Woman-Centered Maternity Nursing Education and Practice

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Abstract

The purpose of this Heideggerian phenomenological study was to uncover the meanings of the clinical experiences of registered nurses working in maternity settings after they studied maternity nursing from a woman-centered, feminist perspective in a generic baccalaureate nursing program. Purposeful sampling was conducted to locate and recruit nurses who had graduated from this nursing program between the December 1996 and December 1998 semesters and were currently working in a maternal-newborn clinical setting. Each participant had taken the required woman-centered, maternity-nursing course during her/his undergraduate education. Data collection included an individual, open-ended interview that focused on the nurses' descriptions of their everyday practices as maternity nurses. Nineteen maternal-newborn nurses between the ages of 23 and 43 years who had been in practice from six months to three years were interviewed. The constitutive patterns identified from the interviews were: "Otherness," "Being and Becoming Woman-Centered," and "Tensions in Practicing Woman-Centered Care." Findings revealed that the nurses had a raised awareness of oppressive maternity care practices and applied ideology of woman-centeredness as a framework for providing more humanistic care. Creating woman-centered maternity care meant negotiating tensions and barriers in medically focused maternity settings and looking for opportunities for advocacy and woman-empowerment. The barriers the nurses faced in implementing woman-centered care exposed limitations to childbearing choices and nursing practices that remain problematic in maternity care.

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Nursing scholars in the late 20th century employed feminist theory to understand and articulate women's experiences in the world, critique the nursing profession, and stimulate social and political action to change women's experiences in health care (Andrist, 1997a; Ashley, 1976, 1980; Mason, Backer, & Georges, 1991; Sampselle, 1990). Feminist pedagogy was celebrated as a way of teaching to connect learning with personal meanings, self-awareness, and social consciousness—all key to social activism (Chapman, 1997; Chinn, 1989; Heinrich & Witt, 1993; Wheeler & Chinn, 1991). But does feminist pedagogy deliver on its emancipatory promise? Scarcely any research has been done to study what meaning, if any, that feminist ideology within nursing curricula has on the worldview of nursing graduates or their clinical practices.

This study was initiated to understand the impact of mainstreaming feminist theory as a framework for teaching maternity nursing in a generic baccalaureate nursing program (Giarratano, 2000). For the past seven years, two other faculty members and this author co-taught a core maternity nursing course that focused student learning around a philosophy of woman-centered care. The course was designed to help nursing students critique childbearing health care practices using a post-modern-feminist perspective and to value a woman-centered philosophy aimed at supporting women in making informed choices (Giarratano, 1997; Giarratano, Bustamante-Forest, & Pollock, 1999). Feminist teaching strategies such as group dialogue, journaling, and reading contextual birth stories were blended with readings from the traditional nursing text and critique of evidence-based research. The framework for teaching woman-centered care was based on Jane Dwinell's (1992) collection of birth stories in which she recalled and critiqued her obstetrical nursing experiences using a feminist perspective. Dwinell equates women-centered birth with a midwifery model of care believing that "birth is a woman-centered activity, that is gentle and peaceful, and comes about at its own speed. A woman is respected, her questions and ideas are respected, and she gives birth when, where, and how she chooses" (p. 2). When this model is used, holistic and mainstream medical interventions are options for women, but technology and medical intervention are used appropriately. The woman is assisted to tap into her strength and power necessary to give birth. Inherent in woman-centered birth is the inclusion of the woman's family, as she defines and desires.

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This teaching project provided the opportunity to evaluate students' learning and transformation as they came to recognize oppressive health care practices in childbearing. Yet the ultimate outcome of any curricular endeavor is the extent to which education influences practice. The purpose of this study was to uncover the meanings of the clinical experiences of registered nurses working in maternity settings after they had studied maternity nursing from a feminist perspective in a generic baccalaureate nursing program.

Background

The women's health movement that evolved from second-wave feminism called for a woman-centered model of health care based on feminist ethics (Andrist, 1997a; Ruzek, 1978; Sherwin, 1998). Woman-centered care models seek to provide holistic health care approaches that empower women and acknowledge the relational needs and social stresses impacting women's experiences. Ideally, the woman is an active participant in making informed choices. Yet, social activism is required to critique and transform traditional practices and to re-educate women in the possibilities of health care. Nurses were called to become empowered and skilled advocates for woman-centered care, challenge indiscriminant intervention, and promote an environment wherein women are allowed to seek equal partnerships with the health professional (American Academy of Nursing, Writing Group of the Expert Panel on Women's Health, 1996; Cheek & Rudge, 1994; James, 1996; Taylor & Woods, 1996).

