

**From the first encounter to management of childbirth  
An insider action research in a labour ward world**

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*To my beloved parents*



## ABSTRACT

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Childbirth leaves a lifelong memory for women and their families. How they were met and treated during labour and birth affects their experience. Therefore it is of utmost importance that childbirth care is of optimal quality in accordance with each woman's and partner's needs.

*Aim:* The overall aim was to explore and improve management of childbirth on a labour ward through insider action research, beginning with the midwives first encounter when the woman and partner arrive on the labour ward.

*Methodology and results:* As part of a local project to improve hospital based labour and childbirth care, an Insider Action Research (IAR) project was carried out. A hermeneutic reflective lifeworld research approach was used to identify and understand patterns of meaning of first time parents' (n=65) experiences of the first encounter on a labour ward. The emerging meaning was captured as a 'waiting to earn permission to enter the labour ward world'. It included 'timing it right', 'waiting to be informed', 'being in an inferior position', and 'facing reality with a mosaic of emotions' (paper I). An interpretive description research approach was then used to examine midwives' (n=37) responses to a collaboratively agreed change in the initial encounters with women in labour and their partners. The overall interpretation was 'glancing beyond or being confined to routines' (paper II). Being an insider action researcher as a clinical staff member and a novice doctoral student was described from a reflective lifeworld approach, and summarised as 'learning how to clinically reflect on and to voice the tacit components of care'. This comprised: 'to catalyse a counterbalance to the medico technical focus', 'to stand alone at the messy front line', and 'to struggle to get the organisation participative' (paper III). An observational study ended the Action Research project by evaluating labour ward routine management of childbirth in healthy women at term over the time of the study. There was a significant reduction in duration of the admission CTG (cardiotocography), use of fetal scalp electrode and of augmentation of labour with synthetic oxytocin. The data also showed a downward trend in the numbers of amniotomy (artificial rupture of fetal membranes) (paper IV).

*Discussion and Conclusions:* To commit to do AR in one's own organisation is challenging. However, undertaking an insider research role to collaboratively focus on routines was an effective approach in developing care, and it may have contributed to avoidance of further increases in intervention in normal labour. From the participant parents' point of view, expert monitoring and support was sought actively through seeking admission to the labour ward once they had an embodied sense of *being* in labour, as they then needed individual support. However, from the organisation's point of view, carers focused more on *observed* signs of labour. Being compliant to technocratic norms, and the prioritisation of 'getting through the work' that midwives experience working in publicly funded settings was challenged through this action research study. The data suggest that midwives are imprisoned in a hegemonic 'CTG faith', and that they rely on medico technical surveillance for normal childbirth, but also that they were still able to reflect on and glance beyond inherent routines. Reducing unnecessary routine intervention in normal labour can free up time for midwives to be present with a woman in labour, and with her partner. New local knowledge derived during this AR process and was best disseminated through everyday dialogues. Further investigation on health care practices from the bottom up perspective, combined with theoretical knowledge, could improve carers competence and capacity.

*Keywords:* Caring, Childbirth, First encounter, Health services research, Insider Action research, Intervention, Midwifery, Quality development

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## LIST OF PAPERS

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This thesis is based on the four following studies, which are referred to throughout by the Roman numerals below:

- I Nyman V, Downe S, Berg M. Waiting for permission to enter the labour ward world: First time parents' experiences of the first encounter on a labour ward. *Sexual & Reproductive Healthcare*. 2011; 2(3):129-34.
- II Nyman V, Bondas T, Downe S, Berg M. Glancing beyond or being confined to routines: Labour ward midwives' responses to change as a result of action research. *Midwifery*. 2013 Jun; 29(6):573-8.
- III Nyman V, Berg M, Downe S, Bondas T. Insider Action research as an approach and a method – exploring encounters from within a birthing context. *Action Research*. 2015 Aug 17; doi: 10.1177/1476750315600225
- IV Nyman V, Roshani L, Berg M, Bondas T, Downe S, Dencker A. Routine interventions in childbirth before and after initiation of action research. *Manuscript*

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In action research one starts in the middle and ends in the middle  
(Hans van Beinum, 1999)



## PREFACE

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This thesis focuses on creating change and new knowledge in the care of women and partners from their first encounter on a labour ward. I started my professional care journey in 1987 as an operating room nurse. I have worked as a clinical midwife for 20 years on a labour ward, where this research has taken place and which is central to the approach employed. I have also been a member of a local 'Aurora team' providing counselling to women and partners who are afraid of childbirth. Effective listening is a key element of care for these individuals. During the counseling sessions I met women and men who expressed how having been listened to, had a significant impact on them. I also met women and their partners who feared the attitudes and behaviors of maternity care professionals. I then realised that we need to reflect on how we communicate and act to prevent women and partners developing a fear of childbirth caused by our attitudes and routines. In 2009, the 'Aurora' practice was downsized due to economical constraints which raised concerns. I wanted to promote good experiences for all pregnant or labouring women and their partners from their first arrival at the labour ward. It is important to increase responsiveness to women and their partners' by identifying individual needs and avoiding women experiencing standardised treatment. The drive to research the first encounter on admission to a labour ward, came after undertaking a study exploring obese women's experiences of encounters with midwives and physicians. These findings showed the importance of midwives and other carers, verbalising their prejudices, not only about significant vulnerable groups, but for all women experiencing childbirth and the necessity for us to reflect on our caring approach. It is clear that women who are supported and treated respectfully during childbirth have a positive experience which highlights the quality and safety of childbirth.



## INTRODUCTION

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The quality of the mother's relationship with health care professionals who attend her in labour is fundamental to the positive, physical and emotional outcomes of childbirth (Berg, 2005; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008; Hunter, 2002; Kennedy, 1995). In Sweden, one midwife normally assists the birthing woman, often accompanied by a health care assistant (*undersköterska*), while in some maternity units the normal practice is that two midwives are present at the birth. Physicians normally are involved in the care of women who have a complicated pregnancy and labour. Hodnett et al. (2013; 2002) found that attitudes and behaviours influence women's evaluation of their birth expectations and experiences, the amount and quality of support, and their involvement in decision making. The creation of a genuinely empathetic and sympathetic professional caring relationship is a mutually reinforcing process, which requires high level communication skills from a competent and capable practitioner (Berg, Olafsdottir, & Lundgren, 2012; Travelbee, 1971).

A number of studies have found that childbearing women place a high value on good quality rapport with a professional, specifically the midwife (Berg, 2005; Flemming, 1998; Frazer, 1999; Lundgren & Berg, 2007; Mosallam, Rizk, Thomas, & Ezimokhai, 2004). Other studies have highlighted the need for a woman to be treated as an individual, to have a trusting relationship with the midwife, and to be assured of the midwife's presence during childbirth. Similarly, women's own responsibilities, participation, trust in own capability and desire to give birth is essential (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Green, Renfrew, & Curtis, 2000; Halldorsdottir & Karlsdottir, 1996; Lundgren, 2004; Nilsson & Lundgren, 2009; Van der Gucht & Lewis, 2014). Fear of childbirth is related to lack of trust in health care professionals, depression, vulnerability and to previous negative childbirth experience (Melender, 2002; Nilsson, Bondas, & Lundgren, 2010; Nilsson & Lundgren, 2009; Saisto, Salmela-Aro, Nurmi, & Halmesmaki, 2001).

Several researchers have employed different methods to enable women to have a positive childbirth experience. Some clinicians have encouraged pregnant women and their partners to summarise their wishes for their pending birth in a birth plan. However, the use of a birth plan did not in that case show to be effective in the promotion of achieving a positive birth experience or having a sense of control (Lundgren, Berg, & Lindmark, 2003). Preparation for childbirth by using a natural alternative approach with psychoprophylactic training compared with traditional antenatal classes did not decrease the use of epidural anaesthetic, the impact on childbirth experience or post-partum stress (Bergstrom, Kieler, & Waldenstrom, 2009). Further research is required to understand the complex encounters during childbirth.

### **Ruling childbirth discourse**

It is known that women's expectations of, and behaviour in labour are coloured by general social opinions (Larkin, Begley, & Devane, 2009). Also carers' notions, according to Downe (2008) influence the societal childbirth discourse. This includes

that patients do not easily question the authoritative voice of medicine and often hesitate to express their own views and needs. They are dependent and look to the health care professionals as knowing best (Edwards, 2000; Fredriksson & Eriksson, 2003). Care encounters involve relationships of power and it is pivotal that carers understand and reflect on their possession of power; otherwise there is a risk of overbalance of power (Fossum, 2003). This imbalance of power can lead to an increased suffering for women and their partners through a lack of individualised care via routine practice.

The initial face to face encounter with a woman on a labour ward is often short, however it is a sensitive meeting, with potentially significant consequences for the woman and partner. The carers' approach may be particularly crucial for first time parents, as they have little or no prior experience of labour wards or of staff in this context; so they enter the environment with maximum uncertainty. There is evidence that strangers form strong impressions of each other within a few seconds of their first meeting (Ambady & Skowronski, 2008; Willis & Todorov, 2006). Thereby, every interaction entails a first impression, which determines how smoothly or awkwardly later interactions will proceed (Harris & Garris, 2008).

It appears that societal confidence to the natural physiological process of childbirth is decreasing. This has been demonstrated by several reports which have shown a continued increase in the routine use of medico-technical and pharmacological interventions for healthy women and babies (Begley, 2014; Scamell & Alaszewski, 2012; Walsh, 2011). This can partly explain opinions that childbirth cannot be 'done' without routine interventions (Downe, McCormick, & Beech, 2001). The increased request for caesarean section by women with a normal healthy pregnancy is an example (Fenwick, Staff, Gamble, Creedy, & Bayes, 2010). Emotional and existential safety is necessary in the delivery room to avoid labouring women experiencing negative perception of birth and consequently fearing future childbirth from being treated as birthing bodies as machines (Nilsson, 2014).

A social relationship, 'knowing and being known'; the reciprocity, created satisfaction and midwifery autonomy was highlighted as the core elements to provide holistic and flexible care (McCourt & Stevens, 2009). Midwives are predominantly the health care provider of women during labour, and are in themselves the 'tool' to enable or inhibit a childbearing women. Midwifery care is associated with improved perinatal outcomes (Sandall, Soltani, Gates, Shennan, & Devane, 2013; ten Hoop-Bender et al., 2014). However clinical midwives state that they fail to provide 'real midwifery' including preserving the normality of childbirth, due to heavy workloads and normative pressure to provide routine care to all women (O'Connell & Downe, 2009). This is often influenced by the context in which they work. Fragmented models of intrapartum care can affect job satisfaction. It is therefore imperative to promote optimal care during childbirth to increase job satisfaction for the midwives and other staff members (Hunter, et al., 2008).

