Woman Centred Care: A Concept Analysis
Abstract

**Aim:** This paper reports an analysis of the concept of woman centred maternity care.

**Background:** Woman centred maternity care describes a form of maternity care that prioritises the needs and wishes of the woman. Although referenced throughout the literature, there is a lack of consensus on its meaning and the concept is inconsistently described and applied.

**Data Sources:** A systematic literature search of the period 1985 to 2013 was completed using Scopus (which contains MEDLINE, Excerpta Medica Database (EMBASE) and Compendex coverage, PsychINFO, Maternity and Infant care (MIDIRS)) and Nursing @Ovid (which contains the Ovid Nursing Database, MEDLINE, PsycINFO, Maternity and Infant care (MIDIRS)), Cumulative Index of Nursing and Allied Health Literature (CINAHL), SCOPUS and Excerpta Medica Database (EMBASE).

**Review Methods:** Data were analysed, referencing time and context, within discipline specific groups of service users, medical service providers, midwifery service providers and policy. All analysis was guided by Rodgers evolutionary concept analysis model.

**Results:** 624 papers were identified form the search and 50 included in the analysis. Nine attributes of woman centred care were identified i.e. information sharing, choice, control, individualised care, quality of care, shared decision making, continuity of care, time and normalcy. Although each attribute was valued independently, the provision of woman centred care was found to be dependent on a combination of all attributes. Antecedents and consequences of woman centred care were identified and implications for practice are described.

**Conclusion:** Woman centred care was found to be a dynamic process that requires active participation from all stakeholders. Although the attributes of woman centred care have remained relatively constant, there remains a continued ambiguity surrounding the concept.

**Keywords:** concept analysis, woman centred, maternity, midwife, pregnancy
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1. Introduction
The concept ‘women centred care’ was first noted in the literature in the 1950’s by Balint (Balint, 1955, Balint, 1956). Today the concept is often viewed as a common philosophy in the provision of maternity care. However, ambiguity exists between the ideology of this concept and its contextual expression in the modern childbirth setting. Interpretations differ depending on context and ethos of care encountered, a fact emphasised in a recent Cochrane review (Dwamena et al., 2012). When the definition of a concept is vague and unclear it diminishes its core value and use (Rodgers, 2000). To facilitate the promotion of women-centred care, a clear understanding of the concept is necessary.

2. Aims
In this paper I describe the attributes of woman centred care in the midwifery context using Rodger’s evolutionary method and examine the evolution of the attributes to their current application. My analysis includes the effect of context on these descriptive attributes. Through clarification of the concept, I identify gaps in knowledge and directions for further development. Due to word limitations, the ‘model case’ is not included here.

3. Concept Analysis Method
This analysis uses the inductive, descriptive approach of Rodger’s evolutionary model (Rodgers, 2000). In the field of modern midwifery and obstetric care, with its continuous organic growth, Rodgers evolutionary model is particularly suited to providing a relevant contemporary concept analysis as demonstrated by Larkin et al. (2009) and Huynh et al. (2008).

4. Sample Selection
The goal when choosing a sample is to produce a rigorous design that supports the ideology of the study (Rodgers, 2000). Rodgers advocates basing selection decisions on questions the researcher wishes to answer; however, rigour during the selection procedure remains an essential component (Rodgers, 2000). A systematic search of published and indexed material contained in two electronic database portals i.e., Scopus (which contains MEDLINE, Excerpta Medica Database (EMBASE) and Compendex coverage, PsychINFO, Maternity and Infant care (MIDIRS)) and Nursing @Ovid (which contains the Ovid Nursing Database, MEDLINE, PsycINFO, Maternity and Infant care (MIDIRS)),...
Cumulative Index of Nursing and Allied Health Literature (CINAHL), SCOPUS and Excerpta Medica Database (EMBASE). Papers were limited to those published in English between 1985 and 2013. Search terms included were woman centred care, women centred care, woman centered care, women centered care, person centred care, person centered care, family centred care, family centered care, patient centred care and patient centered care. Full search strategies are given in Appendix one.

