

# **Midwives' Experiences of Labour Care in Midwifery units.**

## **A qualitative interview study in a Norwegian setting.**

### **Introduction**

In economically developed countries, Norway included, hospital medicalised births are the norm (1, 2). Modern medicine and improved standards of living have saved countless lives during the birthing process, and giving birth in Nordic countries is regarded as safe (3). However, considerable concerns regarding the various implications of medicalised birth have been highlighted (4-6). The aim of the Norwegian government and health authorities is to maintain different birth settings and differentiated care (7, 8). Nevertheless, smaller units are disappearing and births are becoming both more centralised and medicalised over time (2).

Norwegian midwives are mainly trained and work in obstetric units. Practising midwifery in such units has been studied and has been described as a struggle between different paradigms and belief systems, namely, differences between biomedical/technocratic and physiological/normal/natural/holistic understandings of birth (4-6, 9, 10). However, there is no mutual understanding or consensus among midwives regarding what a normal birth actually is (9, 11).

Midwives' experiences with midwifery care have been explored in other countries. These settings require midwives to be trained in the skills of normal birth (12-14). Care in midwifery units is associated with promoting the midwife-mother relationship, facilitating a sense of higher satisfaction and autonomy for both mothers and midwives (13, 15-19). An American study noted that midwives' experiences of the birth centre atmosphere are described as relaxing, quiet, and less restricted with respect to time and guidelines (20). A British report which explores hospital alongside midwifery units, shows that philosophy and practice are closely interrelated and have significant value for midwives and that working in this kind of units enhances their autonomy (21). Furthermore, it has been argued that midwives who choose to practice in birth centres are a special group of individuals who are seeking an accepting and positive culture and desire to work according to a woman-centred philosophy (19). However, distressing factors are also reported from this type of work, such as the loss of obstetric skills, concern about burnout in a high-demand service, and lack of support from midwifery leaders (12, 13). How midwives experience the shift from the obstetric unit to midwifery unit in a Norwegian context is an unexplored field of research. To the best of our knowledge, no previous study has explored this aspect.

In order to enhance clarity, this paper will use the terminology freestanding midwifery unit (FMU) and hospital alongside midwifery unit (AMU), since birth centre may refer to both (21).

## **Methodology and methods**

### **Aim**

The aims of this study were to explore the experience of midwives who started to work in AMUs or FMUs and examine how they experienced labour care in this new setting.

### **Methodology**

An exploratory design with a phenomenographic approach was chosen to explore and describe the variations in midwives' experiences of beginning work in AMU/FMU (22). Phenomenography was developed in Sweden in the 1970s by Marton and was derived from pedagogic research. It is described as an empirical study of the qualitatively different ways in which various phenomena in, and aspects of, the world around us are experienced, conceptualised, understood, perceived, and comprehended (22). A main concern regarding credibility in a phenomenographic study is the relationship between the data and the descriptive categories (23).

### **Methods**

In phenomenographic research, the preferred data collection method is semi-structured interviews with a few initial questions (23). The interview questions were as follows: 1) Can you describe what it was like for you to start working in a midwifery unit? and 2) How would you describe working with labouring women in this setting? The questions were developed based on the aim of the study.

### **Research context**

FMUs offer care during pregnancy for healthy women who expect normal births and want to give birth in a FMU. They also offer postnatal care and some of them provide counselling on women's health issues. The AMUs mainly offer labour - and postnatal care to healthy women and their babies. During birth women have access to non-pharmaceutical medication (and nitrous oxide) and one-to-one support by midwives and their birth supporter. Caesarean section is not available, and some midwives are trained in the procedure of performing a ventouse extraction. The guidelines for admittance and care are negotiated with the host obstetric unit. In FMUs, a general practitioner (GP) may be available if she/he is not occupied elsewhere. She/he can e.g. treat a sick infant or a mother with post-partum haemorrhage, but the GPs are generally not trained in obstetric care. In addition, training in midwifery units is not a required part of midwifery education in Norway. Births in all units are completely funded by the government. There is no official available record for the total number of births that occur in FMUs and AMUs, but less than 1 % (5-600) of mothers gave birth in FMUs in 2012. Currently, there are approximately ten FMUs in Norway and presumably less than five AMUs. The actual number of AMUs is not available because there is no official record of these units.

