TITLE

Family centered nursing practices towards women and their families in the birthing context: A qualitative systematic review

ABSTRACT

Aim: Synthesize qualitative evidence examining how nurses' attitudes, beliefs, and sense of efficacy as well as the context surrounding birth facilitate or hinder family-centered nursing practice.

Design: Thematic synthesis of qualitative studies

Methods: A literature search was conducted in CINAHL, MEDLINE, PsycINFO, SCOPUS, SCIENCE DIRECT, REPÈRES, CAIRN, and ÉRUDIT from October 2020 to June 2021. The PRISMA guidelines were followed, and studies were critically appraised using the Critical Appraisal Skills Programme checklist. Data was extracted by two independent reviewers, and Thomas and Harden's qualitative thematic synthesis method was performed for data analysis.

Results: Thirteen studies were included. Three analytical themes were generated: 1) sharing power: opposing beliefs, 2) feeling a sense of efficacy in fulfilling one's role, and 3) managing a challenging work environment.

Patient or Public Contribution: Synthesizing nurses' experience is essential to promote implementation of favorable changes for care that is more focused on the needs of families.

Keywords: [‘Qualitative systematic review’, ‘nurses’, ‘Attitude of Health Personnel’, ‘Family Practice’, ‘Labor, Obstetrics’, ‘Nurse-Patient Relations’, ‘Psychological Power’, ‘Self-Efficacy’, ‘Workplace’]

Main paper

INTRODUCTION

For a couple, becoming parents is a profoundly important and life-changing event. The very experience of childbirth can have significant short- or long-term effects on the health and well-being of women and their families (Michels *et al.*, 2013). On the one hand, when women hold positive perceptions of their birthing experience, they develop positive feelings for their baby and have better self-esteem as mothers (Christiaens & Bracke, 2007; Goodman, Mackey, & Tavakoli, 2004; Nelson, 2003). On the other hand, if the experience turns out to be negative, the risk of postpartum depression (Bell & Andersson, 2016), symptoms of anxiety (Bell *et al.*, 2016) and post-traumatic stress is increased (Beck & Casavant, 2019). Likewise, early mother-baby relationship (Karakoç & Kul Uçtu, 2021), the desire to have another child (Larkin *et al.*, 2012) or the choice of procedures (e.g. cesarean) for future deliveries (Løvåsmoen *et al.*, 2018) are impacted. Worldwide, the prevalence of a negative childbirth experience is estimated at between 9% and 21% (Henriksen *et al.*, 2017; Smarandache *et al.*, 2016).

Several studies have examined the factors contributing to women's negative perceptions of the birth experience. Among these factors, one of the most important is health care professionals (HCP)' approach while providing intrapartum care (Donate-Manzanares *et al.*, 2019). Indeed, for women, the best and worst childbirth experiences are attributable to the attitudes and behaviors of HCP (Edmonds *et al.*, 2021). For example, the quality of interactions between health care professionals and women (Simpson & Catling, 2016), the lack of tact and sensitivity on the part of HCP as well as the use of rigid protocols

which restrict individualization of care (Donate-Manzanares *et al.*, 2019) contribute to women's negative perceptions of the birth experience'.

Background

In 2018, the World Health Organization (WHO) targeted women's childbirth experience as an indicator of the quality of intrapartum care. This indicator is based on the premise that all women (and their families) should receive intrapartum care that promotes a positive childbirth experience. To optimize the quality of the experience, WHO recommends that HCP adopt a woman- and family-centered approach to care that takes into account women's personal and sociocultural beliefs and expectations, provides a clinical and psychologically safe environment, encourages partner presence, supports women's participation in decision-making, and ensures effective communication (World Health Organization, 2018). According to this type of approach, HCP no longer assume the role of expert in their interventions, but rather a supportive role in line with the needs, objectives, values and expectations of women and their families (Institute for Patient- and Family-Centered Care, 2017; Public Health Agency of Canada, 2018; World Health Organization, 2018). Since nurses are the professionals in attendance for most births, their approach can have a significant impact on the birthing experiences of women and families. They are therefore in a unique position to meet families' needs and serve as the primary link in the exchanges.

Despite efforts to integrate approaches of care centered on the woman and the family in the context of birth, it is possible to observe that the approach of nurses caring for women

and families does not always meet their needs. Faced with the consequences on the psychosocial health of women and families, and the scale of the phenomenon, it becomes imperative to look at professional nursing practices. As nurses' perspectives on their approach to care are poorly empirically documented, it highlights the importance of synthesizing current data to shed new light on nursing practice at the time of birth. Knowledge generated by such a review could help improve nursing care, contributing to promote positive childbirth experience for women and their families. Therefore, this review aims to synthesize qualitative evidence examining how nurses' attitudes, beliefs, and sense of efficacy as well as the context surrounding birth facilitate or hinder woman- and family-centered nursing practice.

