Midwives' lived experience of caring during childbirth – a phenomenological study

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Abstract

Objective: The aim of this study was to obtain a deeper understanding of midwives' lived experience of caring during childbirth in a Swedish context.

Methods: Ten midwives were recruited from one university hospital with two separate delivery units in western Sweden. Data were collected by both written narratives and interviews. With an inductive approach using a descriptive phenomenological method, the answers to the question: “Can you describe a situation in which you felt that your caring was of importance for the woman and her partner?” were analysed.

Results: A general structure of the phenomenon of caring in midwifery during childbirth, including five key constituents: sharing the responsibility, being intentionally and authentically present, creating an atmosphere of calm serenity in a mutual relationship, possessing the embodied knowledge, and balancing on the borders in transition to parenthood.

Conclusions: This study emphasises how the midwives shared the responsibility and their possessed embodied knowledge of childbirth and how new unique knowledge was constructed together with the woman, child and her partner. The study has the potential to increase knowledge and understanding of midwives’ lived experience of caring during childbirth and therefore has implications for practice, education, and research.

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Introduction

Caring as a human mode of being is claimed to be a way of acting and relating to other humans [1]. The more deeply we understand the central role of caring in our lives, the more we realise its centrality within human relations [2]. In professional caring, the client is always in a situation of vulnerability, because caring highlights what matters to the individual, and this must be taken into consideration in a caring relationship [3,4].

In midwifery, caring is frequently described as “being with” the woman [5,6]. Hunter [5] defines this concept as the provision of emotional, physical, spiritual and psychological support by the midwife as desired by the labouring woman. Through a relationship built on mutual confidence, the midwife should seek to increase the woman’s sense of trust [5,7–9]. The midwife can be seen as an anchored companion offering this trustful relationship, where the balance of power between the midwife and the woman is established through mutual agreement and shared responsibility [10]. In the literature, terms and concepts related to “being with” the woman are described as presence, support, a mutual relationship, sharing power and responsibility, responding and respecting the woman. These descriptions overlap one another and are often used together when describing midwifery care during childbirth [7–18].

Several attempts have been made to delineate the process of midwifery care by finding new concepts and models [8,9,11,12,18,19]. Although these studies have many similarities concerning the nature of the midwife-with-woman relationship and structure in midwifery models of care [14,18] they also illustrate some differences. These differences are particularly noticeable when it comes to the complex definitions and interpretations of what midwifery care means regarding equality and shared responsibility in the relationship between the midwife and the woman [8,10,12,14,18]. Therefore, the concept of caring in midwifery requires further exploration to describe what constitutes the phenomenon. The aim of this study was to obtain a deeper understanding of midwives’ lived experience of caring during childbirth in a Swedish context.

Methods

To obtain a deeper understanding of midwives’ lived experience of caring during childbirth, a descriptive phenomenological method based on a lifeworld approach, according to Giorgi [20–22],
was chosen. This method, based on Husserl’s phenomenological philosophy, incorporates the rigorous processes of being present in and dwelling with the data, analysing, describing, and unfolding the meaning of the phenomenon [22,23]. The overall aim of phenomenological research is to capture the way the phenomenon is experienced as closely as possible within the context in which the phenomenon takes place. This requires a phenomenological attitude, which is characterised by openness for the lifeworld and an ongoing reflection of meanings and is attained by phenomenological reduction [20–22,24,25]. The purpose of this method is to obtain systematic, general, critical, methodological, and verifiable knowledge [20,22].

Settings and participants

In this study, ten midwives were selected from one university hospital with two separate delivery units in western Sweden. These delivery units have around 4700 and 1800 births per year, respectively, and serve urban, suburban, and rural areas. Women with both uncomplicated and complicated pregnancies are admitted to these units. The midwives, five from each delivery unit, were purposely selected out of years in the profession and experience of childbirth. The age range of the participants was 37–61 years, and their professional experience was between 7 and 38 years. We based our choice of midwives on the overall aim of obtaining a deeper understanding of midwives’ lived experience of caring for women and their partners during childbirth and of acquiring a more diverse set of descriptions. The ten midwives were not previously known to the authors.

