wilkinson, 1989).

Secondary traumatic stress syndrome may be experienced by healthcare providers who have been exposed to caring for a traumatized patient, or to a traumatizing event (Beck and Gable, 2012). Nurses who work on labour and birth units may encounter traumatizing events. A mixed methods study conducted to inquire about secondary traumatic stress in labor and delivery nurses demonstrated that the top three traumatic events reported by nurses were infant or fetal demise, maternal death, and shoulder dystocia (Beck & Gable, 2012). Four situations that intensified exposure to traumatic birth were being a new nurse, abusive deliveries, patients with a language barrier, and adolescent patients. This is supported by the findings in this study as nurses described situations that included fetal demise, physical and verbal actions against a patient, and caring for patients with a language barrier. Traumatizing situations would replay in

their minds whenever they encountered a similar labour or patient personality, causing them to relive the trauma and feel angst. Elements of disrespectful actions infused into these situations can contribute to the mental stress experienced by nurses, may lead to moral distress and secondary traumatic stress syndrome, and affect their health and careers.

Respectful Care as Element of Patient Safety and High-Quality Care

The purpose of this research study was initially to explore respectful care within a patient- and family-centered care framework; however, it became evident that respectful nursing care is better situated within a framework of quality of care and patient safety. Nurses and women provided stories that illuminated issues related to patient safety, including communication barriers, lack of informed consent, and judgement or pre-existing biases. Historically patient safety has long focused on preventing physical harm in healthcare; however, there has been a recent shift to strive to improve the organizational culture that informs healthcare quality and safety (Institute for Healthcare Improvement [IHI], 2020). The IHI framework for safe, reliable, and effective care focuses on two broad areas of organizational culture and learning systems, and within this framework the areas of psychological safety, teamwork and communication, and transparency are addressed (Frankel, Haraden, Federico, Lenico-Edwards, 2017).

It is important to examine adverse events in healthcare to further understand how to prevent harm, and promote safe practices. According to the IHI, adverse events occur for several reasons including the use of rapidly changing technology, lack of clear right answer or enough time, complex coordinated care for patients, and the hierarchical nature of healthcare which can contribute to disrespectful and abusive behaviour (IHI, 2020). Disrespectful behaviour is a threat to patient safety, limits our progress in improving healthcare, and influences organizational

culture. A culture of disrespect is "harmful for many reasons, but its effect on the safety and well-being of our patients that makes it a matter of urgency" (Leape et al.,2012, p. 846).

The patriarchal and hierarchical nature of healthcare can foster a culture of disrespect. In a hierarchical setting, respect tends to extend upwards to those in higher positions, rather than to those below. In addition, in a hierarchical environment, "the ability to disrespect others with impunity is a measure of status" (Leape et al., 2012, p. 850). This is why certain individuals are able to behave in disrespectful ways without repercussion, whereas others accorded lower status would be reprimanded if they displayed the same actions. Although shifts in healthcare culture are happening, nurses have traditionally been seen as subordinate to physicians.

A recent study in maternity care in the US concluded that the quality of the work environment predicted patient safety and quality of care (Clarke & Lake, 2020). A culture of distress, and a stressful healthcare work environment can contribute to healthcare professional burnout and distress. Nurses who witness disrespectful behaviour are more likely to leave their employment (Morton et al., 2018).

Respectful care during childbirth has received global attention for the last decade, with key reports and research describing the mistreatment of women during labour and birth around the world (Bowser & Hill, 2010; Bohren et al., 2015). Potential contributors linked to disrespect and abuse in facility-based childbirth include the individual and community, laws and policies, governance and leadership, service delivery and the providers themselves (Bowser & Hill, 2010). While disrespectful care within low- and middle-income countries is often explored, this research supports the premise that issues surrounding respectful care are also present in high-income countries and requires further exploration as a universal concept. The Respectful Maternity Care (RMC) movement involved intersectional collaboration to promote and support

respectful practices around the world. The revised World Health Organization guideline on intrapartum care includes the importance of a positive birth experience, and supports the presence of clinical requirements for both safe labour and birth, and the emotional and psychological needs of a woman during childbirth (WHO, 2018). Service delivery and the woman's experience define high quality care, placing the woman and her baby at the center of the care model, with respectful labour and childbirth care being integral to the model. In addition, the International MotherBaby Childbirth Organization (IMBCO), and the International Federation of Gynecology and Obstetrics (FIGO) jointly developed the global initiative, The International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care (2018). See Appendix M. Integral to this initiative is the relationship between the mother-baby dyad and the family, as well as interactions with health providers and the system (Lalonde et at., 2019). It focuses on respect, choice, shared decision making, high quality care among others, and it is envisioned that the 12 steps described can be measured and monitored, striving to continually improve maternity services around the world. The MotherBaby-Family model of care was influenced by Canadian Family-Centered Maternity and Newborn Care: National Guidelines (PHAC, 2017), which guide maternity care in Canada. Lastly, the Patient First Strategy, one of the four foundational strategies for Alberta Health Services, focuses on relationships with those seeking care and working within the system, as well as the need for patient-personalized care.

This research supports that infusing respectful maternity care principles is needed in the local context to strive for a positive childbirth experience for all patients, to improve patient safety, and to provide high quality care. The nurse participants identified many respectful actions that they include in their practice, but their ability to provide patients (women) respectful,

focused care was impacted by relationships with their colleagues, and in their environment. Feeling silenced and unable to address care practices that they recognized as disrespectful demonstrates the need for continued team building and collaboration. Nurses are often placed in the middle of competing demands which may contribute to feelings of distress and powerlessness as they struggle to provide high quality patient-centered care. The women in this study also identified times when they felt respected but also times when they did not, and felt care could be improved, such as less waiting time, and improved communication in the assessment area, and further integration of the birth plan into care. The Respectful Maternity Care movement, the recent recommendations by WHO, global and local patient safety initiatives, as well this research provide a clear path towards the need to support the holistic wellbeing of childbearing women and their families by fostering respectful relationships among and between the maternity care team and those who are in their care.

Limitations

It is important to identify the limitations in any research. This research is limited by the time and space in which the data were collected, as perceptions and experiences can change over time**.** Minimal observational data were collected for a few reasons. The design of the study placed the researcher in open hallways and at the nursing desk, accessible to only public conversations. As birth is a significant moment, the researcher wanted to show respect for birthing women and their families by giving them privacy and not entering the labour room. In turn, the design included two interviews with each nurse who reflected on recent clinical experiences to provide the additional context. The observation period at the desk and hallways yielded limited information and as such only occurred a few times and at one hospital location.

The recruitment was limited to people who speak English and, therefore, limited information was gathered from people who primarily spoke another language. In addition, ethnicity was not collected in the demographic data. There is a need to seek further experiences from women who may identify as Black, Indigenous or as a Person of Color. This is important to address concerns around systemic racism in healthcare and how it may affect labouring women. Seeking additional diverse experiences from LGTBQ2S community would also increase understanding of respectful care.

Chapter 6: Recommendations and Conclusion

The purpose of this chapter is to provide recommendations for respectful care during labour and birth for nursing clinical practice, education, research, administration, and policy. Dissemination strategies and concluding remarks will also be presented. Clinical practice recommendations focus on various in-services, interprofessional team development, and strategies to address equity and diversity. Education recommendations address nursing education and preceptor mentorship. Administration recommendations discuss the inclusion of respectful care in patient safety, and quality care initiatives including the adoption of initiatives such as a Just Culture and the International Childbirth Initiative (See Appendix M), and increased support for nursing staff. Research recommendations involve incorporating respectful care in practice and improving healthcare professional relationships. An executive summary of the recommendations will be brought forward to the women's health executive leadership team who can influence advancement in respectful care.

Clinical Practice

Respectful care includes developing a collaborative relationship with women and their families, integrating birth preferences into care, and ensuring informed choice and consent. It is free from discrimination, and is essential to improving clinical practice. I will offer to facilitate unit in-service discussions on respectful and disrespectful care practices to healthcare professionals on labour and birth units with the intent of increasing awareness and self-reflection that will encourage personal and professional growth, and facilitate changes that are needed in practice. Within this discussion will be a review of the broader historical context of patriarchy and hierarchy in obstetrics. While changing the underlying roots of obstetrics is challenging and will take time, it is imperative that healthcare professionals continue to advance their

understanding of the context and culture that impact their care, and strive to ensure woman receive respectful, evidence-based, high-quality care. Integration of key concepts and documents such as the Rights of the Childbearing Person, Respectful Maternity Care movement and the World Health Organization documents related to a positive birth experience will be included. The information from the in-service training can also be integrated into unit orientation for new nurses.

I plan to advocate to healthcare leaders for training of healthcare professionals on unconscious biases, cultural safety and humility. Education on how to provide culturally safe care during labour and birth, and information on traditional birth practices, values, and beliefs is needed. Partnering with previous patients and their families, members of the Black, Indigenous, and People of Color community, and organizations such as Multicultural Health Brokers can assist in creating a relationship of mutual understanding, trust, and respect. Alberta Health Services is committed to developing their workforce and organization to meet the needs of Indigenous people (AHS, 2020), and partnering with the Indigenous Wellness Core at AHS to support this education and awareness programming is needed. Nurses and other healthcare professionals should have the opportunity to self-reflect on their unconscious biases, their use of language to each other and their patients, examine their role in creating a respectful space that values diversity and inclusion, and be able to identify actions that contribute to and condemn discrimination and racism. It is also vital for healthcare leaders to integrate the healthcare calls to action within the Truth and Reconciliation Commission of Canada report (2015). As such, I will continue to advocate to leaders for a commitment to the calls to action, including the support for Indigenous healing practices during the care of birthing families.

I will also advocate for perinatal rounds that focus on equity, diversity, inclusion in obstetrical care that is accessible to all obstetrical healthcare professional, as well as the development of a working group, such as an Equity, Diversity and Inclusion committee at the unit level to encourage the collaboration of nurses, physicians, midwives, and management.