All retrieved material was scanned for relevance and manually cross referenced for duplication. The articles were sorted into discipline specific groups; service users, medical service providers, midwifery service providers and policy. A final cohort of material to be analysed was produced through computer generated random selection from each discipline. A sample size of 50 papers was deemed appropriate as the literature demonstrates that a sample size greater than 30 is necessary for analysis (Rodgers, 2000; Rodgers, 1989). Details of flow of papers through search, removal of duplications, screen and inclusion are given in Appendix two.

5. Data Analysis

The inductive, descriptive approach of Rodgers evolutionary concept analysis model was used to analyse each article with a preliminary focus on determining themes associated with woman centred care (Rodgers, 2000). This involved the recognition of phenomenon which are consistently present when the concept occurs. Resultant themes were analysed by discipline, potential change with time, context, interdependence, and implication for future practice.

Emergent themes were analysed, organised and a set of attributes for woman centred care determined. A description and definition of each attribute was produced through data analysis of the disciplines. This was achieved through the examination and subsequent recording of data from each article. Data were recorded referencing time frame, discipline, antecedent, consequence, implication for practice and context. The resultant data were compiled and compared for the presence of consistent characteristics. As described in Rodger’s model, data were examined not to produce a definitive definition of woman centred care but to offer a dynamic current description of the concept.
6. Findings

6.1. Characteristics of the concept

Despite the challenges inherent in researching such a complex phenomenon, there was evidence of consensus on the attributes of the concept of women centered care. The attributes identified are information sharing, choice, control, individualised care, quality of care, shared decision making, continuity of care, time and normalcy.

6.1.1. Information Sharing

The communication and understanding of information has been noted consistently as an attribute of woman centered care. Its importance has prevailed throughout the timeframe and disciplines researched however, its implication for practice has evolved with time. The provision of information has progressed from an informal role of the clinician to a fundamental element of woman centered care (Rising, 1998; DOH, 2005; Kaimal & Kuppermann, 2010). Attributes such as choice and control only exist in the presence of informed consent, which is achieved through the sharing of information (Healthcare Commission, 2008).

Information sharing is described as a dynamic interactive relationship between the healthcare provider and women, requiring active participation from both (O’Connell & Downe, 2009; McCourt & Pearce, 2000; Everly, 2012). Effective communication skills are essential for health care providers as women value information that is communicated clearly in a language they understand (Page et al., 1999; Freeman, 2006, Lawrence et al., 2012). The literature notes that this attribute is viewed by midwives as a fundamental component of the midwifery ethos (Everly, 2012). The benefit of education is demonstrated to prevail long after the birth process (Rising, 1998; Suarez, 1993; Healthcare Commission, 2008).

While the literature focuses on the role of the caregiver in communicating information to women, it also highlights the importance of clinician education in the provision of woman centered care. A lack of appropriate information potentially results in women being unnecessarily viewed as ‘high risk’ and not provided with all available choices (Walsh-Gallagher et al., 2013).
6.1.2. Choice

Choice is described as the ability to take control and express preferences that are listened to (Gennaro et al., 2007; Savage, 2006). Choice occurs when the focus of care and decision-making is the woman not policy (Gennaro et al., 2007). In the literature, choice is linked intrinsically to the attribute of information sharing, with the provision of information enabling women to articulate their needs (Everly, 2012; Edwards, 2008) (See Appendix Three)

The literature notes that midwives believe informed choice is fundamental to a midwifery ethos and is central to woman centred care (Freeman, 2006). However, the literature describes conflict between the disciplines of midwifery and obstetrics (Murphy-Lawless, 2011). Both women and midwives feel choice is impeded by the medical model of care (Walsh & Newburn, 2002; Carolan & Hodnett, 2007; Pope et al., 2001, Goldbeck Wood, 1997). Midwives feel they must adapt women’s choices to make them compatible with policy, while women feel their wishes are often overridden in deference to the medical hierarchy and maternity policy (Walsh & Newburn, 2002; Newman & Hood, 2009; Everly, 2012).

