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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Relationships, roles and person-centred practices – collaborative birthing care in Nova Scotia

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Abstract

Background: Collaboration is an important factor in creating and maintaining safe and effective spaces in perinatal healthcare. Family-centred care has been used by perinatal nurses to provide care that focuses on the family. Woman-centred care is defining for midwifery, and centres care around women's expert knowledge and decision making. Person-centred care extends these approaches to include all persons involved in healthcare. The ongoing integration of midwives into existing perinatal healthcare teams in Canada has created new opportunities for collaboration. Understanding how midwives and nurses collaborate can offer insights into how collaboration is influenced by different approaches.

Aim: The aim of this study was to understand how midwives and nurses collaborate in Nova Scotia, Canada.

Methods: Feminist poststructuralism guided this case study. The data collected included 17 individual participant interviews, document review and field notes. Feminist poststructuralist discourse analysis was used to analyse the data.

Results: The two main themes discussed in this article were negotiating roles and practices, and sustaining relationships. In the first theme, participants talked about how they negotiated their roles, how their skills and practices crossed over and the importance of communication and anticipation. In the second theme, participants described how they test trust, the ways in which midwives depend on nurses, and a need for more opportunities to work, learn and socialise together.

Conclusion: The relationships between midwives and nurses in Nova Scotia support their collaboration and contributions to ensuring their workplaces are safe and effective. The participants described intuitive engagement with person-centredness.

Implications for practice:

- The Person-centred Practice Framework should be used to facilitate collaboration in perinatal healthcare
- Individual, institutional and systemic commitments to intentional engagement with practice development are needed to support healthful cultures in perinatal healthcare
- Research is needed to explore how family-centred and woman-centred care approaches may support person-centred practices and cultures

Keywords: Midwife, nurse, collaboration, person-centred, workplace cultures

Introduction

Collaboration has been identified as an important aspect of the delivery of healthcare services. It is a dynamic and ongoing process that requires engagement with sharing, partnership, interdependency and power relations (D'Amour et al., 2005). When collaboration occurs, it has been linked to improved satisfaction for people receiving and providing healthcare, and improved delivery of services (Pomare et al., 2020).

In Canada, midwives and nurses work together in hospitals, in the community and sometimes in people's homes. Depending on the province, midwives may share aspects of perinatal care during labour, delivery and the initial postpartum period. For example, in Nova Scotia, midwives work alongside labour and delivery nurses, home birth second attendant nurses and postpartum nurses, sharing tasks such as labour support, charting and monitoring. This integration differs from perinatal healthcare models in other countries, where midwives often work without the direct assistance of nurses during labour and delivery, and the initial postpartum period. In other jurisdictions, midwives provide all perinatal healthcare, collaborating and consulting with obstetricians and physicians when required.

Manley and colleagues (2011) developed a concept analysis framework to examine effective workplace culture. In this framework, the authors describe culture as '…social contexts that influence the way people behave and the social norms that are accepted and expected' (p 2). This definition can be expanded to apply to our understandings of workplace cultures.

In 2019, Manley, Jackson and McKenzie revised the 2011 framework to include the 10 interrelated values it identified as necessary for safe and effective workplaces. These values are grouped into three clusters: person-centredness, ways of working together and effective care. According to the authors, the most significant is person-centredness, and its importance is highlighted by the fact that it is a cluster unto itself. Collaboration, the phenomenon explored in this study, is identified as one of the values grouped within the ways of working together cluster (Manley et al., 2019).

Midwifery and nursing, two professions historically dominated by women with similar skills, have adapted and created new ways of working together in various Canadian contexts. Before this study, little was known about how the two groups collaborate (Macdonald et al., 2015); the systematic review by Macdonald and colleagues highlighted a clear gap in research on the subject. Exploring how midwives and nurses collaborate is important for developing and understanding person-centred practices, cultures and workplaces.

Background

The capacity for collaboration is often influenced by relationships between people. For the delivery of healthcare services, the focus has often been on the relationships between the person receiving care and the person providing care. Collaboration in healthcare extends beyond one-to-one relationships and often includes relationships among a variety of people who come together for a shared purpose.

Nursing has been centred around the concept of a therapeutic relationship, one that a nurse initiates and sustains with a person receiving care, and which has clearly established boundaries (Registered Nurses Association of Ontario, 2002). Nurses are positioned as the guardians of therapeutic relationships, ensuring their boundaries are adhered to and that they remain professional. The boundaries of therapeutic relationships are meant to protect the person receiving care from unprofessional conduct, recognising that a person receiving care is often made vulnerable by their health needs, care requirements and a system of power imbalances.