Nursing Education

Learning about the history of childbirth in Canada is important for students to understand the evolution of obstetrical care. Teaching undergraduate and graduate nursing students the various models of care, the holistic needs of a birthing person and family in labour, as well as the global recommendations for the care of childbearing can provide nursing students insight on the factors that influence their nursing practice. This understanding may provide the context needed to enable nurses to recognize and challenge any assumptions or ongoing paternalistic aspects of care. It is also important to discuss key documents around respectful maternity care, patient- and family-centered practice, the International Childbirth Initiative, and the WHO recommendations for a positive birth experience.

Nursing faculty is encouraged to ensure that students have access to interprofessional healthcare courses at the undergraduate level. Interprofessional education is supported by the Canadian Interprofessional Health Collaboration (http://www.cihc-cpis.com) and Health Sciences Education and Research Commons (HSERC). HSERC commits to providing University of Alberta students practice in four interprofessional competencies: communication, collaboration, role clarification, and reflection (https://www.ualberta.ca/health-sciences-education-research/ip-education/index.html). An example of a collaborative maternity education program that includes medicine, midwifery and nursing was developed in Vancouver, British Columbia (Saxell, Harris, Elarar, 2010). The development of compulsory interprofessional

courses that include self-awareness, advocacy, interpersonal dynamics, and how to be an effective team member in a safe supportive environment may help foster mutual respect and contribute to creating a positive work environment in the future.

Nurses need to be aware that the interactions they have with students can affect their patients. While this may be a positive impact if the patient receives high quality care, it could also be a negative impact if there is tension between the nurse and the student, or if the student distracts the nurse from providing focused care. Nurse educators can help nurse preceptors work through conflicts or tensions in a timely manner so they do not fester or continue to build throughout their time together. They can also discuss factors influencing the care of labouring women with nurse preceptors to ensure that the individual labouring woman always remains the focus of their care, and that the student's presence enhances rather than detracts from the experience of patient-centered care. Strategies may include a discussion with the student prior to going into the room about their role and what is needed, involving the patient in all conversations while in the room so they feel included rather than ignored, and deferring any conversations that distract the team from current patient needs (e.g., if a woman is pushing, focus on coaching and supporting).

Administration/Policy

A Just Culture focuses on a respectful work culture and provides an avenue for nurses and other healthcare professionals to address their concerns. Supporting and not penalizing those who come forward with concerns on the unit, or about the practice of a colleague is important. I will advocate to labour and birth management and hospital administrators to continue to strive for and integrate the guiding principles of a Just Culture as initiated in 2014 by Alberta Health Services (https://justculture.hqca.ca/education-resources/). This will help to identify disrespectful

actions, and instill processes to prevent them from re-occurring, as well as encourage and support all maternity care providers to speak up against unsafe care. It is important that concerns not be dismissed or deferred back to the nurse to deal with on their own, but rather be explored and viewed as an opportunity to improve care and address systemic influences on practice. This will be instrumental in addressing the concerns among nurses who feel that they do not have the support they need to question their colleague, and improve the culture on the unit. Challenging the hierarchy, and instilling a policy that reflects zero tolerance for disrespectful behaviours can contribute to a safe, positive, and respectful environment. Placing relationships at the center of policy development and addressing the interpersonal factors that impact respectful interactions will continue to improve the workplace environment.

I will promote the adoption of The International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care to the leadership team (see Appendix M). This would demonstrate the unit's commitment to safe and respectful care to childbearing women. It is envisioned that the 12 steps can be measured and monitored, and the inclusion of respectful care as an element of high-quality care and patient safety data can elevate respect from a "nice to have" concept to an integral part of patient care and effective interprofessional teams.

I will recommend the need for interprofessional education, and development days that include defining team roles and responsibilities as well as informed choice, consent and refusal; strategies to explore a person's values, beliefs and preferences, and how to incorporate a birth plan into care; review case vignettes on respectful and disrespectful action; and allow for space to practice advocacy and communication skills. Having the opportunity to discuss concerns and develop solutions together with all healthcare professionals in a safe environment may contribute to improved team practice and help to dismantle paternalistic actions and hierarchy among the

team members. Framing this discussion within the Rights of Childbearing Women and the respectful maternity care movement can provide the context needed to explore these topics.

I will promote a resource to the leadership group that fosters shared decision making on the labour and birth unit which may address patient concerns related to informed consent. An example of a resource that may be used was developed by the Birth Lab (accessed online March 5, 2021 at https://www.birthplacelab.org/decision-making-tool/). It places the pregnant person in the middle of the care circle, and includes ongoing responsibilities around eight elements of person-centered decision making The ongoing responsibilities include taking an inter-professional approach, attending to power imbalances, documenting the information exchange, and revising the plan as needed. This tool provides an approach for shared decision making that can foster respectful interactions with pregnant people and members of the healthcare team.

I will encourage management to examine the support provided to the patient, family members, and healthcare professionals during an emergency. Having one nurse designated to provide continuous support to the patient and family during an emergency will ensure that everyone remains informed and involved. A policy of holding a debriefing session with the family and healthcare providers following an emergency can provide the space and context needed to discuss what happened and address any immediate questions and concerns.

Administrators need to support programs that focus on interprofessional collaboration in an emergency, such as ALARM (Advances in Labour and Risk Management) and MORE^{OB} (Managing Obstetrical Risk Effectively Obstetrics). While these programs provide education on interprofessional communication, it is necessary to include strategies that promote communication to the patient and their family during an emergency. It is also important for management to recognize that emergency situations may be traumatizing for healthcare workers.

It is important address mental health within the workplace, and the administration can demonstrate that it values a healthy workforce by providing paid time to access services and engage in debriefing sessions as a team. The National Standard for Psychological Health and Safety in the Workplace was created in 2013 (Bureau de normalisation du Quebec [BNQ], Canadian Standards Association Group [CSA Group], Mental Health Commission of Canada [MHCC]). MMCC in collaboration with HealthcareCAN, added in two additional factors specific to the healthcare sector: protection from moral distress, and support for psychological self-care (https://www.mentalhealthcommission.ca/English/what-we-do/workplace/workplace-healthcare). On the MMHC website, Alberta Health Services is listed as a signatory of the Declaration of Commitment to Psychological Health and Safety in Healthcare (accessed July 29, 2021 from https://www.mentalhealthcommission.ca/English/workplace-healthcare-declaration) and resources and tools developed by MHCC and HealthCareCAN can be used to promote mental health and wellness in healthcare settings.

I will support and advocate for adequate public healthcare funding so administration has the budget for adequate nurse resources and staffing on the labour and birth unit, such as one to one (1:1) nurse to patient ratios for labouring patients, and an adequate number of Operating Room (OR) trained labour and birth nurses. Adequate staffing will ensure safe, continuous, high quality, patient-centered care is provided in a timely manner. The inclusion of nurses who can float to the labour and birth unit may help limit the need for other nurses to be required to leave their own patient when assistance is needed in the operating room or during an emergency, ensuring continuity of care for women in labour. The development of a staffing tool that monitors patient load and acuity among nurses per shift is needed to ensure patient assignments are transparent and fair.

I will also advocate for units to administer exit interviews when nurses terminate their employment on a unit so administration can gain insight into the reason's nurses leave their unit. This is critical information for administration in order to address the areas contributing to nurse burnout and distress, and increase nurse retention. It can also help identify toxic work environments, including disrespectful behaviours among professionals.

Research

The findings of this study confirm that there is a need to further examine the care of childbearing women and their families in Canada. As awareness of the need for respectful maternity care increases, intervention and evaluation research can provide insights into how elements of respectful care can be incorporated into practice. Considering the emphasis on interprofessional relationships and their impact on respectful care, a multi-disciplinary research team could further explore the complex dynamics impacting the healthcare professionals that work on labour and birth units. An appropriate design could be an institutional ethnography where respectful practice during various shifts (day, evening, night) and with various teams (nurses, midwives, physicians) could be explored to analyze differences in practice. While nurse-physician relationships have been extensively studied, there is clearly a need to address the hierarchical nature of this relationship as well as a need for further research exploring collaboration within the nurse-midwife relationship and the impact on patient care. Exploring the experience of moral distress among obstetrical nurses under the framework of respectful maternity care can increase our understanding of this phenomenon. Research that explores issues around equity, diversity and inclusion as an element of respectful care in healthcare is needed, specifically during the continuum of labour, birth and postpartum. There is also a need to seek

experiences of all childbearing people with research that focuses on the experiences of Black, Indigenous, and People of Color (BIPOC), and those who self-identify as LGBTQ2S+.

Dissemination

An executive summary of the research will be presented to the administration and leadership team at the participating units. An in-service workshop, as well as resources will be offered to the administration team and if permitted, provided during education days. Timely submission of research articles to key journals such as *Birth*, and the *Journal of Nursing and Midwifery* will be made as well as preparing abstracts for poster and oral presentations at relevant conferences. A summary of the research and a proposed draft position statement on respectful maternity care will be presented to CAPWHN (Canadian Association of Perinatal and Women's Health Nurses) to encourage them to promote the importance of respectful care.

Conclusion

Nurses on labour and birth units work in a very rewarding yet complex and dynamic environment, and are required to multitask and balance the wants and needs of the childbearing person, the family, the healthcare team, and the organization. Providing respectful care during labour and birth is critical to ensure high-quality care and to support a positive and safe birth experience. A focus on respectful interactions and relationships among healthcare providers is needed to ensure that everyone has a physiologically safe, collaborative, and positive work environment. It is vital that leaders of healthcare organizations ensure that healthcare providers have the time and resources needed to provide respectful care to their patients, and strive to create a respectful, just culture.

References

Accreditation of Interprofessional Health Education. (2009*). Accreditation of interprofessional health education (AIPHE): Principles and practices for integrating interprofessional education into the accreditation standards for six health professions in Canada*. Canada: Author.

Alberta Health Services. (2014a). *The patient first strategy*. Alberta: Author.

Alberta Health Services. (2014b). *Patient and family centred care resource kit: How to improve the patient experience at the point of care*. Alberta: AHS, Quality and Healthcare Improvement, Engagement and Patient Experience Department.

Alberta Health Services. (2015). *FAQ patient first strategy*. Alberta: Author.

Alberta Health Services. (2020). I*ndigenous health commitments: Roadmap to wellness.* Alberta: Author. Retrieved from https://www.albertahealthservices.ca/assets/info/ihp/if-ihp-indigenous-health-commitments.pdf.