Nurse educators teaching women's health courses reported powerful experiences using feminist approaches to educate nurses in consciousness of social oppression of women and the value of woman-centered health care (Andrist, 1997b; Boughn, 1991; Boughn & Wang, 1994; Valentine, 1997). Yet, the long-term impact of feminist pedagogy on nursing practices and the health care experiences of women has not been investigated. It is unknown

to what extent nursing students educated in a woman-centered care philosophy accept, sustain, or make meaning of feminist values. Researching the ways new graduates who were educated in woman-centered care might assimilate feminist values into their nursing practices is central to advancing gender-sensitive health care systems.

Method

Heideggarian hermeneutic phenomenology was the research method used to describe and interpret the nurses' stories and reveal the shared practices and common meanings of their experiences (Benner, 1994). This philosophical approach opened the way to study nurses as caregivers engaged in the everyday world of practice (see Box on page 17). In this study, postmodern-feminist theory was applied as a critical perspective to interpret dominant childbirth discourses and cultural messages of oppression embedded within the experiences of nurses who cared for women.

Purposeful sampling was used to seek graduates who had taken the woman-centered maternity course and then worked in a maternity health setting or newborn nursery for at least six months since graduation. Names of participants were obtained through advertising in the alumni newsletter, surveying faculty, and from querying the initial participants. New graduate nurses who met the study criteria were recruited until saturation of data was validated.

All participants were initially contacted by telephone to assess their eligibility and interest. A letter explaining the study and the research consent forms was mailed to participants prior to the interview appointment. Questions were answered and consent was obtained before beginning the interviews. An in-depth, open-ended, audiotaped interview, which lasted between one and two hours, was conducted with each participant. Interviews were conducted in person, except for one.

Two interview questions were designed to elicit the participants' reflection on their education and practice by directly acknowledging their history of completing a maternity course that taught woman-centered care. These questions were:

- What is your memory of learning woman-centered maternity care in the nursing school?
- What does learning a woman-centered philosophy of care mean to your current practice as a maternity nurse?

Three remaining questions were designed not only to keep the interview focused on maternity practice but also to allow the participants to talk about experiences important to them. These questions were:

- How would you describe particular situations that stand out for you in your clinical practice?
- What beliefs about maternity care influenced your role in these clinical situations?
- What does being a maternity nurse mean in your personal life?

Nineteen nurses (17 females, two males), who had been in practice in a maternal-newborn practice area between six months and three years, were recruited for the study. Eleven of the 19 nurses had been in practice between 1 and 2 years, while five had worked between 2 and 3 years. Only three nurses had worked less than one year. The ages of nurses ranged from 23 to 43 years, with the largest number, nine out of 19, between the ages of 25 and 29 years. The participants worked in urban settings located in the southeastern region of the United States. Seventeen of the 19 nurses worked in acute hospital settings, which included 10 participants working in labor and delivery settings, four in postpartal/newborn settings, and three in neonatal intensive care units. Two worked in community-based prenatal clinic settings. Nine separate agencies were represented among these diverse settings. Participants described the hospital settings as "fast-paced," "high-risk," "medically-focused," and with "diverse populations." They reported caring for women across all socioeconomic levels and ethnic groups. Birth rates at hospitals varied from 600/year to 5000/year. Birth attendants were obstetricians. The hospital labor areas were designed as labor-delivery-recovery (LDR) suites with separate postpartal newborn nursery settings. Numerous newborn and family visitations were common. The birth settings advertised a family-centered philosophy of care. Pitocin induction, epidural anesthesia, bed rest, continuous fetal monitoring, episiotomies, and fasting were common interventions for women in labor. The nurses usually started the