Choice is only present when all options are available. However, the literature suggests that women are often presented with a predetermined set of choices that conform to policy and predetermined risk factors rather than a comprehensive selection of all available choices (Edwards, 2008; Carolan & Hodnett, 2007). Significantly, the term ‘allow’ is used throughout the literature to describe the provision of choice suggesting a restrictive, patriarchal notion of choice (Newman & Hood, 2009; Gennaro et al., 2007).

Appendix Three:
6.1.3. Control

Control is an attribute of woman centred care that dominates the intrapartum period in particular. However, its meaning is multifaceted and remains largely undefined, regardless of the discipline examined (Namey & Lyerly, 2010). Control is employed in varied contexts to describe phenomena such as, control over a physical or mental process, self-control or the ability to exact control (Savage, 2006; Namey & Lyerly, 2010). Therefore, in utilising control as an attribute, care must be taken to ensure a specific definition and context.

The literature illustrates an interdependent relationship between control and the attributes of information sharing and choice (Fenwick et al., 2001; McCourt & Pearce, 2000; Larkin et al., 2012) (See Appendix Three). Control is associated with the acquisition and relinquishment of power (Kennedy et al., 2003; Fenwick et al., 2001). For women, control is described primarily in subjective terms, often referred to simply as a “feeling of control” (Freeman, 2006; Green et al., 2000). Women consistently rate control as a vital attribute of woman centred care, believing it supports an active role and equality (Savage, 2006; Freeman, 2006). Throughout the literature women associate a lack of control with a medicalised model of care (McCourt & Pearce, 2000; Davis, 2008; Edwards, 2008). This is in contrast to women’s views on midwife-led care where control is seen as shared and transient (Kennedy et al., 2003; Freeman, 2006).

6.1.4. Individualised care
Individualised care is commonly defined as the recognition of women as unique individuals and adapting care to their specific needs (Kennedy et al., 2003). In the application of this attribute, clinicians acknowledge that they are caring for a ‘thinking woman’ who has the ability to make informed choices and decisions (Hildingsson & Thomas, 2007; Kennedy et al., 2003; Kotaska, 2011). Care is tailored to the individual context and its resultant practical application. The literature notes that the successful provision of individualised care is dependent on a woman actively engaging with clinicians and policy (Rising, 1998).

There is a division among the disciplines in the provision of this attribute. Literature referencing the medical profession notes that individualised care is provided when upon examination of the evidence a woman is informed of the risks and benefits of a particular aspect of her care and ‘allowed’ to make an informed choice (Kotaska, 2011; Healthcare Commission, 2008). In contrast, provision of individualised care by the midwifery profession is depicted in emotive, personalised terms. It is described as an open interplay between woman and midwife with listening noted as a key component (Lee-Davis & Walker, 2011; Fenwick et al., 2001; Pope et al., 2001). Individualised care occurs when a midwife tailors a woman’s care plan to her individual needs, sometimes in direct opposition to the midwife’s personal preferences (Carolan & Hodnett, 2007; Leinweber & Rowe, 2010; Pope et al., 2001).

6.1.5. Quality of care

The dynamics of quality of care have evolved with time. Women now value specific components of care such as professionalism and safety. This attribute holds multiple connotations in the literature; it is used to describe quality of care from the woman and midwives perspective, while also describing the physical environment, its perceived safety, maternity policy and services provided (Newman & Hood, 2009; Walsh-Gallagher et al., 2013; Namey & Lyerly, 2010).

Women expect midwives to be professional and clinically competent (Hildingsson & Thomas, 2007; Carolan, 2006) while retaining the historical humanistic aspects of midwifery care (O’Connell & Downe, 2009; Morgan et al., 1998; Hildingsson & Thomas, 2007). Women require a consistent, professional, safe service delivered with an ethos of
care (Kennedy et al., 2003; Carolan, 2006). Midwives also regard safety as a vital aspect of this attribute (Lee-Davis & Walker, 2011; Van-Kelst, 2013; Pope et al., 2001).