Data collection

Data consist of both written narratives and interviews. The midwives were asked to describe and write about a situation in which they felt that their caring was of importance for the woman and her partner during childbirth. By offering the midwives time to reflect over and describe their experiences, possibilities were gained to capture nuances of the phenomenon in a deeper manner [26]. The written narratives from the ten midwives were sent by mail or e-mail to the first author. In-depth interviews were conducted by the first author afterwards so that the ten midwives could give deeper and more comprehensive descriptions of their experiences. The interviews started with an open-ended question [22,26]: “Could you tell me about the situation you previously wrote down in which you felt that your caring was of importance for the woman and her partner during childbirth?” When appropriate, additional questions were asked to obtain a deeper understanding of the midwives’ experiences. The interviews were carried out at the hospital or in the midwives’ homes. Data collection was performed from January 2011 until March 2011; each interview lasted between 30 and 60 minutes.

Ethical considerations

Permission to perform this study was given by the head of the clinic as well as the head of each unit. The study was carried out in accordance with Swedish law [27,28] and the Declaration of Helsinki [29]. The midwives gave written, informed consent and were informed about guaranteed confidentiality and the right to discontinue at any time. Approval was obtained from the University’s Research Ethics Committee.

Data analysis

Together the first and last author analysed the narratives and interviews both as a whole and for meaning according to a phenomenological lifeworld approach [22]. Finally, the findings were discussed by the authors (ILT, IL, and EH) in the research group until a consensus was reached. The procedure of data analysis included the following: the narratives were read and reread to obtain a sense of the whole, the midwives’ descriptions in their language were discriminated into meaning units within a midwifery perspective and with the focus on the phenomenon being investigated. The meaning units were then transformed into midwifery language at a higher abstraction level, in a way that captured the intuited essence. Such analysis process requires dwelling with the data to utilise free imaginative variations. The essence of the phenomenon was attained by going back and forth through the data, trying to discover the meaning of midwives’ lived experience of caring during childbirth. Finally, the transformed meaning units and formed key constituents were synthesised into a general structure of the midwives’ lived experience of caring during childbirth [20–22,25]. In Table 1, all key constituents of the general structure and the varied embodiments of the phenomenon are presented.

Results

The general structure of the midwives’ lived experience of caring during childbirth can be expressed as follows. The experience of midwifery care was described as being the guided guide, meaning that the midwives adjusted their caring from the woman and her partner’s unique situation. Through a caring attitude, they demonstrate courage when sharing the responsibility and their possessed embodied knowledge of childbirth together with the woman and her partner. However, when the parents did not share their unique embodied knowledge, this sharing was restrained. New knowledge, of importance for their caring, was constructed from situations where the midwives were able to be intentionally and authentically present. To be able to care, it was necessary to create an atmosphere of calm and safety in a mutual relationship that could last through the process of giving birth. The midwives help the woman to feel the rhythm in her body and prepare her to give birth and to become a mother. They act as fellow travellers when balancing on the borders with the woman and her partner in the transition to parenthood.

Sharing the responsibility

The midwives demonstrated that they had the courage to share the responsibility of giving birth by expressing a strong belief in the woman’s capacity and understanding birth as a vigorous existential process including psychological and physiological aspects. They described how important it was to have a humble attitude towards the parents during the first encounter so that the parents could open up and feel comfortable.

We look into each other’s eyes. My belief is that this building of a relationship means that the couple and I are taking a common responsibility to reach the goal, which is a normal and positive childbirth (M6).

The midwives started to care by sharing and communicating their embodied knowledge of childbirth, thereby building up trust. Embodied knowledge means that the individual midwife’s knowledge of herself and experience of midwifery was integrated within her and that she is able to use it. However, when sharing it is of importance that the woman and her partner share their unique embodied knowledge about themselves as individuals, as a family, and of giving birth. Feelings of uncertainty could occur among the midwives if the woman did not share her embodied knowledge, and the midwives expressed the importance of understanding the reason for this. They described these feelings of uncertainty as the fear of losing contact with the woman and not being able to respond to
and her partner, the midwives described the importance of having to be sensitive to different emotions and to understand the other approach demands skill that are dependent on the midwives' ability actions through this dialectic sharing of embodied knowledge. This situation. They adjusted themselves and their thoughts, feelings and being intentionally and authentically present

Being intentionally and authentically present

Being intentionally and authentically present

Creating an atmosphere of calm serenity in a mutual relationship

Possessing the embodied knowledge

Balancing on the boarders of transition to parenthood

Table 1

All key constituents in the general structure and their varied embodiments of the phenomenon of midwives' lived experience of caring during childbirth.