THE REVIEW

Design

A thematic synthesis of primary qualitative studies on the phenomenon was developed to identify, analyze, and synthesize their results in order to construct and present a new interpretation. Thematic synthesis allowed new knowledge to emerge that goes beyond the conclusions of previous studies (Thomas & Harden, 2008). The ENTREQ (Enhancing Transparency in Reporting the Synthesis of Qualitative Research) guidelines were used in the development of this review (Tong, Flemming, McInnes, Oliver, & Craig, 2012).

Search methods

The Population, Context, Outcomes (PCO) format served to formulate the research question and determine the keywords (Butler, Hall, & Copnell, 2016). Each part of PCO

in this study was as displayed in Table 1. The bibliographic research was carried out in five English-language databases (CINAHL, MEDLINE, PsycINFO, SCOPUS, and SCIENCE DIRECT) and three French-language databases (REPÈRES, CAIRN, and ÉRUDIT) between October 2020 and June 2021. The "CINAHL Headings," "MeSH," and "APA Thesaurus" enabled the validation of the choice of keywords, and the particularities of each of the databases were considered. The Boolean operators "OR" and "AND" were used to distinguish synonyms and to combine terms. Word truncation made it possible to capture all spelling and ending possibilities (Aromataris & Riitano, 2014; Butler *et al.*, 2016). For example, the following combination of keywords was used to search the CINAHL database: Nurse* AND (attitude* OR "nurse attitude*" OR behavior* OR "self-efficacy") AND (labor OR childbirth OR birth OR "delivery, obstetrics") AND ("nurse-patient relations" OR "professional-family relations" OR "labor support" OR "intrapartum care"). Variant of keywords were used to perform the search such as "experiences", "views", and "perceptions", but were not selected as they restricted the search.

Search outcomes

To be included in this thematic synthesis, the selected studies had to meet the following criteria: 1) be published between January 1, 1990, and June 30, 2021, to produce a complete portrait of the phenomenon because nursing support has been a subject of interest since the beginning of the 1990s; 2) supported the nurses' point of view; 3) examined nurses' attitudes, beliefs and sense of efficacy about their caring approach to women and families or any element of the birthing context that may facilitate or hinder

woman- and family-centered care (in this review, "woman and family-centered care" refers to an approach where nurses individualize care for women and families. Thus, they support them according to their specific needs rather than positioning themselves as an expert in their health situation (Institute for Patient- and Family-Centered Care, 2017)); 4) presented primary research that used a qualitative method of data collection; 5) be published in English or French, as these were the languages mastered by the reviewers; 6) be peer-reviewed and included an abstract. As the objective of this review was to analyze nursing practices, only studies including the nursing population were retained. Those targeting several types of professionals including nurses were selected if nurses' point of view could be distinguished from that of the other professionals. Studies that incorporated the perspectives of both parents and professionals were also included if they could be distinguished from each other. In addition, the context for studying nurses' perspectives concerning their practice with families had to focus on the time of birth. Therefore, studies relating to the postnatal period or other contexts of perinatal care such as perinatal loss were excluded.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram presents the different stages of selection of studies, the results of which are shown in Figure 1 (Moher, Liberati, Tetzlaff, Altman, & Group, 2009). A total of 1,503 references were collected, including publications manually obtained from the reference lists of retained articles. Article references were imported into Endnote X9 software, and duplicates were removed. The remaining 1,281 results were independently sorted by two reviewers (XX, first author; XX, second author) by considering the title and abstract of

articles based on the inclusion and exclusion criteria of the search strategy. Consequently, 1,244 publications were excluded because they did not meet the eligibility criteria. Subsequently, a second sorting was conducted, and the 37 eligible articles were read in their entirety by the same two reviewers (XX, first author; XX, second author) independently. At this stage, 24 articles that did not meet the eligibility criteria were excluded, while 13 articles were selected for thematic synthesis (to know the reasons for excluding articles, refer to the PRISMA diagram). All of the articles selected were in English. The contribution of a third reviewer (XX, third author), an expert in the field, helped resolve disagreement over the admissibility of one article.

Quality appraisal

To assess the quality of the selected studies, the criteria of the Critical Appraisal Skills Programme (CASP) for qualitative study were used (Critical Appraisal Skills Programme, 2018). The 10 criteria of this tool were independently assessed by two reviewers (XX, first author; XX, second author) for each of the selected studies by answering "yes," "no," or "cannot say", and then compared. Any conflicting assessment was resolved by discussion between reviewers. To be included in the review, studies needed to be allotted “yes” for at least seven criteria. Following quality appraisal, no study presented enough concern for the research team to consider excluding it from the analysis. The criteria of the tool and the results of the study quality assessment are presented in Table 2.

Data abstraction and Synthesis

To examine the relevance and adequacy of the data to be included in this thematic synthesis, the characteristics of the studies were extracted and organized in a table (Table 3). The following data were collected for each study: name of the first author, year and country of publication, study aim, design, sample characteristics, and data collection and analysis methods.