This presents an evolving dynamic. Midwives are required to provide evidence-based practice in a professional manner while maintaining the emotional, humanistic essence of midwifery. The literature notes that this straddling of the biomedical and phenomenological worlds has resulted in a practice where midwives strive to maintain their commitment to promote normality while professionally, with the advent of routine monitoring, they continuously search for the abnormal (O’Connell & Downe, 2009; Scamell, 2011). Midwives depict a maternity model that requires a practice that is fundamentally defensive (Kirkham & Stapleton, 2000; Scamell, 2011).

Quality of care is portrayed as dependent on the attributes of information sharing and choice, a co-dependency believed to drive quality (Edwards, 2008). In the last decade the quality of service provided, the safety of the physical environment and the effects of health care policy have emerged in the literature as components of this attribute (Green et al., 2000; Larkin et al., 2012; Edwards, 2008). Women and clinicians note the physical impact understaffing has on quality of care and the negative effect it has on their perceived feelings of safety (Murphy-Lawless, 2011; Walsh & Newburn, 2002; Larkin et al., 2012).

6.1.6. Shared decision making

Shared decision making is seen to be an integral attribute in the provision of woman centred care. It is referenced by all disciplines in the literature however its purpose and application differs with each. This attribute is viewed historically as a dynamic relationship between women and clinicians, established through trust, communication and a sharing of control (Kennedy et al., 2003; Fenwick et al., 2001; Kaimal & Kuppermann, 2010).

The literature points to two important characteristics which women believe promote shared decision making; an open, honest information exchange and a ‘feeling of being involved’ in decisions (Freeman, 2006; Green et al., 2000). The literature indicates women simply want their viewpoints listened to and to be actively included in decisions made about them (Namey & Lyerly, 2010).
It is noted that midwives feel shared decision making is fundamental in their provision of women centred care while also having the potential to place them in conflict with hospital and maternity policy (O’Connell & Downe, 2009; Everly, 2012). For midwives, this attribute is central to the partnership they build with women. However, as with individualised care, standardised policy is seen to provide ethical dilemmas, where the choice is either adherence to bureaucratic policies and procedures or the provision of shared decision-making (Everly, 2012; Finlay, 2009).

6.1.7. Continuity of care

Continuity of care holds diverse meanings throughout the literature. It can refer to a continuity of information or consistency in maternity policy. It may also describe continuity in delivering an ethos of care or more specifically a continuity of carer (Finlay, 2009; Carolan & Hodnett, 2007; Pope et al., 2001). This attribute embodies the humanistic side of midwifery through the formation of relationships and the ensuing support (Freeman, 2006). Continuity of care, and the support it offers, is shown to have emotional and physical aspects that are of equal importance to women and is associated with maternal satisfaction (McCourt & Pearce, 2000; Walsh-Gallagher et al., 2013).

While continuity of care is referenced for all disciplines, the literature refers predominantly to care and support offered to women by midwives (Lee-Davis & Walker, 2011; Freeman, 2006; McCourt & Pearce, 2000) while also noting the role of partners and family (Lee-Davis & Walker, 2011; Leinweber & Rowe, 2010).

Midwives view continuity of care as a fundamental building block in the development of relationships and equality with women (Kirkham & Stapleton, 2000). Women want their relationships with midwives to be empowering and confidence building (Carolan & Hodnett, 2007). By incorporating trust and respect, a powerful alliance is formed (Kennedy et al., 2003; Brown, 2005). The literature refers to the building of relationships as the essence of midwifery. It notes that this sharing of oneself is what differentiates midwives from other health professionals (Leinweber & Rowe, 2010; Kirkham & Stapleton, 2000). However, this level of empathy requires significant emotional investment from midwives with the incidence of secondary traumatic stress among midwives noted (Leinweber & Rowe, 2010). The literature provides little on the woman-obstetrician relationship. Women
consistently describe obstetricians in positions of hierarchy and power (Kennedy et al., 2003; Freeman, 2006).