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As a researcher who had formerly been a teacher of the study participants, I was concerned about how my past and current relationship with the participants would affect the rigor of the study. I planned specific strategies to minimize the bias that our past relationships might bring to the study. I wanted to minimize any power I might possess as a result of the nurses' memories of our previous roles. I spent time talking with them about personal-, work-, or school-related topics before starting the interview. I explained my current role as researcher and how the purpose of the study was to understand current maternity practice from the new graduate's perspective. The interviews were informal, yet focused and dialogical, fostering "collaborative, hermeneutic conservation" around the research topic (van Manen, 1990, p. 99). The open-ended questions kept the participants and me involved in conversation aimed at mutual interpretation of the phenomenon. I expressed a need for them to talk freely about their educational experiences. I dressed casually and interviews were conducted in community sites, such as the participant's home or a coffee shop. I was mindful to keep a nonjudgmental attitude and demeanor regarding whatever experiences the nurses were sharing. Because the maternity course was comprised of large classes of 60–70 students every fall and spring semester between 1996 and 1998, I had never had a personal conversation with over half of the participants prior to this research study.

Lincoln and Guba's (1985) criteria for trustworthiness were used to guide methodological rigor. A reflexive journal was used as an audit trail to record my feelings and perceptions of interactions with participants throughout recruitment, data collection, and member checking, and to record decisions regarding data analysis. Each participant received a copy of his or her transcript to read and validate accuracy. The transcript was returned to the researcher by mail. To further analyze for bias that I might impose on the study due to my previous role as the participants' teacher, I also used Guba and Lincoln's (1989) authenticity criteria. These criteria served as a further measure of how the nurses' construction of reality was collected and fairly represented. For example, I validated that the "fairness" criteria were demonstrated in the transcripts. Review of the texts revealed that the nurses freely shared with me both positive and negative aspects of the teaching strategies in the maternity course. I responded with equal interest in eliciting all points of view and maintained an attitude that enabled the nurses to speak freely. Achievement of the "fairness" criteria was one indicator that I established a relationship that encouraged the nurses to be truthful regarding their perceptions of experiences and that, as researcher, I sought to obtain multiple perspectives. Additionally, the nurses often shared personal, sometimes unpleasant memories of nursing school experiences that were unrelated to the study phenomena. This was further evidence to me that I had established a degree of trust with the participants.

The analyzed data comprised transcribed interviews and observational notes from the reflexive journal. Heideggerian hermeneutical analysis described by Diekelmann and Allen (1989) was used to guide the data analysis and interpretation. A research team, comprising two other qualitative researchers with maternity nursing experience and this researcher, engaged in interpretation of the transcribed data. Prior to sharing the transcripts with the research team members, any identifying information noted in the text was deleted and fictitious names were assigned to the participants' texts to preserve confidentiality. Researchers were provided with a copy of the study proposal, which included Diekelmann and Allen's (1989) guidelines for data analysis. Prior to distributing the transcript, I met with the researchers to discuss the process. The data analysis procedure began with each research team member reading every participant's text and extracting meaning from its wholeness. The research team reread the texts and dialogued until broad categories were identified and consensus was reached on the interpretation of the categories. Categories were refined and compared with each participant's text. Themes were developed and refined from the initial categories. Consti-

tutive patterns of meanings that were common to all the nurses' experiences were identified to express the relationship among the themes. After the data analysis was completed, three selected participants were asked to review the researchers' interpretation. The nurses validated the themes and constitutive patterns as being consistent with their experiences.

Findings

Three constitutive patterns emerged that were evident in each interview (see Table). The first pattern was named "Otherness" and consisted of two themes: (a) perceiving the maternity course as the opening of a whole other light and (b) perceiving that other nurses would not have done that. The second pattern, "Being and Becoming a Woman-Centered Nurse," included two themes: (a) developing a philosophy and (b) putting the whole package together. The third pattern, "Tensions in Practicing Woman-Centered Care," included two themes: (a) temporality and (b) creating woman-centered care in a medically focused environment.

Constitutive Pattern: Otherness

An essence of otherness (difference or alternative) was a prominent pattern in the stories. A sense of otherness emerged on several different levels as the nurses' recalled experiences with woman-centered ideology. The notion of woman-centeredness presented itself to the nurses as encompassing values, beliefs, and actions that are out of the ordinary and uncommon in nursing education and practice. Nurses in the study reflected on the course and woman-centered birth perspectives taught in the course as being "other" and not common practice. Furthermore, the nurses perceived themselves as "other" when compared to their colleagues in practice and believed their colleagues did not embrace woman-centered ideology.