The approach of Thomas and Harden (2008) was chosen to synthesize the data collected from selected primary studies. This approach is a process of identifying and developing themes in three stages which makes it possible to generate new interpretations constructs, new explanations or hypotheses on the phenomenon studied. The NVivo20 qualitative data analysis software was used for data management and analysis. 1) First, a reviewer (XX, principal author) coded the text line by line in an inductive manner to capture the meaning of each sentence. The codes were then assembled by similarities and differences according to a tree structure. This process made it possible to develop the descriptive themes. At this point, the synthesis produced was similar to the results found in the studies included in this review. 3) To go "beyond" and meet the objective of this research, the reviewers interpreted, based on descriptive themes, how nurses' attitudes, beliefs, and sense of efficacy as well as the context surrounding birth facilitate or hinder person- and family-centered nursing practice. This step made it possible to generate the analytical themes and to produce new interpretations of the phenomenon of interest. To ensure process integrity, a second reviewer (XX, second author) read and reread the data, double-checked the codes, and validated the themes. Integrating a third reviewer (XX, third

author) into the team increased code consistency and the validity of both descriptive and analytical themes. Discussion among the reviewers resolved any disagreements (Bradley, Curry, & Devers, 2007).

Ethics

This review was exempt from ethical approval. Information regarding ethical approval was not indicated for one of the selected studies (Dalton, Pjesivac, Eldredge, & Miller, 2021). All others have been approved by an ethics committee.

RESULTS

Study characteristics

This thematic synthesis included 13 qualitative studies and involved 694 nurses from three countries: United States (n = 7), Canada (n = 4), and Brazil (n = 2). The included studies had heterogeneous research designs and most used interviews for data collection methods. Table 3 presents detailed characteristics of these studies.

Thematic synthesis findings

Synthesis of the results of the studies reviewed allowed the construction of six descriptive themes. From these themes, three analytical themes were generated: 1) sharing power: opposing beliefs, 2) feeling a sense of efficacy in fulfilling one's role, and 3) managing a challenging work environment. Figure 2 shows how nurses' beliefs about power, their sense of efficacy in fulfilling one's role and their work environment have an impact on their attitudes towards women and the type of support they offer them.

1) Analytical theme: Sharing power: opposing beliefs

This analytical theme presents two opposing views nurses had about the sharing of power during the birth experience that affected the attitudes they adopted with women. It explains the following two descriptive themes: believing that women are the experts in the birth experience and believing that nurses are the experts in the birth experience.

Descriptive theme: Believing that women are the experts in the birth experience

Some nurses reported the importance of taking a moment with the woman and her partner as soon as they arrive at the birthing unit to determine their expectations regarding the birth experience and the nurses who will accompany them (Duarte *et al.*, 2020; Goldberg, 2005; Knox, Rouleau, Semenic, Khongkham, & Ciofani, 2018). This discussion enabled nurses to base their work on the couple's goals (Duarte *et al.*, 2020; Lyndon, Simpson, & Spetz, 2017). Therefore, nurses believed it is important to recognize the individuality of women (Goldberg, 2006). Every woman was perceived as different and with unique needs. Her preferences were not seen as an interference in the work of nurses but, rather, as engagement in the birth process (Duarte *et al.*, 2020; James, Simpson, & Knox, 2003). In this sense, nurses said they do not try to negotiate or alter the woman's subjective experience (Goldberg, 2006). They were attentive, fully present, and respectful of the desires of the other person, while presenting her with fair and impartial information (Carlton, Callister, Christiaens, & Walker, 2009; Goldberg, 2005). When they disagreed with the woman's decisions, they tried to put themselves in her shoes to see the situation from another point of view. This desire to understand the other created openness and a judgment-free space (Duarte *et al.*, 2020; Goldberg, 2006). In addition, some nurses reported being aware of the power they had over others and recognizing that the woman

was in a vulnerable position (Carlton *et al.*, 2009; Goldberg, 2005; James *et al.*, 2003). Therefore, they upheld the importance of their role in defending the interests of the women with other professionals (James *et al.*, 2003; Knox *et al.*, 2018).

> "I have tried to learn from women, and they have taught me many things. Like they amaze me, women are wonderful creatures, just the fact that we give birth, the human body is simply amazing." (Nurse Jessica) (Goldberg, 2006)
>
> "Every woman is different, and you just never know what they can do until you let them do it." (James *et al.*, 2003)

Descriptive theme: Believing that nurses are the experts in the birth experience

Conversely, other nurses believed that women must rely on professionals' expertise (Dalton *et al.*, 2021; Jacobson, Zlatnik, Kennedy, & Lyndon, 2013; James *et al.*, 2003; Lyndon *et al.*, 2017; Simmonds, Peter, Hodnett, & McGillis Hall, 2013). They said women were not always in a good position to make decisions and that this sometimes even endangered their own safety or that of the baby (Jacobson *et al.*, 2013). These same nurses tried to negotiate the plan of care with the woman through persuasion (Simmonds *et al.*, 2013). Although they recognized the importance of including a woman's perspective in care, they did not feel obliged to comply with requests if they seemed unreasonable or possibly endangering the safety of the mother or baby (Dalton *et al.*, 2021; Lyndon *et al.*, 2017). Responding to women's demands was important if they were within safety limits and did not obstruct the nurses' work (James *et al.*, 2003; Simmonds *et al.*, 2013). Likewise, some nurses excluded women from decisions, explaining that the fetus was in control of the birth process. Thus, they limited women's options while