Expectations associated with this attribute have changed as maternity policy has evolved. In earlier literature, consistency of ethos and levels of care and support defined the attribute (Walsh, 2002; Morgan et al., 1998). With the movement towards caseload midwifery, women seek a familiar midwife throughout the maternity experience (Lee-Davis & Walker, 2011; Green et al., 2000; McCourt & Pearce, 2000). The shift in women’s expectations is significant for future practice as throughout the literature the benefits of supportive relationships and continuity of care such as lower levels of intrapartum analgesia and lower caesarean section rates are well documented (Gennaro et al., 2007; Suarez, 1993).

6.1.8. Time

In the context of women centred care, time describes the perceived and real availability of the clinician to women during her antenatal, intrapartum and postnatal experience. The essence of this attribute has had the most dynamic change during the time period researched. Earlier literature refers to the positive relationship time has with the attributes of choice, control, and individualised care (Kennedy et al., 2003; Rising, 1998; Larkin et al., 2012; Finlay, 2009). Time is noted as the foundation that supports the presence of these attributes (Kennedy et al., 2003; McCourt & Pearce, 2000).

However, more recent literature has focused on the negative effects a lack of time produces. While women consistently rate the importance of midwives spending time with them, the literature notes that women now feel lucky if they receive individual attention and report feeling less supported (Larkin et al., 2012; Finlay, 2009; Van-Kelst et al., 2013; Hildingsson & Thomas, 2007). Women now accept that midwives will spend less time with them, resulting in feelings of vulnerability (Walsh & Newburn, 2002; Brown et al., 2005; Hildingsson & Thomas, 2007).

Midwives value the attribute of time as one that is central to their provision of woman centred care and recognise that they are now, in the main, unable to fully offer this attribute (Walsh-Gallagher et al., 2013). In the hospital setting, in particular, the literature describes midwives feeling under pressure to move women through the ‘system’ as fast as possible,
while simultaneously fearing that this pressure will cause mistakes (Everly, 2012; O’Connell & Downe, 2009). The literature suggests that although women and midwives value the attribute of time our current maternity policy does not promote this attribute (O’Connell & Downe, 2009; Murphy-Lawless, 2011).

6.1.9. Normalcy

While promoting normality has remained an attribute of woman centred care for midwives, its implication for practice has changed with time (Walsh & Newburn, 2002; Winters, 2012; Edwards, 2008). Normalcy is described as the belief that pregnancy and birth are normal physiological events that typically warrant little intervention (Byrom et al., 2010; Suarez, 1993; Newman & Hood, 2009). However, within the medicalised model of care, normalcy is often confused with ‘usual’ or ‘routine’ (O’Connell & Downe, 2009; Walsh & Newburn, 2002).

The literature suggests that this attribute involves the promotion of an environment that supports the normalcy of pregnancy and birth (Kennedy et al., 2003; Lee-Davis & Walker, 2011). The midwives role is to maintain the normal within the medicalised environment and the accompanying pressure to comply (Walsh & Newburn, 2002; Winters, 2012).

Literature describes an opinion held by women that suggests normalcy equates to health during pregnancy and birth (Hildingsson & Thomas, 2007). Although the literature supports the belief that obstetricians and interventions are not necessary for low risk women, standardised protocol and policies define the parameters of low risk and normal (O’Connell & Downe, 2009; Walsh & Newburn, 2002; Davis, 2008).