### **Participants**

We recruited ten participants who had worked in obstetric units prior to beginning their employment in AMU/FMU. They were recruited by phone calls to AMUs (n=5) and FMUs (n=5) with at least 100 births/year, and further in accordance with strategic sampling (24). We presented our purpose for calling to the midwife (not necessarily a leader), answering the phone and asked if she could assist in approaching midwives working in the AMU/FMU. Hence, using snowball technique we phoned midwives as suggested by their colleague. All who were approached agreed to be participants and all who were approached agreed to participate. The locations of the AMU/FMU were both rural and urban. All of the participants who were asked were willing to participate. The midwives were all very experienced, with at least ten years of training. All of them had worked in the AMU/FMU for at least six months, and some of them

had worked there for more than ten years. Eight of the participants in this study had a choice about where to work, i.e., obstetric unit or AMU/FMU, because they were both conveniently located.

### **Data collection**

Data collection occurred during 2010 in the midwives' homes, another private setting, a meeting room in a AMU/FMU or a university, based on the midwives' preferences. The interviewer (first author) is educated as a nurse-midwife (BSc) and sociologist (M.S.Sc), and she has 7 years of experience as a midwife in both obstetric units and FMU. The interviews lasted 60-150 minutes and were audio-recorded and transcribed verbatim. Anonymity was ensured by using pseudonyms.

### **Analysis**

The analysis was inspired by Sjöström/Dahlgren (23) and Larsson/Holmström (25), as there is no single strategy for analysis in the field of phenomenography (26). After the interviews, the analysis continued by listening to audiotapes and reading each transcription. This step aided in obtaining an impression of the data as a whole as well as each interview as a whole. In the second step, the interviews were read again, and text relevant to the interview questions was marked. In step three, the interview was searched for information regarding what it was like for the midwives to begin their practice in a new work setting and how they experienced working with labouring women in a midwifery unit setting. Excerpts were recorded regarding the predominant and non-dominant ways in which each midwife understood the phenomenon under study. Step four included categorisation of both predominant and non-dominant understandings within each category and this categorization enhanced the representation of the various experiences. The categories refer to a collective level and demonstrate the variation in *possible* understandings of a phenomenon, i.e., this is not *the* understanding, as there can be other understandings. The categories do not apply to the understandings of any individual midwife, but they are a description of the variation of understandings between the midwives. Both authors read the transcripts, discussed the findings, and developed the categories.

### **Ethical comments**

The study was reviewed and approved by The Data Protection Official for Research and was conducted in accord with the Nordic nurses ethical research guidelines (27). Midwives were approached and offered participation. Those who agreed to participate were provided full information and were asked for written consent.

## Results

Table 1. Summary of the characteristics of each category derived from the interviews.

Categories	Characteristics
<i>Mixed emotions and de-learning obstetric unit-habits</i>	Having feelings of starting from “scratch”, fright, doubting oneself, and calmness, as well as learning to use a lower voice, move more slowly, not use medications, and cease the performance of certain tasks.
<i>Revitalising midwifery philosophy</i>	Encountering self-beliefs and discovering the important connection between beliefs and midwifery care.
<i>Alertness and preparedness</i>	Managing emergencies on their own, training for emergency situations, performing continuous assessments (is the birth process still normal?), and planning (to be ahead of any pathological development).
<i>Presence and patience</i>	Being present with a woman, providing support and motivation, and facilitating movement, nutrition, and fluids.
<i>Coping with time</i>	Working in line with protocols, allowing individual care, and feeling controlled by others.

### Mixed emotions and de-learning obstetric unit-habits

Commencing practice in a new setting initiated a variety of emotions and behaviours and the cessation of performing obstetric interventional tasks. In the beginning, working in the AMU/FMU setting can be a type of “culture shock” and a frightening experience. Additionally, working in such a setting can lead individuals to question their own competence. Feeling unsafe could be expressed in actions, such as guiding a woman into a birthing position familiar to the midwife and not letting the baby being born in water. In contrast, commencing practice in this new setting could also lead opposite feelings, such as calmness.

