2022

Care ethics framework for midwifery practice: A scoping review

Kate Buchanan

Elizabeth Newnham

Deborah Ireson

Clare Davison

Sadie Geraghty
The University of Notre Dame Australia, sadie.geraghty@nd.edu.au

This article was originally published as:
Buchanan, K., Newnham, E., Ireson, D., Davison, C., & Geraghty, S. (2022). Care ethics framework for midwifery practice: A scoping review. *Nursing Ethics, Early View (Online First)*.

Original article available here:
10.1177/09697330221073996

This is the author's version of the following article, as accepted for publication.

Buchanan, K., Newnham, E., Ireson, D., Davison, C., & Geraghty, S. (2022) Care ethics framework for midwifery practice: A scoping review. *Nursing Ethics*, *Early View (Online First)*. https://doi.org/10.1177/09697330221073996

This article was published in *Nursing Ethics*, 8 April, 2022.

Published version available online at: -
https://doi.org/10.1177/09697330221073996

Care ethics framework for midwifery practice: a scoping review

Abstract

Background: As a normative theory, care ethics has become widely theorized and accepted. However, there remains a lack of clarity in relation to its use in practice, and a care ethics framework for practice. Maternity care is fraught with ethical issues and care ethics may provide an avenue to enhance ethical sensitivity.

Aim: The purpose of this scoping review is to determine how care ethics is used amongst health professions, and to collate the information in data charts to create a care ethics framework and definition for midwifery practice.

Method: The scoping review was conducted according to the Preferred Reporting Items for Scoping reviews (PRISMA-ScR) and Joanna Briggs Institute (JBI) recommendations. The search was applied to the databases CINAHL, MEDLINE, PschInfo and Pubmed which were searched in September 2019 and again in July 2021. The inclusion criteria were guided by the mnemonic for search terms: Participants, Concept, and Context (PCC) and included variations of health care professionals, care ethics and utilization. The search was limited to qualitative studies published in English between 2010 and 2021. A data extraction tool was used to extract and synthesize data into categories. The articles were screened for eligibility by title, abstract and full text review, by two independent reviewers.

Ethical Considerations: The scoping review was guided by ethical conduct respecting authorship and referencing sources.

Results: Twelve of the initially identified 129 studies were included in the scoping review. Data synthesis yielded four categories of care ethics use by health professionals: relationship, context, attention to power and caring practices. In combination, the evidence forms a framework for care ethics use in midwifery practice.

Conclusion: Care ethics use by health professionals enhances ethical sensitivity. A framework and definition for care ethics for midwifery practice is proposed. This review will be of interest to midwives and other health practitioners seeking to enhance ethical sensitivity.

Keywords: ethics, care ethics/ethics of care, scoping review, professional practice, midwifery, feminist ethics

Background

Whilst ethical care in midwifery is guided by the International Confederation of Midwives (1) Code of Ethics, maternity systems are predominantly governed by obstetric medicine, which utilizes bioethical principles to guide care. Bioethical principles are the commonly accepted ethical framework for health care practitioners to guide conduct and analyze ethical issues in health care. Four enduring bioethical principles proposed by Beauchamp and Childress have underpinned the practice of health care since the 1960s (2) these are: non-maleficence (avoiding harm); autonomy (right to make decisions); justice (fairness and equality); and beneficence (doing good). However, despite having these principles behind health care practice, across the globe, women have described experiences of disrespect and abuse in pregnancy, labour and birth (3-5). The literature has described many examples of these four bioethical principles being unheeded. When women describe obstetric violence, dehumanization and trauma in maternity care, it demonstrates a lack of beneficence and non-maleficence (6-9). If mothers express that birth interventions either were not clearly explained or were not free from coercion, informed consent has not been demonstrated and thus autonomy has been disregarded (10, 11). If women describe instances of discrimination, both from institutional structures and relationally, which can occur due to power imbalances then justice has not been upheld (12-14). Or if women are unable to access midwifery continuity of care – endorsed by the World Health Organization (2018) as the gold standard for care the beneficence is limited (15-17). These examples indicate that current ethical frameworks may need to be reviewed for the contemporary maternity services.

Furthermore, such principles, codes and rules may not be adequate to guide midwifery practice, as they fail to consider the complexity of the human experience and the role of relationship and power (18-20). Midwifery (meaning “with-woman” in English) has a long history of women collectively supporting each other in childbirth, and using and passing down empirical knowledge over millennia (21). It is therefore very different to the beginnings of medical practice, particularly the difference in power relationships between doctor and patient (22-24). Some ethicists have described bioethical principles as: imperialist, inapplicable, inconsistent, rhetorical and inadequate (20, 25, 26) Therefore, it is prudent to investigate what other models can offer maternity care professionals in this regard.