In perinatal nursing, the therapeutic relationship has expanded to centre around the family, recognising that while the person giving birth is a central focus of care, the need for care extends to include their family. Family-centred care (FCC), when used to guide maternal and newborn care '…responds to the

physical, emotional, psychosocial and spiritual needs of the woman, the newborn, and the family' (Chalmers et al., 2017, p v). Within the perinatal care context, FCC is understood to value family and informed decision making, and reinforce the notion of the perinatal period as a time of normalcy (Chalmers et al., 2017).

Woman-centred care (WCC) is a foundational philosophy of care that guides the practices of midwives (Bradfield, et al., 2019a; Fontein-Kuipers et al., 2019; Rigg and Dahlen, 2021). A woman-centred approach to the relationships between midwives and those receiving midwifery care centres care around the person giving birth and their role as the primary decision maker (Canadian Association of Midwives, 2022a). When approaching perinatal care from a woman-centred perspective, midwives enter into the relationship valuing that person's autonomy, decision making, expert knowledge about their body and baby, and their capacity to birth in the ways and in the space of their choice (Canadian Association of Midwives, 2015).

The difference between family-centred and woman-centred care is subtle. The former was created to be inclusive of the whole family experiencing birth as a life event (Chalmers et al., 2017). It responded to the recognition that this event impacts not only the birthing person but the family as a whole, who all benefit from full participation in the healthcare journey (Chalmers et al., 2017). FCC was created within a system of power imbalances to inspire a more equitable distribution of power in terms of care, decision making and overall healthcare delivery.

Woman-centred care evolved outside the traditional healthcare system, with midwives centring the needs and expectations of the person giving birth, rather than those of institutions (Bradfield, et al., 2019a,b; Rigg and Dahlen, 2021). In WCC, the reorientation of that person as the key decision maker and the one with control responded to traditional patriarchal and paternalistic approaches to maternal and newborn care (Rigg and Dahlen, 2021). The aim was not a redistribution of power within a formal system, but rather a radical challenge to the historically hegemonic power structures of traditional healthcare systems.

Person-centred care (PCC) differs from FCC and WCC approaches to care, in that its approaches extend our understandings of relationships beyond the people providing and receiving care to include all persons in the care experience, the contexts and environments in which care is provided, the prerequisites for care, and how the persons involved engage and connect with one another (McCance et al., 2011; McCance and McCormack, 2021). Person-centred relationships and collaboration are both central to the endeavour of building safe, effective workplaces (Manley et al., 2019).

All three of the above approaches reorient traditional hegemonic power relations between the persons providing care and the persons receiving care. FCC and WCC seek a more equal distribution of power between families and providers, and women and providers respectively. They are used within existing structures of healthcare but have not transformed the structures themselves. Person-centred care has the potential to transform these structures because all persons involved are included, respected, and enabled to flourish. Exploring how collaboration is currently experienced between perinatal healthcare providers offers opportunities to better understand how existing relationships and roles may be supported to be person-centred, and to create safe, person-centred workplace cultures for the delivery of perinatal healthcare.

Study purpose

The purpose of this study was to explore how midwives and nurses collaborate in Nova Scotia, Canada. It was important to explore how the experiences of collaboration between midwives and nurses are influenced by gender and by social, historical and institutional discourses. The experiences and perspectives of nurses, midwives, mothers, administrative stakeholders and other healthcare providers were explored.

Philosophical perspective

Feminist poststructuralism (FPS) was the guiding philosophical perspective of this research. Informed primarily by Weedon (1987), Foucault (1982) and Cheek (2000), it was used to situate understandings of gender, power relations and discourses as they relate to the ways midwives and nurses experience collaboration. This approach was helpful during analysis because it facilitated a deeper understanding of the context in which collaboration was happening between these two professions. The aim of FPS is to critically analyse, make visible and challenge hegemonic discourses that perpetuate patriarchal relations of power systemically, institutionally, historically and individually (Weedon, 1987).

Both FPS and person-centred methodologies can be located in a critical theory paradigm. Person-centred research can support collective, individual and political transformation (van Lieshout and Peelo-Kilroe, 2021) in healthcare. Similarly, FPS is often used to interrogate and critique the status quo through the analysis of texts (Foucault, 1982; Weedon, 1987; Cheek, 2000), as a starting point for an emancipatory agenda.

Methodology

Stake's (1995) instrumental case study approach was used for this study. Case studies rely on 'binding' (Stake, 1995) or 'casing' (Ragin, 1992), forming boundaries around the case to ensure researchers maintain focus (Stake, 1995). The boundaries of this case were based on geography (the province of Nova Scotia) and time (collaborative experiences in the two years prior to ethical approvals). The aim of the case study was not to produce generalisable findings but findings that reflect a deep understanding of collaboration between midwives and nurses in this particular context (Stake, 1995).