The opening of a whole other light. This theme emerged from the nurses' stories about how they came to recognize that the woman-centered philosophy of childbirth, which they learned in the maternity course, was much different from what they had been exposed to in the dominant culture. They recognized this viewpoint to be "other" when compared to the medical model of childbirth. This sense of otherness emerged through what one nurse described as "taking on a different perspective, looking at women in a different light."

Claire, a labor and delivery nurse for three years, described how this woman-centered focus redefined childbirth for her:

> I found the course opened a whole other tunnel or light for me because I really didn't think of birth in that way [woman-centered]. Everybody I've ever known has had hospital-based birth and medical [focused birth] . . . so it was nice to learn it that way because I had never thought of it that way and it really did—the empowerment of women and all that—it just showed me a different viewpoint.

Other nurses would not have done that. A sense of otherness was also revealed within the nurses' stories of clinical practice in maternity nursing. As practicing nurses, they believed they often saw situations differently or acted differently with women because of their knowledge or values of woman-centeredness.

Amy, a labor and delivery nurse for over a year, shared an example of a situation that required tolerance of a woman's difference. Amy believed her value of woman-centered birth set her apart from what other nursing peers may have done in that situation. Amy knew the lithotomy position was the preferred birth position at her labor unit and she anticipated this to be problematic for a woman highly concerned with modesty. Amy intervened on her behalf:

Table Constitutive Patterns and Themes

Constitutive Patterns	Themes
Otherness	• The maternity course: The opening of a whole other light • Other nurses would not have done that
Being and Becoming a Woman-Centered Nurse	• Developing a philosophy • Putting the whole package together
Tensions in Practicing Woman-Centered Care	• Temporality: A time to be born • Creating woman-centered care in a medically focused environment

> When she was complete, her physician told me to go ahead and put her up. And I knew that if I put that lady up in those leg stirrups, she was going to lose it. So I said, okay, well I'm going to put her up in those little low foot things and I kept her completely covered . . . . So I put her in these and I could tell she was starting to lose it . . . . So I put her bed back together and I went out and told the physician. I said, I'm not putting her up. She's going to have to deliver in the bed. So I turned her on her left side . . . she was much more comfortable on her side. I don't know how many people would have done that on the unit. I just don't think many people would have been comfortable with it. But it's her birth experience.

The labor and delivery nurses perceived their attitudes about birth plans and women's rights to choose options to be different from many other nurses in practice. Amy perceived herself to be much more welcoming of alternative care options than other staff members:

> The woman-centered thing was good. I find that I have more tolerance for women who come in and say, 'I don't want an IV. I really don't want an epidural until I ask for it. I don't want to be offered [the epidural].' I find a lot of nurses get really frustrated . . . And I'm like, it's her birth experience and I guess I got that from you [nursing course]. It's her baby and it's her way of doing things . . . . I think I have more respect for women that want to do something a little different from the norm, you know.

Constitutive Pattern: Being and Becoming a Woman-Centered Nurse

The nurses' journey toward embracing and embodying a woman-centered philosophy of care for practice was described as a process of "being and becoming." Each of the nurses articulated her/his philosophy of woman-centered care and described what it meant to practice as a woman-centered nurse within the context of the work environment. There were times when the nurses clearly described "being" woman-centered in specific clinical situations; however, there were other times they struggled with balancing woman-centered care with other work expectations, making this an ongoing process of "becoming." Putting a woman-centered philosophy into practice was contingent upon many contextual factors, such as the women's desires, the nurses' knowledge and experience concerning the maternity situation, and the nurses' advocacy skills. The nurses described their embodiment of woman-centered care through the stories of woman-involvement, whereby they provided empathic, gender-sensitive care.

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Developing a philosophy. The nurses' stories revealed what it meant to develop a woman-centered philosophy of care within the context of maternal-newborn practice. Two philosophical beliefs concerning woman-centered care were common to all of the nurses in the study. For the first, each of the nurses described woman-centered care as connecting or bonding with women. The second revolved around the importance of knowing the context of women's lives in order to make a difference. The nurses articulated these beliefs of connecting and context and offered an example of how they put each belief to practice.