Alberta Health Services. (2014c). *The people first strategy*. Alberta: Author.

American College of Nurse-Midwives (ACNM), Midwives Alliance North America (MANA), National Association of Certified Professional Midwives (NACPM). (2012). *Supporting healthy and normal physiologic childbirth: A consensus statement by ACNM, MANA, and NACPM.* USA: Author. Retrieved from http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000002179/physioloigical%20birth%20consensus%20statement-%20final%20may%2018%202012%20final.pdf.

Aragon, M., Chhoa, E., Dayan, R., Kluftinger, A., Lohn, Z & Buhler, K. (2013). Perspectives of expectant women and healthcare providers on birth plans. *Journal of Obstetrics and Gynaecology Canada, 35*(11), 979-985.

Austin, W. (2012). Moral distress and the contemporary plight of health professionals. *HEC Forum, 24*(1), 27-38.

Austin, W. (2016). Contemporary healthcare practice and the risk of moral distress. *Health Management Forum, 29*(3), 131-133. DOI:https://doi.org.login.ezproxy.library.ualberta.ca/10.7939/R3D21RZ1S

Austin, W., Lemermeyer, G., Goldberg, L., Vergum, V., & Johnson, M. (2005). Moral distress in healthcare practice: The situation of nurses. HEC Forum, 17(1), 33-48.

Baggs, J., Ryan, S., Phelps, C., Richeson, J., & Johnson, J.(1992). The association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit. *Heart and Lung, 21*, 18-24.

Baillie, L. & Gallagher, A. (2011). Respecting dignity in care in diverse care settings: Strategies of UK nurses. *International Journal of Nursing Practice 17*(4), 336-341.

Baillie, L., & Gallagher, A. (2012). Raising awareness of patient dignity. *Nursing Standard. 27*(5), 44-49.

Baillie, L., Ford, P., Gallagher, A., & Wainwright, P. (2009). Nurses' views on dignity in care. *Nursing Older People, 21*(8), 22-29.

Baker, S., Choi, P., Henshaw, C., & Tree, J. (2005). 'I felt as though I'd been in jail': Women's experiences of maternity care during labour, delivery, and the immediate postpartum. *Feminism & Psychology, 15*(3), 315-342.

Beach, M., Sugarman, J., Johnson, R., Arbelaez, J., Duggan, P., & Cooper, L. (2005). Do patients treated with dignity report higher satisfaction, adherence, and receipt of preventative care. *Annals of Family Medicine, 3*(4), 331-338.

Beauchamp, T., & Childress, J. (2001). *Principles of biomedical ethics.* (5th ed.). New York:

Oxford University Press Inc.

Beck, C. (2004a). Post-traumatic stress disorder due to childbirth: the aftermath. *Nursing Research, 53*(4), 216-224.

Beck, C. (2004b). Birth trauma: In the eye of the beholder. *Nursing Research, 53*(1), 28-35.

Beck, C. & Gable, R. (2012). A mixed methods study of secondary traumatic stress in labor and delivery nurses. *JOGNN, 42*(6), 747-760.

Bergum, V., & Dossetor, J. (2005). *Relational ethics: The full meaning of respect*. USA: University Publishing Group.

Betran, A., Torlini, M., Zhang, J., Ye, J., Mikolajczylk, R., Deneux-Tharaux, C et al. (2015). What is the optimal rate of cesearean section at population level? A systematic review of ecological studies. *Reproductive Health, 12*(1), 57.

Bohren, M., Vogel, J., Hunter, E., Lutsiv, O., Makh, S., Souza, J., Aguiar, C., Coneglian, F., Diniz, A., Tuncalp, O., Javadi, D., Oladapo, O., Khosla, R., Hindin, M., & Gulmezoglu, A. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLOS Medicine, 12*(6), e1001847. doi:10.1371/journal.pmed.1001847

Bowser, D., & Hill, K. (2010). *Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis*. (Report from USAID-TRAction Project). University Research Corporation, LLC, and Harvard School of Public Health. Retrieved from: http://www.tractionproject.org/sites/default/files/Respectful_Care_at_Birth_9-20-101_Final.pdf

Browne, A. (1993). A conceptual clarification of respect. *Journal of Advanced Nursing, 18*, 211-217.

Browne, A. (1997). A concept analysis of respect applying the hybrid model in cross-cultural settings. *Western Journal of Nursing Research, 19*(6), 762-780.

Bureau de normalisation du Quebec, Canadian Standards Association Group, Mental Health Commission of Canada. (2013). *Psychological health and safety in the workplace-Prevention, promotion, and guidance to staged implementation*. Canada: CSA Group & BNQ. Accessed online https://mentalhealthcommission.ca/national-standard/.

Burns-Pieper, A. (2016a, November 7). Stop! Stop!: Canadian women share stories of alleged mistreatment in the delivery room. *CBC News.* Retrieved from http://www.cbc.ca/news/health/child-birth-mistreatment-complaints-1.3834997

Burns-Pieper, A. (2016b, November 7). 'A scene from a horror movie': 9 mothers speak out about alleged mistreatment during childbirth. *CBC News*. Retrieved from http://www.cbc.ca/news/health/hospital-mistreatment-stories-1.3834899

Butler, A., Copnell, B., & Willnetts, G. (2013). Family centered care in the paediatric intensive care unit: an integrative review of the literature. *Journal of Clinical Nursing, 23,* (15-16), 2086-2100.

Canadian Institute for Health Information. (2017, April). *CIHI snapshot: inpatient hospitalizations, surgeries, newborns and childbirth indicators*, 2015-2016. Retrieved from https://secure.cihi.ca/free_products/cad_hospitalization_and_childbirth_snapshot_2015-2016_en.pdf.

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2014). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.* Ottawa:

Government of Canada.

Canadian Nurses Association. (2011). *Position statement: Interprofessional collaboration*. Canada: Author.

Canadian Nurses Association. (2017a). *Perinatal nursing certification exam: exam blueprint and specialty competencies.* Canada: Author.

Canadian Nurses Association. (2017b). *Code of Ethics for Registered Nurses*. Ottawa: Author.

Canadian Nurses Association. (2020). *Anti-Racism Key Messages*. Author. Retrieved from https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/anti-racism-key-messages_e.pdf.

Canadian Patient Safety Institute. (2019, Alberta). *Strengthening commitment for improvement together: A policy framework for patient safety*. Retrieved from https://www.patientsafetyinstitute.ca/en/toolsResources/PolicyFrameworkforPatientSafetyCanada/Documents/PolicyFramework%20Document%20ENG%20FINAL.pdf

Canadian Public Health Association. (2018, December 17*). Racism and public health. Position statement*. Retrieved from https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/anti-racism-key-messages_e.pdf

Caldwell, K., & Atwal, A. (2005). Non-participant observation: Using video tapes to collect data in nursing research. *Nurse Researcher, 13,* 42–54.

Carlton, T., Callister, L.C., Christiaens, G., & Walker, D. (2009). Labor and delivery nurses' perceptions of caring for childbearing women in nurse-managed birthing units. *American Journal of Maternal-Child Nursing 34*(1), 51-56.

Carrese, J., Geller, G., Branyon, E., Forbes, L., Topazian, R., Weir, B., Khatib, O.,. & Sugarman, J. (2017). A direct observation checklist to measure respect and dignity in the ICU.

Critical Care Medicine, 45(2), p.263-270 Theory DOI: 10.1097/CCM.0000000000002072

Chalmers, B. (2017). *Family-centred perinatal care*. Cambridge: University Cambridge Press

Chalmers, B., Dzakpasu, S., Heaman, M., & Kaczorowski, J. (2008). The maternity experiences survey: An overview of findings. *Journal of Obstetrics and Gynecology Canada, 30*, 217-228.

Chalmers, B., Kaczorowski, J., Levitt, C., Dzakpasu, S., O'Brien, B., Lee, L., … Young, D. (2009). Use of routine interventions in vaginal labor and birth: Findings from the Maternity Experiences Survey. *Birth, 36*(1), 13-25.

Chalmers, B., & Hashi, K. (2000). Somali women's experiences in Canada after earlier female genital mutilation. *Birth, 27,* 227-234.

Chalmers, B., & Omer-Hashi, K. (2002). What Somali women say about giving birth in Canada. *Journal of Reproductive Infant Psychology, 20*, 267-282.

Clarke, R., & Lake, E.T. (2020, September/October). Association of clinical nursing work environment with quality and safety in maternity care in the United States. *The American Journal of Maternal Child Nursing, 45*(5), 265-270.

Clayton, A & Thorne, T. (2000). Diary data enhancing rigor: analysis framework and verification tool. *Journal of Advanced Nursing, 32*(6), 1514-1521.

Cook, K., & Loomis, C. (2012). The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education, 21*(3), 158-168.

Corlett, J., & Twycross, A. (2006). Negotiation of parent roles within family-centered care: review of the research. *Journal of Clinical Nursing, 15*, 1308-1316.

Coventry, M. (2006). Care with dignity: a concept analysis. *Journal of Gerontological Nursing,*

32(5), 42-48.

Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five approaches.* (3rd ed.). USA: Sage Publications.

Cruz, E., & Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36-43.

Cusack, L., Thornton, K., Drioli-Phillips, P., Cockburn, T., Jones, L., Whitehead, M. et al. (2020). Are nurses recognized, prepared and supported to teach nursing students: Mixed methods study. *Nurse Education Today, 90,* 104434

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics, 75*, S5-S23.

d'Oliveira, A.F., Diniz, S.G., & Schraiber, L.B. (2002). Violence against women in health-care institutions: an emerging problem. *Lancet*, 359, 1681-85.

DeLellis, A. (2000). Respect in the perinatal experience. *Journal of Perinatal Education, 9(*4**),** viii-xii

Denzin, N., (1978). *The research act: A theoretical introduction to sociological methods*. New York, NY: McGraw-Hill.

