

Comprendre les aspects moraux des pratiques quotidiennes des sages-femmes et des infirmières de la phase intrapartum

Anne Simmonds et Elizabeth Peter

Les auteures recourent au modèle de moralité « expressive-collaborative » de Margaret Urban Walker pour illustrer, sous l'éclairage de la moralité, les pratiques quotidiennes et les connaissances des sages-femmes et des infirmières du volet intrapartum. Elles donnent des exemples de ces pratiques et connaissances morales en s'inspirant d'études qualitatives sur les soins intrapartum. En se fondant sur le modèle de madame Walker pour interpréter les résultats de ces études, elles ont relevé trois thèmes, soit la création d'un espace pour l'établissement de la relation, l'affrontement de milieux moralement hostiles et la renégociation de l'ordre moral-social par la défenses des droits. Les espaces créés par les infirmières et les sages-femmes pour établir une relation avec les femmes en couches leur révèlent quelques-unes de leurs responsabilités morales. Elles doivent toutefois subir les contraintes du milieu : les rapports hiérarchiques au sein des équipes et les institutions qui entravent leur capacité à prendre leurs responsabilités morales, ce qui rend le milieu inhospitalier à certains moments. Elles ont compris que pour redéfinir ces relations, elles doivent se porter à la défense des droits des femmes qui accouchent.

Mots-clés : infirmières du volet intrapartum, sages-femmes, responsabilités morales, défense des droits

Understanding the Everyday Moral Practices of Midwives and Intrapartum Nurses

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The authors use Margaret Urban Walker's expressive-collaborative model of morality to illuminate the everyday practices and knowledge of midwives and intrapartum nurses as moral practices and knowledge. They provide examples of these moral practices and knowledge by drawing on qualitative studies of intrapartum care. Using Walker's model to interpret the findings of these studies, they identify 3 themes: creating a space for relationship, encountering morally uninhabitable environments, and renegotiating the moral-social order through advocacy. The spaces that nurses and midwives create for relationship with labouring women reveal to them some of their moral responsibilities. However, nurses and midwives encounter environmental constraints: Hierarchical arrangements within teams and institutions constrain their ability to enact their moral responsibilities, rendering the environment morally uninhabitable at times. They understand that in order to renegotiate these arrangements they must advocate for women in labour.

Keywords: Perinatal nursing, midwifery, ethics, feminist

Little has been written about the ethics of intrapartum nursing and midwifery care apart from case scenarios aimed at helping practitioners to resolve dramatic issues such as obtaining consent for emergency medical interventions (Finnerty & Chisholm, 2003). While research, particularly that of a qualitative nature, has uncovered some of the everyday practices of midwives and intrapartum nurses, the ethical significance of these practices has not been articulated.

Traditional bioethical approaches in clinical settings typically entail the objective weighing of benefits and harms to determine right and wrong action and the application of principles. However, ethical practice in intrapartum nursing and midwifery is embedded in the everyday relationships that caregivers establish with childbearing women (Thompson, 2002). It is through these relationships that a plan of care is negotiated. These relationships are specific to particular individuals in a particular context and are usually well established prior to the emergence of any potential dilemma or problem. An important consideration is that, unlike most patients, who are admitted to hospital for medical reasons, childbearing women and their fetuses are generally healthy (and childbirth is not considered an illness). As these women usually do not require medical

treatment, the relationship as a vehicle for nurturing and supporting them through the birth process often becomes their main concern (Bowers, 2002).

In this article, we use Margaret Urban Walker's (1998, 2003) expressive-collaborative model of morality to identify the everyday practices and knowledge of midwives and intrapartum nurses as *moral* practices and knowledge. We first describe the model and our reasons for choosing it. We then provide examples of the moral practices and knowledge of midwives and intrapartum nurses by drawing on the results of qualitative studies. We have used exclusively qualitative studies because of their rich description of practices and have concentrated on intrapartum practices, as opposed to including all of perinatal practice, to ensure depth and focus of analysis. We identify three themes of moral practices and understandings: creating a space for relationship, encountering morally uninhabitable environments, and renegotiating the moral-social order through advocacy.