### ***Routine interventions in childbirth***

Only a small proportion of childbirth proceeds without close scrutiny and interventions. The overuse of electronic fetal heart monitoring, cardiotocography (CTG) is

a particular issue. A Cochrane review which compared the effect of admission CTG with intermittent auscultation, found no evidence to support the use of admission CTG to benefit women and babies with low risk. All women should be informed of the risks and benefits of using CTG in labour. In addition, continuous CTG in labour prevents women from changing their position freely. Continued CTG monitoring also requires midwives and physicians to continually interpret the CTG which can hinder caring for the woman's needs in labour (Alfirevic, Devane, & Gyte, 2013). The risk ratio of cesarean section for those randomised to having a CTG on admission to the labour ward was 1.20, (95% CI 1.00 to 1.44), and therefore increases the risk for a caesarean section with 20% (Devane, Lalor, Daly, McGuire, & Smith, 2012). A systematic review of professional's views on fetal monitoring during labour by Smith et al. (2012) verified that the practice of continuous electronic fetal monitoring (EFM) for low risk women continues despite current research evidence.

Other interventions routinely used in labour include: amniotomy (artificial rupture of fetal membranes), the use of internal fetal scalp electrode for CTG monitoring and the use of oxytocin to accelerate labour. Performing an amniotomy is a common intervention during labour, and it is often done to enable monitoring by clipping a scalp electrode on the skin of the baby's head in an effort to accurately and consistently monitor the baby's heart rate. Amniotomy is also performed as an attempt to speed up labour. A Cochrane report summarised the evidence of undertaking an amniotomy versus no amniotomy in women with spontaneous labour. They concluded that there was no statistical significant difference between the group of women having an amniotomy compared to the control group, in length of the first stage of labour, caesarean section rate, maternal satisfaction with childbirth experience, and the incidence of Apgar score less than seven at five minutes. The review concluded that amniotomy should not be introduced routinely as part of standard labour management and care (Smyth, Markham, & Dowswell, 2013). Audibert (2013) suggested that there are different aspects relating to the outcome of having undertaken an amniotomy that were not considered in this review for example, the use of epidural anesthesia. It is known that oxytocin reduces the length of labour, however it does not reduce the chance of having a caesarean delivery. Oxytocin augmentation of labour is widely used in spontaneous labour when progress is deemed to be slow, especially in women having their first baby (Bugg, Siddiqui, & Thornton, 2013).

### **Theoretical frame: Caring and care in childbirth**

What is caring and what is care? Caring can be described from a variety of perspectives. It can be epistemologically seen as a human characteristic, an affect, a moral obligation, an interpersonal interaction, or as a series of therapeutic interventions (Morse, Bottorff, Neander, & Solberg, 1991; Morse, Solberg, Neander, Bottorff, & Johnson, 1990). The basis for holism in caring theory is moments of consciousness wherein there is a possibility to create a caring relationship, involving genuine presence and connectedness between human beings (Watson, 1999). Parse's ontological theory of 'human becoming' focuses on how to be with people in a special way related to the human-universe-health (Parse, 1998). Caring is also described as a major concept in nursing. Meleis (2007) described Watson and Parse as caring theorists, and not nursing theorists because 'the process of caring occurs between two independent

human beings who connect equally in a relationship that transforms them both' (Meleis, 2007, p. 123). The term care is a broad concept, without a clear definition and is used often as a generic word relating to organisations dealing with healthcare (and medical) services (e.g. care system, social care, names on service and medical device companies). In this thesis both the concepts of care and caring will be used and the meanings of these terms will be explained by the context.

Continuity of care is an approach and the cornerstone in midwifery and women-centred care (McCourt, 2005) whereby a humanistic approach is adopted to care alongside technology to foster 'relationship-centred care' (Freeman, 2006). Accessibility to a known midwife during pregnancy and labour has not decreased women's fear of childbirth (Green, et al., 2000; Kjærgaard, Wijma, Dykes, & Alehagen, 2008). Furthermore, continuity of carer has not been assessed as a high priority or valid for its own sake by women, nor has it been found to be a clear predictor of women's satisfaction (Freeman, 2006; Green, et al., 2000). For continuity of carer to be valued by women there had to be an emotional support in the relationship (Dahlberg & Aune, 2013).

The literature describes the concept of care as both a humanistic and holistic approach. From my perspective caring for human beings needs to be holistic, thereby the carer's awareness is a prerequisite to the creation of a caring relationship and presence (Watson, 1999). This perspective accentuates reflectivity and reflects midwifery autonomy (McCourt & Stevens, 2009). The holistic approach claims that body, mind, and spirit belong together and interact with other energy fields (Davis-Floyd, 2001).

### ***Not letting the other alone***

The description of 'care' is often described as relating to sickness and dying and with its features of chaos, emotions and suffering (Lavoie, De Koninck, & Blondeau, 2006). Childbirth at times is experienced by the woman and her partner as life threatening both for the labouring woman and her unborn child/children. The midwife has to support and convince the woman that the labour is not a threat to her life (which for the majority of women it is not), at the same time the midwife needs to be sensitive from the initial entrance of the woman and her partner to the labour ward to their each individual needs and anxiety.

The responsibility for the other, as Emmanuel Levinas (1906–1995) explained was 'not letting the Other alone' (Lavoie, et al., 2006). The philosophy of Levinas and his ontological understanding of care can be adopted within midwifery care on a labour ward, as the sensations of chaos, emotions and suffering/pain are often the experiences of woman during childbirth. Levinas' depiction of care focuses on the sick, in particular, for the dying persons these existential perceptions take on an acute form (Lavoie, et al., 2006). Similarly, for a labouring woman this acute existential perception, commonly in the western world occurs within a hospital context which requires the midwife and other carers to acknowledge the existential sensitivity. Lavoie, et al. (2006) explain further that a human person is a relational being, capable of love, deep feelings, seeking human warmth and the presence of others with bodily, emo-

tional, relational, and spiritual dimensions. Levinas' insight of responsibility towards the Other, brings to the surface ontological dimensions of the concept of care which include: the *relation* involved, the feeling of *affection*, and the *intervention*.

For Levinas, the idea of *relation* with the other should be considered in terms of proximity and asymmetry. Proximity refers to the obligation of the carer, i.e. it is the midwife's assignment, as the responsible being and asymmetrical refers to the role of the midwife and her responsibility for the other (Lavoie, et al., 2006). Levinas also talked about nonreciprocity of relations, which means that proximity could not be dismissed because interrelation exists whether we believe in its existence or not (Cassell, 1991). Therefore the midwife has a responsibility to build a therapeutic relationship with a woman and partner in every encounter whether she/he wants to or not. Finkelkraut (1984) cited in Lavoie et al. (2006) conclusively states that the caregiver has duties not rights, to take care of the Other. Thus the carer and the Other is not on the same level because of the carer's responsible nature (Fredriksson & Eriksson, 2003; Lavoie, et al., 2006).

Feeling of *affection* according to Levinas (Lavoie, et al., 2006) is to understand the other person's emotional life and desires. Affection does not mean love or 'eros', in the sense of passionate love, affection is in the caring situation, goodness and compassion (sympathy and empathy). Affection in the relationship with a birthing woman means that the midwife does not treat her 'as a piece of wood or like a clock need for a repair' (citation Lavoie et al., 2006). Affection is not showing indifference to the women's birthing experience, rather showing that she has been seen and listened to. The bond between women and midwives as derived from Levinas philosophy is, the creation of a good relationship and the feeling of affection.

For Levinas, the *relation* with the Other and the feeling of *affection* requires the *intervention*, which is essential to reach the full meaning of care. The intervention entails a situation where the Other is dependant and in need of the caregiver's compassion, support and care. There has to be an intervention for it to be possible to say that the responsibility of care towards the Other is the caregiver's. Levinas does not describe all the different interventions that can take place. Lavoie et al. (2006) cites Marie-Francoise Collière (1982, p. 243) who divided care of the Other into two categories, the 'usual caring interventions' and 'curing interventions'. The usual caring interventions include fulfilling needs 'to drink, to eat, to evacuate, to wash, to get up, to move, to get about' while the 'curing interventions' aims to treat and limit disease, fight against it, and to attack the causes. The 'curing interventions' have technical aims, which refer to supervising vital signs, carrying out blood tests, giving injections and changing bandages (Lavoie, et al., 2006).

## MOTIVE FOR THE STUDIES IN THE THESIS

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It is clear from the literature that childbearing women value receiving high quality care from health care professionals, particularly from midwives. Women and partners (throughout this thesis the word partner is referring to the other parent, any accompanying family members or others) want consistent care from carers that they trust. Midwives autonomy to provide care for childbearing women within hospitals in Sweden is often restricted due to the medico- technical focus and high workloads. Women's and midwives' experiences of support in childbirth are explored but there is a paucity of how to translate/transfer and implement the theoretical care advances into the institutional context. The literature review and reflection of my own practice lead to the following questions:

- How can we as midwives and other carers improve labour ward care by illuminating the first encounter with women and partners?
- How can we as midwives and other carers increase the use of theory in practice to improve our knowledge about caring and management of childbirth?

## OVERALL AIM

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The overall aim was to explore and improve management of childbirth on a labour ward through insider action research, beginning with the midwives first encounter when the woman and partner arrive on the labour ward.

The specific aims of the four papers included in this thesis are:

To explore the meaning of first time mothers' and their partners' first encounter with midwives and other maternity care staff when they arrive on a hospital labour ward. (Paper I)

To examine midwives' responses to the collaboratively agreed changes made for the initial encounters with women and their partners in the labour ward. (Paper II)

To describe an insider action researcher's experiences as a peer midwife and a novice researcher doing action research collaboratively to develop theory and practice in the first encounter on a labour ward. (Paper III)

To explore interventions before and after the action research was initiated, starting with the woman's and partners' arrival on the labour ward. (Paper IV)

# METHODOLOGY

To develop midwives first encounters with women and partner and foster a caring approach within a hospital based childbirth context requires participation of carers at the outset of the research process. Action research (AR) is a strategy that can be used for implementing change in specific contexts in real world environments (Parkin, 2010). This thesis resulted in four papers of which paper I relates to women’s and partners’ experiences of the first encounter with midwives. Their experiences became the knowledge and theory of *what* to start to focus in action. This theory from the women’s and partners’ lifeworld descriptions lead the action research process to midwives reflecting on their own routines of encountering women and partners when they arrived to the labour ward. Paper II describes *how* midwives reacted and reflected on their care in the first encounters. Paper III highlights the methodology of AR through my experience of *how* it was as a novice doctoral student to be a change agent in the organisation in which I work. Paper IV identified *what* happened to routine management of childbirth as a result of the AR process.

The methods used in the four papers are displayed in Table 1. AR can be conducted from a variety of epistemological perspectives using a variety of methods, including both qualitative and quantitative methods (Coghlan & Brannick, 2014; DeLuca, Gallivan, & Kock, 2008). Before the description of the different methods used in the four papers, the AR approach, context and development of the insider process is outlined.