In the beginning, it was a strong experience...I started doubting myself ...can I do this? And it sometimes gave me jitters and I felt stressed. I had to go back all the way to scratch, like a student again and I thought about the responsibility you possess as a midwife. Can I do this, am I good enough, do I work in an acceptable way...feeling a bit of hopelessness (Anette).

I got this strong feeling of calmness. I should not do anything else than just be there...I should not answer any phone calls, not tidy up elsewhere. I should just be there with her (the labouring woman) (Eva)

How to behave, what to do, or absolutely what not to do was also an issue. The AMU/FMU context could entail a need to change bodily behaviour; established midwives could hush newcomers who are speaking too much or too loud or are moving too fast. It was said that they were used to run between women and different tasks in the obstetric units. The need for change was also related to obstetric interventions, which are restricted by guidelines. The midwives also had to adapt to the non-use of pharmaceutical pain relief.

Not to perform an amniotomy, I think...it's not easy when the cervical dilatation is about 7-8 cm, and the amniotic water-membranes are expanded and tense, I very much want to do an amniotomy... (Hanne).

Not to intervene medically on pain...was a big challenge for me...not to offer medical pain relief, not to have access to epidurals which is a rescue line for many women. This is not an issue for the birthing women here, but it was very frustrating for ME (the interviewee enhanced “me” here), that I could not offer something which help (Berit).

This category shows that the midwives in this new setting encounter both distressing and pleasant emotions, and some of them feel that they must behave differently (from “obstetric unit-behaviour”) and de-learn certain “obstetric unit-habits”.

## **Revitalising midwifery philosophy**

The new setting included working in different ways (from obstetric units), which resulted in a considerable change for some of the midwives. Working in an AMU/FMU could initiate reflections on midwifery philosophies. The connection and coherence between what a midwife thinks and does is very important and could be understood as a necessity. The acknowledgement of understanding birth as a normal physiological process was, for some, regarded as crucial, and the midwife had to “act as she preached”.

I had to change from focussing on disease to focussing on health and wellbeing. Getting used to having my hands on my back and to not have full control, and not to do it (give birth) for her (the labouring woman) (Grete)

Furthermore, the change in philosophy was described as a process linked to experiencing (normal) birth in this new setting; the more normal births the midwife experiences, the easier it is to believe in it.

For each birth I get more and more confident, and with adequate selection, the birth will turn out ok. And now I'm really starting to believe this. In the beginning I had trouble believing it and thought something could happen anyway, and of course it can. But why should it, when everything is alright? (Berit).

Supporting both a traditional medical understanding of birth (birth can only be normal in retrospect) *and* an understanding that birth is natural was also described:

I know that birth is not normal until it's over. Medical assistance can be urgently required, and to me it's a feeling of safety to be close to the hospital. You have to be geographically near a hospital in case any emergency, but of course... we see that the births turn out ok also at the FMUs far away from hospitals. It's a natural process to give birth, it's not a disease, and most women do manage (Frida).

## **Alertness and preparedness**

Particularly for midwives working in FMUs, a particularly careful assessment of the labouring woman is strongly emphasised. In this context, every choice the midwife makes can, in an instant, significantly affect the birth process. The data in this category were derived from the midwives working in FMUs only and describe how they, in an especially vigilant manner, assess and watch the birthing process. Midwives working in FMUs seek confirmation of normalcy, as normalcy is the “ticket” to midwifery unit care. The midwives feel that they must prepare for any complications, transferrals, and emergency situations because they are very often alone on duty.

Sometimes I have to observe and assess with extra concentration...e.g., foetal heart rate, and ask myself what do I actually hear now? Does this have significance, what to do? In an obstetric unit I could do a CTG and get the answer, here I can't do that. You have to be much more alert and focussed, than when you are surrounded by medical assistance (Anette).

Situations occur when there is uncertainty regarding whether a woman can stay in AMU/FMU. In remote areas, transferral could require a complex assessment of how to transport the woman (by private car, ambulance, or air) before a decision is made due to weather conditions. For the most remote FMUs, it could be hours before the woman can arrive in an obstetric unit if the weather is very bad.

Depending on the characteristics of the eventual problem, you have to assess how to transfer, how urgent is it, what are the possible consequences of this particular complication... A woman can also be transferred, due to the midwife's intuition. If it's 4 cm for 6,7,8 hours and the woman is in distress or pain and you think; this'll last for another 24 hours, and she needs an epidural, you'll have to transfer (Dina).