Walker's Expressive-Collaborative Model of Morality

In offering an alternative to mainstream moral theorizing, Walker does not begin with hypothetical and abstract principles. She begins firmly with the everyday experiences of people engaged in meeting their moral responsibilities. Her moral epistemology rests on the assumption that the production of moral knowledge is necessarily influenced by how people are situated in terms of class, race, gender, and sexual orientation.

Walker's (1998, 2003) expressive-collaborative model of morality contains three theoretical propositions. The first is that moral knowledge is located in human social life. Here, morality exists in the context of daily practices, which, in turn, both shape ethical theory and inform one's everyday choices and perceptions. Morality, from this perspective, is "a socially embodied medium of mutual understandings and negotiation between people over their responsibility for things open to human care and response" (Walker, 1998, p. 9). The expressive-collaborative model is distinct from the traditional theoretical-judicial model, as the latter relies on the application of impersonal ethical formulas or principles to guide moral action. Walker describes a moral world that is inextricably linked with the social world, where our responsibilities to each other and to ourselves are negotiated in a climate of reciprocity and understanding. In the realm of care during childbirth, this would mean that practitioners remain open to a woman's preferences with regard to pain management during labour while also offering a clinical perspective on the progress of labour and the range of interventions that might be helpful. The end result would be a mutually negotiated understanding of how best to meet the woman's need for pain relief and to respect her other birth preferences.

In Walker's second theoretical proposition, those practices that are characteristic of morality are described as "practices of responsibility": They "implement commonly shared understandings about who gets to do what to whom and who is supposed to do what for whom" (1998, p. 16). Practices of responsibility are multifaceted; they define and express our understanding of agency. In nursing, they are often directed at people who are vulnerable, in need of health services, and therefore susceptible to the choices and actions of nurses (Peter & Liashenko, 2003). They encompass the knowledge, skills, and clinical judgement that form the basis of nursing practice. However, our practices of responsibility and moral accountability are not fixed entities; they are shaped by social roles and identities in and among the institutions and individuals that determine how responsibilities are to be shared. Nurses therefore perceive their social-moral world differently from other practitioners, by virtue of their social identities and relationships in their places of work.

Finally, Walker (1998) contends that morality is not socially modular but is a part of everyday life, and therefore that moral understandings spring from social understandings and are not abstract, isolated from social reality and context. Walker asserts that the social world is a morally differentiated one, arguing that because hierarchical power relations are the rule, diverse moral identities and positions are created as a matter of course. According to this view, one's social position and role define for what and to whom one is accountable. People understand the moral-social world differently, depending on how they are positioned, and this in turn influences the types of knowledge they use to evaluate the moral habitability of the environments in which they live and work. Walker (2003) describes a morally inhabitable environment as one that fosters cooperation and recognition and in which differently situated people experience their responsibilities as intelligible and coherent. Such an environment is possible if moral arrangements and social orders are transparent, revealing who has responsibility for what, and if criteria are identified for distributing and evaluating responsibilities.

Emerging Themes and Moral Practices and Understandings

Walker (2003) proposes that moral practices can be illuminated and understood if one pays close attention to the narratives of individuals. Therefore, we searched for qualitative studies focusing on the subjective voices of nurses and midwives with regard to the ethical nature of their practice. Although studies of people's perspectives and experiences, also known as "views studies," can be difficult to locate (Harden et al., 2004), the importance of using qualitative methodologies to examine life experiences from the perspective of the person with the experience is being

increasingly recognized in health services research (Patterson, Thorne, Canam, & Jillings, 2001). The studies included in our analysis used a variety of approaches to examine nurses' and midwives' view of their practices. The commonality was how they brought the practitioner's voice to the forefront. We will briefly describe the focus and findings of each of the studies and then follow with an analysis informed by Walker's model.