<table>
<thead>
<tr>
<th>Key constituents</th>
<th>Varied embodiments</th>
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<tbody>
<tr>
<td>Sharing the responsibility</td>
<td>Building up trust with the woman and her partner</td>
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<td></td>
<td>Having the courage</td>
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<td></td>
<td>Using the woman's and her partner's embodied knowledge about themselves</td>
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<td></td>
<td>Strongly believe in the woman's capacity to give birth</td>
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<td></td>
<td>Being the guided guide</td>
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<td></td>
<td>Following the woman, walking along, leading without taking over</td>
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<td></td>
<td>Understanding birth as an existential, psychological and physiological process</td>
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<td></td>
<td>Showing genuine interest</td>
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<td></td>
<td>Being able to listen and respond to the uniqueness of the person</td>
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<td></td>
<td>Being courageous to meet, share and stay in the moment</td>
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<td></td>
<td>Respecting, confirming and being there</td>
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<td></td>
<td>Mediate positive feelings</td>
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<td></td>
<td>Showing professional intimacy</td>
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<td></td>
<td>Being the one inviting</td>
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<td></td>
<td>Knowing how to initiate and accomplish the relationship</td>
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<td></td>
<td>Regarding the family as a whole and as separate individuals</td>
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<td></td>
<td>Protecting the woman, child and partner</td>
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<td></td>
<td>Mediate feelings of calm, safety and strengthen the parents in decision making</td>
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<td></td>
<td>Being open and sensitive to changes in the relationship</td>
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<td></td>
<td>Changing attitude from the one being to the one doing</td>
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<td></td>
<td>Knowing how to mediate the knowledge</td>
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<td></td>
<td>Being able to interpret the woman's situation through her body</td>
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<td></td>
<td>Helping the woman prepare herself for giving birth</td>
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<td></td>
<td>Constructing knowledge in the moment</td>
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<td></td>
<td>Using previous experiences and feelings</td>
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<td></td>
<td>Empowering and being empowered</td>
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<tr>
<td></td>
<td>Between past, present and future</td>
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<tr>
<td></td>
<td>In changes of roles and life</td>
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<tr>
<td></td>
<td>In feelings of happiness, sorrow, fear and hope</td>
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<td></td>
<td>Between normality and abnormality</td>
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<td></td>
<td>Between life and death</td>
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| her needs. This was also regarded as a hindrance for sharing the responsibility together with the woman and her partner. Suddenly something happened in the room, in the feeling, in the connection. As the woman is getting fully dilated she becomes totally changed; afraid, “edgy”, hard to get in contact with. . . The woman removes the nitrous oxide mask from her face and tells me what she has been through in her life. From that moment, something happened in me. I could imagine what the woman had gone through. I said that it was good that she told me because I understood why she suddenly “went into another room” (M3).

The midwives described how they were the guided guide when caring, sometimes by following the woman who was following her own body, sometimes by walking with the woman when she needed further support to get through, and sometimes by leading the woman and telling her what to do to manage the situation. However, they never took over the shared responsibility of giving birth from the woman. Through this sharing of responsibility and embodied knowledge, the midwives were able to help the women, to find their unique rhythm of giving birth, and to prepare them for giving birth and becoming parents.

She (the woman) was guiding me through her labour and delivery so that I could guide her (M 10).