encouraging them to be "open-minded and flexible" (Simmonds *et al.*, 2013). They also mentioned finding it difficult to deal with families who wanted to control the labor process (Simmonds *et al.*, 2013), and perceived this as a lack of confidence towards them (Dalton *et al.*, 2021). In addition, nurses seemed to have clear expectations about women's behavior, i.e., being polite, kind, and altruistic (Simmonds *et al.*, 2013). Simmonds *et al.* (2013) also stated that the experience was sometimes considered secondary, as the important thing was to have a healthy baby. Given that nurses perceived childbirth as a risky event and that safety must be ensured, the information given to women was sometimes manipulated to preserve cooperation or even trust between the physician and the woman (Jacobson *et al.*, 2013; Lyndon *et al.*, 2017).

> "… really what this is all about is getting out a healthy baby. It's not about a huge birth experience… I want people to clearly understand that the process doesn't matter… There's really no such thing as "natural childbirth"… All we're doing is catching a baby–that's all we're doing." (Simmonds *et al.*, 2013)
>
> "Years ago, I had a mom give me a birth plan that was really not a good birth plan. Like if you have to resuscitate my baby, I want you to do it on my chest. You can't do CPR on somebody's chest. […] It's got to be their way, or no way, very distrusting […] The husband kept quoting the World Health Organization studies […] it was almost like they didn't trust the doctor and the nurses." (Nurse Helen) (Dalton *et al.*, 2021)

2) **Analytical theme: Feeling a sense of efficacy in fulfilling one's role**

This theme involves nurses' perceptions of their sense of efficacy in exercising their role with families and explains the following two descriptive themes: having professional autonomy, the freedom to act that makes all the difference, and taking care of a woman in pain, an art that can be learned with experience.

Descriptive theme: Having professional autonomy, the freedom to act that makes all the difference

Certain studies addressed the importance of nurses' autonomy in the performance of their duties (Jacobson *et al.*, 2013; James *et al.*, 2003; Simmonds *et al.*, 2013). When they were able to exercise their autonomy, nurses said they felt efficient, supportive, and capable of making a difference (Sleutel, Schultz, & Wyble, 2007). Moreover, this autonomy allowed them to exercise their role of defending the woman's interests (James *et al.*, 2003). They felt frustrated when this autonomy was not granted to them and mentioned that this could also lead to interprofessional conflicts, particularly with physicians. It was difficult for nurses to ignore the woman's requests in order to respect the physician's instructions, with which they did not always agree (Sleutel *et al.*, 2007). Therefore, they said they tended to avoid such interprofessional conflicts (Simmonds *et al.*, 2013) but nevertheless tried to respond to women's expectations without going against the physician's orders. To avoid conflict, nurses sometimes faded into the background, and women paid the price (Glenn, Stocker-Schnieder, McCune, McClelland, & King, 2014; Simmonds *et al.*, 2013). Nurses also revealed that they felt they must please everyone—women, physicians, and colleagues—and that it was not always easy to sort out the different requests (Carlton *et al.*, 2009; Jacobson *et al.*, 2013; Simmonds *et al.*, 2013).

> "We have a lot of freedom on how we manage our labor patients and I think that the doctors for the most part, trust our judgment, unless there's a problem. They just kind of stand back and wait to hear from us. We call them when we're ready." (James *et al.*, 2003)
>
> "If I encourage or permit a woman to push in any other way than 10-second Valsalva, the physician would question my abilities in front of the patient." (Sleutel *et al.*, 2007)

Descriptive theme: Taking care of a woman in pain, an art that can be learned with experience

Nurses believed that experience allows them to integrate all facets of the nursing role and thus adopt fair and sometimes even intuitive intervention strategies with women (James *et al.*, 2003). Experience gave them confidence in their interventions, and they often spoke of their "bag of tricks," a repertoire of supportive interventions based on years of practice and skills development (James *et al.*, 2003). Conversely, many reported a lack of confidence in supporting women who wanted to give birth naturally (Knox *et al.*, 2018). They considered the cause to be a lack of training and low exposure to physiological childbirth (Carlton *et al.*, 2009; Knox *et al.*, 2018). Some had gone so far as to say they felt completely useless (Knox *et al.*, 2018). On another note, some nurses became more comfortable in their practice or learned to adjust based on feedback on their care from families. Indeed, when families expressed that the nurse made a difference in their experience, the nurses felt valued (de Souza, Ferreira, Barbosa, & Marques, 2013; Glenn

et al., 2014; James *et al.*, 2003). Otherwise, they sometimes felt guilty and powerless and sought the source of this dissatisfaction (Goldberg, 2006; Simmonds *et al.*, 2013).