Methods

The case

Nova Scotia is a province in eastern Canada, where midwifery became a regulated healthcare profession in 2009. It was integrated into maternity care services at three model sites, two in rural communities and one in an urban centre. Each of the sites has experienced a suspension of services for a period of time, related to shortages and burnout of midwives.

The need for increased government support and a commitment to grow the midwifery profession in Nova Scotia are two recommendations in a report by external reviewers tasked with evaluating the state of midwifery in Nova Scotia in 2011 (Kaufman et al., 2011). All data for this research were collected in the winter and spring of 2018, and at the time there were seven midwives practising in the province. The provincial government has since increased that number to 18 but there has been no meaningful commitment to expand the midwifery programme beyond the three original model sites.

In 2020, midwives as primary healthcare providers attended 3% of births (230) in Nova Scotia (Canadian Association of Midwives, 2022b). Registered nurses work in perinatal care in a variety of settings throughout the province, as second attendants with midwives, physicians and obstetricians in hospitals and with midwives at home births. Nurses only work with midwives at the three model sites.

Participants and ethics

Purposeful and snowball sampling were used to recruit participants. Study posters and letters of information were distributed via email and hard copy, to midwifery clinics/offices, birth units and the provincial midwifery association. Posters were shared through social media with the provincial midwifery consumer advocacy group. Participants were encouraged to share information with others who might potentially join the study.

There were 17 participants in this study: six nurses; five midwives; two mothers; a healthcare colleague; and three other stakeholders (leaders and decision makers). The study author (DM) reviewed the consent form with all participants, who provided verbal and written consent before participating in

research activities. They were informed that they could withdraw from the study at any time up to the beginning of analysis. Ethical approval was received from the University of Ottawa, the Nova Scotia Health Authority and the IWK Health Centre before data collection.

Data collection

Three data collection strategies were used: interviews, document review and field notes. These strategies were consistent with Stake's (1995) case study approach.

One-on-one, individual, semi-structured interviews were conducted with all 17 participants. Interviews took place in private settings and were each 30 to 90 minutes in duration. All were audio-recorded and transcribed verbatim.

Document review was used to assist in developing a deep understanding of the context of collaboration between nurses and midwives in Nova Scotia. There were 24 documents reviewed for this study: 22 media reports, one institutional policy and one institutional report. The documents were used to identify social and institutional discourses related to midwifery and/or collaboration between midwives and nurses.

Field notes were also maintained throughout the study. Reflections of study progress, decision making, study activities and observations of interviews were recorded. The field notes served as a secondary data source, provided an audit trail and were reviewed for clarification and contextual information.

Analysis

Feminist poststructural discourse analysis (FPSDA; Aston, 2016) was used to analyse the data collected for this study. FPSDA began with an examination of the values, beliefs, practices and discourses evident in the participant interviews. This allowed for further examination of the feminist poststructuralism concepts of gender, power relations, agency and the use of language in the transcripts.

The process began with listening to and reading each transcript to identify quotations that contained important issues. Next, the transcripts were examined and the values, beliefs, practices and discourses in the quotation representing each issue were identified. Next was a closer examination of the FPS concepts and the language used to convey all of these ideas. This process was applied to all transcripts. Similar issues were grouped together to create subthemes, and similar subthemes were then grouped together to create main themes. The analysis was circular, with each of these steps re-examined and reflected on. For trustworthiness, thesis committee members were consulted throughout the analysis. Preliminary findings were shared through discussions with four participants (two nurses and two midwives), which aligned with feminist research approaches of inclusion and engagement with participants throughout the research process.

Findings

Several themes and subthemes were identified in this study. One theme, and its corresponding subthemes, has been published elsewhere (Macdonald and Etowa, 2021). This article will share two further themes. The first is 'negotiating roles and practices' and the second is 'sustaining relationships'. Each has subthemes, as set out below.

Theme 1: negotiating roles and practices

This theme highlighted how nurses and midwives were engaged in ongoing negotiations around how they provided birthing care. Participants recognised that every birth is different, and that each nurse and midwife had to adapt to the uniqueness of that birth and each other. This was reflected in the three subthemes:

- A constant negotiation of roles
- Crossover of skills and practices
- Communication

Subtheme: a constant negotiation of roles

Midwives and nurses talked about their understandings of their own professional roles and of their roles in relation to each other. Participants' understandings were clear and they identified the need for flexibility in those roles when collaborating. As a result, participants were often negotiating their roles at the point of care, depending on the unique needs of each birth.

Colin, a midwife, believed that flexibility was important when she worked with nurses. Flexibility ensured that the needs of the person giving birth and of the providers were met. Colin valued respect and communication, which allowed her to work flexibly and in collaboration with nurses.