**Table 1.** Overview of the methods

Paper	I	II	III	IV
Design	Interpretative	Interpretative	Methodological	Explorative observational
Data	Individual interviews Focus groups First-time mothers and partners (n=65)	Interviews Midwives (n=37)	The insider action researcher’s log	Women’s obstetric records (n=903)
Data analysis	Hermeneutic, reflective lifeworld	Interpretative description	Hermeneutic, reflective lifeworld	Descriptive and comparative statistics

## Action research

### *The philosophy of action research*

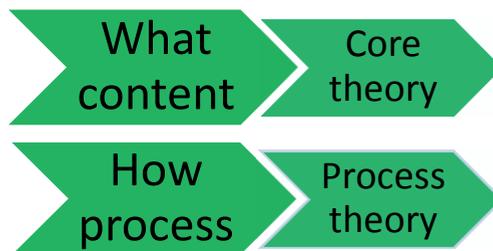
Several researchers from different fields have conceptualised action research. Kurt Lewin is recognised to be the founder of AR, which originated in the labour organising traditions (Lewin, 1946). The strength of AR is how it focuses on generating solutions to practical problems. It promotes the practical involvement of those involved in a situation which improves both their practice quality, gives valuable insights and

provides data (Coghlan & Brannick, 2014; Meyer, 2000; Winter, Munn-Giddings, & Atmer, 2001). It is an inquiry approach that differs from traditional academic research; in particular with regards to its relation to practice relation to practice. The process involves different purposes, relationships, ways of conceiving knowledge and a systematic development of knowing and knowledge (Reason & Bradbury, 2006). There are a variety of definitions of action research. In essence, it is a participatory democratic process which develops practical knowing, by bring together action and reflection, theory and practice, in participation with others (Hart, 1995). A significant feature of all action research is to build a direct link between intellectual knowledge/theory and action to develop human persons and their communities (Reason & Torbert, 2001). The selected research topic adheres to an expectation that it will make a useful contribution to the organisation (Coghlan & Brannick, 2009).

An integrated approach to research includes three voices and audiences: first, second and third person (Reason & Bradbury, 2008; Reason & Torbert, 2001). These three audiences of research, is often implicit in inquiry, Reason and Marshall has developed a view of these three audiences:

‘All good research is for me, for us, and for them: it speaks to the three audiences... It is for them to the extent that it produces some kind of generalizable ideas and outcomes... It is for us to the extent that it responds to concerns for our praxis, is relevant and timely...[for] those who are struggling with problems in their field of action. It is for me to the extent that the process and outcomes respond directly to the individual researcher’s being-in-the-world’ (Reason & Marshall, 1987, pp. 112-113).

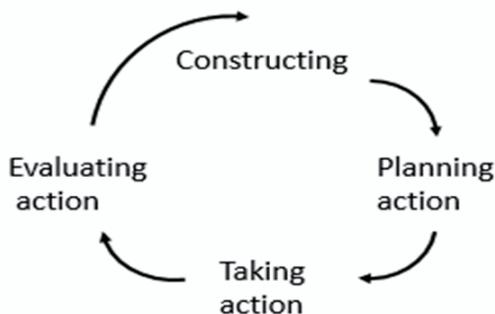
The ontological assumption is that action researchers view themselves as trying to live in a way consistent with their values (McNiff & Whitehead, 2011). The focus or the intended goals in an action research is twofold. It is an inquiry into *what* the planning, taking action, and evaluating leads to, e.g. further planning, action etc the ‘core’ action research.. The other cycle is a reflection cycle, *how* the AR process in itself is developing, the ‘thesis’ action research (Zuber-Skerritt & Perry, 2002) (Figure 1).



**Figure 1.** The focus in action research, own interpretation based on Zuber-Skerritt and Perry (2002).

The lack of a clear definition of AR can cause confusion. It can be described as an approach to research (Coghlan & Brannick, 2014), it has been said that it is neither a method nor a technique, but an approach to living in the world to create collaborative learning (Greenwood, 2007). Nevertheless, it has been used as a method for improving practice (Koshy, Koshy, & Waterman, 2010). In action research the epistemological assumption means sharing the processing of the knowledge production with the researched and therefore it cannot be a value free approach to knowledge. The purpose of academic action research and discourse is not only to describe, understand and explain but to make change (Reason & Torbert, 2001), using a variety of methods e.g. interviews, observations, research log, and surveys (Coghlan & Brannick, 2014; DeLuca, et al., 2008). The methodological assumption is that the AR takes place in a social context with other people and begins with an experience of a concern (McNiff & Whitehead, 2011).

The process of AR is described as cycles and/or spirals of planning, acting, observing, and reflecting. However, in reality these stages overlap and can be seamless and responsive (Kemmis & McTaggart, 2000). The AR cycle described by Coghlan and Brannick (2014) was used in this project. The cycle starts with a concern and a definition of the context and purpose, followed by cycles with four phases; constructing, planning action, taking action and evaluation (Figure 2). The cyclic process is further described in paper II and IV. The process involves cycles of action and reflection to investigate practice for the purpose of improving learning which in turn, intends to improve practice (McNiff & Whitehead, 2011).



**Figure 2.** The Action research cycle (Coghlan and Brannick, 2014, 9)  
(Drawn freehand by VN).

In AR the ethics involves authentic relationships between the action researcher and their peers which involves a sharing of knowledge production with those participating (Coghlan & Brannick, 2009). To learn from the process in real situations action researchers have to explicate the intellectual framework and engage with the research themes (Checkland & Holwell, 2007). Thereby when people commence the AR process they have an implicit intention to create change. It is this process that is the

knowledge or understanding which is derived and thus the theory (Dick, Stringer, & Huxham, 2009).

The ‘double challenge’ of combining both action and research makes it difficult to outline general principles of how AR should be carried out. The initiation can be research-driven whereby the researcher is looking for settings that are characterised by the theoretical approach he/she is interested in and has the knowledge of. Alternatively, it can be problem-driven where the practitioners may be confronted by a seemingly difficult problem and seeks help from theoretical specialists. There can also be a mixture of these two ways of initiating the AR, which develops from discussions between researchers and practitioners (Avison, Baskerville, & Myers, 2001).

In addition, AR has been divided into two groups, the first is when the researcher is the external observer and reports what other practitioners are doing, which is known as interpretive action research or as an externalist form of theory. The second group is the person centered form of theory, where people put forward their own explanations. This division has led to further sub groups, where the words ‘participatory’ and ‘collaborative’ are utilised. This can be confusing because AR is collaborative and requires participation (McNiff & Whitehead, 2011). Participative action research (PAR) is the form of AR that expects resistance to those who have the power, or the traditional AR where action researchers often are hired as consultants by those in control (Herr & Anderson, 2005). PAR was built on the critical pedagogy presented by Paulo Freire. The common approach in PAR is the participative worldview, that emphasis emancipatory and inclusiveness in the construction of knowledge that leads to action. This process is a cycle of critical reflection and learning which focuses on broader societal analysis (Herr & Anderson, 2005; Koch & Kralik, 2006). Cooperative inquiry involves two or more people researching a topic through their own experiences and emphasizes the inter-subjectivity among researchers and participants. The inquiry involves a dialogue and reciprocity, to understand our world and to develop new and creative ways of functioning. It also involves learning how to act in order to make changes and find out how to do things better towards greater humanisation (Heron, 1996).

I have chosen to use the traditional term ‘action research’ (Coghlan & Brannick, 2014) which I adapted as an approach to living in the world, to create collaborative learning, and through processing develop practical knowing in order to bring together action and reflection through linking theory and practice.

### ***Insider action research***

This AR was done from an insider perspective. An insider action researcher (IARr) is a complete member of an organisational system who undertakes academic research in their own organisation, with the ambition of remaining as an employee when the research is completed. This is in contrast to organisational research that is done by researchers who temporarily join the organisation for the duration of the research (Adler & Adler, 1987; Coghlan & Brannick, 2014). An IARr has insights from the lived experience as a native and focuses on research in action rather than research about action (Coghlan & Brannick, 2014).

## ***The quality criteria in action research***

The quality of AR should be judged by its own validity criteria. Most action researchers acknowledge that the goals of AR include: achieving action oriented outcomes, educating both researchers and participants, getting results that are relevant to the local setting, using a comprehensive research methodology and generating new knowledge. The elements of validity criteria connected to the goals of AR comprise: the outcome, catalytic, democratic, process, and dialogic validity criteria (Herr & Anderson, 2005). These criteria are described in the following sections.

The outcome validity is to achieve action oriented outcomes in order to move participants forward in the research project and investigate to what extent the action occurs. To achieve successfulness of the AR the IARr is required to address the problem using a complex approach, rather than just focusing on trying to solve a single problem (Herr & Anderson, 2005). Many action researchers find this difficult and quit doing AR at this stage. Hence, there is no one single solution that fits multiple situations (Dickens & Watkins, 1999).

Catalytic validity asks if the research process focused energising participants toward reflecting on reality in order to transform it, i.e. did the research educate the researcher and staff. Are the researchers themselves open to reorienting their view of reality and their role. All those involved in the AR should deepen their understanding of the issue to some extent as well as move to action change. For the researchers it is important to keep a log by which ones own can own and others change process and understanding can be monitored (Herr & Anderson, 2005).

Democratic validity criteria refers to how the results are relevant to the local setting and if the research is done collaboratively and is appropriate to the context, including how the multiple perspectives have been taken into account. For example, are the members of the community seen as members or viewed as outsiders by the action researcher. Democratic validity deals with ethical and social justice (Herr & Anderson, 2005).

Process validity is the inclusion of multiple voices. If the AR process is superficial the outcomes will reflect this. In addition, process validity is an enquiry into if there has been an inclusion of multiple perspectives via a variety of methods, and several data sources (e.g. observation, interviews) this guards against viewing the activities as simplistic or in a self-serving way (Herr & Anderson, 2005).

Dialogic validity criteria asks if the research is monitored through peer review and if it is disseminated to a broader audience. To promote both the democratic and dialogic validity AR needs to be done collaboratively (Carr & Kemmis, 2003; Torbert, 1981). Peer review reflects the third person perspective, which implies the generalising of ideas and outcomes (Peter Reason & Marshall, 1987).

## **The study context**

The setting for this thesis was on a labour ward within a maternity unit, in a general

hospital located in Western Sweden. In 1997, as a result of a planned merger of two hospitals, the two maternity units merged into the current labour ward. The number of deliveries prior to the merger in each maternity unit was approximately 1500 respectively 2000 for the two units. The labour ward is now the sixth largest in Sweden, and facilitates approximately 3500 births per year, which includes high and low risk women. Around 100 health care professionals are involved on the care at the labour ward; approximately 50 midwives, 20 health care assistants and 30 physicians. Data from 2014 showed that there were 5000 employees within the organisation, and 800 beds providing healthcare and medical services for a population of 270,000, with a turnover of SEK 4.4 billion.

The merger took several years, both at a macro and micro level. The fusion process was at times tense for staff. As a clinical midwife familiar with both sites, I could feel and see the difficulties and the frustration among staff. The staff from the unit which had been closed had to travel longer distances to work and were forced to move to an unfamiliar working environment with unfamiliar colleagues. For a period of time it proved difficult to decide on specific ways of practice but as time passed the differing routines melted together, which eased the working life for many of the staff. The result of the merger increased the workload with throughputs of women and outpatient visits increasing to 6500 per year.