Dickert, N., & Kass, N. (2009). Understanding respect: learning from patients. *J Med Ethics, 35,* 419-423. doi:10.1136/jme.2008.027235

Dillon, Robin S. (Winter 2016 Edition). Respect. *The Stanford Encyclopedia of Philosophy.* Edward N. Zalta (ed.), Retrieved from <https://plato.stanford.edu/archives/win2016/entries/respect/>.

Dillon, R. (1992). Respect and care: toward moral integration. *Canadian Journal of Philosophy, 22*(1), 105-132.

Elliot, H. (1997). The use of diaries in sociological research on health experience. *Sociological Research Online*. Retrieved from http://journals.sagepub.com/doi/abs/10.5153/sro.38

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: meta-ethnography. *Journal of Advanced Nursing, 66*(10), 2142-2153.

Erickson, F. (2011). A history of qualitative inquiry in social and educational research. In Denzin, N., & Lincoln, Y. (Eds). *The SAGE Handbook of Qualitative Research* (4th ed.). Thousand Oaks, CA: Sage Publications.

Evans, K. (2016). *Consent: A guide for Canadian Physicians (4th Ed.).* Accessed online https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#informed%20consent

Fetterman, D. (2010). *Ethnography step by step* (3rd ed.). Thousand Oaks, CA: Sage Publication.

Foster, M., Whitehead, L., & Maybee, P. (2010). Parents' and health professionals' perceptions of family centred care for children in hospital in developed and developing countries: a review of the literature. *International Journal of Nursing Studies* 47, 1184–1193.

Frankel, A., Haraden, C., Federico, F., Lenoci-Edwards, J. (2017). *A framework for safe, reliable, and effective care. White paper.* Cambridge, MA: Institute for Healthcare Improvement.

Frankena, W. (1986). The ethics of respect for persons. *Philosophical Topics, 14*(2), 149-167.

Fry, M., & Stainton, C. (2005). An educational framework for triage nursing based on gatekeeping, timekeeping and decision-making processes. *Accident and Emergency Nursing*, 13(4), 214-219. http://dx.doi.org/10.1016/j.aaen.2005.09.004

Gagnon, A., Meier, K., & Waghorn, K. (2007). Continuity of nursing care and its link to

cesarean section rate. *Birth, 34*(1), 26-31. doi: 10.1111/j.1523-536X.2006.00143.x.

Gallagher, A. (2007). The respectful nurse. *Nursing Ethics, 14*(3), 360-371.

Gallagher, A. (2012). Raising awareness of patient dignity. *Nursing Standard, 27*(5), 44-49. 66(10), 2142-2153.

Gallagher, A., Li, S., Wainwright, P., Jones, & Lee, D. (2008). Dignity in the care of older people- a review of the theoretical and empirical literature. *BMC Nursing, (7)*11.

Gaskin, I.M. (2011). *Birth matters*. New York, USA: Seven Stories Press.

Gleddie, M., Stahlke, S., & Paul, P. (2017). Nurses' perceptions of the dynamics and impacts of teamwork with physicians in labour and delivery. *Journal of Interprofessional Care,* DOI:10.1080/13561820.2018.1562422.

Goer, H. (2010). Cruelty in maternity wards: fifty years later. *The Journal of Perinatal Education, 19*(3), 33-42.

Goldberg, H. (2009). Informed decision making in maternity care. *Journal of Perinatal Education, 18*(1), 32-40.

Gooding, J., Cooper, L., Blaine, A., Franck, L., Howse, J., & Berns, S. (2011). Family support and family centered care in the neonatal intensive care unit: origins, advances, impact. *Seminars in Perinatology, 35*, 20-28.

Government of Canada (1985), *Criminal Code, R.S.C. C-46 When a child becomes a human being* 223(1). Retrieved from https://laws-lois.justice.gc.ca/eng/acts/C-46/section-223.html

Harper, B. (2005). *Gentle birth choices (2nd Ed.).* Rochester: Healing Arts Press.

Harrison, T. (2010). Family-centered pediatric nursing care: state of the science. *Journal of Pediatric Nursing,* 25, 335–343.

Hastings, M. (2015). *Pulling back the curtain on disrespect and abuse: The movement to ensure respectful maternity care.* (Policy Brief). Washington, DC: White Ribbon Alliance. Retrieved from https://www.healthpolicyproject.com/pubs/5877_RMCPolicyBrief.pdf

Health Quality Council of Alberta. (2013). *Provincial Framework: Managing disruptive behaviour in the healthcare workplace.* Alberta: Author.

Higginbottom, G. (2006). "Pressure of Life": Ethnicity as a mediating factor in mid-life and older peoples' experience of blood pressure. *Sociology of Health & Illness, 28,* 583-610.

Higginbottom, G., Pillay, J., & Boadu, N. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report, 18*(17), 1-16.

Higginbottom, G., Hadziabdic, E., Yohani, S., & Paton, P. (2014). Immigrant women's experiences of maternity services in Canada: A meta-ethnography. *Midwifery, 30,* 544-559.

Higginbottom, G., Mrogan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity care-services in Canada: a systemic review using a narrative synthesis. *Systematic Reviews*, 13.

Hinton, L., Locock, L., & Knight, M. (2014). Partner experiences of "near miss' events in pregnancy and childbirth in the UK: qualitative study. *PLoS One, 9*(4), doi:10.1371/journal.pone.0091735

Hochschild, A. (1983). *The Managed Heart*. USA: University of California Press.

Hodges, S. (2009). Abuse in hospital-based birth settings? *The Journal of Perinatal Education, 18*(4), 4-11.

Hodnett, E. (1996). Nursing support of the laboring woman. *Journal of Obstetric,*

Gynecologic, and Neonatal Nursing, 25, 257-264.

Holyoake, D. (2011). Is the doctor-nurse game still being played? *Nursing Times, 107*(43), 12-13.

Huffman, D., & Rittenmeyer, L. (2012). How professional nurses working in hospital environments experience moral distress: A systematic review. *JBI Libr Syst Rev, 7*(28), 1234-1291. doi:10.11124/01938924-200907280-0001.

Institute for Healthcare Improvement. (2020). *PS 101: Introduction to Patient Safety*. Online learning module. Accessed Jan 2021from www.ihi.org/education/webtraining/

Institute for Patient and Family Centered Care. (2010, June). *Bulletin: Pinwheel pages*. (Issue 33). Retrieved from http://www.ipfcc.org/resources/newsletters/issue33.htm

Institute for Patient and Family Centered Care. (2010). *Patient and family centered maternity care: the core concepts.* USA: Author.

Institute for Patient and Family Centered Care. (2017). *Patient and family centered care.* Retrieved from http://www.ipfcc.org/about/pfcc.html

Jansen, L., Gibson, M., Bowles, B., Leach, J. (2013). First do no harm: interventions during childbirth. *The Journal of Perinatal Education, 22*(2), 83-92. doi: 10.1891/1058-1243.22.2.83

Janssen, P., Saxell, L., Page, L., Klein, M., Liston, R., & Lee, S. (2009). Home versus hospital birth with registered midwives and physicians: outcomes from five years in British Columbia. *CMAJ 181*(9), 617.

Jewkes, R., Abrahams, H., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Soc Sci Med, 47*, 1781-1795.

Jewkes, R., & Penn-Kekana, L. (2015). Mistreatment of women in childbirth: Time for action on

this important dimension of violence against women. *PLOS Medicine, 12*(6). doi:10.1371/journal.pmed.1001849

Johnson, B., & Abraham, M. (2012). *Partnering with patients, residents, and families: A resource for leaders of hospitals, ambulatory care settings, and long-term care communities.* Bethesda, MD: Institute for Patient and Family Centered Care.

Jolley, J & Shields, L. (2009). The evolution of family-centered care. *Journal of Pediatric Nursing, 24*(2). 164-170. doi:10.1016/j.pedn.2008.03.010

Jordan, B., & Davis-Floyd, R. (1993). *Birth in four cultures: a cross cultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States (4th Ed.).* Prospect Heights, Ill: Waveland Press.

Kaufman, T. (2007). Evolution of the Birth Plan. *Journal of Perinatal Education*, 16(3), 47-52.

Keen, D., & de Chesney, M., (2014). State of the art in nursing research using ethnography. In de Chesnay, M. (Ed.,. *Nursing research using ethnography: Qualitative designs and methods in nursing.* (p.24-32). USA: Springer Publishing.

Kennedy, H., & Lyndon, A. (2008). Tensions and teamwork in nursing and midwifery relationships. *JOGNN, 37,* 426-435, DOI:10.1111/j.1552-6909.2008.00256.x

Kenaszhuk, C., Wilkins, K., Reeves, S., Zwarenstein, M., & Russell, A. (2010). Nurse-physician relations and quality of nursing care: Findings from a national survey of nurses. *CJNR, 42* (2), 120-136.

Kenten, C. (2010). Narrating oneself: Reflections of the use of solicited diaries with dairy interviews. *Forum: Qualitative Social Research, 11*(2).

Kitzinger, S. (1999). Professional issues. Birth plans: how are they being used. *British Journal of Midwifery, 7*(5), 300-303.

Kitzinger, S. (2012). Rediscovering the social model of childbirth. *Birth, 39*(4), 301-304.

Klein, M. (2009). Many women and providers are unprepared for an evidence-based, educated conversation about birth. *The Journal of Perinatal Education, 20*(4), 185-187.

Klein, M., Liston, R., Fraser, W., Baradaran, N., Hearps, A., Tomkinson, J., Kaczorowski, J et al. (2011). Attitudes of the new generation of Canadian obstetricians: How do they differ from their predecessors? *Birth, 38*(2), 129-139.

Klein, M., Kaczorowski, J., Hearps, S., Tomkinson, J., Baradaran, N., Hall, W…Fraser, W. (2011). Birth technology and maternal roles in birth: Knowledge and attitudes of Canadian women approaching childbirth for the first time. *JOGC,* 598-608

Knapp, L. (1996). Childbirth satisfaction: the effects of internality and perceived control. *Journal of perinatal education,5,* 7-16.

Knoblauch, H. (2005). Focused ethnography. Forum: *Qualitative Social Research, 6*, 3, Art. 44

Kolahdooz., F., Launier, K., Nader, F., Yi, K., Baker, P., McHugh, T-L., Vallianatos, H., & Sharma, S. (2016). Canadian Indigenous Woman's Perspectives of Maternal Health and Health Care Services: A Systematic Review. *Diversity and Equality in Health and Care*, 13(5), 334-348.