Being prepared for any possible situation also requires skills in emergencies. The midwives feel competent in addressing emergencies due to their background as obstetric unit - midwives. Thus, dealing with emergencies is not a new task, but having the responsibility for acting in emergency situations on their own is a new aspect of their job. To be able to deliver a baby in

an emergency situation is a crucial skill and a matter of life or death for the baby, and this is a skill gained through regular training.

I have to be able to turn shoulders and you have to practice. You must deliver breeches, use forceps on the head. You have to stop bleeding and resuscitate babies. You've got to have it in your hands, you can't be in doubt about what to do, every minute counts and there is no one to help. You must be able to solve the problems on your own (Dina).

I have to know what and how. I do not have the doctor right outside the door, I'm the last person in the line, I have to solve emergency situations. I have to ask myself, do I know what to do if this happens and that happens? (Berit).

### **Presence and patience**

The midwives emphasised that being present with the woman was of utmost importance and could prevent transferral and intervention. In addition to psychological support, caring was characterised by combining knowledge, such as anatomy and physiology, with the practices of Eastern cultures. De-learning the use of medication was noted, and the absence of pharmaceuticals influenced how midwifery was carried out.

Not using artificial oxytocin made me much more aware of the baby's position and the birthing mechanism, and how I can guide the mother with movements to help the baby descend, so we can avoid transferral (compared to previous obstetric unit-work). Acupuncture is also used in enhancing descent (Janne).

The focus on the midwife's presence can be understood as crucial for determining the result of the birth process. One midwife in an AMU, said that leaving a woman, even for only a couple of minutes, could lead to the need for interventions such as epidurals and transferral. Presence was also connected to patience. Being present with a woman was described as creative and in accordance with the practices of midwifery, and with similarities to moving around in a fitness centre; from sitting on a ball to hanging on a rope. To be patient was also part of the care and was considered important. Patience was connected to individual care and the ability to not anticipate anything; rather than following protocols, midwives should follow the woman in her labouring process.

Midwifery unit care and its strong emphasis on the midwife's presence with the woman, could be considered to be *the* art of midwifery itself.

I had no idea that this (AMU-setting) was midwifery; the art. I thought I knew what the midwifery art was, but really, I didn't, before I came here (Ida).

Birth can last for hours and days. Even if midwifery unit care could be perceived as "the art of midwifery", this type of work could also be perceived to be demanding and exhausting as it can be demanding to assist a woman, believe in and support her. To successfully accomplish these tasks, the midwife must trust that the way she works is beneficial for the woman.

A tired midwife can get blind, lose faith, and feel hopelessness, and then the woman too loses faith, and it can easily lead to transferral. In these situations, we call for another midwife (Janne).

### **Coping with time**

This category describes how the midwives in this study understand and address protocols according to time as an aspect of birth. The findings indicate different ways to manage time in a FMU versus an AMU. The midwives working in FMUs seemed to be more autonomous in managing time. The lack of medical personnel was emphasised as an advantage because they could not comment about time and/or propose intervention. Even if it seems to be the same partogram in all Norwegian birth units, the implications of the partogram appear to be different. Normal birth can take some time; obstetric unit-staff would have been shocked... the lines are many times passed. If we should follow the lines, not many women could have given birth here. The lines do not comply with normal birth; they follow birth which is intervened with. You have to trust your own competence to work in a FMU. If we start the partogram too early, we have to transfer women we have a good intuition about (Dina).

I can make individual assessments about time in labour and we have no protocols for listening to foetal heart sound or vaginal explorations (Cecilie).

The midwives working in AMUs felt more restricted in how they dealt with the aspect of time during birth. The partogram is supposed to be used from the moment the woman is in established labour, but this was not always the case, as one of the midwives described that she sometimes does not start the partogram until the baby is born. The use of partograms and dealing with time in accordance with protocols were also expressed as threats of shutdown by medical staff “Crossing” the partogram lines (without any sign of pathology) was understood by the midwives as a quite common indication for transferral. The use of electronic partograms was also viewed by the midwives as another sign of control over their practice.