In 2010 the local Regional Council introduced a systematic quality development project, entitled 'Care 2010'. This was in accordance with the national Swedish governmental recommendations for Good Care (2009). The objective of the 'Care 2010' project was to introduce a quality development model through which each clinic within the organisation would set goals based on a structured approach. The overall objective was to decrease the time needed for each hospital stay, and to create a basis for continuous quality development. Caring, within the merged labour ward was not a subject for scrutiny. In general, a registered midwife's caring competencies are not regularly subjected to quality assessment. It is assumed that when the midwives have successfully completed a program of midwifery education that they possess the knowledge of how to care. Caring as a subject has therefore not been a matter for structural evaluation. The mission statement for the labour ward is defined as 'attaining a healthy mother and child with minimum interventions, and a positive childbirth experience for the woman and partner'. Mindful of the mission statement, a project group was formed on the labour ward to develop the care of a woman during labour and birth. This commenced with an examination of the care of women and partners from their arrival to the labour ward.

In this study context the routine for labouring women and their partners, is that they are supposed to make a phone call to the labour ward before arriving. When they did arrive they were met by a midwife, or sometimes by a health care assistant, who showed them in to an examination/waiting room or a labour room. The first midwife greeted them and undertook an assessment. Details were noted about when the contractions had begun, if the waters had broken, and if there were other signs of labour. The midwife then normally started the electronic fetal monitoring, the cardiotocography (CTG) and usually left the room before the CTG was of satisfactory quality and

length, with the continuing recording being monitored from the midwives office and staffroom. The midwife would in the meantime read and document in the woman's records or take care of her/his other responsibilities including labouring women.

### ***My insider action research journey***

In AR, inquiry into the process over time is important (Reason & Bradbury, 2006). This section describes the evolvment within practice. When the merger of the labour wards took place (1997), I had been a registered midwife for two years. Eleven years later, in 2008 I was still working on the same labour ward and this is when my research journey began. It started with a study of obese women's experiences of encounters with staff. I realised that we, as midwives seldom talked about our own behaviors, nor utilised theoretical knowledge about caring. Instead we based our practice on how to meet the needs of women and their partners on our individual experiences and conclusions.

In 2009, the service for women who had tocophobia (fear of childbirth) was down-sized due to economical constraints. Having earlier worked in this service and heard women and partners tell of their stories about their fears and how they described them as being caused by maternity health care professionals behaviours and attitudes contributed to my aspirations to improve care.

During my Masters of Science, I researched 'Obese women's experiences of encounters with midwives and physicians' (Nyman, Prebensen, & Flensner, 2010) and I found that health care professionals often do not reflect on their own behaviors or attitudes. My enquiry began by questioning, how we as midwives could transfer the care approach applied in the fear of childbirth service to all encounters with women and partners? This was the origin of my Doctor of Philosophy studies.

After some searching I managed to get a supervisory team, who were also the external research team for myself as the insider action researcher. The three supervisors had different experiences of health care research and AR, and were from different European countries; Sweden, England and Finland. None of us, however had done insider AR before. My supervisors/external research team visited me a couple of times on the labour ward and this required me to continuously detail the plans and actions. This process with the supervisor/external research team was for me a reflective process and provided the mental distance I needed as a change agent in my own organisation.

A timetable (Table 2, Appendix) illustrates an extract of the actions taken during the course of this four year AR project. In the spring of 2009, I discussed the AR with the Head of the unit, who was supportive of my research. Most of 2009, apart from the regular clinical half time job involved writing the thesis plan. This was quite difficult as in AR it is impossible to know how the research will evolve, which results in the need for special ethical consideration (Holian & Coghlan, 2012). All staff at the maternity unit and stakeholders received a brief introduction and description about the project and of the AR approach. In this presentation I discussed recent research about the increasing amount of unnecessary interventions in labour and the importance of supporting women and partners during childbirth. I have continued to present evi-

denced based research to results in the need for my colleagues at every opportunity as a clinical researcher and practicing midwife within my organisation.

Simultaneously to the 'Care 2010' project being introduced I was seeking to form a local research group for this AR. A group was formed on the labour ward for the 'Care 2010' project which included: five midwives, two health care assistants and one physician. This group subsequently became my insider research group and was called the normal labour process (NLP) group. The NLP group chose me as the group leader. It was a coincidence that the quality development 'Care 2010' and my interest in doing AR amalgamated. In fact, it was the best thing that could have happened at that time with high workloads and economical constraints. In hindsight, it would probably have been impossible to gather staff to take part in research activities outside their working hours, even if many midwives were interested in improving care.

The first mission of the NLP group in March 2010, was to map the care pathway for a woman experiencing a normal labour. This process required eleven meetings to reach a joint decision on what to focus on. We used the process cycle 'plan, do, study and act' (PDSA) by Deming (1993). The first issue highlighted by the group was the woman and partner's arrival to the labour ward and their first encounter with staff, described in paper I. Throughout this process I updated the Head of unit and clinic about what the NLP group was undertaking, and documented my own thoughts and actions in a log. The NLP group introduced a brainstorming activity in October 2010, at a labour ward staff meeting to involve all midwives and health care assistants about what to focus in the first encounter. Additionally, to stimulate interest and reflection I bought books in Swedish about good encounters for all to read. These books were frequently borrowed.

In November 2010 we had to move to another ward for five months to allow for renovations of the labour ward. In the temporary ward there were less delivery rooms, less labouring women, (some labouring women were occasionally directed to other hospitals) and therefore less strain for staff, as the same number of staff remained. The NLP group's activities continued at the temporary ward. The research and the project work continued and progressed well because staff had more time to engage. From December 2010 the research on the first encounter became a regular item on the staff meeting agenda. A problem with working shifts is that not all staff can attend staff meetings scheduled in office hours. Therefore additional meetings were held in the evenings prior to a scheduled staff meeting, this allowed more staff to engage.

During these meetings I highlighted findings from my initial work in 2009, on parents' experiences of the first encounter. I wanted to encourage the staff to read and reflect on these experiences. An example of a citation from this research elucidated that the admission CTG which was said to be compulsory, was often left left to continue for an unnecessary period of time. This has been described in the initial research: *'They started the electronic fetal monitoring and went out and then they came back after an hour'* leaving the woman and partner with questions like: *What is going to happen, what is it that should be checked and why, and are we going to be able to stay?* (parent, Paper I).

While still located on the temporary labour ward, I commenced interviewing colleagues in March 2011. I enquired about their experiences of the first encounter with women and partners further to the work undertaken by NLP group. From the beginning I had planned to do focus group interviews with my colleagues to learn about their experiences, but it was impossible due to time constraints. I decided to visit the ward when I was off duty to do individual interviews, when the midwives had time during their regular working hours. These visits are called 'fieldwork' and are noted in my log. It was at this stage that I then had to design the informed consent in an individual interview format, as it is only during the AR process that the researcher can appropriately decide which data collection method will work best. Before the interviews with colleagues I did a pilot interview with five colleagues (after receiving a written informed consent) who had left the labour ward between 5-11 years earlier, in order to develop my own interviewing technique and scoping the field. The process and midwives reactions and reflections are described in paper II.

I then interviewed the NLP group members in March 2011 and later in May 2012 about their views on participation within this AR. I also discussed with the Head of the unit about how to evaluate the women's and partners' experiences of the first encounters. My question was, had the emphasis on the first encounter had any effect, on current practice? We planned to evaluate this, however at this time the clinic had purchased a web based survey, QuickSearch (QS) software package to evaluate maternity care services from the perspectives of women and partners. A question relating to the first encounter was then included in the survey. The QS survey results were regularly discussed at staff meetings, included in the both positive and negative feedback about the first encounter. The intention was then to use the data from the QS survey to evaluate parents' experiences, unfortunately there was a low response rate. Therefore, their experiences of the first encounter still remains to be evaluated.

In 2011, the NLP group's process work continued and the inquiry moved to other aspects of care including interventions in normal labour decided by midwives and/or physicians. The interventions were a subject for scrutiny as the clinical goal was to attain 'a healthy mother and child and a positive childbirth experience for the woman and partner, with minimum interventions (in the spontaneous labour process)'. The NLP group commenced an evaluation of routine interventions during labour and birth, which was repeated every sixth month. The interventions evaluated were: duration of admission CTG, documentation of reason to do amniotomy, use of oxytocin, and the degree to which fetal scalp electrode was used. These specific interventions were chosen as they were commonly used and are easily measured. This evaluation became an iterative task for the NLP group, and the outcomes were highlighted at staff meetings in order to illuminate the trends in the routine management of childbirth.

In May 2011 I presented my research to the labour ward and to the community based antenatal midwives. I had two reasons for doing this presentation. Firstly, to inform the midwives about the ongoing research on the first encounters. The second reason was to inform the staff about the AR approach, which was a new endeavour for all of us. A year later I informed the antenatal midwives again about the labour ward midwives experiences of the change process. It was important to inform these midwives

as the labour ward midwives and community midwives usually meet a couple of times per year, otherwise we work separately, and there are very little rotation between these groups and organisations.

During the summers I did not have time for the doctoral studies, I had to work full time as a clinical midwife and I decided to let the researcher role 'rest'. While in practice I tried to stay with the labouring woman and partner in the first encounter during the admission CTG to make them feel comfortable. Before I left the room, I informed the woman and partner about what I had found from my assessment. I also attempted to answer the questions that many women and partners have but do not ask, and do not ask during the first encounter. The questions relate to the pending childbirth and consist of; when, where, how, why and who. I could of course not provide an answer concerning the time of birth, but it was possible to answer when, where, how, why and who as related to the current situation (paper I).

I also spent time reflecting on my midwifery practice during and after my shift. It wasn't always easy for me to follow the new pathway of care relating to the first encounter because of cultural and organisational constraints, even though I desired to do so, like my other colleagues. In another attempt to emphasis affirmative encounters with women and partners the Head of the unit and myself encouraged colleagues to forward positive birth stories. This effort failed, no one emailed any stories. We however continued telling each other wonderful birth stories where the team work had been influential for the birth outcome, the parents and maternity care professional's satisfaction. This attempt is an example of the processing in AR, where actions sometimes fail.

During 2012, we had less meetings in the NLP group. We were now all familiar with the process, and almost all staff were also knowledgeable. At staff meetings evaluations continued to inform the staff, as previous years, about our management of childbirth. In December 2012 two more midwives and one health care assistant wanted to join the NLP group, which was an indication that the work of NLP group was regarded as interesting. A new focus on having workshops on how to care for a woman during normal labour developed. The aim was to discuss the everyday practice on the labour ward with a focus on midwifery practice routines. Usually our local workshops or conferences dealt with medical and obstetric issues or risk scenarios. In May 2013 we commenced these workshops for all clinical midwives and health care assistants where the emphasis was practical midwifery and routine management of normal labour. The majority of midwives expressed how they appreciated these workshops in particular, newly qualified midwives. They had realised that here were many different approaches by the midwives to the management of and birth. The evaluation sheets also showed that most staff appreciated having time to talk undisturbed about the management of normal labour.

In the background, I had to start the doctoral thesis write up and present new theoretical and practical knowledge related to the AR. The earlier plans to evaluate the women's and partners' experiences through the web survey had failed. The AR process continued and when I listened to colleagues discussions on the labour ward, another

idea took form in 2013. This was to study if there had been any change in the management of labour as an effect of this AR, such as length of admission CTG and other interventions in labour in comparison to before the NPL group project (paper IV).