One model that could address the ethical inconsistencies of a default biomedical ethics for midwifery is care ethics. Care ethics is a normative ethical theory based on feminist philosophical perspectives concerning care as a central human practice with moral significance (26-29). Care ethics takes into consideration what is overlooked in principle-based bioethics, especially aspects of: relationship, context and power (18-20). Feminist ethics were developed in response to traditional ethical theories, where individualism, principalism and rationalism dominated, offering instead a relational perspective (25-27). Further, care ethics describes care not just as an act by and for and for only specific people (e.g., nurses or parents, infants or the ill) but as a universal human experience that acknowledges all humans as interconnected and mutually interdependent; thus, moral responsibility becomes attached to care and accordingly, care ethics has been proposed as a means of enhancing ethical sensitivity (30-33).

Care ethics has appeal for midwifery considering the human rights and ethical issues that many women experience in contemporary maternity systems (18, 34, 35) Whilst care ethics theory is well developed,

there is little empirical evidence of its use in practice suggesting a gap in the knowledge currently available. This review therefore examines published articles that describe how care ethics was used by healthcare professionals in practice and to apply this knowledge to the context of midwifery, to produce a working definition of care ethics for midwifery practice.

Aim

The purpose of this scoping review is to determine how care ethics is used amongst health professions, and to collate the information in data charts to create a definition for midwifery practice that justifies the application of care ethics for midwifery practice.

Review question

How is care ethics used in practice by health care professionals?

Method

This scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews and the Preferred Reporting Items for Scoping reviews (PRISMA-ScR) (36-38). A preliminary search of databases produced no empirical data regarding care ethics utilization and midwifery. This features as a prominent gap in literature related to contemporary maternity systems. This prompted investigation as to whether and how care ethics are being utilised in other health professions.

Scoping reviews provide an overview of evidence and are utilised: to map key concepts that underpin an approach; to clarify a working definition of a concept; and to summarize the conceptual boundaries of a topic, where they are sometimes called mapping reviews (39, 40). A scoping literature review was chosen for this study as it is a useful method for clarifying key concepts in an emerging field and identifying knowledge gaps to understand and report on the body of literature that address and inform practice in a field (38).

Search strategy and study selection

The PCC mnemonic of: **P**articipants (health professionals), **C**oncepts (care ethics) and **C**ontext (practice, use, and application) was used to develop search terms for this review (38). A three-step approach informed by the JBI framework was used in this review. Firstly, a preliminary search of MEDLINE and CINAHL was undertaken to identify articles relating to the topic. Text words contained in titles and abstracts and key words of relevant articles, were used to develop a full search strategy (Appendix 1. Logic grid with key terms and Search Strategy). The second search included all identified keywords, which were entered into the databases CINAHL, MEDLINE, PUBMED and PsychInfo. Thirdly, the reference list of all included sources of evidence were screened for additional studies. We included

studies published in English for feasibility. To capture contemporary practice and development in an emerging normative theory, we included studies published in the last ten years. We sourced only primary research papers as we wanted to collate empirical evidence from contemporary practice related to the review question – a description of how care ethics is used by health professionals, whilst allowing a broad scope of the literature.

All identified articles were uploaded into EndNote v9 and duplicates were removed, after which 129 articles remained. Studies were included if: the participants were health care professionals, where the concept was care ethics, and the context was care ethics use in practice. The sourced articles were all qualitative studies with designs covering phenomenology, grounded theory, case studies, qualitative descriptions, action research and feminist research. Studies were deemed ineligible if their concept was 'health care (ethics)' as opposed to 'care ethics'. These were uploaded to RAYYAN © (41) and screened by title and abstract by two reviewers (KB, DI) resulting in 36 articles for full text review. Full text was assessed in detail by two reviewers (KB, DI) against the inclusion criteria. The literature retrieval resulted in the retention of 12 articles describing care ethics as used in practice by health professionals (30, 42-52). The results of the search and the study inclusion process are presented in a PRISMA-ScR flow diagram. Figure 1. Prisma flow diagram (Appendix 2. PRISMA-ScR flow diagram).

Data charting

Data charting, a systematic and descriptive data extraction process for scoping reviews, was used to collate the data according to JBI methodology for scoping reviews (38). The purpose of data charting is to identify, characterize, code and summarize research evidence in relation to a specific topic (38). This structured process optimizes reliability and enables the data to be presented in an organized way.

To implement this process, we developed a data extraction tool (data chart). The draft data extraction tool was piloted and modified during the process of extracting data. Each information source was screened for the review question: how is care ethics used in practice. To do this, we used a priori codes which we developed form a literature review on care ethics theory. Care ethics has been broadly described as including four broad concepts: relationship, caring practices, context and attention to power (18, 25, 26, 28, 29, 53). These concepts were decided upon by the research team using an iterative process and became the final four a proiri codes. Each article was reviewed and screened for these a priori codes. The final data chart included the a priori codes and examples from the articles where this code was identified (Table 1. Results: Care ethics use in health practice).