In recent years there has been a subtle shift in the description of the midwifery role. Earlier literature described a supportive role; however, recent literature describes this attribute in more aggressive terms with emphasis shifting from supporting normalcy to guarding normalcy (Lee-Davis & Walker, 2011; Byrom et al., 2010; Carolan & Hodnett, 2007). This active championing of normalcy by midwives has produced major benefits for women and heath care budgets with less interventions and lower levels of intrapartum analgesia (Carolan & Hodnett, 2007).
7. Antecedents

Antecedents refer to features that must be present for woman centred care to exist. These differ for each discipline analysed:

The primary antecedent for clinicians is a respect for the ethos of women centred care coupled with a motivation to engage in a thought process and behaviour that places the woman’s needs and wishes as a priority (Kennedy et al., 2003). Maternity care policy that promotes and supports women centred care must be in place. Further, the physical components and infrastructure supporting the concept must be available for clinicians to offer all attributes described in this analysis.

The primary antecedent for women as service users is engaging with any form of maternity service. This, accompanied by an active desire for and participation in woman centred care, is essential as this interaction drives the provision of the concept (O’Connell & Downe, 2009). Woman centred care is dependent on the presence of clinicians and maternity units that support and offer the attributes to women. The ethos of woman centred care must be maintained throughout the multidisciplinary team to be successful.

When examining the provision of woman centred care in relation to policy, consistent maternity policy was noted to be the primary antecedent. Policy was most effective in promoting women centred care when women, as service users, were involved in its design and implementation (Newman, 2009).

8. Consequences

The consequences of woman centred care were unique to each stakeholder. For women, it is associated with increased levels of maternal satisfaction throughout the antenatal, intrapartum and postnatal period. Indeed, many attributes are noted in the literature to have benefits long after the birth experience. For example, in McCourt & Pearce (2000), continuity of care during the antenatal period was shown to encourage and support a self confidence in women, developed throughout the antenatal and Intrapartum periods which was maintained as a life skill well beyond the postnatal timeframe.
The literature links the provision of woman centred care with increased levels of job satisfaction and autonomy for midwives (Warren, 2003). However, it is noted that without supportive policies the provision of woman centred care can incur fear and stress. Woman centred care is associated with less interventions, less intrapartum analgesia and therefore less cost (Gennaro et al., 2007; Carolan & Hodnett, 2007). Woman centred care is shown to increase maternal satisfaction and subsequently women centred maternity policies are welcomed by the public. (Morgan et al., 1998; Savage, 2006).

The literature notes that although the medical discipline encourages woman centred care, the attribute of control remains an issue. The ensuing conflict can result in dissatisfaction and frustration for both obstetricians and women. Yet when woman centred care is supported by obstetricians, maternal satisfaction increases particularly in the area of shared decision making (Green et al., 2000; Hildingsson & Thomas, 2007).

Varying degrees of woman centred care are observed. This variation is noted to be dependent on the woman’s expectations, the health care provider’s complicity in supporting the concept and the context in which care occurs. This, coupled with individual disciplines beliefs regarding the appropriateness of certain attributes, reflects how fully woman centred care is embraced.

9. Related Concepts

A range of terms is used to infer woman centred care. Internationally, the term ‘patient’ can refer to women in the maternity setting. However, ‘patient centred care’ is also used to describe a related concept connected primarily to the nursing and medical profession (Stewart, 2001). There are many similarities between the aims of woman centred care and patient centred care including choice, empowerment, education and support. However, there are subtle differences noted (Royal College of Nursing, 2013). Patient centred care deals primarily with individuals who are sick and need intervention. Woman centred care refers to women who are predominantly healthy and clinicians who strive to avoid unnecessary intervention. Family centred care is another closely related concept and can be seen to reflect the holistic view of the midwifery profession. Nevertheless, the literature principally links this concept to paediatric and neonatal care (Mikkelsen & Frederiksen, 2011; Hutchfield, 1999). Woman centred care places the woman firmly at the centre of the
care plan but with family centred care this position is shared between the neonate and the parents (Smith, 2012; Hutchfield, 1999). Although these terms were found throughout the literature as a reference to woman centred care, they were only used in this concept analysis on meeting the previously stipulated criteria.