In analyzing the findings of the studies, we identified three themes relating to moral practices and understandings: creating a space for relationship, encountering morally uninhabitable environments, and renegotiating the moral-social order through advocacy. We should point out that moral practices are dynamic and can be changed through a shifting of blame and responsibility, the introduction of new information, or changing social roles and normative expectations. Walker's work makes it clear that practices of morality are practices of responsibility shaped by social identities and roles in which hierarchical power relations are the rule (Walker, 1998). Consequently, these identified moral practices and understandings reflect the social and geographical positioning of the participants in the studies.

Creating a Space for Relationship

The narratives of nurses and midwives reflect a social-moral world based on their relationships with women and with other health-care providers in the perinatal hospital setting. The midwives and nurses all created a space for relationship with labouring women that allowed them to recognize some of their moral responsibilities. This space, in turn, helped the women and their partners to assume their growing responsibilities as parents of a newborn child.

Walker's (1998) view of morality is that it is interpersonal and collaborative. The relationships through which moral responsibilities are understood and enacted are constructed between people and require self-direction, responsiveness to others, and mutual accountability. The studies we examined spoke specifically to the practices of midwives and intrapartum nurses in establishing such relationships. For example, Goldberg (2005) used a "feminist-phenomenological" approach to explore ethical perinatal nursing practice from a relational perspective. Using the narratives of Canadian nurses and mothers, she identified some of the essential aspects of relational perinatal nursing practice, focusing on the importance of "introductory engagement." These initial encounters were used to create a respectful space capable of supporting and sustaining a trusting and respectful relationship. Practices described by one nurse included ensuring that women were warm and comfortable and that the initial history-taking was as much about the questions the woman wished to ask as about the information the nurse needed to collect.

The collaborative nature of moral practices also includes the relationship between the mother and her unborn child during the birth process. Thompson (2003) used personal narratives of mothers and midwives and articulates an “ethics of intimates” and engagement that includes both the relationship between midwives and labouring women and the contexts in which care takes place. Thompson concludes, based on her findings, that the midwife’s primary relationship is with the mother and the mother’s primary relationship is with her baby. By enacting her moral responsibilities to the mother by creating a space for relationship, the midwife enables the mother to maintain a connection to her unborn child.

Moral responsibilities also include practices such as paying attention, interpreting actions, and responding to situations and circumstances by means of thought, action, or feeling (Walker, 1998). Hyde and Roche-Reid (2004) describe midwives’ creation of a “lifeworld,” a Habermasian concept that represents a symbolic space for appreciating the views of women, for reflexivity and relation, and for reaching consensus through dialogue. Midwives in the study created this space by making the woman the central player in the birth and using communication strategies that enabled her to actively participate in decisions about her care. Kennedy, Shannon, Chuahorm, and Kravetz (2004) theorize that a relationship marked by mutuality, disclosure, and validation provides the foundation for a care environment in which a woman’s physical and emotional needs are met. In order to create this environment, the midwife has to be aware of the context of care, such as the nature of professional relationships, philosophies guiding practice, and system-wide policies. Like Goldberg (2005), Kennedy et al. refer to an “engaged presence” in this space, where the midwife gathers observations and combines these with the woman’s subjective knowledge to more fully understand the situation and provide appropriate care.

Encountering Morally Uninhabitable Environments

Walker (2003) notes that context can be obscured by cultural settings and social organizations that promote particular roles and ideals while leaving others invisible. As moral understandings of what is required and how one may be called to account circulate in a practice setting (Walker, 1998), one should be aware of the ways in which social context shapes relationships, practice, and decisions about the care of childbearing women. The experience of encountering environmental constraints within hierarchical moral-social arrangements among the nurses, midwives, physicians, and institutions is a common theme across the studies. These arrangements often inhibited the actions of the participants, leading them to engage in surreptitious moral practices and understand-

ings in order to meet their responsibilities to labouring women. Other elements of the moral-social order that shaped the everyday choices, perceptions, and actions of the nurses and midwives were the culture of hospitals, including their ethos of efficiency and economic profit, and the use of technology.