The next stage was to decide when to cease the AR project for the purpose of writing up my doctoral thesis. I still needed however to find out what my colleagues thoughts were on taking part in the AR. In May 2013 the Head of the unit planned focus group sessions with the staff to discuss possibilities and requirements for professional development where I was invited to participate and this is where I obtained feedback about their experiences of participating in the AR. This led to the completion of my data collection. I also ceased to participate in the NLP group in order to allow other midwives to take part and examine different aspects of normal physiological birth whilst enabling me to continue with the thesis write up.

### **Lifeworld research approach**

For action researchers the knowledge creation process is a joint endeavor where a shared horizon creates knowledge of the practical change through an ongoing dialogue. These hermeneutic dialogues are interpretations, not only connected to texts or expressions, but also to the practical steps, becoming the results of embodied experiences, also for the researcher (Van Beinum, Faucheux, & van der Vlist, 1996).

In the process of undertaking this insider action research, four individual research studies were conducted to understand the experience of women's and partner's first encounter in the labour ward, and the subsequent practice developments which took place. The rationale for using different methods was to elicit an in-depth understanding from diverse perspectives of how to improve care of a woman in labour and her partner.

One of the perspectives pursued was reflective lifeworld research approach and it was used in two of the studies. The epistemological understanding of reflective lifeworld approach is how the everyday world is lived, experienced and described by humans (Dahlberg, Dahlberg, & Nyström, 2008). Initially a brief summary of the philosophical underpinnings of related phenomenological methodologies is presented.

Husserl (1859-1938) was the founder of phenomenology and philosophised to 'let the things show themselves' by his technique of phenomenological reduction which allows a researcher to have a change in attitude called 'bracketing' or suspend their pre-understandings (Healy, 2011). Husserl is known therefore for his descriptive approach to phenomenology, as the phenomenon/experience is described without any reflection to previous experience.

Heidegger (1889-1976) was a student to Husserl, and his theory was that the being in itself questions and understands the world. Heidegger's interpretative phenomenological approach is in stark contrast to Husserl. Heidegger says that bracketing is unrealistic and he went on to present a fundamental conception of phenomenology (Kisiel, 1993). Heidegger's methodology refers only to the phenomenon/the experience 'as experienced by us' (Healy, 2011, p. 220). He also clearly linked phenomenology to

hermeneutics; the art of interpreting text for understanding. Healy (2012) clearly explains why Heidegger linked phenomenology with hermeneutics. By using Sheehan's description, Healy clarifies that human beings are hermeneutists and thereby we as human beings make sense of our own experiences. For example, whenever a woman and partner experience their first encounter it is only they who can reveal how that encounter was. By following Heideggerian hermeneutics the researcher is required to follow the principles of the hermeneutic circle whereby interpretation can only be possible by relating the phenomenon/the experience to the context (Healy, 2012). This principle is defined further by Palmer as 'the part is understood from the whole, and the whole from the inner harmony of its parts' (Palmer, 1969, p. 77).

Merleau-Ponty (1908-1961) was Husserl's successor and investigated the ground for our 'being in the world' and our knowledge of it through lived bodies, a relationship between the human and the world. Gadamer (1900-2002) continued Heidegger's hermeneutical philosophy through investigating human interpretation where every interpretation depends on 'horizon of interpretation' (the experiences of the world and prejudiced memories and anticipations). To see beyond the understanding that is already there, one has to challenge this existing horizon (Dahlberg, et al., 2008; Gadamer & Melberg, 1997). The language is the tool we have in all dialogue, questioning and understanding. All speech and text is basically dependent on the art of understanding, the hermeneutics, and an art that cannot be mechanised or controlled (Dahlberg, et al., 2008; Gadamer & Melberg, 1997; Gadamer, Weinsheimer, & Marshall, 2004b).

A reflective lifeworld research approach requires the researcher to adopt an open stance throughout the study, reigning back in pre-understandings, and keeping a sensitivity and pliability to the studied phenomenon. The prerequisite when starting reflective lifeworld research is to have an interest in how human beings experiences are experienced and to understand the meaning they give to that experience. Dahlberg (2011) explains that 'there is always an intentional relationship with the things that make up our everyday lives' and therefore human beings experiences are experienced 'as something and something that has meaning' (Dahlberg, 2011, p 21). This approach therefore aims to identify patterns of meanings, comprehension and explanations (Dahlberg, et al., 2008), which emphasises interpretation as the key for understanding phenomenon in daily life (Gadamer, Weinsheimer, & Marshall, 2004a), and how human beings relate to and interact with the world (Dahlberg, et al., 2008; Merleau-Ponty, 1962).

## **Interpretive description**

Interpretive description (ID) is a qualitative research approach that fits complex experiential questions asked by applied health researchers. It facilitates for the researcher to ground the inquiry in feeding the needs in the specific discipline, and thereby illuminating insights in a logical and systematic way (Thorne, 2008). It is defined as a non-categorical methodological frame, meaning that the researcher does not have to stick to the 'classical' qualitative methods; grounded theory, ethnography and phenomenology, and avoids hereby constraints and limitations in developing knowledge that aims to inform clinical practice (Thorne, Kirkham, & O'Flynn-Magee, 2008). The ID approach guides the systematic generation of thematic patterns, and all theoretical

and practical knowledge that researchers bring into the study should be acknowledged and is considered as the platform on which the design is built, 'the scaffold'. The scaffolding also is taken into consideration during data gathering and in the interpretation of analysis (Thorne, 2008). This is in contrast to the 'traditional' qualitative methods where the pre-understanding, the theoretical and practical knowledge that the researcher has should be 'bracketed' or 'bridled'.

Gadamer and colleagues (2004b) highlight that the study of a human being's world cannot be reduced to one single method and therefore this research follows different methods in an effort to provide the whole picture required to: examine labour ward midwives' routine management of childbirth (before, during and after birth), to illuminate institutional encounters and care routines, and to examine how encounters affect routines.

### **Data collection**

#### *Paper I*

A total of 65 persons participated in audiotaped interviews or group discussions. Both focus group discussions and individual interviews were used to capture the meanings of the study phenomenon, the parents' first encounter with labour ward staff. The inclusion criteria included Swedish speaking first time mothers who experienced spontaneous onset of labour, and gave birth to a live fetus, along with their partners. The women were recruited consecutively from the labour ward register to ensure the inclusion of both Swedish-born and Swedish speaking immigrant women.

To gain an insight into the lived experience of, admission to the labour ward close to the event, thirty, first time mothers were interviewed before discharge via individual interviews. This was commenced within 72 hours following childbirth on the postnatal ward in their rooms or elsewhere on the postnatal ward. Participants were recruited and the interviews conducted by two master students who worked on a different ward and who had not been engaged in their clinical care. The women signed a written informed consent form, which highlighted that they could freely withdraw consent at any time, and that their identity should be protected by confidential handling of the data.

To obtain a general perspective at two months following childbirth when parents had time to reflect on their experiences, focus group discussions were undertaken with other parents. A month after birth I phoned and invited first time parents to attend a group discussion at the hospital which I facilitated and the focus centred on their experiences of arriving to the labour ward. The focus group discussions allowed the participants to reflect on and respond to each other's experiences of the first encounter at the labour ward. All women signed a written informed consent and before the focus group discussions started they were also orally informed that they could freely withdraw consent at any time. They were also informed that the confidential handling of the data would protect their identity.

Seven of the women for the individual interviews declined, one interview was deleted due to poor sound quality, and one woman was incorrectly included. One person who

was unable to take part in the focus group for personal reasons was interviewed individually. I interviewed three couples whom were immigrants from three different European countries separately in their homes since they did not want to participate in a focus group. Forty-seven declined participation in the four focus groups (5-12 participants in each group) for a range of different reasons, including not having anything to contribute, having other appointments at the same time, no car for transport, partner working and other practical reasons (Table 3).

**Table 3.** Characteristics of study participants study I

Summary of Interviews	Women			Partners		
	Invited	Participated	Declined	Invited	Participated	Declined
Age, years		20-38			20-48	
Individual Interviews	39	30	7*			
Focus group	41	19	22	41	16	25
In Total		49			16	

\* 2 dropped out for other reasons

After a short presentation, the individual interviews and group discussions commenced with an open key question: ‘How was it to enter the labour ward?’ Clarifying questions were asked such as ‘could you explain what you mean’, ‘could you please extend further’. The individual interviews lasted 10 to 60 minutes and the group discussions 30 to 70 minutes. All interviews and focus group discussions were transcribed word for word. All the text data were analysed together as initial analysis indicated that there was little difference in the accounts given at each time point, in the interviews and focus group discussions.

### *Paper II*

In this study midwives were interviewed (Table 4), as they were responsible for the interventions during the first encounter. All 57 midwives employed on the labour ward were eligible to take part in interviews. They were informed about the purpose of the study verbally, and asked to sign a consent form if they were happy to participate. They were informed that they could freely withdraw consent at any time. The consent form included permission to use individual quotes, and they were assurances that their identity would be protected by confidential handling of the data.

**Table 4.** Characteristics of interviewed midwives study II

	All	Interviewed
Number of midwives	57	37*
Age, years	30-63	34-62
whole population	mean: 49,5 median: 51	mean: 49 median: 52
Working experience	mean: 19 median: 20	mean: 19 median: 14
Years on the current labour ward		mean: 12 median: 14

\* 4 of the interviewees were also members of the normal labour process group

During the first 5 months after the action plan was launched, I interviewed midwives in a private room at the labour ward on the occasions when they were free from their duties. The interviews were guided by a set of trigger questions: 'How do you perceive the changed approach in care for women and their partners at their arrival to labour ward?' 'What does the change mean to you?' Clarifying questions were asked such as 'can you explain what you mean? Can you please extend further?' The interviews lasted 15-20 minutes while some interviews were shorter. The focus of the interviews however was always on these questions so that rich data could be collected on this precise aspect in a short period of time. Rapid engagement was enabled, as I knew the interviewees thereby limiting the need to form effective conversational relationships at the beginning of the interviews. I also indiscriminately interviewed eligible midwives on the days I was there doing fieldwork. After 37 interviews were completed, it was agreed within the external research team that theoretical saturation had been reached, and so no more data were collected.

### *Paper III*

This paper described my experiences as a novice doctoral student and a staff member at the labour ward initiating and running an insider action research project within my own organisation. The data forms the basis of the reflexive account that was collected iteratively and informally between 2010 and 2013, as the AR process unfolded. Data consisted of 70 pages of logged text (personal notes) including reflections from clinical work, process group, formal and informal interviews, hand-outs, participant observation, and communication with colleagues and the external research team. Keeping a research log is useful for developing first person inquiry through the capturing of experiences close to when they happened. It functions as an analytical tool, a systematic record of events and dates, personal thoughts and feelings to enable reflection and an understanding of your own actions. It is also a way to park painful experiences (McNiff & Whitehead, 2009).