Koster, D., Romijn, C., Sakko, E., Stam, C., Steenhuis, N., de Vries, D et al. (2019). Traumatic childbirth experiences: practice-based implications for maternity care professionals from the woman's perspective. *Scandinavian Journal of Caring Sciences, 34*(3),

Koskenniemi, J., Leino-Kilpi, H., Suhonen, R. (2012). Respect in the care of older patients in acute hospitals. *Nursing Ethics, 20*(1), 5-17.

Kotaska, A. (2017). Informed consent and refusal in obstetrics: A practical ethical guide. *Birth, 44*(3), 195-199.

Kramer, M., & Schmalenberg, C. (2003). Securing 'good' nurse physician relationships. *Nursing Management, 34*(7), 34-38.

Kramer, M., & Schmalenberg, C. (2004). Essentials of a magnetic work environment: Part 1. *Nursing, 34*(6), 50-54.

Kvale, S. (2007). *Qualitative research kit: Doing interviews.* London: SAGE Publications Ltd doi: 10.4135/9781849208963

Lalonde, A., Herschderfer, K., Pascali-Bonaro. D., Hanson, C., Fuchtner, C., & Visser, G. (2019). The international childbirth initiative: 12 steps to safe and respectful MotherBaby-Family maternity care. *International Journal of Gynecology & Obstetrics.* DOI: https//doi,org/10.1002/ijgo.12844

Larkin, P., Begley, C., Devane, D. (2009). Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery, 25*, e49-e59.

Leape.L., Shore, M., & Dienstag, J. (2012). Perspective: a culture of respect, part 1: the nature and causes of disrespectful behaviour by physicians, *Academic Medicine*, 87, p. 845-52).

Leape, L., Shore, M., Diestag, J., Mayer, R., Edgman-Levitan, S., Meyer, G., & Healy, g. (2012). Perspective: a culture of respect, part 2: creating a culture of respect. *Academic Medicine*, 87(7), p. 853-858.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry.* USA: Sage Publications.

Liva, S., Hall, W., Klein, M., &Wong, S. (2012). Factors associated with differences in Canadian perinatal nurses' attitudes toward birth practices. *JOGNN, 41*(6), p.761-771.

Lothian, J. (2006). Birth plans: The good, the bad, and the future. *JOGNN,* 35,2, 295-303.

Lothian, J. (2008). Choice, autonomy, and childbirth education. *The Journal of Perinatal Education, 17*, 1, 35-38.

Lyndon, A., Simpson, K., & Spetz, J. (2017). Thematic analysis of US stakeholder views on the influence of labour nurses' care on birth outcomes. *BMJ Qual Saf, 26*, 824-831.

Macdonald, M. (2006). Gender expectations: Natural bodies and natural births in the new midwifery in Canada. *Medical Anthropology Quarterly, 20*(2), 235-256.

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health*, *18*(1), 41-59).

Manoljlovich, M., Kerr, M., Davies, B., Squires,J., Mallick, R., & Rodger, G. (2014). Achieving a climate for patient safety by focusing on relationships. *International Journal for Quality in Health Care*. 26, 4. 579-584.

Mason, J. (1988). Midwifery in Canada. In Kitzinger, S (Ed), *The Midwife Challenge*. London: Pandora Press, Unwin Hyman Limited.

MaternityCare Consumers of Alberta Network. (2014). *Maternity care priorities in Alberta: Final report on a listening campaign*. Alberta: Author. Retrieved from www.maternitycarealberta.com

Matthews, R., & Callister, L. (2003). Childbearing women's perceptions of nursing care that promotes dignity. *JOGNN, 33(*4), 498-507. doi:10.1177/0884217504266896

Mazzotta, C.P., (2016). Emotional labour and traumatization among nurses. *Nursing and Palliative Care* 1(2), 28-32

McAndrew, H., Leske, J., & Schroeter, K. (2018). Moral distress in critical care nursing: The state of the science. *Nursing Ethics, 25*(5), 552-570.

McAra-Couper, J., Jones, M., & Smythe, L. (2011). Caesarean section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology, 22(*1), 81-97.

McClure, R., & Murphy, C. (2007). Contesting the dominance of emotional labour in professional nursing. *Journal of Health Organization and Management, 21*(2), 101-120.

McGee, P. (1994). The concept of respect in nursing. *British Journal of Nursing, 3*(13), 681-684.

McKinnin, J. (2016*). Reflection for nursing life: principles, process and practice.* Abingdon, Oxon : Routledge.

Mei, J., Afshar, Y., Gregory, K., Kilpatrick, S., & Esakoff, T. (2016). Birth plans: What matters for birth experience satisfaction. *Birth*, 43:2, 144-150.

Meth, P. (2003). Entries and omissions: Using solicited diaries in geographical research. *Area, 35*(2), 195-205.

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comande, D…Althabe, F. (2016). Beyond too little, too late and too soon: a pathway towards evidence-based, respectful maternity care worldwide. *Lancet, 388*, 2176-92.

Mitchinson, W. (2002*). Giving birth in Canada 1900-1950*. Toronto, Canada: University of Toronto Press.

Mirghafourvand, M., Charandabi, S., Ghanbari-Homayi, S., Jahangiry.L., Nahee, J., & Hadian, T. (2019). Effect of birth plans on childbirth experience: A systematic review. *International Journal of Nursing Practice* 25(4).

Molloy, L., Walker, K., & Lakeman, R. (2017). Shared worlds: multi-sited ethnography and nursing research. *Nurse Researcher, 24*(4), 22-26. doi:10.7748/nr.2017.e1506

Morse, J. M. (2007). Does health research warrant the modification of qualitative methods?

Qualitative Health Research, 17, 863-865.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), Article 2. Retrieved from http://www.ualberta.ca/ijqm/

Morton, C., Henley, M., Seacrist., & Roth, L.M. (2018). Bearing witness: United States and Canadian maternity support workers' observation of disrespectful care in childbirth. *Birth*, 45, 263-274.

Nilsson, L., Thorsell, T., Hertfelt Wahn, E., & Ekstrom, A. (2013). Factors influencing positive birth experiences of first-time mothers. *Nursing Research and Practice.* Retrieved from http://dx.doi.org/10.1155/2013/349124

Noel-Weiss, J. (2007). *Medicalizing motherhood: maternity care in Canada in the 1920's and 1930's.* Paper presented at the 16th Annual Breastfeeding Seminar 2006, Toronto, Canada

Oh, Y., & Gastmans, C. (2015). Moral distress experienced by nurses: A quantitative review. *Nursing Ethics, 22*(10), 15-31.

Papastavrou, E., Efstathiou, G., Tsangari, H., Suhonen, R., Leino-Kilp, H., Patiraki, E…Merkouris, A. (2012). Patients' and nurses' perceptions of respect and human presence through caring behaviours: A comparative study. *Nursing Ethics, 19*(3), 369-379

Penticuff, J., & Walden, M. (2000). Influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas. *Nurse Researcher, 49*(2), 64-72.

Peterson, M., Cohen, J., & Parson, V. (2004). Family-centered care: Do we practice what we preach? *JOGNN, 33*, 421-427.

Peterson, W., Medves, J.M., Davies, B.L., & Graham, I.D. (2007). Multidisciplinary

collaborative maternity care in Canada: Easier said than done. *Journal of Obstetrics Gyneagologists of Canada*, 29(11), 880-886.

Phillips, C. (1994). *Family Centered Maternity Care*. Minneapolis: International Childbirth Education Association, Inc.

Public Health Agency of Canada. (2018). *Chapter 4: care during labour and birth*. Ottawa: Author.

Public Health Agency of Canada. (2017). *Family-centered maternal and newborn care: National guidelines.* Ottawa: Author.

Public Health Agency of Canada. (2012). *Canadian hospitals maternity policies and practices survey*. Ottawa, ON: Author.

Public Health Agency of Canada (2009). *What mothers say: The Canadian Maternity Experiences Survey.* Ottawa, Ontario: Author.

Rankin, J. (2015). The rhetoric of patient and family centred care: an institutional ethnography into what actually happens. *Journal of Advanced Nursing*, 71(3), 526-534. doi:10.1111/jan.12575

Reaves, S., Perrier, L., Goldman, J., Freeth, D., Zwarenstein, M., Zwarenstein, M (2013). Interprofessional education: effects on professional practice and healthcare outcomes. (Protocal) *Cochrane Database of Systemic Review,s* 2013, Issue 3.

Regan, M., McElroy, K., & Moore, K. (2013). Choice? Factors that influence women's decision making for childbirth. *Journal of Perinatal Education*, 22(3), 171-180.

Rodney, P.A. (2017). What we know about moral distress. *American Journal of Nursing*, 117(Supp), S7-S10.doi: 10.1097/01.NAJ.0000512204.85973.04

Roper, J., & Shapira, J. (2000). *Ethnography in nursing research.* USA: Sage Publishing Inc.

Rose, D., Peter, E., Gallop, R., Angus, J., & Liaschenko, J. (2011). Respect in forensic psychiatric nurse-patient relationships: A practical compromise. *Journal of Forensic Nursing, 7,* 3-16.

Rosenstein, A. (2002). Nurse-physician relationships: impact on nurse satisfaction and retention. *The American Journal of Nursing, 102*(6), 26-34.

Rudman, A., El-Khouri, B., & Waldenstrom, V. (2007). Women's satisfaction with intrapartum care. *Journal of Advanced Nursing, 59,* 474-487.

Saxell, L., Harris, S. & Elara, L (2010). The colloboration for maternal and newborn health interprofessional maternity care education for medical, midwifery, and nursing students. *Journal of Midwifery & Women's Health*, 54 (4), 314-320.

Shakibazadeh, E., Namadian, M., Bohren, M., Vogel, J., Rashidian, A., Pileggi, S., et al. (2017). Respectful care during childbirth in health facilitities globally: a qualitative evidence synthesis. *International Journal of Obstetrics & Gynaecology, 125*(8), 932-942

Shields, L., Pratt, J., & Hunter, J. (2006). Family centered care: a review of the qualitative studies. *Journal of Clinical Nursing, 15,* 1317-1323.