The data chart also includes information about participants, study methods and key findings relevant to the care ethics review question. The health care professions that utilised care ethics within the captured articles included nursing, medicine, physiotherapy, and social work. A summary of the review findings is presented both as a final data chart and diagrammatically (Figure 2. Four categories that form a care ethics framework for use in practice). The findings are also discussed in the results section, with the categories are defined and described along with specific examples detailing care ethics use in health care practice.

Ethical Considerations

The scoping review was guided by ethical conduct referencing sources and respecting authorship.

Results

[Editor – please insert Table.1 Results: Care ethics use in health care practice]

We identified from the empirical papers that care ethics was used in health care practice in four broad categories. These categories are; relationship, caring practices, context and attention to power, that together offer a framework for enhancing ethical sensitivity for practice. Figure 2. Four categories that form a care ethics framework for use in practice below illustrates the interrelationship between these categories as utilised in the ethics practice of health professionals. Next the four categories are developed in detail, with evidence and examples from the evidence sourced. Finally, the findings are synthesized in a definition of care ethics for health care practice.

Figure 2. Four categories that form a care ethics framework for use in practice (First author only).

Relationship

Ten of the reviewed papers identified the primacy of relationship, central to understanding the person at the center of the care, as a means for facilitating enhanced ethical care. These articles depict humans as social and relational beings, acknowledging that the carer and care receiver are interrelated and interconnected but often unequal in terms of power and resources. Therefore, ethical care must value the importance of relationships, and this is demonstrated through responsiveness, presence, trust, honesty, communication and respect (42-46,30, 47-49, 51).

De Panfilis et al. (2019) interviewed sixteen nurses and doctors to explore how care ethics informs the way health practitioners manage ethical issues in palliative care. De Panfilis and colleagues established that the relationship between health professionals and patients assisted health professionals to understand what patients' values are in decision making. The authors described the term relationship as personal involvement through emotional support and respecting patient dignity. They describe the practice of care ethics as involving care that centers on a patient's views, emotions, thoughts and values. Juujari (2019) has similarly described how a focus on relationships enhances ethical reasoning in nursing practice with older patients. Their focus group study collected thirty-one nurse and physiotherapist views on ethical decision making using a care ethics lens. This study found that primary nurses developed deep ethical reasoning due to relationship and nuanced understanding of patients. These primary nurses had insights into each patient's specific wishes and context, which aided in ethical decision making. Jujari and colleagues identified that nurses feel a moral responsibility because they have developed this relationship and feel answerable to patients whereas they proposed that physicians are more bound by legal responsibility.

A qualitative study by Barlow, Hargreaves and Gillibrand (2018) concurs that nurses were guided by governing bodies codes and standards (based on deontology and consequentialism) but further utilised care ethics in their practice to enhance ethical decision making. The authors interviewed 11 nurses and identified it was the patient centered relationship-based care that nurses formed with patients that contributed to the resolution of ethical dilemmas. Barlow and colleagues describe the nurse's relationship with patients as accountable, seeking what is best for the patient, being collaborative and others focused, which also included other elements of care ethics such as acknowledging the role of emotions and power imbalance.

A socio-historic study by Barken and Davis (2020) set in the Indigenous communities of the Pentlatch people in Canada, describes care workers (including nurses) as utilizing the feminist care ethic in their approach to caring for the elderly. Relationship was described as based on meaningful connection. The authors highlighted that relational care includes the physical, social, and emotional needs of older persons in their homes. The authors argue the feminist care ethics approach as providing an alternative to guiding health policies as an ethical, relational moral practice.

From the articles screened it is evident that care ethics, with a central focus on relationship, has the potential to enhance ethical sensitivity. This relationship forged by the health professional was shown to

be responsive, because the carer knew those they were caring for, they were actively present and more readily respectful to the needs and values of their patients.

Caring practices

Nine of the reviewed papers identified caring practices as the way the entire care experience was provided to a patient. The good or ethical emerges from how care is practiced. Care practices were described as an ethical endeavor in and of itself through the attitude and stance of the care giver. Care was often described by the authors using Tronto's (1993) four aspects of care ethics: responsibility, responsiveness, attentiveness and competence. Current care ethics emphasize the importance of the views of the person at the center of the care as the expert of their own life and experiences. (30,43,45-47-51).

Schuchter and Heller (2018), in a pilot participatory study, demonstrated the use of care ethics as part of an ethical consultation model 'Care Dialogues' in a nursing home setting. Using care ethics was described as enhanced consideration for patient feelings and emotions and resulted in better caring for the elderly. The authors describe how a bottom-up approach of care ethics practice, with ethics from the perspective of the one being cared for, generates greater understanding and empathetic involvement regarding a patient's day to day care. Schutcher and Heller (2018) suggest care ethics be used in practice through consistent participation of the people concerned to ensure their insights contribute to their care. They suggest that ethical consideration of care be toward understanding and learning rather that a focus on decision-making and that ethical reflection is situated in everyday practice.