> "I know from experience that the most important tool is your hand. You have to lay your hands on the abdomen to feel what's going on. Then you have to use your ears to listen to the patient." (James *et al.*, 2003)
>
> "A barrier to providing supportive care is education of the nurse. Many of the nurses could be better trained in therapies: What to do to help with their [patient's] comfort level and what to do when they hit certain stages." (Carlton *et al.*, 2009)

3) Analytical theme: Managing a challenging work environment

The work environment for nurses can both facilitate and hinder person and family-centered practices. This analytical theme explains how a high and complex workload as well as team building impact the support offered to families by nurses.

Descriptive theme: Managing an increasingly high and complex workload

The heavy workload as an obstacle to supportive activities came up time and time again in the discourse of nurses (Carlton *et al.*, 2009; Glenn *et al.*, 2014; Sleutel *et al.*, 2007). Although the task of providing physical and psychological support was a priority for nurses, it was the first to be neglected when the workload was too high (Lyndon *et al.*, 2017). To control the volume of work and compensate for their lack of presence with women, nurses advocated the use of technological tools such as continuous fetal monitoring to ensure the monitoring of fetal well-being (Carlton *et al.*, 2009). In addition, during busy periods, they suggested that women take the epidural because, in their opinion, a medicated woman required less care (Carlton *et al.*, 2009; Knox *et al.*, 2018).

Paradoxically, nurses worried about this increased and routine use of obstetric interventions in the context of birth (Carlton *et al.*, 2009; Jacobson *et al.*, 2013). In fact, they felt that these interventions contributed to dehumanizing care and reducing the time spent with women (Goldberg, 2005; James *et al.*, 2003). In addition, nurses believed that if they had access to more tools, their job would be easier. For example, they wished clearer guidelines for when the epidural should be administered, material to support physiological childbirth, and better adapted infrastructure (Knox *et al.*, 2018; Sleutel *et al.*, 2007).

> "I think of all the little details that have to be attended to, written down, taken care of, from the patient's point of view. It seems like the complexity of the patients is increasing, which then increases the complexity of the nursing care you provide." (Glenn *et al.*, 2014)

> "Sometimes you feel like that you can't give the best care that you would like to. You're only one person. You can't be two places at once. The other night I was juggling three or four [laboring women], and two went complete at the same time." (Carlton *et al.*, 2009)

Descriptive theme: Engaging in team building

Teamwork improved the coordination of care and promoted a stimulating work environment (Simmonds *et al.*, 2013; Sleutel *et al.*, 2007). Nurses reported the importance of stable work teams for developing intimacy and complicity among members (de Souza *et al.*, 2013). Knowing the strengths and weaknesses of one's colleagues was very reassuring and increased the performance of members (de Souza *et al.*, 2013; Glenn *et*

al., 2014). The integration of new members into the team was sometimes seen as a challenge, as they needed to gain confidence and develop a sense of belonging (Simmonds *et al.*, 2013). Mentors strongly influenced the practice of young nurses, however peer pressure could be very important depending on the culture of the unit (Carlton *et al.*, 2009). If they were criticized for the time they spent with women in the birthing room, some succeeded in modifying their practices to conform to the standard imposed by their peers (Carlton *et al.*, 2009; Simmonds *et al.*, 2013). Others became frustrated if they noticed that colleagues were neglecting the supportive task with women; they saw a lack of professionalism (Lyndon *et al.*, 2017; Sleutel *et al.*, 2007). In addition, trying out new ideas was sometimes a source of conflict and frustration, in that some nurses found there was a lack of willingness to innovate on the part of colleagues, which they described as resistance to change (Sleutel *et al.*, 2007). In short, sharing a similar vision of care in a birthing unit remained an important communication challenge (Jacobson *et al.*, 2013).

> "I've been on teams where working together really makes a difference… sometimes, even though the monitors are beeping and clearly, like, the baby's in trouble. Nobody will go into the room… I'm the one that's going in… It's like they all disappear… I worked on another team where, y'know, the alarm goes beeping and you've got five nurses beside you suddenly, right? I didn't ask for them, they just like, all come into your room for help… that that's kind of nice. You know that you're being well supported and that, if anything happens you can rely in them to come and help you." (Simmonds *et al.*, 2013)

> "Another frustration is the same nurses who refuse to continue educate themselves and are stuck on old ideas/skills. I feel that our patients deserve better than that." (Sleutel *et al.*, 2007)

DISCUSSION

This thematic synthesis aimed to identify, analyze, and synthesize qualitative evidence of primary studies to better understand how nurses' attitudes, beliefs, and sense of efficacy as well as the context surrounding birth facilitate or hinder person- and family-centered nursing practice. The three analytical themes generated by this thematic synthesis made it possible to reflect the perspective of nurses concerning their own professional practice in the context of birth.