> *'It also means that it's super important that we're communicating well, and that respect is existing on both sides. That they understand our role and when we need their help, and that they're there and that they have our back... that I'm not asking them to do more than is fair and the same for them. Because there is room there to abuse each other, to say, I don't need to do that, the midwife will do it, or I don't need to do that, the nurse will do it. We really are always having to finesse in a really busy life – what is your role and what is my role and what is fair for me to do and what is fair for you to do? And if I'm exhausted can you step up and do a little more? And if you guys are overwhelmed can I step up and do a little more? It is really a constant negotiation. It's not perfect'* (Colin, midwife).

Discourses of flexibility are present in midwifery and perinatal nursing. In midwifery, this discourse reinforces the expectation of midwives accommodating a variety of changing needs, decisions, spaces and contexts. In perinatal nursing, nurses must integrate a nursing discourse of flexibility for the needs of the birthing person and of the primary care provider with a medical discourse of institutional standardisation and governance. Colin's experience of 'having to finesse' and being engaged in a 'constant negotiation' of roles when she worked with nurses challenged the medical discourse because she approached the negotiation of roles with nurses with flexibility rather than adhering to established social and institutional expectations that standardise a hierarchy of roles.

Subtheme: a crossover of skills and practices

All the participants talked about how the skills and practices of nurses and midwives were similar, crossed over and overlapped. Midwife, nurse and mother participants recognised this crossover as unique when midwives and nurses collaborated because both providers stayed with the person giving birth throughout labour, during birth and in the initial postpartum period. Chelsea, a midwife, believed that this crossover and similarity of skills left nurses feeling unsure about their roles when they worked with midwives.

> *'It really does crossover quite a bit... the skill set. Like the actual clinical skill set, as well as the supportive care piece because typically nurses are doing all the supportive care until a doctor comes in and catches a baby. So with midwives, because we're there once the client is established in her active labour, some nurses really enjoy that, that supportive care piece and aren't sure then what their role is. So I do always try to have a chat with a nurse as we're getting settled in to say like "you do what you do and I'll just follow your vibe and my client's vibe. I'll kind of work around you all"'* (Chelsea, midwife).

Chelsea valued collaboration with nurses and accommodated nursing practices that crossed over with midwifery practices. She talked with the nurses to demonstrate her willingness to integrate the two. Chelsea recognised how the nursing discourse was positioned differently to a midwifery discourse of supportive care in labour and birth. A nursing discourse reinforces the assumption that nurses are present to provide care and support to birthing people throughout labour and birth, with the primary care provider arriving in time for the delivery of the baby. A midwifery discourse of 'with woman' reinforces the expectation that midwives, as primary care providers, are present to provide care and

support birthing people throughout labour and birth. Chelsea recognised that the assumptions of nursing practices for birthing care, based on a nursing discourse, were challenged by her presence, practices and skills as a midwife. Chelsea used her agency to challenge hegemonic practices because she chose to make space for the practices that were shared between midwives and nurses, rather than direct nurses' clinical practices.

Daisy, a nurse, valued opportunities to work with midwives and the flexibility that the crossover of practices and skills offered to her own nursing practices. Daisy believed in her own capacity as a nurse and in the abilities of the midwives she worked with.

> *'The mum is delivering, the midwife assists her. And sometimes both of us are there at the perineum, sometimes I'm just standing off to the side, it just depends on the scenario. And I don't know, it's one of those things – I'm comfortable I think because of my years of experience in labour and delivery, but also because I believe in those midwives and what they can do. So I'm never in a panic about a delivery and having everything be perfect, like a baby comes and they don't need much, they need mum's arms, you need a warm blanket, and they're... I just find like we just naturally... we know what has to be done, so if she's doing one thing I'll do the next. And it works well I find'* (Daisy, nurse).

Daisy aligned herself with a midwifery discourse of birth as a normal process. This was demonstrated by her attitude about birth, and her articulation of her comfort with birth and lack of panic around deliveries. This viewpoint, along with her experiences as a perinatal nurse, meant she was comfortable with flexibility in her practices; she could anticipate what had to be done.

Claire, a mother, talked about how the collaboration between the midwife and the nurse positively influenced her birth experience. Claire believed the two worked well together and that they were easily able to 'trade off' birth tasks. She valued their capacity to collaborate and believed that this made the birthing environment pleasant for her.

> *'I just feel like it was really flawless the way that they work together and the way they had a really positive kind of friendly rapport with each other. It was just a really pleasant environment, because they were just... they were very friendly toward each other and they really traded off easily. It was just like, "Oh, you've done that. Great, thank you so much. And I'll do this thing". And it was nice even to hear them just discussing what they would do and how they would accomplish things, because it again just made it very comfortable and I felt so confident in what they were doing. And I think like the culmination for me was when I was pushing and just having them both like be so supportive and the way that they both talked to me and the way that I felt in that, like, really challenging moment, and just how they were so in sync. And even like talking to each other while I was pushing, about what they were seeing and what was happening, I felt really good about it and I felt really encouraged by it'* (Claire, service user/mother).