Simkin, P. (1991). Just another day in a woman's life? Women's long term perceptions of their first birth experience. Part 1. *Birth 18*, 203-210.

Simmonds, A. (2008). Autonomy and advocacy in perinatal nursing practice. *Nursing Ethics, 15*(3), 360-370.

Simpson, K., & Lyndon, A. (2017). Labour nurses' views of their influence on caesarean section birth. *American Journal of Maternal Child Nursing*, Mar/Apr 2017, 42(2), 81-87.

Skott, C., & Eriksson, A. (2005). Clinical caring-the diary of a nurse. *Journal of Clinical Nursing, 14,* 916-921.

Sleutel, M. (2000). Intrapartum nursing care: A case study of supportive interventions and ethical conflicts. *Birth, 27*(1), 38-45.

Smallwood, A. (2009). Cardiac assessment teams: A focused ethnography of nurses' roles. *British Journal of Cardiac Nursing, 4,* 132-139.

Smith, S., & Nickel, D. (1999). From home to hospital: Parallels in birthing and dying in twentieth century Canada. *CBMH/BCHM, 16*, 49-64. Retrieved http://www.cbmh.ca/index.php/cbmh/article/view/1547/1528

Snowden, C., Elbourne, D., Forsey, M., Alfirevic, Z. (2012). Information-hungry and disempowered: A qualitative study of women and their partners' experiences of severe postpartum haemorrhage. *Midwifery, 28*(6), DOI:10.1019/j.midw.2011.12.012

Soet, J., Brack, G., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth, 30*, 36-46.

Stark, M., Remynse, M., & Zwelling, E. (2016). Importance of the birth environment to support physiologic birth. *JOGNN, 45*(2), 285-294.

Stein, L. (1967). The doctor-nurse game. *Archives of General Psychiatry, 16*(6), 699.

Stein, L., Watts, D., & Howell, T. (1990). The doctor-nurse game revisited. *The New England Journal of Medicine, 322*(8), 546-549.

Svensson, R. (1996). The interplay between doctors and nurses- a negotiated order perspective. *Sociology of Health & Illness, 18*(3), 379-398.

Task Force on the Implementation of Midwifery in Ontario. (1987). *Report of the task force on the implementation of midwifery in Ontario*. Toronto, Ontario: Author

The White Ribbon Alliance. (2011). *Respectful maternity care: the universal rights of*

childbearing women. Washington DC: Author. Retrieved from http://www.healthpolicyproject.com/pubs/46_FinalRespectfulCareCharter.pdf

Tomlinson, P., & Bryan, A. (1996). Family centered intrapartum care: revisiting an old concept. *JOGNN, 25,* 331-337.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspectives of family centered-care: a qualitative study. *Journal of Clinical Nursing, 21,* 2477-2487. doi:10.1111/j.1365-2702.2012.04138.x

Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Call of Action*. Manitoba, Winnipeg: Author. Retrieved from www.trc.ca

Turpel-Lafond, M.E. (2020). *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health*. Government of British Columbia. Retrieved from https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

Valimaki, T., Vehvilainen-Julkunen, K., & Pietila, A. (2007). Diaries as a research data in the study of daily caregivers with Alzheimer's disease: methodological issues. *Journal of Advanced Nursing, 59*(1), 68-75.

Van Teijilingen, E.R., Hundley, V., Rennie, A.M., Graham, W., & Fitzmaurice. (2003). Maternity satisfaction studies and their limitations: "What is, must still be best". *Birth, 30*(2), 75-82.

Vedam, S., Stoll, K., Rubashkin, N., Martin, K., Miller-Vedam, Z., Hayes-Flein, H., Jolicoeur, G., & the CCinBC Steering Council. (2017). The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. *Population Health, 3*, 201-210.

Vedam, S., Stoll, K., Taiwo, T., Rubashkin, N., Cheyney, M., Strauss.N., McLemore, M.,

Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq., & the GVtM-US Steering Council. (2019). The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health, 16* (77). doi.org/10.1186/s12978-019-0729-2

Wagner, M. (2001). Fish can't see the water: The need to humanize birth. *International Journal of Gynecology & Obstetrics,75*, S25-S37.

Wainright, P., & Gallagher, A. (2008a). Demonstrating dignity. *Nursing standard, 23*(10), 24-25.

Wainright, P., & Gallagher, A. (2008b). On different types of dignity in nursing care: a critique of Nordenfelt. *Nursing Philosophy, 9*, 46-54.

Waldenstrom U. (2003). Women's memory of childbirth at two months and one year after the birth. *Birth, 30*(4), 248-254.

Wall, S., Austin, W., & Garros, D., (2016). Organizational influences on health professionals experiences of moral distress in PICUs. *J HEC Forum, 28*(1), 53-67.

World Health Organization. (2015a). *WHO statement: The prevention and elimination of disrespect and abuse during facility-based childbirth*. Geneva, Switzerland: Author.

World Health Organization. (2015b). *WHO statement: caesarean section rates*. Geneva: Author.

World Health Organization. (2018). *WHO recommendations: intrapartum care for a positive childbirth experience*. Geneva: WHO.

Wilkinson, J. (1989). Moral distress: A labour and delivery nurse's experience. *JOGNN, 18*(6), 513-519.

Wilson, B., & Crowe, M. (2008). Maintaining equilibrium: A theory of job satisfaction for community mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 15*(10), 816-822.

Wolcott, H. (2010). *Ethnography lessons*: A primer. Walnut Creek, CA: Left Coast Press.

Wolcott, H., (1999). *Ethnography: A way of seeing*. Walnut Creek, CA: AltaMira Pres.

Wolf, Z. (2003). Exploring the audit trail for qualitative investigations. *Nurse Education, 28*(4), 175-178.

Ye, J., Zhang, J., Mikolajczyk, R., Torloni, M., Gulmezoglu, A., Betran, A., (2015). Association between rates of caesarean section and maternal and neonatal mortality in the 21st century: a worldwide population based ecological study with longitudinal data. *BJOG, 123,* 745-53.

Zimmerman, D., & Wieder, D. (1997). The diary: Interview diary method. *Urban Life, (5)*4, 479-99.

Zwelling, E. (1999). Trendsetter: Celeste Phillips, the mother of family centered maternity care. *JOGNN, 29*(1).

Zwelling, E., & Phillips, C. (2001). Family-centered maternity care in the new millennium: Is it real or is it imagined? *Journal of Perinatal Neonatal Nursing, 15*(3), 1-12.

Appendix A

Family Centered Maternal and Newborn Care: National Guidelines
Underlying Principles
PHAC, 2017

1. A family-centered approach to maternal and newborn care is optimal
2. Pregnancy and birth are normal, healthy processes
3. Early parent–infant attachment is critical for newborn and child development and the growth of healthy families.
4. Family-centered maternal and newborn care applies to all care environments
5. Family-centered maternal and newborn care is informed by research evidence
6. Family-centered maternal and newborn care requires a holistic approach
7. Family-centered maternal and newborn care involves collaboration among care providers
8. Culturally appropriate care is important in a multicultural society
9. Indigenous peoples have distinctive needs during pregnancy and birth
10. Care as close to home as possible is ideal
11. Individualized maternal and newborn care is recommended
12. To make informed choices, women and their families require knowledge about their care
13. Women and their families play an integral role in decision making
14. Health care providers' attitudes and language have an impact on a family's experience of maternal and newborn care
15. Family-centered maternal and newborn care respects reproductive rights
16. Family-centered maternal and newborn care occurs within a system that requires ongoing evaluation
17. Best practices in family-centered maternal and newborn care from global settings may offer valuable options for Canadian consideration

Appendix B

Principles of Family-Centered Maternity Care
Phillips, 1994

1. Childbirth is seen as wellness, not illness. Care is directed to maintaining labour, birth, postpartum, and newborn care as a normal life event involving dynamic emotional, social and physical change.
2. Prenatal care is personalized according to the individual psychosocial, educational, physical, spiritual, and cultural needs of each woman and her family.
3. A comprehensive program of perinatal education prepares families for active participation throughout the evolving process of preconception, pregnancy, childbirth, and parenting.
4. The hospital team assists the family in making informed choices for their care during pregnancy, labor, birth and for the postpartum/newborn care and strives to provide them with the experience they desire
5. The father and/or supportive persons of the mother's choice are actively involved in the educational process, labor, birth, and the postpartum and newborn care.
6. Whenever the mother wishes, family and friends are encouraged to be present during the hospital stay, including labour and birth.
7. Each woman's labor and birth are provided in the same location unless a caesarean birth is necessary. When possible, postpartum and newborn care is given in the same location and by the same caregivers.
8. Mothers are the preferred care providers for their infants. When mothers are caring for their babies the nursing role changes from performing direct newborn care to facilitating the provision of care by the mother/family.
9. When mother-baby care is implemented, the same person cares for the mother and baby couplet as a single family unit, even when they are briefly separated.
10. Parents have access to their high-risk newborns at all times and are included in the care of their infants to the extent possible given the condition of the newborn.

Appendix C

10:10 Principles of Family Centred Perinatal Care
Calmers, 2017

Family Centered Principles

1. Care addresses the needs of women, their newborn/s and their chosen family supports during pregnancy, birth and postpartum.
2. Care is sensitive to the individual psychological and social needs of women and their families- as perceived by them- including their needs for knowledge, emotional support and spiritual considerations.
3. Care is culturally sensitive and informed.
4. Care is individualized to meet each family's needs.
5. Families are care for with respect and with concern for their dignity.
6. Families are encouraged, prepared and supported to be activity involved in the care of their newborn, whether a healthy term infant or a sick or preterm baby requiring intensive care.
7. Families take an active role in decision-making about their care, based on evidence-based information, provided without either covert or overt coercion and with full knowledge about the potential adverse effects of any care procedure.
8. Families are offered knowledgeable and appropriate care to support breastfeeding and when needed, alternate feeding methods.
9. Feedback from families is encouraged and facilitated and is monitored and rigorously evaluated by caregivers and the healthcare facility.
10. Information about mother's partners and their infants is strictly confidential.