First, the results of this study showed the duality of beliefs held by nurses regarding the sharing of the power to act in their relationships with women. These findings were consistent with the empirical evidence on power in nursing. In fact, power is naturally conferred to nurses, given the professional position they occupy (Baptista, Santos, Costa, Macêdo, & Costa, 2018; Delmar, 2012). As a result, the nurse–patient relationship is asymmetrical, and this imbalance places the patient in a situation that leaves little room for self-determination (Baptista *et al.*, 2018; Delmar, 2012). However, providing person- and family-centered care implies that the power to act is given back to families, thereby allowing them to assume control of their experience (Delmar, 2012; Molina-Mula & Gallo-Estrada, 2020). For families to exercise this power, nurses must first admit their control over the other (Oudshoorn, 2005), a fact that many are uncomfortable recognizing. Therefore, the results of this thematic synthesis showed that some nurses came to

recognize their position of power, and when this was the case, they were able to respect the subjectivity of the other and better meet the woman's needs. However, when they believed they were best placed to decide on a woman's behalf, they oftentimes acted regardless of the needs expressed by the woman. In addition, it is important to link these results with studies dealing with women's satisfaction with the birth experience. Indeed, control over the experience seemed to be a determining point for these women to be able to qualify their experience as positive or negative (Baxter, 2020; Fair & Morrison, 2012). It is therefore appropriate to concede that nurses' beliefs about power can both facilitate, and hinder nursing practice centered on the needs of women and families.

Autonomy and professional experience are two elements mentioned by the nurses in this study as having an impact on their sense of effectiveness in fulfilling their role. First, nurses described autonomy as essential to their advocacy role with women, and they found it difficult to be restricted in their actions when faced with certain medical decisions. An integrative review of the literature on nurses' professional autonomy confirms this perception (Pursio, Kankkunen, Sanner-Stiehr, & Kvist, 2021). The sharing of leadership and inter- and intra-professional collaboration are considered as important factors that can either facilitate or limit nurses' autonomy (Pursio *et al.*, 2021). Establishing collaborative and trusting relationships between physicians and nurses has a major impact on the agency of the professional nursing role (MacDonald, 2007). Second, work experience, or lack thereof, affected nurses' sense of effectiveness in carrying out their role. This is consistent with the results of other studies arguing that the more

experience nurses have, the more they can develop their support skills and the more confidence they have in their interventions (Barrett & Stark, 2010; Makarem *et al.*, 2019). The issue of challenges related to the work environment was also addressed by this study' results. Indeed, nurses believed that their high and complex workload contributed to reducing the time they spent providing physical and psychological support to women. Henriksen *et al.* (2017) corroborated these results, as the women interviewed in their study said they lacked support during labor and delivery and time with the nurse to have their questions answered. These women were less satisfied with their birth experience. Moreover, the studies by Kutney-Lee *et al.* (2009) and O'Connor, Ritchie, Drouin and Covell (2012) clearly associated the nurse's workload with patient satisfaction. Therefore, the results of this thematic synthesis showed the importance that the nurse workload be assigned according to the time needed to provide physical and psychological support to the woman and the family. Finally, the nurses participating in this research explained how team cohesion contributed to the improvement of care as well as to the accomplishment of daily tasks. These comments are corroborated by other studies that strongly linked effective teamwork to the quality of care (Clark, 2009; Goosen, 2015). The nurses in this research also experienced team difficulties concerning the integration of new members, the lack of professionalism and the resistance to change of their colleagues. This discourse suggests that team members had different views of care. Sharing a common goal is an essential attribute of teamwork (Rosengarten, 2019). When some members work according to their own ambitions or have different values, teamwork suffers greatly (Moore, Prentice, & McQuestion, 2015; Rosengarten, 2019).

Implications

This new perspective on nursing practice in the context of birth has important implications in various areas of the nursing discipline. First, at the practice level, nurses must increase the empowerment of women and families. To better meet their needs, nurses must be sensitive to the specific situation of each family and promote their participation in decision-making in order to give them back some control over events. Nurses must then be open, fully present and respectful of the desires of the other.

With respect to training, the results showed that nurses with little experience often felt useless and required more preparation to support women in labor. Therefore, it is necessary for all nurses to receive adequate training and preparation to practice with families in the context of birth. In addition, the results showed that nurses had certain difficulties establishing collaborative relationships with their colleagues, especially with physicians. To evolve in a work environment where relationships are very complex, nurses must develop more negotiation, mediation, and conflict resolution skills.

As for the managers of birth units, the results indicated that they must aim to improve team dynamics and communication to give each member the freedom to challenge decisions and to exercise their role effectively. This can be achieved by providing various opportunities for professional development, and by developing clear guidelines on interdisciplinary collaboration. For example, to improve communication within teams, simulations with the various professionals involved with women and their families are proving to be an effective strategy (Clark & Lake, 2020) . The nurse–family ratio must

also promote the safe care of families. These actions improve the work environment and, as a corollary, women's satisfaction with their birth experience (Lyndon *et al.*, 2012).

Finally, it is necessary to conduct primary research on the perspective of nurses concerning their practice in the context of birth. This phenomenon has clearly been under studied, given the small number of studies identified in this review. A suggestion for future research would be to broaden the focus to family care, rather than focusing only on women. In addition, studying the relational experience of nurses with women and families could shed new light on the phenomenon.