Claire valued the flexibility and communication between the nurse and the midwife and how they negotiated their practices to attend to birthing tasks. She was included in their communications and this made her feel confident. The midwife and nurse worked together and with Claire in person-centred ways. In a person-centred discourse, the person receiving care is respected and included in all aspects of their care. This respect and inclusion is then extended to all other members of the care team. For Claire, the person-centred approach during her birth contributed to her positive birth experience.

Subtheme: communication

Communication was recognised by almost all participants as an important skill for collaboration. Participants talked about how nurses and midwives communicated, and provided examples of clear communication. Participants also discussed how communication enhanced provider anticipation of birthing needs.

Susan, a stakeholder, described changes to how communication was used to resolve conflict during her time working with nurses and midwives. She valued the use of communication to resolve a situation that arose between a nurse and a midwife. Susan believed they were able to avoid a potential conflict because they each valued their relationship with one another.

> *'So in a situation once, the nurse questioned what happened in the room, and the midwife could pick up on that the nurse might have questioned that. And they had an open discussion before the midwife left the care area. So I think that's wonderful, like nobody has to run to a manager to make things come together and talk. They had open conversation together, because their relationship was important to both of them. And that was made so clear to me from both parties…. To see the changes over the decades it's just been a pleasure, and inspiring that can happen at that level with two people, two professionals and both walk away from it with a clearer understanding of each other's perspective'* (Susan, stakeholder).

Susan's experience illustrated how the nurse and the midwife challenged institutional expectations of conflict resolution. In an institutional discourse, a formal process is needed when disagreement occurs in the workplace. Susan described how the midwife and the nurse used their agency to initiate their own resolution. Susan welcomed this challenge to institutional expectations and saw this as a positive and inspiring change, reflecting a commitment to maintaining professional relationships between nurses and midwives.

Theme 2: sustaining relationships

This theme highlighted how midwives and nurses worked to sustain their professional relationships with each other. The participants recognised the vital role that their relationship played in their abilities to provide collaborative birthing services to people giving birth and their families. There were three subthemes associated with this main theme:

- Testing trust
- Midwives depending on nurses
- Needing more opportunities together

Subtheme: testing trust

Several participants talked about the role of trust in the sustainability of professional relationships between nurses and midwives. They recognised that trust was often established between two individual providers and the visibility of that trusting relationship influenced the experience of people giving birth. Eve, a nurse, talked about her experiences learning about midwifery and how that informed her capacity to trust midwives.

> *'So a lot of that I didn't know until I kind of learned it through the grapevine and asked questions, and then over time watched their approach and the care that they gave their clients, and learned to trust a little more, because again when you're not familiar with the background or the training that someone receives then you don't know what their approach is going to be, and you wonder if they're going to recognise things in time that would prevent or avoid a certain consequence. So I think I was afraid to trust what they'd be able to do in an emergency. And working with them now closely I have much more confidence in their abilities and then in my own to support them I guess'* (Eve, nurse).

Based on her position as a nurse, Eve initially questioned how midwives practised. She valued safety and believed that midwives had different practices, which challenged her understanding of safety. Eve was professionally socialised as a nurse within a medical discourse of birth that reinforced assumptions of nurses and physicians as safe providers of birthing care. Working with midwives exposed Eve to new birthing care providers and challenged those assumptions. She learned to trust the midwives and their practices because she could see shared values of safety. Eve tested her trust of the midwives and was eventually able to trust them, which increased her confidence in working alongside them.

Subtheme: midwives depending on nurses

Several midwives talked about how they depended on nurses to provide midwifery services. This was particularly important for home births, as a number of nurses had been hired to attend home births with midwives, as registered nurse second attendants. This role was initiated to support the sustainable delivery of home birth services. Midwives' dependence on nurses was not limited to the home birth.

Annabelle, a midwife, described how she depended on nurses at both hospital and home births. She relied on their presence in hospital as her back-up at every birth. Annabelle valued support from the nurses as well as their clinical and administrative capabilities. She believed she could depend on them.

> *'So the biggest thing here is working with the nurses on the floor, they back us up for our births. And they also if we're transferring care, if they're involved with any of our clients, you know they're always so good to help us out in any way, shape, or form. So if I have someone coming in, you know I'm like "okay they're going to be here before I'm here. Can you get them settled in, give me a call if it sounds super urgent, I'll be there as soon as I can". Helping me get things ready for a precipitous delivery, they can do all that stuff. Get them registered or, if I have two women in labour at one time, they can kind of labour sit one of them and help and do that while I'm with the other one. So they've been really great to work with. Just in general, they're awesome and they do back us up at every birth'* (Annabelle, midwife).