### *Paper IV*

Paper IV is an observational study that evaluated what happened after the initiation of the AR project. It included data from the maternity records of healthy women with a healthy pregnancy, who had a single, live fetus with cephalic presentation and spontaneous onset of labour between 37 complete weeks and to 41 weeks + 6 days gestation. A random selection was done to ensure equal numbers of nulliparous and multiparous women in 2009 and 2012. From January to December the random selection of two nulliparous and two multiparous women's records, every third day was undertaken to ensure a good representation of labours throughout each year. From the random selection 903 records were analysed (441 in 2009 and 462 in 2012) and 101 records were excluded. Data were obtained retrospectively from the hospital obstetric database. Exclusion criteria: induction of labour, elective or emergency caesareans, a caesarean in a previous birth, breech presentation, and twins in the current pregnancy, or if they had a history of chronic diseases, diabetes mellitus and/or hypertonia, or other conditions developed during pregnancy that require increased surveillance of the fetus or woman during labour. This exclusion criteria made it possible to collect records without knowing, a priori, anything of the interventions undertaken in each labour.

## **Data analysis**

### *Paper I and III*

The analysis in paper I and III was based on a hermeneutic, reflective life world research approach described by Dahlberg et al. (2008). The approach aims to identify patterns of meanings, comprehension, and explanations. In paper I and III all the interviews were transcribed word for word. The analyses of the text aimed at discovering qualitative meanings in the text, and synthesising in a final comprehensive interpretation of the phenomenon. Following the hermeneutic circle, the whole of the text was described and interpreted in terms of the details and the details in terms of the whole. First, I read through the text to get a sense of the whole. Next, in further readings, an intensive dialogue with the text was performed where meaning units were identified and clustered. Successively, themes of meaning were recognised and described together with all authors. These formed a basis for a final comprehensive interpretation of the explored phenomenon (Dahlberg, et al., 2008).

In paper III an auto-ethnographic writing style was used for the first level themes of meaning, to take account of direct engagement with the data as one of the many ways of knowing and inquiring within the world (Heron, 1996; Reason & Torbert, 2001). This allows for the telling of a personal narrative (Ellis & Bochner, 2000) as a type of critical enquiry into the practice of a researcher and/or practitioner (McIlveen, 2008). In keeping with this intent, the personal pronoun was used. A collective pronoun was used for the final comprehensive interpretation which was undertaken with my external research team/supervisors.

### *Paper II*

Interpretative description (ID) as described by Thorne (2008) was used to illuminate the midwives change process in their practice during the first encounters. This method guided me to begin with a question to aid understanding the midwives perceptions and opinions. I continued interviewing until theoretical saturation was reached, meaning that no further opinions were emerging that added to the understanding. This knowledge generated new insights that provided a further reflect on and increase understanding about midwives clinical values. All interviews were transcribed word for word. First, the transcripts were read, reflected on and analyzed by VN, TB, and MB. An English version of the findings at this stage was then written and SD provided analytic input. In an iterative process of reflection, critical examination, and informed questioning, data were divided into blocks expressing meanings. In further readings these meanings were synthesised and tied together into themes consisting of essential meanings that answered to the overall research question.

### *Paper IV*

Mann-Whitney U-test, Fisher's exact test, and Chi-square test were used for comparison between groups. The SPSS statistical package, version 20 (SPSS Inc., Chicago, IL, USA) was used for the analysis, which used medians as descriptive measures.

## **Ethical considerations**

Ethical approval and permission to undertake the research was obtained from the Regional Ethics Board in Gothenburg, Sweden (study I Dnr: 347-09, study II Dnr: 590-11, study IV Dnr: 786-14) based on the principles outlined in the Helsinki Declaration. All women gave birth at the local hospital, and were required to have knowledge of the Swedish language. In study II (Dnr: 590-11) the ethical board concluded that the study did not fall under the Swedish ethical legislation based on the Helsinki declaration. Instead the team was advised to ensure that the midwives were not pressured to participate in the interviews, considering the fact that I was employed at the same labour ward. I was not in a managerial position, so I did not have the power to force colleagues to participate, which also is not the way to do AR.

Professional morality is more useful than trying to create guidelines for action researchers (Williamson & Prosser, 2002). To be able to continue as a full member and an employee it was a prerequisite to consider what would be appropriate to do and in order to avoid doing harm to my colleagues. Furthermore, it is not possible to guarantee confidentiality and anonymity as colleagues ultimately knew who participated, even if data collection and analysis was made confidential and anonymous (Williamson & Prosser, 2003), and this is a reason to be careful in the writing up. We did not know in advance where the journey would take us, and it involved the midwives willing participation. Yet, as Meyer (1993) observed this is not always the case as change can be threatening and cause anxiety (Meyer, 1993).

## RESULTS

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The four papers in this thesis are aimed at exploring and improving management of childbirth care, as described and evaluated from different perspectives. The results described investigate women's and partner's experiences of the first encounter (paper I), and midwives experiences of own practice with an emphasis on the first encounter (paper II). A methodological description of doing AR within one's own organisation is described in paper III. Subsequent effects of the care development processes were explored by measuring the midwives usage of routine interventions in labour and birth before and after implementation of this AR (paper IV).

### Parents' experiences of the first encounter (paper I)

The phenomenon was identified as consisting of four thematic meanings: *Timing it right*, *waiting for help*, *negotiation from an inferior position*, and *facing reality with a mosaic of emotions*. The comprehensive understanding of the phenomenon was: *waiting to earn permission to enter the labour ward world*.

*Timing it right* involved trying to ascertain the right moment to leave home in order to arrive at the labour ward at the 'right' time. Participants described their experiences of how far they had advanced in the labour process as being based on their embodied sensations, which was in contrast to the assessment of physical signs of labour made by the maternity staff. *Waiting for help* meant to hand over the responsibility and control to the midwife or other staff who first attended them. Filled with questions about what, when, why, and where things were going to happen, they waited for the midwife to pose questions, inform and advise. *Negotiating from an inferior position* meant that given the new unknown situation, decisions were left in the hands of the midwife. An initial sense of anxiety was ameliorated when being met by a midwife who showed interest and willingness to listen to their needs, and who remained in the room from the first moment. Participants wanted to talk to the midwife at the first encounter about the specific nature of their contractions, but felt they were not always listened to. Accepting the professionals' assessment seemed to be the norm. *Facing reality with a mosaic of emotions* meant being in the 'real' situation of labour for the first time and feeling ill at ease and unsure in the new environment, a feeling that diminished with the creation of a positive relationship during the first encounter. The recall of cognitive knowledge about self-coping measures for labour was difficult to achieve during the first encounter and was lost in the face of the realities of labour. Being able to ask questions and confide uncertainties to a midwife who understood the process and was able to confirm the normality of feeling apprehensive enabled the women to relax into the flow of labour.

The final interpretative understanding *was described as waiting to earn permission to enter the labour ward world*. This experience evolved from a combination of the stress involved in trying to arrive at the labour ward at an appropriate time from the point of view of the ward staff and the subsequent feeling that one occupied an inferior position with a mosaic of emotions. Entering the milieu of the labour ward is not easy; it was a completely new context of unfamiliar rules. To gain entry, participants

had to make a phone call, and then wait for advice either to stay at home or be invited to come. They arrived at this first crucial meeting with a general sense of tension, insecurity and hesitation. Once on site, the woman and her partner entered into a period of passive waiting for help. This was followed by a new dutiful waiting for a final decision of being allowed to stay or to be sent home – a decision over which the women and their partners had very little power, and in which they seemed to have little choice. Having to wait before and after the first encounter seemed to be accepted as an inevitable part of the process. An asymmetric power relationship was expressed in the obedient acceptance of waiting for attention and information in an unfamiliar world. The entry to the labour ward sets the tone for the rest of the birth, and the first encounter has the potential to influence the experience of subsequent intrapartum care. These findings suggest that the labour ward entry process is not parent-centred.

## **Midwives' experiences of highlighting encounters (paper II)**

Midwives' views and feelings about the focus on the first encounter with women and their partners on the labour ward identified an overall thematic pattern with two poles: *glancing beyond routines and being confined to inherent routines*, including four underpinning elements.

*Glancing beyond routines* describes how the changed care approach provided increased potential to support each woman and partner, by focusing on their individual needs in a holistic sense. It meant *valuing the idea* of talking about the first encounter and the routines. This emphasis supported staff to be open to the parents' feelings, including their anxieties. It involved creation of a relational space which had previously been made impossible by the focus on electronic surveillance. *Acquiring extended space to create a lingering presence* challenged established norms and behaviours, and gave space for and enabled a changed approach to be established. This 'official' permission, to be present and lingering from the very beginning of the encounter with a couple, was mediated to an extent by the level of acceptance of the new way of working by colleagues on shift that day. A 'lingering, presence' was established that benefitted both the woman and partner, and midwife. *Glancing beyond routines represent* the growing awareness that led to a change in the care approach.

*Being confined to inherent routines* expresses the experience of being committed to pre-existing local cultural norms, which prioritised routine surveillance of the foetus over other activities. *Resistance to the need for change* involved the belief that inherent routines were already optimal at the first encounter. There was a reaction that highlighting the first encounter was in fact an unnecessary critique of current practice; that the changed care approach was nothing new, and did not add to the quality of the first reception of the woman and her partner. Embedded in this element was also the view that the first encounter is primarily an assessment situation; the midwife is required to conduct vaginal and other clinical examinations to establish whether the woman is in active labour or not in order to make a subsequent plan for care. Feeling the pressure to change involved the feeling that a decision to change the routines around the first encounter had been taken by someone else. The main argument for not being able to adopt the new approach was time constraints, including the necessity of monitoring

other women's CTG traces simultaneously. There was an organisational belief that the CTG trace was an essential tool for identifying if there was any imminent or actual pathology in the fetal heart pattern and prompt commencement of a CTG trace was therefore deemed to be an important safety standard. Midwives expressed that without a wider system change, the move away from using CTG was not seen as achievable.

### **Illuminating the process of doing insider action research (paper III)**

Three thematic meanings evolved: *the struggle to initiate a clinical insider action research project, standing alone at the messy front line*, and *being a catalytic counterbalance to the prevailing medico technical focus*, and was concluded by a comprehensive understanding of the phenomenon was: *learning how to clinically reflect on and to voice the tacit components of care*.

*The struggle to initiate a clinical insider action research project* meant that the task taken on by the normal labour process group (mapping the pathway of normal labour) was a major undertaking, largely due to inexperience to work with process management. This resulted in uncertainty and a significant level of frustration for all of us in the newly formed normal labour group, particularly during the first year. In the beginning I had many questions about how to conduct action research; how to best initiate the process and encourage the staff to participate. Other questions which arose as the studies continued included; what to do next, and how to make the process more democratic. *Standing alone at the messy front line* meant managing one's own and others anxiety and frustration over high workloads and shortage of staff which both acted as an impediment to the normal labour process group's work. A peak point where I really wanted to quit the research occurred after a couple of years and was a result of feeling like very little was being achieved. I became aware of my fear of failure; both failure in succeeding with my ambitions to create knowledge about the improvement process, and to improve care approach at the first encounter, and hence failure in managing to complete my doctoral studies. *Being a catalytic counterbalance to the prevailing medico technical focus* meant that change was difficult to detect when it concerned the approach to the first encounter, as I was not observing colleagues in action during their first encounters. We began to spontaneously discuss our own first encounters and aspects of care crucial to normalising labour. The focus on problems and potential pathology were regularly observed and confronted. This was a clear and positive result that developed throughout the years.