A central theme in Thompson's (2003) study was the use and abuse of power in relationships that often became evident through the conflicting values of the institution and the individual. While hospitals appeared to value efficiency, the personal and professional ethics of midwives focused on the individual needs and wishes of birthing women. Midwives in this study felt that power imbalances within institutions and among caregivers constrained their ability to use professional judgement in fulfilling their responsibilities to the women in their care. Similarly, Hyde and Roche-Reid (2004) found that a labouring environment that requires efficiency in order to maximize profits necessarily minimizes communication, evaluation of relationships, and mutual understanding.

Consistent with a socially critical moral epistemology, Walker (1998) argues that we do not fully understand the structures that influence the perceptions that can impede our moral recognition of those who are marginalized or different. For example, while participants in one study reported that they felt constrained by the use of routine medical interventions, they also identified mothers' lack of knowledge and preparation, inability to speak English, and "high risk" designation as barriers to the provision of effective care (Sleutal, Schultz, & Wyble, 2007). These are factors over which women may have little or no control, depending on their life circumstances. Walker (1998) notes that "diminished" participants may be accorded less respect, compassion, and reciprocity and therefore be subject to paternalistic attitudes, when they are in fact capable of making appropriate choices. Sleutal et al. raise concerns about nurses' ability to recognize moral practices that are necessary for birthing women who present special challenges.

Sleutal (2000) presents a striking and disturbing example of the misuse of power in relationships. A nurse in the study reported that she had to "try to be tactful with the doctors so they feel in control" (p. 43). At times she felt that she was a "co-conspirator," assisting with routine medical practices that were not part of the woman's plan for birth and that in the nurse's opinion were not medically indicated. At other times the nurse would perform the care tasks she deemed appropriate as long as they were hidden from the physician. According to Goldberg (2005), the experiences and narratives of women and their caregivers exist in gendered, cultural, and politicized contexts. In Sleutal's study, the oppressive structures in the nurse's environment may have precluded the negotiation and mutuality that Walker views as an essential component of moral practice.

Some midwives believed that a preoccupation with the use of technology within a “technocratic system of obstetrics” limited their ability to enable choice and promote informed decision-making, even though the latter is a culturally defined norm in midwifery (Hindley & Thomson, 2005; Hyde & Roche-Reid, 2004). They reconciled these conflicting practices by reinforcing the idealistic notion of informed choice amongst themselves and by citing the poor practice of “other” midwives. There was also a belief that the use of technology enhances professional status, but at the cost of relegating intuitive knowledge and other skills to a lower level (James, Simpson, & Know, 2003). Midwives struggled to reconcile the “ideal” of informed choice with the realities of practice, in which they sustained positions of authority over women and their choices in order to function within the medical-technological model (Hindley & Thomson). Other contextual influences on relationship included a medical “active management of labour” model, a culture of litigation, the politics and economics of competing health service agendas, busy work environments, and a generation of nurses and midwives trained and practising in technological environments such that they are unable to consider alternative models of care.

Renegotiating the Moral-Social Order through Advocacy

According to Walker (2003), a morally inhabitable environment is possible if moral arrangements and social orders are transparent, revealing who has responsibility for what, and if criteria are identified for distributing and evaluating responsibilities. At times the participants challenged the uninhabitability of the moral-social order through the use of advocacy. At other times they did not, or could not, challenge the arrangements in which they found themselves. Consequently, the arrangements did not always foster the recognition, cooperation, and shared benefits needed for nurses and midwives to meet their moral responsibilities in a way that they believed to be optimal.