Limitations

The results of this thematic synthesis must be considered in the context of its limitations. Indeed, although a family perspective was sought, it became clear that the studies conducted to date have focused solely on the care offered to mothers without taking the family perspective into account. As proof, no study identified the couple or the father as the target of care. This factor restricted the exploration of the studied phenomenon because the lack of data on nurses' experiences with families does not reflect the complexity of practice. In addition, two quantitative studies that addressed the perspective of nurses on their practice were excluded owing to the nature of this review (Miltner, 2000; Payant, Davies, Graham, Peterson, & Clinch, 2008). Their exclusion may have reduced the understanding of the phenomenon under study. Including studies focusing on other perinatal care contexts, such as postpartum care or perinatal bereavement, could have broadened our understanding of the phenomenon. The authors have chosen to focus on the moment of birth since a unique intimacy between the nurse and the family is

created at that period, that differs from other contexts. Finally, all studies included in this review were conducted in three specific countries (USA, Canada and Brazil). Our results may be characteristic of the nursing realities of these geographic regions and may not be transferable to other settings.

CONCLUSION

This thematic synthesis of qualitative studies highlights the relevance of focusing on nurses' experience to better understand what is affecting provision of woman- and family-centered nursing care in the context of birth. The key findings suggest that nurses' beliefs about sharing power with women, their sense of efficacy in fulfilling their role, and challenges related to their work environment contribute to the provision of high-quality intrapartum nursing care. The results of this review can thus serve as a framework for improving nursing care so as to promote a more positive childbirth experience. In a context where the negative perception of a birth experience has important psychosocial consequences for families, this review invites HCP to reflect on the space created for mental health protection in the care offered to women and their families at the time of birth.

Conflict of Interest statement

No conflict of interest has been declared by the authors.

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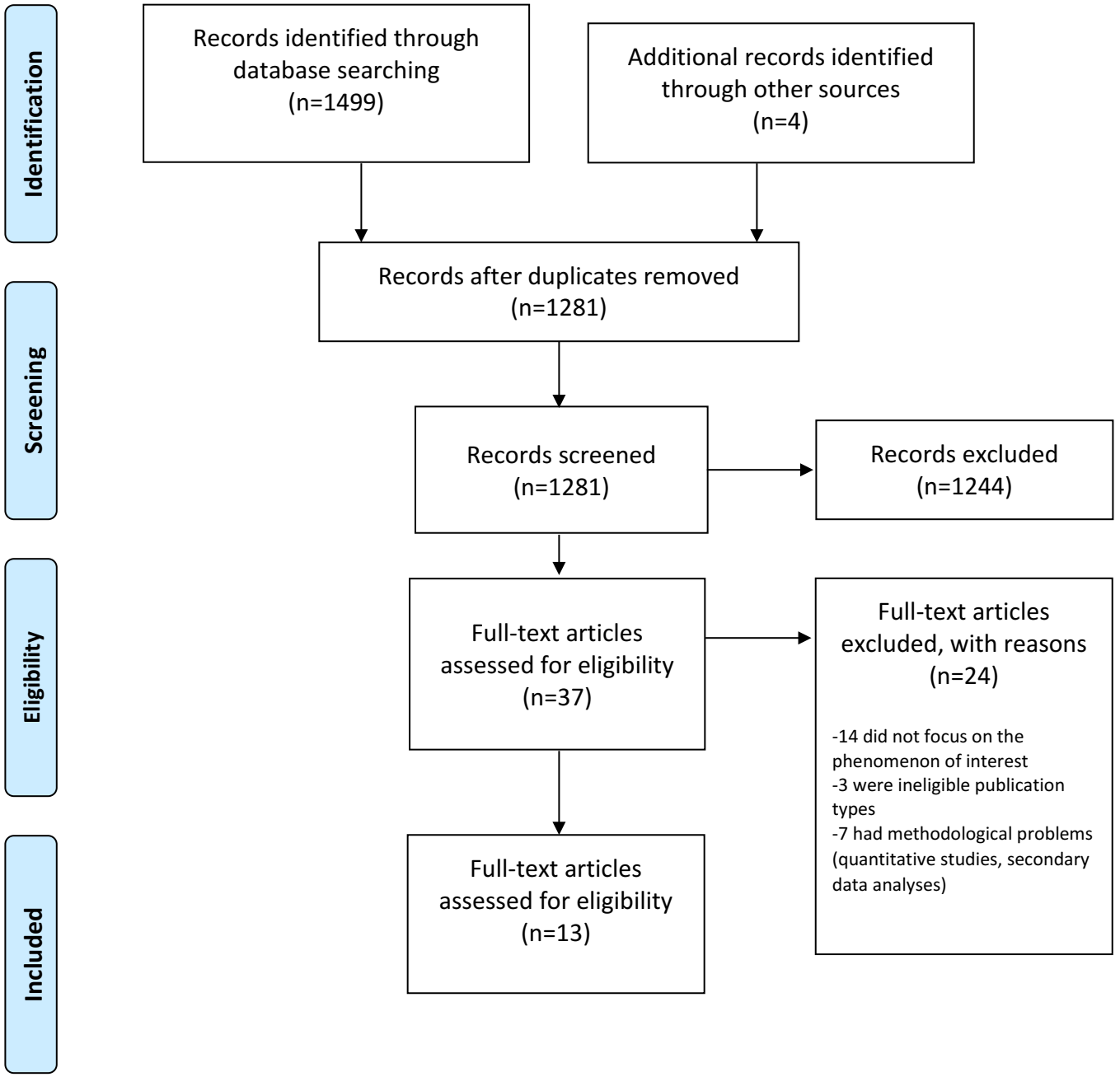
Table 1 PCO search tool