Caregiver Centered Principles.

1. Care is based on the best available evidence-based information
2. Pregnancy and birth are regarded as healthy normal life events with caregivers remaining vigilant for deviations from normal
3. Interventions are used only when essential
4. Care is interdisciplinary requiring integration among caregivers
5. A holistic approach to care is expected of providers regardless of disciplinary background
6. Professional education of caregivers should include the diverse principles of family centered care as outlined in this book
7. Families are entitled to full open and honest communication about all aspects of their care and are entitled to apology in the event of an avoidable negative outcomes
8. Care respects the reproductive and sexual rights of women and families
9. Care is always non-abusive
10. Aggregated information about family centered, psycho-social and clinical practices and outcomes is made publicly available and accessible regardless of social economic or educational background

Appendix D

Faculty of Nursing

What does respect mean to you?

LABOUR AND BIRTH NURSES NEEDED FOR RESEARCH ON RESPECTFUL CARE DURING CHILDBIRTH

We are looking for volunteers to take part in a study titled *Exploring respect during childbirth among nurses, women and their families*.

As a nurse participant in this study, you would be asked to complete two interviews. In between the two interviews you would be asked to reflect on respect in your day to day practice for up to ten shifts. It is optional to maintain voice memos or a written journal about your experience in providing respectful care.

Your participation is completely voluntary, each interview would last approximately one hour.

In appreciation for your time, you will receive a $10 gift card of your choice at either Starbucks or Tim Hortons for each interview.

For more information about this study, or to volunteer for this study, please contact:

Leanne Johnson
Phone: **XXXXXXXX**
Email: **leanne.johnson@ualberta.ca**

This study has been reviewed and approved by the University of Alberta Health Research Board.

University of Alberta Ethics ID number Pro00085738

Appendix E

Faculty of Nursing

Did you have a baby within the last 12 months at a hospital in XXXXX?

You are needed for a research study on respectful care during childbirth.

We are looking for volunteers to take part in a study titled *Exploring respect during childbirth among nurses, women and their families*. You have the option to invite your partner and/or family member who were with you during labour and birth to participate in the study with you.

Your participation is completely voluntary. As a participant in this study, you would be asked to complete one interview lasting about one hour.

In appreciation for your time, you will receive your choice of either a $10 Tim Hortons or Starbucks gift card.

For more information about this study, or to volunteer for this study, please contact:

Leanne Johnson
at
XXXXXXXX
Email: *leanne.johnson@ualberta.ca*

This study has been reviewed and approved by the University of Alberta Health Research Ethics Board.

University of Alberta Ethics ID number Pro00085738

Appendix F

Interview Guide- Nurses

Demographics/Background Information:
Age
How long have you been practicing on the labour and birth unit?

Interview 1 Questions:
Tell me what does respect mean to you?
What nursing actions convey respect to women and families in labour and birth unit? (Prompt can you tell me a story about this?)
What clinical actions could be perceived by patients and families as disrespectful? (Prompt can you tell me a story about this?)
What factors facilitate your ability to provide respectful nursing care? What factors hinder your ability?
What does respect in the context of patient and family centered care mean to you?

Interview 2 Questions:

What does respect mean to you, has this changed?
What insights have you gained about respectful nursing care while keeping a research diary (voice memos)?
How is respect to women and their families conveyed during childbirth?
Tell me more about this experience (use stories research diary or transcribed voice memos)?
What did you do as the nurse in this situation? What about that conveys or not conveys respect?

Appendix G

Interview Guide- Women (with or without family members)

Demographics/Background Information

Age
How many children do you have?
How old is your infant?
Who accompanied you during childbirth?

Interview Questions:

Tell me what respect means to you?
Would you like to tell me your birth story?
Can you think of examples during your birth where you felt respected
Can you think of examples during your birth where you felt disrespected?
How did nurses convey respect to you? How did they not?

If family members present:

Tell me what respect means to you?
Would you like to tell your experience in the labour room?
Can you think of times during the birth of your child where nurses were respectful? Can you think of times where they were not?

Appendix H

To the staff on Labour and Birth,

Your unit is participating in a research study titled *"Exploring respect during childbirth among nurses, women and their families".* The purpose of the research is to understand the experience of respectful care during childbirth among nurses, women and their families. This research will contribute to the international focus on respectful maternity care and our understanding of respect in the context of patient and family centered care. This study is part of a dissertation towards a PhD in nursing.

A component of this focused ethnography is observation. The researcher, Leanne Johnson will be completing a series of observation sessions in the public space of the unit (example hallways) and at the open nursing desk. These sessions are looking at the labour and birth space, information on the walls and interactions that occur in the public space. She will not be observing in any patient rooms or in the private staff area.

A poster will visible when the observation sessions are occurring. NO personal information will be recorded (example your name) but rather positions such as nurse, physician, birthing person, family member will be used. There will be NO record of who was on shift during the observation periods or the dates in which they occurred. Only field notes will be kept by the researcher.

This research has been approved by the University of Alberta Health Research Ethics Board and has received operational approval through Northern Alberta Clinical Trials & Research Centre (NACTRC)

If you have any questions or concerns about these observation sessions, please contact Leanne Johnson RN, MN, PhD(c)

Phone: xxxxxxxx
Email: leanne.johnson@ualberta.ca

Version: November 22, 2018, University of Alberta Ethics ID number Pro00085738

Appendix I

UNIVERSITY OF ALBERTA

EDMONTON·ALBERTA·CANADA

Faculty of Nursing

ATTENTION:

OBSERVATION OCCURING ON LABOUR AND BIRTH UNIT

This labour and birth unit is participating in a study titled *Exploring respect during childbirth among nurses, women and their families*.

One part of this study is to observe the labour and birth unit to gain understanding of the space and day to day interactions including the physical layout, written material on the walls and conversations heard in the main hallway.

Observations are only occurring in the public space and not in the birth rooms. No personal information will be recorded.

For questions, concerns, or for more information please contact Leanne Johnson, the investigator on site (see nursing desk).

This study has been reviewed and approved by the University of Alberta Health Research Board.

University of Alberta Ethics ID number Pro00085738

Appendix J

NURSE PARTICIPANT CONSENT FORM

Title of Study: Exploring respect during childbirth among nurses, women and their families

Research Investigator:	**Co-Supervisors:**
Leanne Johnson, RN, MN	Drs. Beverley O'Brien and Solina Richter
3-141 Edmonton Clinic Health Academy	3-141 Edmonton Clinic Health Academy
Faculty of Nursing	Faculty of Nursing
University of Alberta	University of Alberta
Edmonton, AB, T6G 1C9	Edmonton, AB, T6G 1C9
leanne.johnson@ualberta.ca	beverley.obrien@ualberta.ca
	solina.richter@ualberta.ca
XXXXXXX	XXXXXXXXX

Why am I being asked to take part in this research study? You are being asked to be in this study because you are working as a labour and birth nurse and we want to understand what respect means to you in your nursing practice. Before you decide whether or not participate in the study, one of the researchers will go over this form with you. You are encouraged to ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

What is the reason for doing the study? The purpose of the research is to understand the experience of respectful care during childbirth among nurses, women and their families. This research will contribute to the international focus on respectful maternity care and understanding of respect in the context of patient and family centered care. This study is in completion for a student project towards a PhD in nursing.

What will I be asked to do? You are being asked to complete a total of two "in-person" interviews and reflect on your experience of respect in your day to day clinical practice.

- Two interviews lasting up to one hour of your time approximately one to two months apart.
- In-between the two interviews, you are asked to reflect on respect in your day to day clinical practice for up to ten shifts. It is optional to write in a research diary or speak into a personal recording device to record your reflections. It is anticipated that each

reflection would take approximately 10 mins of your time. These reflections will then be further discussed during the second interview. If you choose to write or record your reflections, the recordings will be transcribed and/or written information will be used in the research. You do have the option to keep the written or oral recording upon completion of the research.

With your consent, allow storage of study information in a secure data repository for possible use in future research.

What are the risks and discomforts? There are minimal risks to being in this study. It is possible that an increased self-awareness of clinical practice may lead to positive or negative feelings. If negative feelings occur and it is your wish, referral to mental health services will be explored with you. It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant.

What are the benefits to me? You may not get any benefit from being in this research study. However, the possible benefits include self-awareness and increased understanding of how respect is enacted in your day to day clinical practice. We hope that the information we get from doing this study will help us better understand how respect is provided during labour and birth.

Will I be paid to be in the research? You will be reimbursed for parking costs that may occur during the time of the interview. You will also receive your choice of either a $10 Tim Hortons or Starbucks gift card for each interview.

Do I have to take part in the research? No, participation in the study is voluntary. You do not have to answer any questions in the interview that you do not feel comfortable with. You do not need to record your reflections in between the two interviews. You can withdraw at any time up to two weeks after the last interview. You would still receive a gift card even if you withdrew early.

Will my information be kept private? During the study we will be collecting data about you. Direct quotes from the interview may be used in the final report but will not be connected to your name. We will do everything we can to make sure that this data is kept private and kept separately from your name. No data relating to this study that includes your name or could identify you in any way will be released outside of the researcher's office or published by the researchers. Sometimes, if required by law to report certain information (e.g. harm to child) so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private

Study data will be stored in at *University of Alberta Health Research Data Repository* for possible re-use in a future study. Data will be kept for a minimum of 5 years. Any personal information (i.e. your name, address, telephone number) you will be removed prior to sharing study data with other researchers. Any researcher who wants to use this data must have the new project approved by an appropriate ethics board.

What if I have questions? If you have any questions about the research now or later, please contact Leanne Johnson via email leanne.johnson@ualberta.ca or phone XXXXXX.

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at 780-492-2615. This office has no affiliation with the study investigators.