Kuis and Goossensen (2017) have conducted a qualitative pilot study of 31 nurses to evaluate good care from a care ethics perspective. They created a three step care ethics evaluation of care model. Central to their evaluation of good care was the caring practices described by Toronto's (1993), where they explained that experienced nurses were responsive in that they saw what was important to patient, beyond their diseases/illness. The authors described that nurses were attentive by searching for who the patient was, rather than relying on general insights or first impressions. It was concluded that the care ethics method was patient-centered, enabling nurses to identify important issues from patient perspectives, suggesting this is ultimately what humanizes care. De Vries and Leget (2012) and Ward (2012) have also discussed the practice of care as set out by Tronto (1993), namely attentiveness and responsiveness, are important in identifying what is meaningful to patients. Juujari (2019) confirms care ethics practice is both an attitude and a mode to care.

Lachman (2012) has also utilised Toronto's practice of care ethics to analyze a case study of diabetic alcoholic man who declines treatment, describe how nurses can use attentiveness to first identify the needs of the patient – beyond medical diagnosis. Responsibility and competence were demonstrated in the case study as care that combines activities, attitudes and knowledge of the situation. Attentiveness was demonstrated in the case study as detecting the needs of the patient. Finally, responsiveness was demonstrated where the nurse verified with the patient that the care given met the patient's needs.

Lachman summarizes good care as a commitment to attending to a patient's needs physical, psychological, cultural, and spiritual needs of the patient and family.

Vanlaere, Coucke and Gastmans (2010) study of a care ethics lab in Belgium is an example of how care ethics can be used in practice to enhance empathy among nursing students in an e-simulation lab. The lab was designed to teach nursing students ethical care with the aim to generate empathy through reflection. In this qualitative study, it was described that ethical reflection and sensitivity were enhanced via generating an understanding of patient's needs. The students cared for an individual in the care ethics e-lab and then through guided discussion answered questions related to what helped most in providing good care. The authors describe 'Good care includes everything that care providers undertake in order to respond to the vulnerability of other... this means being attentive to the person and providing more than minimal needs" (p. 325).

The articles captured particular caring practices that enhance ethical sensitivity. Ethical caring practices were often described as using Tronto's (1993) seminal conceptualization of care ethics as responsibility, responsiveness, attentiveness and competence. Understanding that caring practices are in and of themselves what is good about the care.

Context

Eleven of the papers in this scoping review use care ethics to describe care that is sensitive to the uniqueness of a situation and to an individual's social, emotional and existential context, as a means of identifying what is meaningful to a patient. Care ethics as an ethical model, thus allows for the acknowledgment of tacit, embodied and experiential knowledge, as important and integral to ethical care. Accordingly, good care is individualized, holistic and receptive to context, partnering with the person at the center of the care to determine what is ethical (30, 42 – 50, 52)

In the reviewed studies, acknowledging individual context was a key element towards achieving ethical care. De Vries and Leget (2019) compared two case studies of elderly cancer patients and identified that care ethics approaches highlighted the variety of patient contexts, what is meaningful to patients and thus what is morally relevant. Describing the first case study, choosing end- of- life chemotherapy; the authors acknowledged the bioethical principals helped decision-making to a point, however, when including a care ethics interpretation that includes the context of: physical vulnerability, mental decline, social stressors and existential (facing dying), the decision to undergo treatment or not was better understood. The second case study highlighted that care givers may believe themselves to be doing the right thing when overriding a patient's decision, and yet care cannot in fact be deemed good care unless it is embedded in the patient's sociocultural context and values. De Vries and Leget (2019) argue that bioethical principles neglect this context and recommend that the patient's position should guide any ethical approach.

Kuis and Goossensen (2017) research findings also preface the importance of a patient's context and perspective. This study interviewed 31 participants to create a care ethics evaluation of a care model and conducted focus groups with health professionals to determine the value of the model. The authors demonstrated that an insider perspective, where the values of patients are followed, both enhanced

ethical care and contributed to humanizing care. Context was also highlighted in the study by Jujarvi (2019), where nurses' understanding of a patient's context supported them to address sociocultural needs, and where the care ethics approach helped to meet these ethical deliberations.

Baur, Nistelrooij, Vanlaere, and van Nistelrooij (2017) have also detailed that emotions are a valuable source of knowledge, serving as a vehicle for ethical care. The authors developed a care ethics reflective tool to use with emotionally turbulent practices (moral dilemmas) as a way of thinking/doing ethics, rather than principle-based ethics. The study concluded that since caring is an emotional and political practice, moral space and attention to these factors must be provided by health professionals for good care to occur. The authors also advocated for the necessity of institutions to be caring, where the role of emotions as set out in care ethics is incorporated into practice.

The reviewed articles all take into consideration that appreciation of a patient contexts enhances ethical sensitivity. Understanding and valuing what is important to the person at the center of care and considering the role of emotions and values as a source of knowledge, are proffered as important aspects in enhancing ethical care.