The final interpretive understanding: *Learning how to clinically reflect on and voice the tacit components of care* meant that an insider researcher became the active agent to create space in which staff could consider the importance of, and techniques for, responding to the women's and partners' needs in their first encounter. It was a process of adjusting and searching to find a balance between being an insider and an outsider, including acceptance of the inherent and physical chaos embedded in doing IAR. The four years of negotiations about normalising labour starting with the first encounter contributed to a change and to a counterbalance to the prevailing medico technical focus of care. To change care approach and routines on the labour ward is to change fundamentally how it is to be a professional carer.

## Effects on rates of routine interventions (paper IV)

This before and after study involved a 20 % random sample of healthy women with healthy pregnancy giving birth in 2009; before the AR started and in 2012; a year after implementation highlighting the care in the first encounters. The randomly selected 1004 electronic records were opened. When we studied the records some were excluded since they did not meet the inclusion criteria. In total 101 records were excluded.

There was a small but significant difference in the duration of the admission CTG between the years. The use of scalp electrodes and use of oxytocin had reduced significantly ( $p < 0.001$ ). Amniotomy showed a downward but non-significant trend. The amniotic fluid was significantly more often meconium stained in 2012 (19.3%) compared to 2009 (14.3%) ( $p < 0, 004$ ). There were no significant differences in postpartum bleeding, low Apgar score at 5 minutes, and mode of delivery between the years (Table 5).

**Table 5.** Rates of interventions during labour and birth, both nulli- and multiparous women included

Admission CTG (minutes )	35.0 (6-636)	31.0 (7-651)	0.001 <sup>a</sup>
Amniotomy	227 (52.1)	210 (45.6)	0.053 <sup>b</sup>
Scalp electrode	369 (83.7)	312 (67.5)	< 0.001 <sup>b</sup>
Oxytocin augmentation	189 (42.9)	161 (34.8)	0.014 <sup>b</sup>

Data are given as median (range) or *n* (%). <sup>a</sup>Mann-Whitney U-test. <sup>b</sup>Fisher's exact test

The length of CTG monitoring from admission to birth was unchanged between the years, and in 2012 the total time on the ward increased for nulliparous women in 2012 compared to nulliparous 2009 (Table 6).

**Table 6.** Length of CTG monitoring from admission to birth

	Year 2009 Nulliparous n=216	Multiparous n=225	Year 2012 Nulliparous n=246	Multiparous n=216
Total CTG hh:mm Median (range)	5:05 (0:08-17:57)	1:45 (0:07-9:12)	4:55 (0:22-19:05)	1:59 (0:10-12:20)
Time from admission CTG to birth, hh:mm Median (range)	7:37 (0:13-41:20)	3:05 (0:05-20:36)	9:13 (0:18-48:14)	3:41 (0:05-41:12)

## DISCUSSION

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### A synthesis of the results

The findings from this research have focused on the process of improving care for women and partners. The concept of ‘bemötande’ or ‘bemeeting’ (my paraphrase) has been identified.

The concept “encounter” is often used in caring science, emphasising the element of caring in the encounter. The word refers to openness, courage, immediate presence and availability, but the meaning is blurred (Holopainen, Kasén, & Nyström, 2014). Furthermore, Parse writes that a carer needs to be truly present during encounters, and to understand the ontology of human becoming. It is to believe that humans are unitary beings, meaning that humans cannot be known by studying the parts. Initial physical presence by the carer enables the creation of a sense of a lingering presence (Parse, 1998). The metaphor for an “encounter” is presented as a path to the space of togetherness where we can get a glimpse of a mutual existence and where the interpersonal encounter is created (Holopainen, et al., 2014).

To open up an understanding of the Swedish word used for the phenomenon first encounter within this thesis, a description is necessary. When talking about encounters in Swedish the word ‘bemötande’ is the usual word of usage. The word ‘bemötande’ has been used in the native Swedish language version of this thesis when describing the phenomenon and there is no direct translation or counterpart to this word in English. The second element of the word, i.e. ‘möta’ has the same meaning as ‘to meet’, and the prefix ‘be’ signals that you meet what is around you<sup>1</sup>. The English word ‘befriend’, an act of making a friend, has a similar meaning but is not used in a neutral way, nor used to inquire about the receiver’s feelings of an encounter<sup>2</sup>. In a caring context the concept ‘bemöta/bemeet’ (where the same tenses as for the verb ‘meet’ could be used, prefixed with ‘be’) means that you have adopted a holistic approach towards other people by taking into account that the meeting has an emotional impact.

In the Swedish language the word ‘bemötande’ can also be used as a noun, for example in the question: Hur upplevde du bemötandet? (Meaning: How did you experience the other’s behaviour/manner in the meeting/reception/greeting?) It is also used as a transitive verb: Hur bemöter man en orolig kvinna? (Meaning: How do you meet/treat/behave when meeting a worried woman?). In this context, an encounter and meeting with the woman and partner becomes the responsibility of the midwife, an undertaking that holds high value for all parties involved; the midwife, the woman

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<sup>1</sup>I have not been able to trace whether the prefix ‘be’ in the case of the Swedish word ‘bemöta’ literally can be said to have the meaning ‘meet what’s around you/meet what’s close to you’ or ‘answering to’. Both of those meanings are accurate and are listed in the etymological dictionary as possible from a grammatical viewpoint <http://runeberg.org/svetym/0122.html> and <http://g3.spraakdata.gu.se/saob/>

<sup>2</sup>Befriend is identified as a noun and an adjective. The verb befriend is primarily defined as ‘to act as a friend to, to help, favour, to assist and promote. It is a derivative of the verb befriend along with befriender and ‘befriended’. Another definition of befriend is a companionship and support of a friend especially in lay capacity. <http://www.oed.com.ezproxy.ub.gu.se/view/Entry/17064?redirectedFrom=be+friend#eid>

and her partner. The literal meaning of 'bemötande/bemeeting' does not imply if it is good or bad. Instead it confers the receiver permission to experience an encounter as a person, as well as granting the giver an experience of how to meet another person.

It is a word that includes the emotional perspective of an encounter or meeting as well as the physical perspective and it can be used both from the giver's and receiver's point of view. It describes a meeting, reception, treatment, attitude, and approach in one word. An understanding of this concept means one may speak about a good/fine/nice/pleasant, trustworthy, faithful 'bemötande/bemeeting' or a bad/unpleasant 'bemötande/bemeeting' or, it might of course be a neutral 'bemötande/bemeeting'.

The word also implies two humans or one human and an institutional agent, i.e. one can talk about the 'bemötande/bemeeting' from the midwife (on the phone) being great as well as the 'bemötande/bemeeting' from the ward staff being great when referring to the reception, treatment, attitude, and approach at the first physical encounter. It is however not possible to talk about the 'bemötande/bemeeting' from a deer in the woods or from the neighbour's dog (even though the neighbour most certainly will object to that). This means that there is always a person involved in an experience of quality, or lack of quality associated with a 'bemötande/bemeeting'; this person's experience of the caring situation being of crucial importance to the outcome of an encounter and subsequent interrelations within the healthcare context.

The prototypical 'bemöta' is not reciprocal. An open and nice 'bemötande/bemeeting' from the carer invites the person/s to a dialogue, which is the prerequisite for the well-being of the person/s. I use 'bemötande/bemeeting' in order to reinforce the reader's conceptualisation of the encounter between women and partner, and their midwife. I will also use 'meeting' and 'encounter' and comment if necessary for grammatical explanations. The effect of this kind of fruitful 'bemötande/bemeeting' is in line with the quote about 'not letting the Other alone' (Levinas, 1985, p. 119). A good 'bemötande/bemeeting' is a prerequisite for the possibility to create a caring relationship between the woman and partner, and midwife.

The 'bemeeting' influences every interaction with others. It powers the achievement of trying to change behaviours and routines (paper II). It impacts the process of how to clinically voice the tacit components of care (Paper III).

To be compliant to the technocratic norms and 'getting through the work' that midwives experienced working in publicly funded settings (O'Connell & Downe, 2009) by means of the medico technical surveillance was challenged through this AR (paper IV). We experience ongoing difficulties in seeing changes to our routine management of childbirth as compatible with existing values and norms, given that we are imprisoned in a hegemonic 'CTG faith'. Continuous CTG monitoring during normal labour may be an unintentional substitute for the presence, the 'being with' the labouring woman and partner. The throughput/high 'turnover' of pregnant and labouring women leads to an increased mental workload for the staff, and can also be considered a hindrance for midwives to glance beyond routines. It was easier to stick to the inherent fragmented task oriented routines (paper II), even concerning the first 'bemeeting'.

The importance of being present and remaining attendant for a length of time during the first encounter was emphasised throughout this AR.

We know that every interaction entails a first impression, which determines how smoothly or awkwardly later interactions will proceed (Harris & Garris, 2008). The first encounter in a labour ward world is perhaps for some their first ever institutional health encounter with a carer, and as such this single 'bemeeting' is likely to influence the woman's and partner's experience of future encounters. The feelings that remain in the Other after a single encounter determines also how later interactions with other carers will proceed within the context.

The historically inherited curing actions, 'the technological model of birth' (Davis-Floyd, 1987) is accepted, but to support via the 'caring actions' requires us to be emotionally involved, which necessitates time, reflection and competence. Arrival on the labour ward illustrates that the interaction was powered by professionals, who decide what to ask, and how the answers were interpreted and valued (paper I), demonstrating the power imbalance in practitioner-patient encounters (Gwyn, 2002; Harvey & Koteyko, 2012; Pilnick & Dingwall, 2011). The asymmetric power relationship was apparent when women and partners had to wait for permission to enter the labour ward world (paper I).

The final stage of the process was focused on improving encounters and management of childbirth care through an evaluation of the routine interventions which comprised normal labour care. This led to a new knowledge/awareness and a subsequent reduction in the use of unnecessary routine interventions during the time of this project (paper IV). This reduction in the burden of unnecessary routines led to more time being available for the first 'bemeeting', enabling the midwife to be more present for the first encounter.

Caring in this significant period of unawareness that women and partners experience, is to 'not leave the Other alone' (Levinas). For the women and partners being so close to parenthood and to meeting the baby, but not knowing anything about when, who, why, where and how until the CTG was done could be stressful. Being in this situation with a mosaic of feelings meant that a good bemeeting and confirmation about the normality of the uncomfortable feeling of not knowing became very important and a greater capacity to relax into the flow of labour. The midwife's presence at the 'arrival', the beginning of the woman's and partner's journey through the labour ward world, as well as the chance to ask questions was appreciated. It was important to highlight the when, who, why, where and how questions that woman their partner did not always dare to ask, because they were afraid that the answer would indicate that they came too early and/or had misjudged their bodily feelings. Dahlberg and Segesten (2010) specified that patients in general (here the labouring women and partners) seem to feel less important and are more likely to experience a feeling of helplessness and despair at the same time as they are dependent on carers. For midwives to tell what they know before leaving the room is to provide emotional and social support from the start. Emotional and social support that is shown to reduce the rate of caesarean section and operative vaginal deliveries, as well as the need for pain relief (Hodnett, et al., 2011).