Connie, a labor and delivery nurse for two years, believed connecting with and knowing each woman's social situation and being sensitive to the importance of the childbearing experience (context) were essential to providing woman-centered care:

> I really try to bond with them. I ask a lot of questions—do they have other children? are they excited?—not to pry, but just to get a better idea of where they're coming from and what kind of family support they have.

Connie described a labor situation where she connected with the woman and considered the context of the mother's life situation to make a difference in her care. As Connie tended to a teenaged mother who was a victim of rape, she was mindful of the impact the experience would have on the mother and her future relationship with the baby that she had decided to keep.

Connie described her nursing care that centered on the meaning of this birth event in this young woman's life:

> The baby looked exactly like her. And so that's something. I was like, this is what we are going to focus on. I mean, she had red hair, the baby had red hair . . . . And she cried when she held him . . . . I made sure I didn't leave the room and go outside to chart because they did have lots of questions . . . . I really worked on making sure the baby stayed warm the whole time so we could bathe him right then and there. Absolutely making sure that they didn't have to be separated at any point in time or anything like that. Anything that would make it more traumatic.

In summary, Connie went beyond usual practice to give this new family the best start possible, given the circumstances.

In addition to reflecting on their professional practices, the nurses also recalled ways their woman-centered philosophy influenced their personal lives. Thus, the development of a woman-centered philosophy became more than a philosophy for professional practices—it became a philosophy for life. Five participants had given birth since graduation and described how their knowledge of woman-centered birth enhanced their own experiences. Each of the nurses also described sharing their knowledge of woman-centered birth with friends and relatives. Thus, the nurses integrated their schooling, nursing practice, and personal lives in the development of their woman-centered philosophy of childbirth (Pinar, 1994).

Anita was one of the participants who reflected on her feelings of embracing a woman-centered philosophy for practice that also enabled her to create her own woman-centered birth. As a neonatal intensive care unit nurse for almost two years taking care of only sick babies, "bad" perinatal outcomes, and mothers in crisis situations, Anita found the inner strength to maintain her philosophy of "normal" birth and gave birth with minimal medical intervention:

> I took on [woman-centered philosophy] a lot for myself—me being a woman and not having children yet. I took a lot of it personally and actually for myself . . . .

With her professional and personal knowledge, Anita found the resources that enabled her to have what she called a "birth experience" rather than a "medical situation." Anita felt her birth was woman-centered because her caregivers supported her choices as labor progressed.

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Putting the whole package together. The theme of putting the whole package together described the nurses' continuum of development as they attained the knowledge and skills to become functional on the maternity and newborn specialty areas, while also trying to care for women within a woman-centered philosophy. The nurses aspired to achieve competency in nursing skills and fulfill institutionalized job expectation, while also implementing woman-centered care.

Patricia, who had worked about one year on a labor and delivery unit, recently encountered an unexpected experience of newborn meconium staining at the time of birth. She felt her lack of attention to the proximity of the suction equipment prior to the birth was an example of her still needing to "put it all together":

> Well, I'd like to get the suction, but it was over at the head of the bed and the baby just didn't want to wait, it just delivered. It wasn't one of those that was willing to sit there with its head out for a minute while we hooked up to suction . . . .

Anticipating what equipment was needed was a goal Patricia still aspired to achieve. Patricia's good memories of this situation were that she responded immediately and calmly to the situation. Patricia described her self-development as a nurse in need of balance:

> That I would be able to take care of the whole experience, both the medical aspects as well as the more holistic aspect of what the woman and her family want to have from the experience. That I'm able to help them incorporate whatever meaning they want to have from it into

the experience. At the same time, giving them medically correct care.

Although Patricia was hopeful that more nursing experience in the medical care would benefit her ability to be a woman-centered nurse, she was also fearful that she would get too close to medical routines of practice and would lose her sensitivity:

> There's always this fear that I will somehow be, that I will just get so used to doing it that way [only medically-focused], that's going to end up being what I do in spite of the fact that I don't believe it should be done that way . . . that somehow you get co-opted by whatever environment you're in and you become like it.