Attention to power

Eight of the 12 papers reviewed referred to attention to power in ethical care. In the reviewed studies, the application of care ethics, draw attention to potential power imbalances in the relationship between care givers and care receivers. In this sense, the one being cared for is sensitive to power imbalances, where the expert determines what is good, and thereby patients become vulnerable to this power difference, such as in the doctor/ patient relationship add ref Some articles have highlighted that power difference may be the influence of structural forces such as standardized guidelines, institutions and policies. In this review, we therefore identify care ethics as a means of equalizing interpersonal or structural power differentials (30, 42, 44, 46, 48 – 50, 52).

In the action research conducted by Abma and Baur (2015), care ethics advocates are mindful of broader structures of power that produce oppression and exclusion (Amba, 2020). Care ethics was used to prevent organizational processes from dominating, by reducing hierarchic power relations to a more equal relationship in an aged care resident meal program. The successful collaboration between health professionals and aged care residents was fostered through both mutual respect for both expert and embodied knowledge of residents and through the facilitator being mindful of the power position which together increased resident empowerment in long term care. Lachman (2102) also confirmed in their case study that a focus on meeting the care needs of a patient or family, ensures that paternalistic abuses of power do not occur.

Ward and Barnes (2016) has also explored power dynamics as elderly people navigated a new Care Act in the United Kingdom. The authors translated their findings from their two participatory studies between elderly residents and social workers, into resources using a care ethics lens. Ward (2015) identified that there was little acknowledgment within a policy framework for the complexities of elderly issues. It was through equal relationships with social workers that the elderly felt cared for when accessing support services. The authors detailed how using a care ethics framework in discussion with

older people, moved the focus from being task orientated to being attentive to care receivers. Through care ethics, greater insights into caring practice were gained which helped shape both policy and practice. Similarly, Schuchter and Heller (2018) have confirmed in their care ethics study that the only way to equalize the patient / care giver asymmetry of power is to give voice to patients as experts of their own reality. They describe equalizing asymmetries through looking beyond social roles and giving priority to the values of the patients. Ethical deliberation was guided by patient narratives with democratization of opportunities to speak and thus the dominance of expert knowledge was annulled in favor of the patients.

The articles reviewed describe how care ethics was utilised to draw attention to potential power imbalances and equalize power in a relationship to achieve more ethical care. Power balance is attained though removing standardized care and structural dominance, respecting epistemological and embodied knowledge toward the person at the center of the care having a voice and becoming empowered

Synthesis of findings

The scoping review met the literature review aim to map key concepts that underpin care ethics resulting in a framework for practice and to formulate a working definition of a care ethics. Thus, a definition for health care practice is presented.

Definition of care ethics for health care practice:

Care ethics recognizes that care is a universal human experience. Care ethics is founded on relationship, based on presence, trust and respect, forged on knowing the person at the center of care. The practice of care is holistic, is attentive, responsive, responsible and competent. The richness and complexity of the individual socioemotional context is considered, and the caregiver equally values other ways of knowing. Care ethics recognizes the asymmetry of caring relationships and attention to this power imbalance is required. Only the person being cared for can determine what constitutes ethical care.

Discussion

There has been call for empirical research into care ethics to guide future health professionals practice (18, 28, 29, 53, 54). However, it has been acknowledged by ethicist researchers that there are difficulties in empirical research informing normative ethics (55). Ethical research is often interested in conceptual clarification and normative justification whereas empirical research is focused on definitives via description and analysis. Therefore, it is difficult to be precise about the relationship junction between the empirical data and ethical analyses, which may account for the limited research into the ethics guiding health professionals practice (56).

This scoping review endeavored to summarize how health professionals had used the normative theory care ethics in practice. Through the systematic analysis and synthesis of the literature, a framework was proposed to integrate the normative care ethics theory to guide future health care practice. From these findings we have established that care ethics is practiced using four central care ethics tenets; relationship, caring practices, context and attention to power. These four categories offer a framework for midwifery practice toward enhanced ethical sensitivity. The rise in mistreatment and abuse in the system is complex both at the systems level and interpersonal level (57). Care ethics addresses the interpersonal level through everyday reflective ethical practice.

Care ethicists argue one cannot introduce the good from the outside nor by applying top-down normative theory or ethical principles and codes but rather from insights gleaned from practice (53). There are many codes and guidelines to try and improve disrespect and abuse in the maternity system. The international Code of ethics for Midwives guides ethical behavior (1). Midwifery codes center the midwife-woman relationship as integral to ethical practice. Midwifery practice centers relationship with the childbearing woman as the very core of good practice (59, 60). The literature review highlighted relationship as a central and vital component to improved ethical conduct. Care ethics and midwifery align in prioritizing relationship as central to good care. Midwifery as a relational practice is one critical solution to improved care and reduction of abuse and disrespect in the maternity system and yet it remains underutilized (58).