Annabelle seemed to value the hegemonic medical discourse that positioned nurses in supportive roles for primary healthcare providers. This discourse has gendered roots, with the nursing profession historically dominated by women and the physician role by men. The assumption, reinforced by the medical discourse, that nurses are positioned to support and assist primary care providers, worked for Annabelle as a primary care provider. She accepted the medical discourse and came to depend on the nurses to support and assist her when she needed them to. The power relations between Annabelle and the nurses were complex. The nurses exercised their power when they chose to support and assist Annabelle with clinical and administrative tasks. Once they offered their assistance, then Annabelle exercised power through her decision to depend on them for their assistance. This relation of power did not seem to be filled with tensions, as Annabelle praised the nurses.

Subtheme: needing more opportunities together

Most participants talked about midwives and nurses needing more professional and social opportunities together. They wanted and needed to know one another and to better understand each other's strengths individually and as a team. Participants believed that there were professional benefits for their practices and their relationships of having opportunities to learn, work and socialise together.

Bridget, a nurse, valued her relationships with midwives and additional opportunities to strengthen them. She believed that opportunities to learn together and to socialise together enhanced the ability to collaborate. Bridget described the impact that learning together had for improving collaboration.

> *'I can tell you things that I think have strengthened it here, is the MORE^{OB} [a learning programme for interprofessional obstetric teams]. Learning together not just going to a midwifery course or going to a course on nursing or going to a course on physician skills. It's we all sit down in the same classroom and we all learn the same stuff. I think that was huge for collaboration. And I think being in the same facility, working closely in the same unit together makes a huge difference. I think that's a huge strength. And I think playing together, doing social things outside work. Like not just a tea in the tea room, but like let's have a staff party, so and so's retiring. They come. You know, we plan a lot of social events. I think those things are important, they may not be professional things always, but I think they are important in making everyone, you know, making our bonds strong, our relationship strong, professionally too'* (Bridget, nurse).

Bridget aligned herself with a discourse of interprofessional collaboration, where healthcare providers from different professions are valued, respected and included in collaborative endeavours. For Bridget, the responsibility of fostering interprofessional collaboration extended beyond the institution where she worked, to the healthcare providers themselves, who initiated tea breaks at work and social events outside the work environment. Bridget and her colleagues used their collective agency to participate in institutional and social interprofessional activities.

Discussion

The findings presented in this article illustrate how midwives and nurses in Nova Scotia experienced collaboration. In the two main themes – 'negotiating roles and practices', and 'sustaining relationships' – participants described how nurses and midwives collaborated with flexibility and the importance of building relationships. Using a person-centred lens to examine these findings, this article will now discuss how midwives and nurses appeared to embody person-centredness when they collaborated, describe the potential of using feminist poststructuralism in person-centred care research, and explain the importance of terminology.

Embodiment of PCC in collaboration

Building on the work of McCormack and McCance (2010) about the assumptions that inform understandings of person-centredness, Tichen and colleagues (2017) point to several key related values. These are respect, self-determination, reciprocity and mutuality. These values can help us to see how the midwives and nurses collaborated in person-centred ways.

Respect involves understanding the values and beliefs of others and forms the foundations for interdependent and positive relationships (McCormack et al., 2021). Respect was clearly illustrated in three subthemes: 'a constant negotiation of roles', 'testing trust' and 'midwives depending on nurses'. In a constant negotiation of roles, Colin, a midwife, talked about how respect supported role flexibility between midwives and nurses and facilitated their adaptations to each birth. In testing trust, Eve, a nurse, talked about how, after observing and working with midwives, she trusted and respected their professional expertise. In midwives depending on nurses, Annabelle, a midwife, described her dependence on nurses as back-up. She felt able to depend on the nurses because she respected them. In each of these findings, the midwives' and nurses' understandings of each other's values and beliefs informed the respect they shared and supported their person-centred interdependence.

Self-determination is another value related to person-centredness (McCormack and McCance, 2010), and can be understood as having the choice to determine one's own actions. Self-determination and the related values of autonomy and accountability are important within the caring environment because they provide a foundation to navigate innovation and risk (McCormack and McCance, 2010). There were two clear examples of self-determination in the findings of this study, in the subthemes 'a crossover of skills and practices' and 'needing more opportunities together'. In the first of these, Daisy, a nurse, described how she determined her own practices based on the context, needs of the birth, her own professional abilities and her understanding of risks. She was confident in her professional abilities and those of the midwives. In the second, Bridget, a nurse, talked about the importance of learning and socialising together. While there were formal opportunities for learning, the nurses and midwives also initiated social activities to strengthen their relationships. This contributed to stronger relationships that supported person-centredness.