Constitutive Pattern: Tensions in Practicing Woman-Centered Care

Every nurse in the study described tensions experienced as they came to recognize and confront the barriers to woman-centered maternity practice. The nurses described clinical situations where the barriers became visible to them and they experienced tensions in their senses of what "ought to be." The nurses realized that their abilities to offer choices and alternatives to routine care were often limited and controlled by others with more power. They came to see that some women they cared for did not want care outside a conventional model. As relatively new nurses, sometimes they lacked the knowledge of how to negotiate barriers. The nurses' stories revealed ways the health care delivery system was designed to limit women's knowledge, autonomy, and access to alternatives of care so that conventional, medicalized birth was considered the only way to give birth.

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Temporality: A time to be born. The theme of temporality emerged as the nurses described tensions specific to the speed of labor and timing of birth. The nurses described clinical situations where they believed the birth time was manipulated primarily for the convenience of the caregiver. In these cases they believed women's rights were violated and women were sometimes put at more risk for complications.

Steve, a labor and delivery nurse in a busy teaching hospital, described how the tension of time impacted a young mother's birth experience. Steve felt the medical personnel's desire to teach the use of forceps and speed up the delivery process was a barrier that prevented woman-centered care and led to the woman having an unnecessary forceps delivery:

> I had a patient, she was a [15-year-old] primigravida and she was pushing for quite some time, and she was getting there but it was slow, slow, slow . . . . So everything was going to where this person could, with a little patience or coaching and some work, have a vaginal delivery without forceps assistance . . . . But [the doctor] wanted to teach someone under him how to use forceps . . . . I was really kind of like thrown back when the request was made for forceps. I was like, 'Forceps?'

At the time, Steve felt there was nothing he could do to change the series of events. Yet afterwards, he expressed his concerns and validated his perception of the situation with the physicians.

Creating woman-centered care in a medically focused environment. This theme reflected the nurses' descriptions of all barriers embedded in the system that prevented them from practicing woman-centered care and their struggle to overcome or minimize the barriers. The nurses' stories revealed barriers such as the routine and frequent use of medical interventions for all women, the power of doctors' orders that controlled basic nursing care, and staffing issues. The barriers limited the nurses' abilities to promote the woman's autonomy and offer choices, especially during labor and birth.

Claire described the medical environment that dictated routine care and impacted her relationships with the women, which are so important to providing woman-centered care:

> I'm in a very, very, very fast-paced environment . . . so most of the time I'm going to have two patients and they're usually on pitocin, which means I have 15-minute checks on both patients. So that doesn't leave me any real room to communicate and talk and try to get the comfort measures in and get a relationship going to where I could use any of that woman-centered things that we talked about. And at first when I was practicing it kind of, I was very discouraged . . . shoot, I don't even get a chance to influence these women because I'm so busy . . . . [The doctors] have standing orders. Everybody gets an IV, everybody gets continuous monitoring. And women give me their birth plans saying I want to get up and walk around and I'm like, I can't do anything for you. I have to call the doctor then at 2:00 in the morning because I work at night . . . the doctors are not happy. I cannot go and detach them from the monitor unless I have a doctor's order.

Like Claire, all nurses identified multiple barriers to what they believed were woman-centered care practices. They perceived they were unable to change many of these barriers. However, the nurses articulated ways how, in some instances, they were able to confront and overcome the barriers through acts of advocacy. Claire described how she helped couples who wanted natural birth:

> I act as a mediator between the couple and their doctor or the other nurses that they might come in contact with . . . . If I'm going on a lunch break I'll tell the nurse, 'Look, she really likes pressure on her back . . . she does not want to be offered the epidural. She does not want to be offered Demerol. Don't offer her that.'

Oftentimes, the barriers represented ethical dilemmas in which the nurses struggled in choosing actions and negotiating risks. Mary negotiated being a woman-centered childbirth educator for a hospital-based prenatal class that she believed was intended to prepare women and partners for the medical routines. Mary said the class content was designed to follow a core curriculum approved by the education committee at the hospital. Although she did not consider herself able to confront the committee or obstetricians on the committee to change the rules, she sought ways to teach woman-centered principles and empower women to ask questions. As Mary described:

> We're not supposed to be teaching about the philosophy of birth and birth plans anymore—it did not get approved [by the education committee]. I had a long spiel about birth plans and developing your own philosophy, personal philosophy for each woman. Well, I don't say that anymore. But when I get to the episiotomy or to the forceps, I kind of weave in [philosophy of birth choices]—in my own way.

All the nurses described ways they sought to humanize care within the existing framework of a highly medicalized environment where care options were restricted. The nurses' visions for improving women's experiences were contingent upon negotiating the barriers to woman-centered care.