The reviewed articles also captured particular caring practices that enhance ethical sensitivity. Ethical caring practices were often described as using Tronto's (1993) description of care ethics as responsibility, responsiveness, attentiveness and competence. For midwifery, it is the caring practices a woman receives during labour and birth that either strengthen and empower or disempower and dehumanise women (61, 62). The reviewed articles demonstrated health professionals who considered a patient's context, socioemotional and embodied knowledge demonstrated greater ethical sensitivity. Supported in feminist midwifery literature, midwives honor women's ways of knowing and embodied knowledge, which in turn strengthen women's capabilities (63, 64). Through relationship and knowing context the health provider is able to respond more individually in meeting care needs which is proffered as important to ethical care.

The articles reviewed also describe care ethics was utilised to draw attention to potential power imbalances and equalize power in a relationship to achieve more ethical care. Midwifery research points to drivers of disrespect and abuse in the maternity system due to disempowering experiences such as when informed consent isn't fulfilled and the provider has decided the course of action for the woman (7, 10, 11). Power balance is attained though removing standardized care and structural dominance, respecting the one at the centre of the care to make decisions that is right for them, which in turn empowers citizens to develop their own ethical language (50, 65) which democratizes ethics itself.

Midwifery has been shown to demonstrate the practice of care ethics (18) where midwifery and care ethics correlate in their shared philosophies, epistemologies and normative approach to context and political aspects of care (18 -20). In highlighting care ethics in practice, new ways in which midwifery may be able to counter the disrespect and abuse that occurs in the contemporary maternity system

were identified.The risks to good care involve negative aspects of patriarchy, power and politics, where these may be a contributing factor in the rise of abuse and obstetric violence toward women in the maternity system (18-20). Care ethics describe the importance of relationships, which corresponds to a component of midwifery philosophy which is based on relationship with woman. The strengths of care ethics would, therefore, likely be a valuable new addition to the midwifery professional ethos – caring for women in interdependency, reciprocity, and solidarity. The findings of this study suggest that care ethics could be further explored as a supplementary paradigm to the bioethical principles that currently guide maternity care in Australia and internationally.

Limitations

The limitations of this scoping review account for an element of subjectivity in deciding which papers to include, in addition to aspects of data extraction and categorization. Scoping reviews are limited by subjectivity of interpretation, where this review applied a feminist lens, this study recognizes that other lenses could also be applied. This was balanced by a dual member checking process, as described in the methods section. Further, some empirical care ethics papers may exist that we are not aware of through this process, and grey literature was not searched. The search was limited to the previous 10 years, however a common decision when gleaning understandings from contemporary practice.

Conclusion

In this scoping review, care ethics has been identified and successfully used empirically by health professionals. Through a review of the literature on care ethics practice, it has been demonstrated that relationships, caring practices, sociocultural contexts and attention to power, create a framework for practice and contributes to enhanced ethical sensitivity. A definition of care ethics for health care practice has been offered. Recommendations from the review have been presented. Together the strengths of care ethics would, therefore, likely be a valuable new addition to the midwifery professional ethos – caring for women in interdependency, reciprocity, and solidarity.

Implications of the findings for midwifery practice

In this paper we have categorized and defined care ethics practice for midwifery. This is an important first step and we recommend further research in applied care ethics to advance care ethics for health care practice.

We recommend the care ethics framework for everyday reflective ethical practice as a protective factor in reducing abuse and trauma in the maternity system.

We suggest further research is required to understand ethics from the woman's perspective and further testing of care ethics in midwifery practice to challenge the current dominance of medical ethics principalism, which is currently failing women in maternity care setting and to further develop a more feminist ethics for childbearing women to receive good ethical care

This review of the literature may be of interest to other health professionals, academics and policy makers who are interested in fostering change toward more ethical care.

Acknowledgements

The contents of this paper form part of a PhD study

Funding

No funding to declare

Conflicts of interest

There is no conflict of interest in this project.

Appendices

Appendix I: Logic grid with key terms and Search Strategy

Appendix 2. PRISMA-ScR flow diagram

Appendix 3: Table 1. Results: Care ethics use in health professional's practice

Appendix 4.: PRISMA ScR Checklist

References

1. International Confederation of Midwives. International Code of Ethics for Midwives. Hague, Netherlands2014.
2. Beauchamp TL, Childress JF. Principles of biomedical ethics. Eighth edition ed. New York, NY: Oxford University Press; 2019.
3. World Health Organisation. The prevention and elimination of disrespect and abuse during facility-based childbirth. WHO. Geneva2014.
4. Salter CL, Olaniyan A, Mendez DD, Chang JC. Naming Silence and Inadequate Obstetric Care as Obstetric Violence is a Necessary Step for Change. Violence Against Women. 2021;27(8):1019-27.
5. Sadler M, Santos MJDS, Ruiz-Berdún D, Rojas GL, Skoko E, Gillen P, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reproductive Health Matters. 2016;24(47):47-55.
6. Cole L, LeCouteur A, Feo R, Dahlen H. "Trying to give birth naturally was out of the question": Accounting for intervention in childbirth. Women & Birth. 2019;32(1):e95-e101.
7. Forssén ASK. Lifelong Significance of Disempowering Experiences in Prenatal and Maternity Care:Interviews With Elderly Swedish Women. Qualitative Health Research. 2012;22(11):1535-46.
8. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. The Lancet. 2014;384(9948):e42-e4.