10. Implications for practice

‘Woman-centred care’ is a phrase used to express an ethos of maternity care which prioritises the needs of the woman (Gennaro et al., 2007). A current dynamic concept analysis provides a foundation in the development of policy to support woman centred care. The continued ambiguity of woman centred care is an indicator that further analysis is needed on this concept. The description provided by this analysis may aid in the recognition of woman centred care however it also demonstrates an organic shift in its provision. This primarily occurred due to the specific effect the attribute ‘Quality of Care’ has on a consistent provision of the concept. The present depressive economic status was found to have an oppressive impact on the provision of woman centred care by midwives. Stresses on staffing levels, healthcare budget cutbacks and a lack of resources to provide continued education, all reflect negatively on the provision of woman centred care. The practical application of woman centred care was often described as a compromise between the woman’s needs and policy (Everly, 2012; Finlay, 2009).

Healthcare policy throughout the reviewed timeframe was noted to be paternal and hierarchal with a distinct juxtaposition of encouraging choice while referring to ‘allowing’ women control in certain aspects of care (Newman & Hood, 2009; O’Connell & Downe, 2009; Davis, 2008). As maternity services predominantly adopt a medical model, the attributes of normalcy, choice and control are skewed by ‘usual’ or ‘routine’ practice. The attribute of normalcy has, in particular, undergone a dynamic evolution, with ‘normal’ being interchanged with ‘usual’. Midwives must be encouraged to maintain their role as protector of normalcy in order to preserve a fundamental characteristic of woman centred care. This finding has implications in the development of midwifery, obstetric and hospital policy.

Although the literature demonstrates that the attributes of woman centred care are integral to the midwifery ethos, the provision of woman centred care by midwives was noted to be
dependent on the availability of attributes and the support of consistent policy. Midwives cannot fully support woman centred care when all attributes of the concept are not available. Many attributes are interdependent and cannot truly exist without the presence of others i.e. information and choice. It is hoped that this analysis will provide a foundational framework for additional focused study on woman centred care.

References


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Appendix one:

Ovid Search Terms:

("woman centred care" or "women centred care" or "woman centered care" or "women centered care" or "person centred care" or "person centered care" or "family centred care" or "family centered care" or "patient centred care" or "patient centered care").mp. [mp=tx, bt, ti, ab, ot, nm, hw, kf, ps, rs, an, ui, dw, tc, id, tm, ct, sh]

And

(pregnancy or maternity or birth or labour or labor).mp. or *natal/ or *partum/ [mp=tx, bt, ti, ab, ot, nm, hw, kf, ps, rs, an, ui, dw, tc, id, tm, ct, sh]

In Ovid 10 Resources selected and searched| Hide | Change

Books@Ovid July 16, 2013, Journals@Ovid Full Text July 16, 2013, Maternity and Infant Care 1971 to June 2013, Ovid MEDLINE(R) 1946 to July Week 1 2013, Ovid Nursing Database 1946 to July Week 1 2013, PsycBOOKS 1806 to July 2013, PsycCRITIQUES 1956 to July 2013 Week 2, PsycEXTRA 1908 to July 01, 2013, PsycINFO 1806 to July Week 2 2013, Your Journals@Ovid

Universal Search: Scopus, CINAHL, EMBASE.com
Scopus Search Terms:
"wom* centred care" OR "wom* centered care" OR "person centred care" OR "person centered care" OR "family centred care" OR "family centered care" OR "patient centred care" OR "patient centered care"
pregnancy OR maternity OR birth OR labour OR labor OR *natal OR *partum

AND PUBYEAR > 1984
Appendix Two:

Prisma Flow Diagram

- # of records identified through Ovid database search = 4492
- # of records identified through Scopus database search = 781

4492 records after duplicates removed

4492 records screened

3868 records excluded

624 full-text articles assessed for eligibility

50 studies were included in the final synthesis

Notes: The 50 studies were organized by discipline. 574 were excluded by random selection while retaining the original distribution ratio.