Discussion and Implications

The nurses in this study experienced woman-centered care of childbearing women and babies through a sense of otherness in their world of nursing education and clinical experiences. The learning of woman-centered maternity nursing meant awareness that a woman-centered maternity nursing course and feminist ideology did not represent mainstream nursing education or maternity care within the community. As the nurses entered practice and continued to develop the everyday skilled know-how of being a maternity nurse, they learned the contextual nature of clinical care, the culture of the heath care system, and appropriate levels of patient involvement (Benner, Tanner, & Chesla, 1996). Within this continuum of development, the nurses continued to value the ideal of woman-centered care and attempted to find openings to practice as woman-centered nurses.

The nurses' stories described how the exposure to a woman-centered philosophy influenced them to practice differently in certain situations. Curriculum scholar Maxine Greene (1995) theorized that emancipatory education that focuses on lived situations and reflective encounters releases the imagination that can make "empathy possible . . . give credence to alternative realities . . . break with the taken-for-granted" (p. 3).

Raised critical consciousness was evidenced by the nurses' concern for social injustices and the effects of dominant childbirth practices on women's experiences. Greene (1988) believed such behaviors result from an awakened and active learner who has a conscious connection to the world and a personal sense of "what

ought-to-be." Nursing praxis was made possible as a result of their heightened consciousness of women's oppressions experienced in the dominant birth culture. The intentional actions of the nurses to change a usual birth position, value a birth plan, and consider cultural context were examples of participants seeking freedom from domination for women in their care. While their values and behaviors left the nurses with a perception of being different or other, this represents a sense of growth expected from an emancipatory educational experience, where learners can "become different . . . find their voice . . . and play participatory and articulate parts in a community in the making" (Greene, 1995, p. 132).

The findings of this study revealed that these nurses perceived barriers to practicing woman-centered care. The nurses' stories described health care systems that, for the most part, were not designed for woman-centered childbirth and newborn care. Their basic education in woman-centered maternity care was insufficient to help them overcome many barriers in the health care system. The barriers included staffing and work demands, power issues related to physicians' orders and routine policies, the highly medical environment that controlled women's choices and knowledge, and the professional development of the new graduate. The nurses were often too busy to connect with women to get to know women's desires or offer options. Many times the institutionalized barriers controlled what options the nurses could offer. In some instances, the nurses were afraid to confront a certain physician or lacked the professional development to know how to advocate for the woman.

The findings of this study indicated that continued development of advocacy and empowerment-building skills and a supportive environment are required for nurses to create woman-centered care. A limitation of the study is that the nurses who participated worked only with obstetricians and did not have the opportunity to interface certified nurse midwives who aim to use a midwifery model of care. At this stage of their development, the nurses were still having difficulty negotiating the highly medically focused environments. Nursing managers and preceptors in maternity settings need to facilitate the development of advocacy skills, assertiveness training, and collaboration with physicians. Likewise, nurse leaders, childbirth educators, and staff nurses in maternity practice must continue to work toward creating birthplaces where caregivers can connect with women and give the power of knowledge and options back to women, which is the heart of woman-centered care.

This study indicated the need to improve utilization of research by physicians, nurses, and childbirth educators to support appropriate childbirth options and to revisit childbirth education as a site for empowerment of women. Models of maternity care need further evaluation to understand ways a medicalized birth environment violates family-centered principles and woman-centered ethics. The nurses in this study often faced ethical dilemmas where they felt manipulation of medical procedures or lack of full informed consent was violating women's rights. This research suggests that nurses need clear and safe avenues for reporting, confronting, and changing practices that put women at risk or violate their right to be informed.

Foremost, the findings of the study illuminated the potential power of feminist ideology in preparing new graduates to become critically awakened to injustices in health care delivery, envision multiple possibilities, and strive to make a difference. As relatively new nurses, just beginning practice, they were keenly aware of ways the current health care system controlled women's childbirth and newborn care experiences. This supports the need for nursing education to continue to evaluate the benefits of integrating critical theory into mainstream curriculum and minimizing the sense of otherness that penetrated the education and practices of these nurses. Likewise, a need exists to continue to research the ways woman-centeredness improves women's care, including women's perspectives.

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