9. Morton CH, Simkin P. Can respectful maternity care save and improve lives? Birth. 2019;46(3):391-5.
10. Cook K, Loomis C. The Impact of Choice and Control on Women's Childbirth Experiences. J Perinat Educ. 2012;21(3):158-68.
11. O'Brien D, Casey M, Butler MM. Women's experiences of exercising informed choices as expressed through their sense of self and relationships with others in Ireland: A participatory action research study. Midwifery. 2018;65:58-66.
12. Perera D, Lund R, Swahnberg K, Schei B, Infanti JJ. 'When helpers hurt': women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. BMC Pregnancy Childbirth. 2018;18(1):211.
13. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. Best Practice & Research Clinical Obstetrics & Gynaecology. 2020;67:113-26.
14. Clesse C, Lighezzolo-Alnot J, de Lavergne S, Hamlin S, Scheffler M. The evolution of birth medicalisation: A systematic review. Midwifery. 2018;66:161-7.
15. Renfrew MJ, Ateva E, Davis D, Dixon L, Johnson P, Knutsson A, et al. Midwifery is a vital solution—What is holding back global progress? Birth. 2019;46(3):396-9.
16. Homer CSE. Models of maternity care: evidence for midwifery continuity of care. Medical Journal of Australia. 2016;205(8):370-4.
17. ten Hoope-Bender P, de Bernis L, Campbell J, Downe S, Fauveau V, Fogstad H, et al. Improvement of maternal and newborn health through midwifery. The Lancet. 2014;384(9949):1226-35.
18. Buchanan K, Newnham E, Ireson D, Davison C, Bayes S. Does midwifery-led care demonstrate care ethics: A template analysis. Nursing Ethics. 2021:09697330211008638.
19. MacLellan J. Claiming an Ethic of Care for midwifery. Nursing Ethics. 2014;21(7):803-11.
20. Newnham E, Kirkham M. Beyond autonomy: Care ethics for midwifery and the humanization of birth. Nursing Ethics. 2019:969733018819119-.
21. Donegan JB. Midwives in History and Society. Jean Towler , Joan Bramall. Isis. 1987;78(2):290-1.
22. Willis E. Medical Dominance: The division of labour in Australian health care (1st ed.). : Routledge; 1989.
23. Donnison J. Midwives and medical men. A history of inter-professional rîvalries and women's rights,. Medical History. 1978;22(1):98.
24. Kirkham M. A Fundamental Contradiction: the business model does not fit midwifery values. Midwifery Matters. 2017(152):13-5.
25. Tronto JC. Moral boundaries : a political argument for an ethic of care. New York: Routledge; 1993.
26. Held V. The ethics of care : personal, political, and global. Oxford ;: Oxford University Press; 2006. Available from: http://site.ebrary.com/id/10211833.
27. Gilligan C. In a different voice : psychological theory and women's development. Cambridge, Mass.: Harvard University Press; 1982.
28. Klaver K, Elst Ev, Baart AJ. Demarcation of the ethics of care as a discipline. Nursing ethics [Internet]. 2014. Available from: https://nls.ldls.org.uk/welcome.html?ark:/81055/vdc_100058200673.0x000006.
29. Leget C, van Nistelrooij I, Visse M. Beyond demarcation: Care ethics as an interdisciplinary field of inquiry. Nursing Ethics. 2019;26(1):17-25.
30. de Vries M, Leget CJ. Ethical dilemmas in elderly cancer patients: a perspective from the ethics of care. Clinics in geriatric medicine. 2012;28(1):93-104.
31. Leget C. Analyzing dignity: a perspective from the ethics of care. Medicine, Health Care & Philosophy. 2013;16(4):945-52.