PCO	Search
Population	Nurses
Context 1	Attitudes, beliefs, behaviors, sense of self efficacy
Context 2	Labor, birth, childbirth
Outcomes	Nurse-patient relationship, nurse-family relationship, labor support

Figure legends

Figure 1. PRISMA diagram: study selection process (Moher et al., 2009)
Figure 2. Nurses' personal characteristics and context surrounding birth that contribute to a nursing practice centered on a family perspective



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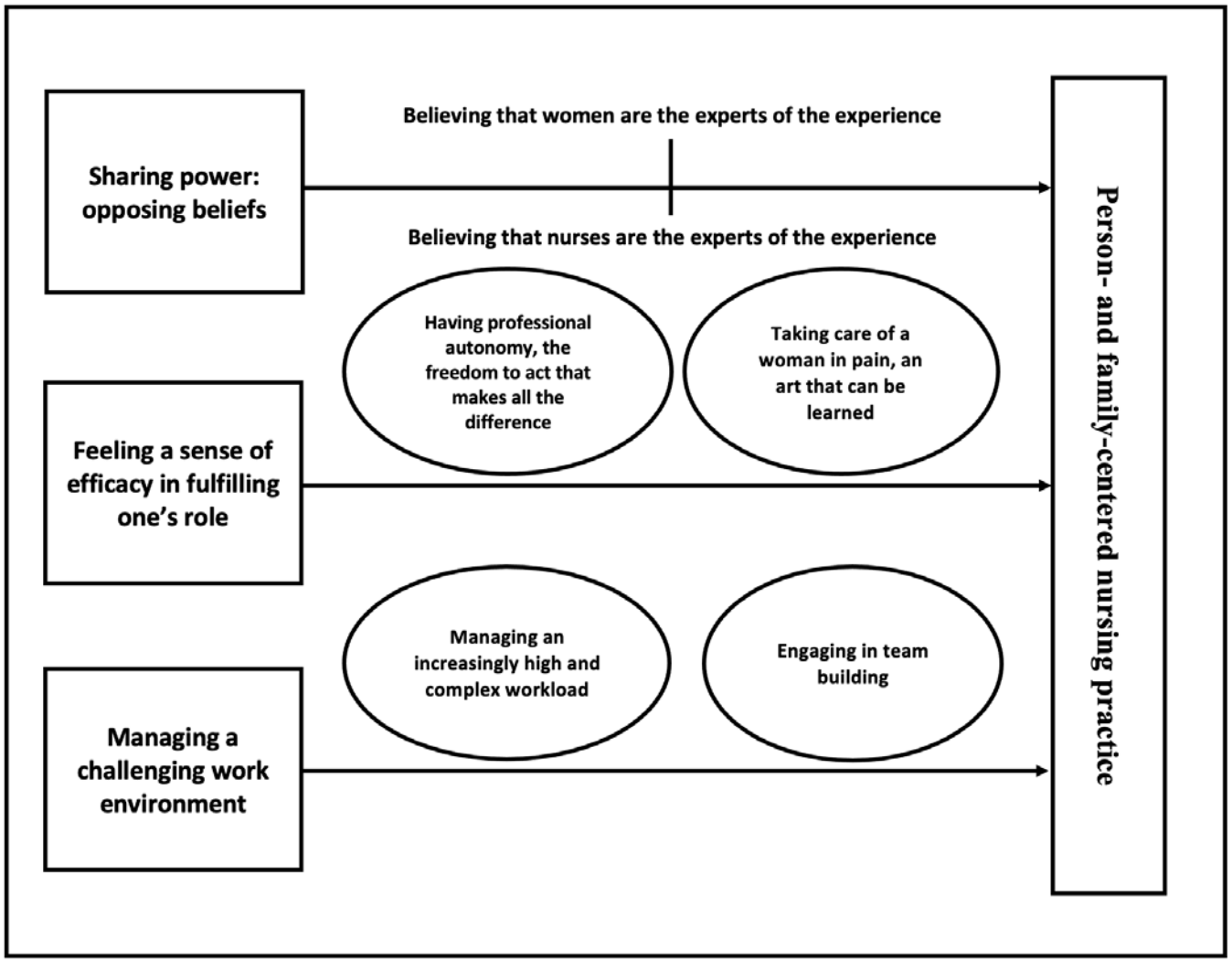

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