Being intentionally and authentically present

By showing genuine interest and curiosity in the unique woman, partner, and unborn child, the midwives based their caring on the situation. They adjusted themselves and their thoughts, feelings and actions through this dialectic sharing of embodied knowledge. This approach demands skills that are dependent on the midwives' ability to be sensitive to different emotions and to understand the other person. By not only being present most of the time with the woman and her partner, the midwives described the importance of having awareness within this presence, by being open and sensitive and being able to listen and respond to both verbal and nonverbal communication.

I went into the room. The woman sat straddled over a chair and breathed through the contractions. She seemed to be in much pain and concentrated. She looked only with a brief glance at me, and I felt that she was a woman with high integrity and I had to get close to her very gently (M8).

The midwives were required to develop communicational skills that spanned the entire spectrum of interaction and had to be able to change from intense communication to one of mastery inactivity, listening, and showing empathy. They described the importance of being authentic and courageous to meet, share, and stay in the moment. This included the way the midwives showed that they respected the woman, partner, and the unborn child, how they confirmed their feelings and showed them that they did not intend to leave them.

The ability to dare to receive and process the information the woman gives without talking, through the body – and waiting, because that is what I have to do, just wait (M1).

The midwives had positive feelings in and for their work and aimed to create a positive atmosphere so that the parents could feel safe and not frightened of going through the process of giving birth. For them, it was a great pleasure to be assisting the woman and her partner to become parents, even though they could sometimes find themselves in difficult, demanding situations. They described how they managed to show the woman and her partner professional intimacy to make them feel well cared for. It was not a question of becoming too private, it was more about being aware of the limit between being too private and showing professional intimacy.

I must show that I dare to stand there and that I understand that it is tough and hard. I will say that it is OK to express
Creating an atmosphere of calm serenity in a mutual relationship

By being the one inviting, the midwives were able to start to build this mutual relationship that could last through the process of giving birth. They were aware of the importance of the first contact in this relationship-building process and that it was just as important for them to create this relationship.

I’m open to the invitations they give me and the way they receive mine. I hope my invitations include humour, joy, curiosity, openness, personality, confidence, trust, warmth, and care. I regard this first encounter as very important (M6).

The midwives articulated the skill of connecting with the woman, her partner and the unborn child during the management of labour by referring to “tuning in” or “finding the key” to the unique family. Together, they created an atmosphere of calm safety by immediate feelings of confidence and trust and letting the woman and her partner be involved in the decision making. They described how they connected with the family both as a unit and as separate individuals.

To maintain this atmosphere, it was extremely important for the midwives to protect the woman, partner and unborn child from unnecessary interventions and other things that could disturb or distract the woman in the process of giving birth. In this atmosphere of calm serenity, the midwives changed from silently being with the woman and her partner to performing different caring actions. The mutual relationship changed constantly during the process as a result of the embodied knowledge the woman, partner and unborn child shared with the midwife.

In this situation, I did not talk about anything really. I sat there, and the husband stood on the other side and massaged the woman’s back because she was lying on her side. So I just sat there; I was just being there (M2).

Possessing the embodied knowledge

Concerning the phenomenon of caring, there was a variation in the narratives of how the midwives used their possessed embodied knowledge of giving birth. The variation was seen for their thoughts, feelings and actions and how they conveyed them to the woman, the partner, and the unborn child. The midwives expressed their possessed embodied knowledge through their eyes, voice, hands, and body. All midwives described this journey of getting the knowledge into their bodies. When they were newly examined, the midwives had focused more heavily on and in themselves, it is OK to be sad and to scream, and I let the woman and her partner know that I wish them well (M3).

The midwives did not only convey their own embodied knowledge based on the shared knowledge in the unique situation, new knowledge was also constructed through this unique encounter.

It is I who have the knowledge; of course I have the knowledge, but I can share these skills with them, and then we will see what we need to do (M1).

As a part of their caring, the midwives were using their possessed embodied knowledge to empower the woman, partner, and unborn child and by doing so the midwives were empowered themselves. Empowerment was used by the midwife to increase a sense of well-being and a feeling of being strengthened by gaining or regaining a sense of coherence, for the woman, partner, and unborn child and for herself.