Earlier (using paper partogram) we could just draw a line in the partograms and write the woman has to sleep. Now that’s not possible, and that leads to that we start the partograms very late....it’s no longer a good working-tool for us, it’s just control (Hanne).

## Discussion

Commencing work in AMU/FMU resulted in emotional disturbances for some of the midwives, such as experiencing fright. This result has also been described by others (18) and can be understood based on the different contexts of AMU/FMU and obstetric units; the latter is the main work setting for most midwives in Norway. Obstetric-led units are heavily medically influenced by both doctors and midwives (10). Stone notes that professional preparation for FMU-work requires another type of training than that required for work in obstetric units. She notes that midwives who come from a obstetric units to a FMU (in a large German city) have to re-learn birth assistance practices, such as allowing birth to last longer than in obstetric units (14). In the current study, beginning practice in the new work setting was also associated with confronting beliefs about the birthing process itself. Supporting normality has been described as a core element of midwifery philosophy (28, 29). In the present study, the coherence between a philosophy supporting normality and the birth care given was an issue for some of the participants, but this issue was discussed in different ways. This coherence has also been described by others (21). For some individuals, the “natural/normal/physiological philosophy” was a necessary fundamental concept for practice. For others, it was not the main concept, but it was still important to keep in mind. The significance of believing in normality can be understood based on coherence with available resources. A midwifery strategy for coping in the AMU/FMU setting can be to adhere to a philosophy that underpins and supports normality and work in accordance with this philosophy (or choose to work in a obstetric unit). To work in line with a midwifery philosophy in obstetric units is described as challenging in many aspects (6, 10, 20, 30). It is worth noting that O’Connell and Downe’s metasynthesis showed that midwives, rather than doctors, are the dominant influence in the practice of medicalised birth care (10). The reported difficulties associated with working in line with their midwifery philosophy influenced midwives to work in midwifery units instead of obstetric units (19). Choosing to work in a AMU/FMU could be based on philosophical grounds. Nevertheless, some of the participants initially experienced a distressing period, both emotionally and professionally. The reasons for choosing to work in an AMU/FMU were not the aim of the current study and will not be discussed further.

Careful observation of the labouring process was an issue of greatest importance, particularly for the FMU midwives. The midwives in these settings felt that they must be very much aware that eventual emergencies may arise and must be taken care of in an appropriate manner by themselves. Because medical assistance could be hours away the midwives felt very responsible and adapted to this responsibility by focussing on being foresighted and prepared. This finding

was also reported by others (31). If an emergency occurs, they must know what to do and be able to do it. To ensure their ability to respond in an emergency, midwives train for emergency situations. Such training is also described in other studies (32). For the current study, the findings in this category were based on data from the FMU- midwives only, but other studies show emergency training also in AMUs (21). However, AMU-midwives in one study did point out that medical assistance was readily available and this made them feel supported when emergencies occurred (21). This may also be the reason why the AMU-midwives in the current study did not emphasise aspects related to emergencies. The midwives in Stone's study did not consider obstetric unit-experience after certification to be crucial or important. In the current study, obstetric unit birth emergency experience was considered, by most midwives, to be useful. This experience helped them to manage emergencies in a new setting.

Presence and patience were spoken of by all midwives. It was strongly emphasised that to be with the mother and to be patient are highly important to avoid transferral and eventual interventions. The midwives revealed different strategies that are in line with the notion that it is important to be in the birthing suite with the woman and either sit there talking/being quiet or assisting the woman more actively with her needs regarding position change, food, and beverages. To be present with the woman has been emphasised as a core value in midwifery in other studies (28, 33) and is referred to as an aspect of "what midwifery is all about" and "the art of midwifery"; it can be interpreted in line with the notion of "real midwifery", which is considerably valued by midwives (10, 34). However, it is also worth noting that this type of work, despite being understood as "real midwifery", was also felt to be demanding. It was recognised as a valuable and acknowledged strategy for a midwife to ask for help when she is too tired to support the woman. Other studies also found that supportive labour assistance can be tiring for a midwife and a risk factor for burnout (13). Also other aspects are noted; Walsh and Devane mention that midwives in midwifery units are afraid of losing their skills in high-risk care (13). Thorngren and Crang-Svalenius found that midwives are concerned about this kind of work, small delivery numbers, and the feeling of isolation in FMUs (18). This was not an issue for the informants in the present study, and it was not actualised by the interviewer either.