32. Osuji PI. Relational autonomy in informed consent (RAIC) as an ethics of care approach to the concept of informed consent. Medicine, Health Care, and Philosophy. 2018;21(1):101-11.
33. Vosman F, Niemeijer A. Rethinking critical reflection on care: late modern uncertainty and the implications for care ethics. Medicine, Health Care, and Philosophy. 2017;20(4):465-76.
34. Freedman LP, Kujawski SA, Mbuyita S, Kuwawenaruwa A, Kruk ME, Ramsey K, et al. Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth. Reproductive Health Matters. 2018;26(53):107-22.
35. Lokugamage AU, Pathberiya SDC. Human rights in childbirth, narratives and restorative justice: a review. Reproductive Health. 2017;14(1):17.
36. Tricco AC, Lillie E, Zarin W, O'Brien K, Colquhoun H, Kastner M, et al. A scoping review on the conduct and reporting of scoping reviews. BMC medical research methodology. 2016;16:15.
37. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Annals of Internal Medicine. 2018;169(7):467.
38. Peters MDJ, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. JBI Evid Synth. 2020;18(10):2119-26.
39. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implementation science : IS. 2010;5:69.
40. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2005;8(1):19-32.
41. Ouzzani MH, H Fedorowicz, Z and Elmagarmid, A. Rayyan - A web and mobile app for systematic reviews Systematic Reviews. 2016;5.
42. Abma TA, Baur VE. User involvement in long-term care Towards a relational care-ethics approach. Health Expectations: An International Journal of Public Participation in Health Care & Health Policy. 2015;18(6):2328-39.
43. Barken R, Davies MJ. A relational ethic of rural home support on two Gulf Island communities, 1978–2018. Journal of Aging Studies. 2020;53:100847.
44. Barlow NA, Hargreaves J, Gillibrand WP. Nurses' contributions to the resolution of ethical dilemmas in practice. Nurs Ethics. 2018;25(2):230-42.
45. Baur V, Nistelrooij I, Vanlaere L, van Nistelrooij I. The sensible health care professional: a care ethical perspective on the role of caregivers in emotionally turbulent practices. Medicine, Health Care & Philosophy. 2017;20(4):483-93.
46. De Panfilis L, Di Leo S, Peruselli C, Ghirotto L, Tanzi S. "I go into crisis when ...": ethics of care and moral dilemmas in palliative care. BMC Palliative Care. 2019;18(1):N.PAG-N.PAG.
47. Juujärvi S, Ronkainen K, Silvennoinen P. The ethics of care and justice in primary nursing of older patients. Clinical Ethics. 2019;14(4):187-94.
48. Kuis EE, Goossensen A. Evaluating care from a care ethical perspective: A pilot study. Nursing Ethics. 2017;24(5):569-82.
49. Lachman VD. Applying the Ethics of Care to Your Nursing Practice. Medsurg Nursing. 2012;21(2):112-4.
50. Schuchter P, Heller A. The Care Dialog: the "ethics of care" approach and its importance for clinical ethics consultation. Medicine, Health Care & Philosophy. 2018;21(1):51-62.
51. Vanlaere L, Coucke T, Gastmans C. Experiential learning of empathy in a care-ethics lab. Nursing Ethics. 2010;17(3):325-36.
52. Ward L, Barnes M. Transforming Practice with Older People through an Ethic of Care. British Journal of Social Work. 2016;46(4):906-22.
53. Timmerman G, Baart A, Vosman F. In search of good care: the methodology of phenomenological, theory-oriented ‘N=N case studies’ in empirically grounded ethics of care. Medicine, Health Care, and Philosophy. 2019:1-10.

54. Edwards SD. Is there a distinctive care ethics? Nursing Ethics. 2011;18(2):184-91.
55. Kon AA. The role of empirical research in bioethics. Am J Bioeth. 2009;9(6-7):59-65.
56. van der Meiden J, Noordegraaf M, van Ewijk H. Relational ethics as enrichment of social justice: Applying elements of contextual therapy to social work. Qualitative Social Work. 2020;19(1):125-41.
57. Bohren M, Vogel J, Hunter E, Lutsiv O, Makh S, Souza J, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Medicine. 2015;12.
58. Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. The Lancet. 2014;384(9948):1129-45.
59. Bradfield Z, Hauck Y, Kelly M, Duggan R. "It's what midwifery is all about": Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model. BMC Pregnancy and Childbirth. 2019;19(1):29.
60. Davison C, Hauck YL, Bayes SJ, Kuliukas LJ, Wood JG. The relationship is everything: Women's reasons for choosing a privately practising midwife in Western Australia. Midwifery. 2015;31(8):772-8.
61. Newnham, Elizabeth, Lois McKellar, and Jan Pincombe. Towards the Humanisation of Birth: A Study of Epidural Analgesia and Hospital Birth Culture. Cham: Springer International Publishing AG, 2018. https://doi.org/10.1007/978-3-319-69962-2
62. Borrelli SE, Spiby H, Walsh D. The kaleidoscopic midwife: A conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth. A grounded theory study. Midwifery. 2016;39:103-11.
63. Perriman N, Davis DL, Ferguson S. What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. Midwifery. 2018;62:220-9.
64. Westergren A, Edin K, Walsh D, Christianson M. Autonomous and dependent-The dichotomy of birth: A feminist analysis of birth plans in Sweden. Midwifery. 2019;68:56-64.
65. Olsman E, Willems D, Leget C. Solicitude: balancing compassion and empowerment in a relational ethics of hope-an empirical-ethical study in palliative care. Med Health Care Philos. 2016;19(1):11-20.