The facilitation of choice and a woman’s control over her birth experience that are considered integral to client-centred care were not always a reality. Autonomous decision-making has been described as a relational process between women and nurses or midwives in which anxieties are understood and wishes respected (Goldberg, 2005; Hindley & Thomson, 2005). Some midwives avoided working with certain medical practitioners or tried to “counter the system” in order to advocate for their clients (Thompson, 2003). Some women were described as being treated like disengaged others. For example, there were reports of “ritualistic” electronic fetal monitoring, even though nurses claimed they did not favour this practice.

Both nurses and midwives recognized their professional obligation to act as advocates and to put the mother's interests above all others, although some perceived an inability to change a practice environment that was "intolerable to professional integrity" (Hindley & Thomson, 2005, p. 310). Some nurses believed that a woman's vulnerability during labour requires advocacy but described this in terms of nurses' taking control, using their intuition and judgement to make decisions — "having the guts to do what you believe to be right and in the best interests of the woman and her baby" (James et al., 2003, p. 820). Others believed that advocacy is a matter of balancing the needs of the mother within the limitations imposed by the system (Sleutal, 2000). Midwives supported their clients' autonomous choices by acting as "conduits" and providing an invisible structure and guidance, thereby enabling women to choose how to move through labour (Kennedy et al., 2004). This description suggests that while the women had the power to choose, their choices were mediated and possibly restricted by the "invisible" structure or guidance provided by the midwife.

Hyde and Roche-Reid (2004) report that while medical-technological practice, with its claim of safer childbirth, exerts professional and political power over midwifery practices, midwives have greater power relative to women: Midwives use their expert knowledge and experience to get women to agree with their plans for care. Some nurses in the James et al. (2003) study described different but equal knowledge or power with physicians; however, the practices they described were those prescribed by the physicians. The nurses in the study linked power to the control and management of labour and described themselves as "powerful" when they "ran the labour for the doctor." Although nurses' ethical practice was not specifically "named" in this study, the focus on autonomous practice, with autonomy being described as "the power to determine what needs to be done in providing patient care" (p. 815), suggests that nurses were focused on their autonomous decision-making relative to physicians rather than on advocating on behalf of childbearing women. This finding raises the question of the extent to which power was shared among the nurses and the birthing women in this study.

In her initial pilot study, Sleutal (2000) looked at techniques that one nurse used to enhance labour progress and prevent Caesarean birth. During the course of analyzing the findings of that study, Sleutal found conflicting descriptions of moral nursing practices. The nurse described practices that both allowed women to follow their body rhythms and labour at their own pace and took action to hasten and control the birth. For this nurse, advocacy entailed balancing the needs of the mother within the limitations imposed by a system dominated by a medical

model of practice. Nurses in Sleutal's subsequent study were critical of the practices of their nurse colleagues, describing them as sabotaging their own efforts to provide effective care by promoting the use of epidurals when the nurses were on their scheduled breaks. They labelled colleagues who behaved in this way as lazy, uncaring, and unmotivated. According to Walker (1998), practices of responsibility that lack clarity and transparency can give rise to a culture of blame. In a perinatal setting where team members have confidence in each other's skills and respect each other's perspectives and contributions, staff are more likely to raise issues and seek mutual support, thus promoting a trusting and calm milieu for the labouring woman and her family (Ontario Women's Health Council, 2000).

Discussion

Practices of responsibility reflect the morality of everyday nursing and midwifery. They encompass the knowledge, skills, and clinical judgement that form the basis of nursing; they include paying attention, interpreting actions, and responding in thought, action, or feeling to situations and circumstances (Walker, 1998). Nurses and midwives practising in diverse hospital settings in Canada, the United States, Great Britain, and Australia share common understandings about the centrality of relationship to practice, what constitutes an engaged relationship with labouring women, and how such a relationship can be achieved. These findings support Walker's view that morality is interpersonal and collaborative, as it is constructed between people and requires self-direction, responsiveness to others, and mutual accountability (Walker, 2003).

There is also recognition that the "ideal" of promoting informed choice, usually enacted through relationship, is not always evident in practice. Thompson (2003), for example, makes a distinction between actual practice and midwives' inferred or expressed "preferred ethical response," which includes supporting and knowing the woman (p. 592).