Reciprocity is an important value related to person-centredness (Tichen et al., 2017), and describes an exchange between persons for mutual benefit. Reciprocity is important for staff relationships within a caring environment, because its presence can illustrate that a team is effective (McCormack and McCance, 2010). An example of reciprocity was shown in the subtheme 'communication', when Susan, a stakeholder, described how a nurse and a midwife promptly resolved a potential conflict that occurred in the birthing space. Susan recognised that the relationship was important to both of them and they resolved the situation for their mutual benefit.

Mutuality can also be linked to person-centredness (Tichen et al., 2017) and can be understood as sharing between two or more persons. Mutuality is important for staff relationships within the caring environment but achieving it presents problems in many places (McCormack and McCance, 2010). Mutuality was expressed by Claire, a mother, in the subtheme 'a crossover of skills and practices'. Claire described how the midwife and nurse who attended her birth were in sync with one another, communicated clearly and included her in discussions throughout her birth. The relationship between the midwife and nurse extended to and included Claire. Mutuality between the midwife, the nurse and Claire contributed to Claire's positive birthing experience.

Arguably, the PCC values described above, in their relation to the study findings, can also be linked to woman-centred care and family-centred care. The difference for this study is how the values were extended to all the study participants. Often respect, self-determination and mutuality in a WCC or FCC therapeutic relationship are directed to the person receiving care, while the concept of reciprocity is not often discussed or acknowledged between the persons providing and receiving care, let alone between healthcare providers. In this study, the PCC values were multidirectional and inclusive of all persons included in the care activities and relationships, particularly between and among the healthcare providers. This was transformational for the midwives and nurses, because inherent hierarchies within the medical model were challenged. This created a space that transformed collaboration into a more person-centred experience. Challenges to existing power structures are often identified with the application of critical and transformative approaches (Weaver and Olsen, 2002) such as feminism, feminist poststructuralism and person-centredness.

Feminist postructuralism – a complementary methodology for person-centred care research

In this research, FPS provided the philosophical grounding for the case study. The study was not designed with the aim of informing practice development or understanding how person-centredness was experienced by midwives and nurses who collaborate. However, as the author grew more familiar with the Person-centred Practice Framework (McCance and McCormack, 2021) and practice development, and reflected on the use of FPSDA for analysis, the potential contributions of FPS and FPSDA to PCC research were clear.

FPS is situated within a critical paradigm and is often used to critically examine concepts of gender, discourse and relations of power within the context of the phenomenon of study. As a theoretical perspective, it is rooted in understandings of multiple realities, critiques of the status quo and aims for transformation and/or emancipation (Weedon, 1987). When paired with FPSDA (Aston, 2016) FPS is useful to explore gender and relations of power, critique how power is expressed and reinforced, and identify strategies for change (Weedon, 1987).

Similarly to FPS, person-centred research methodologies, such as practice development, are situated within a critical theory paradigm (McCormack and Titchen, 2006; Radbron et al., 2021). Tichen and colleagues (2017) argue that person-centred research can be situated in three paradigms: practical (associated with interpretive approaches); emancipatory (linked to critical approaches); and transformational (a new paradigm incorporating critique through art and cognition). The emancipatory thread of person-centred methodologies (Tichen et al., 2017) aligns with the critical paradigm of FPS.

Practice development, as a person-centred methodology, encourages new ways of thinking that can change practices or behaviours (McCormack and Titchen, 2006). This aim is similar to that of FPS, which offers a methodology to critique the status quo and common assumptions (discourses) to inform change. The shared paradigm of critical theory illustrates the potential of FPS as a methodology that is complementary to the aims of person-centred research.

One critique of poststructuralism, which can be extended to FPS, is that the cycle of constant critique of ever-changing meanings, relations of power and discourses can result in paralysis (Francis, 2000).

In other words, when a researcher applies an FPS lens to their research, their ongoing engagement with critique may not result in action. Where there is no action, there is no change. Based on this arguable limitation, FPS may offer a first step to explore person-centredness within changing contexts and understandings of concepts such as power relations, gender, subjectivity and discourses. The use of a variety of methodologies to explore person-centredness is congruent with Dewing and colleagues' advocacy for multiple methodologies to be used to explore person-centredness at multiple levels – individual, collective, institutional and systemic (2017).

FPS as a philosophical underpinning and FPSDA as an analytical method may begin to address Wright's (2017) critique of the problematic origins of practice development within a white male critical theory philosophical tradition. Wright's work clearly aligns black feminist theory and intersectional concepts of race, power, oppression, emancipation and inclusion with the work of PCC and practice development theorists. FPS combines feminist and poststructuralist philosophical approaches. While poststructuralism can be located within the white male critical theory philosophical tradition, the addition of feminism, as in Weedon's (1987) FPS, may offer a stepping stone towards the integration of additional transformative methodologies in person-centred research. Further, when a specific feminist approach is applied (for example, intersectionality), FPS may be more inclusive in reflecting broader alignments with theories and persons who have been marginalised by the structures and systems that person-centred health research aims to transform.