Time was a central aspect of how the midwives assessed birth. Time is a controversial aspect, and it is a prominent characteristic in economically developed societies birth care systems (4). The midwives in FMUs experienced a certain sense of autonomy regarding time that the midwives in AMUs did not. This result is in line with Walsh and Devane's findings (13). However, the FMU midwives also expressed the need for strategies to overcome the experience of being under someone else's control; for example, the midwife who stated that the partogram was sometimes not initiated until after the baby was born did work in a FMU. There is no clinical value whatsoever to commencing the partogram *after* the baby is born (other than to provide documentation of the birth). The current study also revealed other strategies regarding time, which could be interpreted as corresponding to a sense of powerlessness rather than professional autonomy. The partogram can be understood as a control mechanism that gives midwives the feeling of being trapped and/or confined. To work in line with protocols versus in line with a woman's individual labouring rhythm has been understood as submitting to "with-institution ideology" versus "with-woman ideology" (35, 36). According to the dominating medical understanding of birth, as far as we know, all Norwegian birth units use partogram with alert – and actionline. When considering how the aspect of time in normal labour became relevant and consolidated its position in childbirth, one can question the relevance of standardisation of time in normal/physiological labour (37). Regarding time, Walsh says that it is similar to "being of an optimum labour length, and beyond this pathology ensues" (38). Time itself is interpreted as a risk factor for adverse birth outcomes. On the one hand, the partogram

*can* assist in assessing when to intervene or *not* intervene, but the findings of the current study do not indicate that professional judgment is systematically and profoundly acknowledged. On the other hand, one can take the stance that every healthy woman gives birth according to her individual labouring rhythm; thus, it is problematic to argue for any standardisation of clock-time in labour. There are other ways of assessing the well-being and safety of the mother and child. The current study showed that the understandings and strategies regarding clock time vary, and the use of a partogram was questioned. Previous studies have also addressed the understandings of birth phases and the routine use of Friedman's partogram. Further research and changes in the use of partograms have been suggested and a study comparing different partograms is outlined (39-41). An additional suggestion for future research could be to compare outcomes between care without partograms versus care with (different) partogram(s).

### **Limitations**

The main credibility concern associated with the phenomenographic approach is the relationship between the empirical data and the categories (23). A method of mitigating this concern is to include excerpts from interviews. Furthermore, to strengthen credibility and reduce the risk of bias, more than one researcher can analyse and interpret the data (42). This approach was implemented in the current study, and both authors agreed on the findings and categorisations. In addition, the validity of this approach could be strengthened by the fact that the second author is not familiar with midwifery.

While some researchers note that a phenomenographic study should include twenty participants to be able to obtain different understandings according to the actual phenomenon under study (24, 25), others claim that this approach does not prescribe any specific sample size (43). In the present study, the last interviews did not contribute to any further information regarding the midwives' understanding of their work. This result *could* imply saturation, but this hypothesis cannot be verified. There were also practical and economic limitations associated with performing more interviews. In summary, the number of participants in this study can be viewed as a weakness and, therefore, may make transferability difficult.

It may be of importance that the shift from obstetric unit to AMU/FMU for some of the participants was more than ten years ago. This could imply that significant experiences were forgotten, or they may have provided idealised stories (10). However, time may also have made it possible to reflect more deeply upon their experiences, thus yielding stories that realistically reflect their perspectives.

### **Conclusion**

Working in a midwifery unit can initially be emotionally distressing for a midwife. First, it may require de-learning of a medical approach to birth, and second, it requires a revitalising (and re-learning) of birth care based on the promotion of physiological birth. Midwifery, particularly in FMUs, does require an especially careful assessment of the labouring process, the ability to be foresighted, and capability in emergencies. Practising in midwifery units is also associated with the experience of "the art of midwifery" and enables revitalisation of the midwifery philosophy.

This study has elucidated midwifery in midwifery units in Norway, where FMUs are primarily located in rural areas. The study has also confirmed findings from other studies. For instance, midwifery units enable midwife autonomy; however, this autonomy has its limitations, as other individuals are making the rules and a sense of powerlessness may influence the midwives.

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