The discrepancy between real and ideal practice is most often attributed to factors outside the control of nurses and midwives, including hierarchical power imbalances, dominating medical models of practice, system-wide pressures for efficiency and economy, and the use of technology. It is interesting to note that some of this discourse is shaped in such a way that attention is deflected away from the agency and the ability of nurses and midwives to make choices about care. For example, when agency and intention were attributed to "technology," nurses and midwives seemed to be side-stepping responsibility for how and when technology is used. There was also inconsistency between the self-

understanding of nurses and midwives as powerless and their narratives describing ways in which they exerted power over labouring women. Walker (2003) notes that our social location is critical to morality because it shapes the way in which we assign, accept, or deflect responsibilities. When practice responsibilities are unattainable or incoherent, a morally inhospitable environment is created, which has a negative impact on nursing satisfaction and care delivery (Peter, Macfarlane, & O'Brien-Pallas, 2004). If nurses and midwives believe that their values of engagement, relationship, and normality in birth are marginalized in the highly medicalized hospital birthing environment, their moral understanding and enactment of practices of responsibility may be restricted, along with their moral identity.

In their attempt to meet the particular needs of women while also conforming to institutional policies, medical practices, and the particular culture of the workplace, nurses and midwives are playing an ambiguous moral and social role. They function as “boundary workers,” called upon to navigate the values of others in order to deliver the health services for which they are accountable (Liashenko & Peter, 2006). One wonders about the degree to which nurses and midwives are truly able to foster autonomy for birthing women while straddling this line. One also wonders about the mental and moral fatigue that results from constantly seeking the middle ground while knowing, at some level, that it is not always possible to find an acceptable compromise among competing and conflicting values in situations and relationships that are mitigated by power imbalances.

According to Walker (1998), morality entails mutual understanding and negotiation. A new understanding that emerged from this interpretive review is the symbolic meaning, for nurses and midwives, of their relationship with women. While aware of when and why they were falling short of the ideal, nurses and midwives sensed that this relationship was integral to their practice and needed to be safeguarded. There was a suggestion, at times explicitly stated, that the role of nurses and midwives is to “rescue” women from a hostile environment, although no strategies beyond advocacy in a general sense were articulated, leaving the reader wanting to know more. This lack of strategizing points to the need for research that gives nurses a voice and uses their knowledge and experience to shape changes in practice and practice environments. It also highlights the need for us to question the “rescue” mentality and the belief that we are acting virtuously by making decisions independently “in the best interests” of women, when in fact this paternalistic attitude might be compromising a core value of perinatal care: placing the woman, and her choices, at the centre of practice.

Conclusion

The studies analyzed in this review were based almost exclusively on the narratives of perinatal nurses, midwives, and mothers. While these narratives form the basis of our professional self-understanding, they do not necessarily reflect the real world of practice. They can, in fact, reflect “preferred” accounts of nursing (Nelson & McGillion, 2004). This potential limitation was evident in personal accounts that tended to focus on the expert or exemplary actions of the participant while suggesting that the actions of “others” were less than ideal. This approach can serve to spotlight the actions of an individual while obscuring the contexts and power differentials that influence moral practices. Further research in this area would benefit from a critical ethnographic approach that involves interviews with practitioners and childbearing women, as well as participant-observation to capture the contexts in which these interactions occur.

While the emergence of relationship as a central value in the practices of perinatal nurses and midwives underscores the need for a relational view of autonomy and decision-making, this appears to be only one element in understanding what intrapartum care “should” be. Clearly, we need to examine both the local (hospital) context and the sociopolitical environment of childbirth, including the position of women in society, biotechnology, and the power of traditional medicine. Margaret Urban Walker’s expressive-collaborative model contributes to our understanding of moral practices in the perinatal setting and highlights the need for a political and ethical approach in order to improve the care of women during childbirth.

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