CONSENT

Title of Study: Exploring respect during childbirth among nurses, women and their families

---

Research Investigator:
Leanne Johnson, RN, MN
3-141 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
leanne.johnson@ualberta.ca

XXXXXXX

Co-Supervisors:
Drs. Beverley O'Brien and Solina Richter
5-269 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
beverley.obrien@ualberta.ca
solina.richter@ualberta.ca
XXXXXXX

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without penalty?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐
Future Contact		
Do you agree to be contacted for follow-up or to facilitate future research?	☐	☐
Use of my research information beyond this study		
Do you agree for your information to be securely stored at *University of Alberta Health Research Data Repository* to facilitate future reuse?	☐	☐

Who explained this study to you? _____

I agree to take part in this study:

Signature of Research Participant _____

(Printed Name) _____

Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix K

WOMAN PARTICIPANT CONSENT FORM

Title of Study: Exploring respect during childbirth among nurses, women and their families

Research Investigator:	**Co-Supervisors:**
Leanne Johnson, RN, MN	Drs. Beverley O'Brien and Solina Richter
3-141 Edmonton Clinic Health Academy	3-141 Edmonton Clinic Health Academy
Faculty of Nursing	Faculty of Nursing
University of Alberta	University of Alberta
Edmonton, AB, T6G 1C9	Edmonton, AB, T6G 1C9
leanne.johnson@ualberta.ca	beverley.obrien@ualberta.ca
	solina.richter@ualberta.ca
xxxxxx	xxxxxxx

Why am I being asked to take part in this research study? You are being asked to be in this study because you have had a baby within the last 12 months at a hospital in XXXXX and we want to understand what respect during childbirth means to you. Before you decide whether or not to participate in the study, one of the researchers will go over this form with you. You can ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

What is the reason for doing the study? The purpose of the research is to understand what respect means to nurses, women and their families. This study is in completion for a student project towards a PhD in nursing.

What will I be asked to do? You are being asked to complete one "in person" interview lasting about one hour. You can choose to include your partner and/or family members who were with you during labour and birth.

What are the risks and discomforts? There are minimal risks to participating in this study, however discussing your birth experience may cause positive or negative feelings. If you feel that you need more support, mental health services will be explored with you. It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable actions to minimize any known risks to you.

What are the benefits to me? You may not get any benefit from being in this research study. The possible benefits to you include the opportunity to discuss your birth experience and help us better understand how nurses can provide respectful care during childbirth.

Will I be paid to be in the research? You will be reimbursed for parking costs that may occur during the time of the interview. You will also receive your choice of either a $10 Tim Hortons or Starbucks gift card for your time.

Do I have to take part in the research? No, participation in the study is voluntary. You do not have to answer any questions in the interview that you do not feel comfortable with. You can withdraw at any time up to two weeks after the last interview. You would still receive a gift card even if you withdrew early.

Will my information be kept private? During the study we will be collecting data about you. Direct quotes from the interview may be used in the final report but will not be connected to your name. We will do everything we can to make sure that this data is kept private and separately from you name. No data relating to this study, including your name will be made public. Sometimes, we may be required by law to report certain information (e.g. harm to child) so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private

Study data will be stored in at *University of Alberta Health Research Data Repository* for possible re-use in a future study. Data will be kept for a minimum of 5 years. Any personal information (i.e. your name, address, telephone number) you will be removed prior to sharing study data with other researchers. Any researcher who wants to use this data must have the new project approved by an appropriate ethics board.

What if I have questions? If you have any questions about the research now or later, please contact Leanne Johnson via email leanne.johnson@ualberta.ca or phone XXXXX**.**

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at 780-492-2615. This office has no affiliation with the study investigators.

CONSENT

Title of Study: Exploring respect during childbirth among nurses, women and their families

---

Research Investigator:
Leanne Johnson, RN, MN
3-141 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
leanne.johnson@ualberta.ca

xxxxxxx

Co-Supervisors:
Drs. Beverley O'Brien and Solina Richter
5-269 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
beverley.obrien@ualberta.ca
solina.richter@ualberta.ca
xxxxxxxxx

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without penalty?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐
Future Contact		
Do you agree to be contacted for follow-up or to facilitate future research?	☐	☐
Use of my research information beyond this study		
Do you agree for your information to be securely stored at *University of Alberta Health Research Data Repository* to facilitate future reuse?	☐	☐

Who explained this study to you? _____

I agree to take part in this study:

Signature of Research Participant _____

(Printed Name) _____

Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix L

FAMILY MEMBER PARTICIPANT CONSENT FORM

Title of Study: Exploring respect during childbirth among nurses, women and their families

---

Research Investigator:
Leanne Johnson, RN, MN
3-141 Edmonton Clinic Health Academy
Faculty of Nursing
University of Alberta
Edmonton, AB, T6G 1C9
leanne.johnson@ualberta.ca
xxxxxxxxxxx

Co-Supervisors:
Drs. Beverley O'Brien and Solina Richter
3-141 Edmonton Clinic Health Academy
Faculty of Nursing
University of Alberta
Edmonton, AB, T6G 1C9
solina.richter@ualberta.ca
beverley.obrien @ualberta.ca
xxxxxxxxxx

Why am I being asked to take part in this research study? You are being asked to be in this study because your partner had a baby within the last 12 months at a hospital in XXXXX and we want to understand what respect during childbirth means to you. Before you decide whether or not to participate in the study, one of the researchers will go over this form with you. You can ask questions if you feel anything needs to be made clearer. You will be given a copy of this form for your records.

What is the reason for doing the study? The purpose of the research is to understand what respect during labour and birth means to nurses, women and their families. This study is in completion for a student project towards a PhD in nursing.

What will I be asked to do? You are being asked to complete one "in person" interview lasting about one hour with your partner.

What are the risks and discomforts? There are minimal risks to participating in this study, however discussing your experience may cause positive or negative feelings. If you feel that you need more support, mental health services will be explored with you. It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable actions to minimize any known risks to you.

Possible benefits to you include the opportunity to discuss your experience and help us better understand how nurses can provide respectful care to families during childbirth.

Will I be paid to be in the research? You will be reimbursed for parking costs that may occur during the time of the interview. You will also receive your choice of either a $10 Tim Hortons or Starbucks gift card for your time.

Do I have to take part in the research? No, participation in the study is voluntary. You do not have to answer any questions in the interview that you do not feel comfortable with. You can withdraw at any time up to two weeks after the last interview. You would still receive a gift card even if you withdrew early.

Will my information be kept private? During the study we will be collecting data about you. Direct quotes from the interview may be used in the final report but will not be connected to your name. We will do everything we can to make sure that your data is kept private and kept separately from your name. No data relating to this study, including your name will be made public. Sometimes, we may be required by law to report certain information (e.g. harm to child) so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private

Study data will be stored in at *University of Alberta Health Research Data Repository* for possible re-use in a future study. Data will be kept for a minimum of 5 years. Any personal information (i.e. your name, address, telephone number) you will be removed prior to sharing study data with other researchers. Any researcher who wants to use this data must have the new project approved by an appropriate ethics board.

What if I have questions? If you have any questions about the research now or later, please contact Leanne Johnson via email leanne.johnson@ualberta.ca or phone XXXXXX**.**

If you have any questions regarding your rights as a research participant, you may contact the Health Research Ethics Board at 780-492-2615. This office has no affiliation with the study investigators.

CONSENT

Title of Study: Exploring respect during childbirth among nurses, women and their families

---

Research Investigator:
Leanne Johnson, RN, MN
3-141 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
leanne.johnson@ualberta.ca

xxxxxxxx

Co-Supervisors:
Drs. Beverley O'Brien and Solina Richter
5-269 Edmonton Clinic Health Academy
Faculty of Nursing, University of Alberta
beverley.obrien@ualberta.ca
solina.richter@ualberta.ca
xxxxxxxxxx

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without penalty?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐
Future Contact		
Do you agree to be contacted for follow-up or to facilitate future research?	☐	☐
Use of my research information beyond this study		
Do you agree for your information to be securely stored at *University of Alberta Health Research Data Repository* to facilitate future reuse?	☐	☐

Who explained this study to you? _____

I agree to take part in this study:

Signature of Research Participant _____

(Printed Name) _____

Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee _____ Date _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT

Appendix M

The International Childbirth Initiative (ICI)

The 12 steps to Safe and Respectful MotherBaby-Family Maternity Care (summary version)

(https://icichildbirth.org)

Step 1: Treat every women and newborn with compassion, respect and dignity, without physical, verbal or emotional abuse, providing culturally safe and culturally sensitive care that respects the individual's customs, values, and rights to self-expression, informed choice and privacy.

Step 2: Respect every woman's right to access and receive non-discriminatory and free or at least affordable care throughout the continuum of childbearing, with the understanding that under no circumstances can a woman or baby be refused care or detained after birth for lack of payment.

Step 3: Routinely provide MotherBaby-Family maternity care. Incorporate value and partnership-based care grounded in evidence-based practice and driven by health needs and expectations as well as by health outcomes and cost effectiveness.

Step 4: Acknowledge the mother's right to continuous support during labour and birth and inform her of its benefits, and ensure that she receives such support from providers and companions of her choice.

Step 5: Offer non-pharmacological comfort and pain relief measures during labour as safe first options. If pharmacological pain relief options are available and requested, explain their benefits and risks.

Step 6: Provide evidence based practices beneficial for the MotherBaby-Family throughout the entire childbearing continuum.

Step 7: Avoid potentially harmful procedures and practices that have insufficient evidence of benefit outweighing risk for routine or frequent use in normal pregnancy, labour, birth and the post-partum and neonatal period.

Step 8: Implement measures that enhance wellness and prevent illness for the MotherBaby-Family, including good nutrition, clean water, sanitation, hygiene, family planning, disease and complications prevention and pre-and-post natal education.

Step 9: Provide appropriate obstetric, neonatal, and emergency treatment when needed. Ensure that staff are trained in recognizing (potentially) dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and a safe and effective referral system.

Step 10: Have a supportive human resource policy in place for recruitment and retention of dedicated staff, and ensure that staff are safe, secure, respected and enabled to provide good

quality, collaborative, personalized care to women and newborns in a positive working environment.

Step 11: Provide a continuum of collaborative care with all relevant health care providers, institutions, and organizations with established plans and logistics for communication, consultation and referral between all levels of care.

Step 12: Promote breastfeeding and skin-to-skin contact, refer to the 10 Steps of the Baby-Friendly Hospital Initiative and integrate into practice, training and policies.