And it was precisely when I said this, ‘Everything is going just fine; the baby’s heartbeat is so good; it is a strong, healthy baby’, the woman’s eyes met mine and she looked at me, and I felt wow! Something happened here with this woman. It was so incredibly strong for me, too, the woman looked so incredibly calm, and she felt safe and she was capable of doing this.

It was so cool (M2).

Balancing on the borders of the transition to parenthood

The midwives followed the women and their partners in this borderland of the women’s past, present and future, between life and death, hope and fear. They followed them through the transition to becoming a mother and father and becoming a family. The midwives had a strong belief in the fact that giving birth was a normal life event and they were therefore vigilant in preserving normality even when risks occurred.

I think that this feeling of life and death will never be as close to one another as they are at birth. Some things are so deeply rooted in us – instincts and emotions that we are not always aware of. Some women may not be prepared for this, it is such a strong experience (M3).

By using their own previous life experiences and feelings related to life and death, hope and fear, the midwives were balancing on the borders of their own past, present, and future as well – as a way of understanding what the woman was going through. In order to possess these skills, the midwives explained that it was necessary to be in touch with oneself. When they were, the midwives could be a support for the ones they were caring for. However, they all said that this ability could change during their own lives, and they were all aware that they could not manage this every day.

As I stood there, I was working with my own feelings at the same time. The woman and I shared bits of a similar story, but it was impossible for me to share this with the woman; I could understand the woman’s reaction and what she was going through more than she could imagine (M3).

Discussion

This study focuses on midwives’ lived experience of caring during childbirth. The midwives demonstrated their caring skills by describing themselves as “being the guided guide”, dependent on the woman’s and her partner’s unique situation. Our findings show how the responsibility and knowledge was shared between the midwives, the woman, and her partner when caring, and it presents some new aspects of the phenomenon of caring in midwifery. New findings are that midwives not only connect with the woman when caring during childbirth, as described in detail in many previous
and Berg when saying description of “being with” the woman. This also call a "paradigm case", a clinical situation during birth. This is supported by Thorup et al. midwives, and this is supported by several studies study also demonstrate that presence is just as important for the tion midwives' ability to provide caring through presence in the sphere of calm serenity in a mutual relationship. We must ques-

inviter or responding to their invitations, both verbally and clearly revealed that they were available to the parents, being the only or return, were allowed the space to be themselves. The midwives professional intimacy with the woman and her partner so they, in order to be able to use their skills and knowledge without being restrained. In this sharing of embodied knowledge from both directions, new knowledge was created and helped to carry the caring process forward. This also helped the midwife, the woman, and her partner to have courage to meet both the expected and the unexpected during childbirth. Berg [8] describes that embodied knowledge is an important tool for midwives in their work. The word “embodied” focuses on the fact that the knowledge is deeply rooted and integrated, meaning that the midwife is her knowledge, and this agrees with the findings in our study. This sharing of responsibility and embodied knowledge between the midwife, the woman, her partner and the unborn child could be understood as a unique feature that differs from other caring encounters.

The midwives in our study illustrated the importance of creating a caring relationship with the woman which has similarities with Hunter's [5,32] description of “being with” the woman. This also aligns with the findings of Kennedy [11,33] who describes midwifery care as the development of a relationship based on mutual respect, trust, and alliance between the woman and the midwife. For the midwives in our study it was important to connect with the partner and the unborn child as well. They also talked about the danger of not finding the way in to the woman or losing contact, and when this happened, the midwives could be restrained in responding to the woman's needs.

The results show that it was important for the midwives to be able to be intentionally and authentically present as much as they could. Previous research demonstrates the benefits of continuous support in labour for the woman, unborn child, and partner [5,13,15,16,32,34]. Within midwifery, the concept of presence carries considerable meaning and significance, where it has been shown how valuable the presence of a midwife is to women and how it may benefit their future role as mothers [10,35]. The results of our study also demonstrate that presence is just as important for the midwives, and this is supported by several studies [5,1,13-16,32]. Through this presence, the midwives in this study were able to show professional intimacy with the woman and her partner so they, in return, were allowed the space to be themselves. The midwives clearly revealed that they were available to the parents, being the inviter or responding to their invitations, both verbally and nonverbally. This aligns with what Mayeroff [2] says about being truly caring. By being present, the midwives created an atmosphere of calm serenity in a mutual relationship. We must question midwives’ ability to provide caring through presence in the context of a modern, institutional birth environment in which they frequently have simultaneous responsibility for more than one woman in labour.