FPS and FPSDA illuminated how the experiences of collaboration between midwives and nurses in Nova Scotia changed dominant discourses, challenged traditional relations of power and united two historically gendered professions. The positive experiences of collaboration that participants described and the intuitive embodiment of person-centred processes highlighted the potential for intentional person-centred practice development. FPS and FPSDA may offer an additional methodology and method of analysis that can bring critical insights into practice development and person-centred research to support transformative changes in perinatal healthcare.

The importance of terminology

PCC is not often talked about or well understood in perinatal settings. When PCC is talked about it is often added to FCC and WCC, as an adjustment to indicate improved inclusivity, but the transformative potential of PCC has not yet been fully embraced or operationalised within institutions that reinforce traditional hierarchies of power within therapeutic relationships. This is consistent with an overview of person-centred practice by McCormack and colleagues (2015). In this study, midwives and nurses intuitively engaged in person-centredness and flourished as providers.

Based on the findings of this study, it is suggested that the Person-centred Practice Framework (McCance and McCormack, 2021) needs to be intentionally implemented to support collaboration in perinatal care. PCC can be useful in places where collaboration between midwives and nurses is challenging. This is important in the Canadian context because of the ongoing integration of midwifery into many existing healthcare teams. In Canada, midwifery is provincially regulated and while some provinces have had regulated midwifery for more than 20 years, others are still working on it (Canadian Association of Midwives, 2022b). This means that not all perinatal nurses have opportunities to collaborate with midwives. In Canada, in places where midwifery is newly regulated and integrated, midwives become 'new' additions to existing perinatal healthcare teams.

The abandonment of FCC or WCC is not suggested here; both approaches have been and remain important for perinatal nurses and midwives. Midwifery and nursing as predominately female professions continue to be subjected to structural, systemic, professional and individual sexism, which continues to limit their contributions to global healthcare (The Lancet, 2020). WCC continues to be an integral paradigm for midwives (Bradfield et al., 2018), particularly for those who continue to work at the margins of healthcare (philosophically, politically and literally). In many jurisdictions globally, WCC continues to be an important and necessary philosophy of care (Bradfield et al., 2018) to support gender equity and to distinguish midwifery from the historical hegemonic hierarchies of power in healthcare.

Intentional use of the Person-centred Practice Framework (McCance and McCormack, 2021) and ongoing person-centred practice development within perinatal healthcare offers the potential to reorient the ways that nurses and midwives (and other healthcare providers) collaborate. PCC can embrace and build on the varying philosophies about therapeutic relationships in perinatal care, such as FCC and WCC, because it shares their aim of redistributing power, focusing on relationships and supporting human flourishing for all persons involved in birthing care. The findings from this study, where midwives and nurses intuitively engaged in person-centred collaboration, illustrate how healthcare providers can flourish when they work together in person-centred ways. Imagine the possibilities of *intentional* person-centred collaboration in perinatal care!

Conclusions

Collaboration between midwives and nurses was important to the participants in this study. The findings are reflective of the three values clusters identified by Manley and colleagues (2019) for safe effective workplaces: person-centredness, ways of working together and effective care. Based on these collaborative experiences between midwives and nurses, we can begin to understand how collaboration, a value grouped in the ways of working together cluster, influences the working spaces for midwives and nurses in Nova Scotia. The efforts to collaborate, and to build and sustain relationships, have enabled midwives and nurses to engage in person-centred practices that support safe and effective workplaces.

The intuitive and unprompted experiences of person-centredness described by participants in this study provide hopeful examples of how collaboration in perinatal healthcare can support person-centred and healthful cultures. Person-centredness can be a unifying concept for perinatal healthcare and one that levels historical and systemic hierarchies of care and highlights the value of all persons involved in birthing care. This changes power dynamics to be more inclusive of all persons who receive and provide healthcare.

Strong advocacy is required for an intentional person-centred reorientation of perinatal services in Canada. This is an opportunity to unify a deeply territorial area of healthcare and begin to heal historical tensions, which continue to sustain siloed approaches to perinatal care across the country, and globally.

Implications for practice

Based on this study, several implications for practice can be drawn. These recommendations may not be limited to the Canadian context.

- Advocate for individual, institutional and systematic engagement in person-centred practice development initiatives to support the creation and sustainment of healthful cultures and workspaces in perinatal healthcare
- Introduce and integrate the Person-centred Practice Framework, person-centred values and person-centred language into workplaces to facilitate collaboration among perinatal healthcare providers
- Identify leaders who can support person-centred practices and practice culture shifts, formally and informally
- Engage in research to explore how understandings of FCC and WCC support person-centred practices for midwives, nurses and other perinatal healthcare providers

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