The midwives in our study talked about caring moments when they followed something new about caring, for example how they followed their inner feelings of their possessed embodied knowledge and dared to try a new, caring action, such as singing for the woman so she could find her rhythm to give birth. This agrees with what Benner et al. [36] call a “paradigm case”, a clinical situation that alters one’s way of understanding and perceiving future clinical situations. The midwives possessed embodied knowledge that helped them to be prepared for the unexpected. By being part of constant dialectic learning, new knowledge was acquired. This leads to the advancement of their skills when it comes to practising caring in midwifery, as also described in other studies [9,32,37]. The midwives in this study demonstrated their caring and communications skills by describing themselves as “being the guided guide”, dependent on the woman’s knowledge, which could explain why it is quite difficult for midwives to describe what they really are doing and what it means to be caring in midwifery. The becoming parents are, before the first encounter in most cases not known to the midwives therefore they neither know how the encounter will develop, nor do they know what new unique knowledge will be created. All the midwives in the study talked about their great humility towards and curiosity of new situations, even though most of them had been working for a long time.

Many previous studies have confirmed the importance of empowerment for the woman and her partner during the childbearing period [13,14,17,38], but the results from our study also show that the midwives were empowered by the response from the woman, her partner and the unborn child. This empowerment was important for the individual midwife, her process of growth, and her self-confidence in becoming the one with the possessed embodied knowledge of giving birth. According to the midwives in our study, nobody can be empowered without a caring attitude, and empowerment seems to be an important dimension of caring in midwifery.

The process when the midwife follows the woman through the phases of childbirth has been described as a journey [6,9,10,38,39]. However, in our study the midwives explain that they follow the woman through the phases of giving birth and through the transition to the unknown, but also that they follow the partner and the unborn child through the journey, balancing on the borders between their past, present, and future, between hope and fear, life and death.

In all the narratives and interviews there was a visible process of caring and the midwives emphasised the meaning and importance of the first contact, finding a way to connect with this unique woman and her family. They described how the encounter developed into a mutual relationship and the way that the relationship changed during the process and after the birth. The caring of the midwives had the overall purpose of promoting the women's capacity to give birth in a positive manner. The experience of childbirth can in this way be an opportunity for growth and development in the lives of the families, as well as for the midwives. Caring seems to play an important role in fostering midwives' professional growth and the development of excellence.

Strengths and limitations

As for all qualitative studies, the results must be interpreted in relation to their contexts, time and place [22]. The strength of this study was the reflected written narratives and the follow-up interviews to gain a deeper understanding of the phenomenon being studied [26]. This type of data collection provided rich and extensive descriptions to the process. By using imaginative variations in the analysis of the written narratives and interviews with the midwives, an eidetic understanding and a general structure which
captured the essences of the phenomenon were obtained [22]. A limitation of the study could be that the midwives were asked to describe a situation where they felt that their caring was of importance for the woman and her partner. They all choose to talk freely about a positive situation when they were experiencing that they where able to be truly caring. However, in future research it would be interesting to ask midwives to describe the lived experience of caring without focusing a positive situation.

Conclusions

The lived experiences of caring and what it meant to be caring during childbirth were expressed by experienced midwives through detailed descriptions. New findings are that the midwives not only connect with the woman, they connect with the partner and the unborn child as well. By being the guided guide and sharing the responsibility together, they create a trustful relationship through a caring attitude and an atmosphere of calm safety, where the woman has the opportunity to prepare herself to give birth. As described in this study, the midwives, when caring, attend the parents throughout the process of giving birth by balancing on the borders of the past, present, and future. This study also emphasize how the midwives use their possessed embodied knowledge of childbirth and how new unique knowledge is constructed together with the parents-to-be. These findings have the potential to increase knowledge and understanding of midwives’ lived experience of caring during childbirth and therefore have implications for practice, education and research.

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References