## Reasoning about 'bemeeting'

In my belief, the literature about women's experiences of childbirth emphasises the importance of receiving a 'good bemeeting'. Words that in Swedish has a holistic notion taking into account that the meeting has a positive emotional impact, similar to the understanding of the holistic communication to promote wellbeing that stresses the carer's incorporation of therapeutic communication through listening, being compassionate, and reflective. (Dossey, Certificate, Keegan, & Association, 2012). For me the word 'bemeeting' when talking about encounters refers to our attitudes, how we 'are' when we do something in an interrelationship with others. A review about women's experiences of childbirth satisfaction recognises the importance of a 'good bemeeting', which leaves the woman and partner with a feeling of contentment. It reveals that the influences of pain, pain relief, and intrapartum medical interventions on subsequent satisfaction are neither as obvious, as direct, nor as powerful as the influences of the attitudes and behaviours' of the carers (Hodnett, 2002). Further, continuity of care, a cornerstone in midwifery and of women-centred care (McCourt, 2005), a consistent trustful professional care (Green, et al., 2000), and a humanistic approach to care where technology alongside with 'relationship-centred care' (Freeman, 2006) was valued, and are components of a 'good bemeeting' from staff.

The 'bemeeting' refers to the social interaction that occurs in the first and subsequent encounters and is highly topical. During 2014, the Patient Advisory Committee in Sweden received 32 735 complaints regarding health services, which was an increase of 1 564 cases (5%) from 2013. The amount has increased every year. In 2000 the number of complaints was 18 546. In the main problem area described as 'Communication' 48% of the complaints regarded the 'bemeeting' (bemötande) the patients' received. Next after the 'bemeeting' came 'not listened to', followed by 'dialogue/participation with patient/next of kin', 'cultural/language barriers, interpreter questions', 'empathy', 'abuse', and 'information to patient/next of kin' (Diagram 1)<sup>3</sup>. My understanding of the general interpretation of the reason for the increase in complaints is an increasing knowledge among people about how to access the complaints system. However, the fact remains that a great number of patients/service users have experienced a disrespectful and inadequate 'bemeeting'.

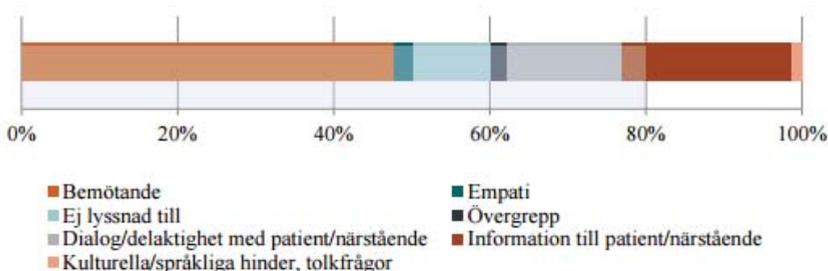


Diagram 1. Communication decomposed at sub-problems

<sup>3</sup><http://www.ivo.se/globalassets/dokument/publicerat-material/rapporter/ovrigt/sammanställning-av-klagomal-till-patientnamnderna-under-2014.pdf>

Several years of clinical work on the labour ward and knowledge of studies on experiences of healthcare encounters initiated a need to reflect on our 'bemeeting', our approach and attitudes. If the 'bemeeting' is experienced as positive, courteous and supportive it implies that the carer has shown compassion, respect, and concern through actively listening and responding. The full meaning of care according to Levinas requires an intervention making it possible to say that the responsibility of care towards the other is the carer's. It means that the carer always have an intention to do something in a care situation (Lavoie, et al., 2006). A positively experienced 'bemeeting' reflects the importance of Levinas' concept of care; a relationship where the feeling of affection is included in the intervention. Hence, in the intervention the Other's experience of this 'bemeeting', the carer's engagement and friendliness is automatically judged by the women and partners. The responsibility of care towards the Other requires a level of engagement which goes beyond the fact of being there. It is to care about the experience the Other is going through (Levinas). Understanding the 'bemeeting' where the 'be' signals that 'we meet what is around us' means to me what Levinas wrote 'not letting the Other alone' (Levinas, 1985, p. 119). According to Levinas (Ethics and infinity) 'someone who does not spontaneously respond when a facial expression is giving her or him a message has abdicated a duty of responsibility and laid the guilt on the other' (Eliasson, Kainz, & von Post, 2008, p. 507). Holistic communication means being concerned through listening, being compassionate, reflective, focused, and incorporating a therapeutic communication with the objective to promote wellbeing (Dossey, et al., 2012). For me it means to give a 'good bemeeting' in every interaction, even in the context of short encounters. A 'good first bemeeting' from staff paves the way for the feeling in the woman and partner of the lingering presence.

## **Support and surveillance**

Marie-Francoise Collière (1982) defined curing and caring interventions. The 'usual caring interventions' entails fulfilling needs such as; to eat, drink, evacuate and to be able to move about (Lavoie, et al., 2006). To support a woman in labour and partner, the 'caring interventions' including the midwife's presence could many times be sufficient 'interventions' in a woman's childbirth. However, in a hospital's medico-technical context childbirth is often instead 'cured'. The purpose of these 'curing interventions' is to treat or limit the disease and fight against it. The 'curing interventions' have a technical aim, activities like supervising vital signs, carrying out blood tests and giving injections (Lavoie, et al., 2006). Transferred to our labour ward context, it means using e.g. CTG, epidural anesthesia, amniotomy, scalp electrode, augmentation of labour. My understanding from clinical work and from the literature describing women's expectations and experiences requires in addition to the desired curing interventions more knowledge and training for professionals in the caring and socially supporting interventions, including a compassionate and affirmative 'bemeeting'. The emotional and social support that labouring women and partners asked for was underprovided. This could be caused by the fact that staff themselves lack the time to renew own emotional, physical, mental and spiritual energy (Ghaye, 2007).

How is it possible for women to see childbirth as a normal event, when neither midwives nor obstetricians view it as a happening where they should not always inter-

ferre? The power of our attitudes and behaviours, women's expectations, the amount and quality of support, and involvement in decision making (Hodnett, et al., 2013; Hodnett, 2002) has through this thesis been highlighted in an attempt to change professionals' opinions that childbirth cannot be 'done' without routine intervention (Downe, et al., 2001). The ambition to improve the 'bemeeting' was with the help of reflection on own routines, an attempt to try and create a good and secure feeling for the women and partners starting at their arrival, and through the fostering of a new awareness for the midwife to accomplish what Parse (1998) expressed as a 'lingering presence'. The feeling of contentment gained from a 'good bemeeting' is pivotal for the woman and partner when entering the labour ward world where organisation of care and the institutional norms mean that the staff, in reality, may not be able to be physically present at all times.

The desired support and surveillance was often provided by the wired CTG which hindered women from changing position and moving around. Even wireless monitoring devices were a hindrance to mobility because the moving around could disrupt quality of the CTG. Via the monitor that could be viewed both inside and outside the labour room, the midwife and others were informed about the baby's heart rate and the frequency of contractions. Regardless of the reasons for continuous monitoring, the woman had a need to be seen as a unique person, and cared for as a 'woman with child' who wanted to create a communion with the midwife (Bondas, 2005). To be left alone with the CTG monitoring as the link to the midwife could be one reason for the parents' experiences of neglect (Nyman, Downe, & Berg, 2011). The immobilisation could lead to the need for other interventions, for example, if the CTG showed a decrease in the baby's heartrate (normally, when using continuous CTG for many hours the registration will sooner or later show harmless decelerations) and was interpreted as abnormal an amniotomy could be performed to be able to monitor the baby's heart more accurately by using a scalp electrode. Also, if the CTG trace showed fewer contractions it could lead to an intervention to augment labour progress with intravenous oxytocin. When judging the labour pace via the CTG, the frequency of contractions which also are displayed on the monitor, increase the risk of interventions to increase the frequency of contractions in a labour without considering that contractions are normally sparser at times.

To provide different non-pharmacologic pain management during labour, like ambulation, massage, and different positions presents significant benefits to women and their babies without causing harm (Chaillet et al., 2014). These activities are currently many times impeded by the routine excessive use of CTG monitoring. This surveillance of the unborn baby does not contribute to the support for the woman and partner and when in an unfamiliar context in a subordinate position it is unlikely that they will feel able to ask for tenderness from unknown persons. That is why the responsibility of the Other in a care situation is always the carers'. The overly rigorous focus on the unborn baby through the use of continuous CTG monitoring is accepted and indirect supportive for the woman, as the woman is all the time 'with child' in her mind and body. However it could be contradictive because it could also create a sense of not being seen or listened to as a unique person (Bondas, 2005). The best continuous support was said to come from a person who was solely there to provide support and

who was not a member of the hospital staff (Hodnett, et al., 2013). The reason to this could be that the partner is emotionally concerned, like the labouring woman for the baby's health. We, the professionals are many times overly focused on obstetrics and surveillance of the unborn baby.

### ***Two in one***

The overly focus on the surveillance of the unborn child could leave the woman and partner short of support for themselves as individuals. The view of 'taking care of' implies a meeting between two persons, one offering care and 'the other' taking part in it or receiving the care. It is 'the other' who constitutes the finality of care (Lavoie et al., 2006). To begin with, in maternity care the 'finality' of care has to be described: 'the other' is 'the others' as there are at least two (the partner excluded), i.e. the woman and the unborn child. This is an aspect that makes the finality of maternity care challenging; the midwife has to focus on both the woman's and the unborn child's health, at the same time. Within the risk focusing context the women lacks receiving the care they need for the benefit of interpreting the monitored CTG and the unborn child's health. In conclusion, when trying to define the nature of midwifery care, we should never forget its finality, here the *human persons in one*. This is what makes the caring in midwifery unique and ethically significant. Midwives and other staff have a major challenge in managing to take care of (at least) double the amount of individuals in every labour and birth they attend. Further the 'finality' of midwifery care includes the other parent in a unique way.

### **Answering the questions about improvement**

I will try to answer the three questions which are seen to be fundamental to the enhancement of organisational performance as posed by Langley et al. (2009): What were we trying to accomplish? How do we know that a change is an improvement? And what change can we make that will result in improvement? (Langley, et al., 2009). These questions are linked to the theoretical foundation, the PDSA cycle (Plan, Do, Study, and Act) (Deming, 1993) which also was used by our NLP group.

Firstly, what were we trying to accomplish. What was the aim of this project? The aim was to do AR in order to bring about a process of reflection which would lead to the improvement of care approach in the labour ward *world* starting in the first encounter. The word world indicates the institutional setting, a context with certain constraints and rules. These rules are influenced by institutional micropolitics; the things that happen behind the scenes, discussions about ideological commitments, different interests, and power differences (Herr & Anderson, 2005). One thing I have achieved as a result of having started an AR in my own organisation is a deepening understanding of what we study (and should study). This led to the creation of more sophisticated questions, a process which Herr and Anderson (2005) believe to be pivotal to any audience interested in AR. In paper II and III an attempt was made to deepen the understanding of the characteristics of the process of change in an institutional setting.

The second question is how we know that a change is an improvement (Langley, et al., 2009). We measured routine management of childbirth and there was a decrease

in some routine interventions during normal labour, without causing increased harm for the mother and child. We know that women give birth at different paces (Zhang et al., 2010) and it is difficult to determine the exact onset of labour (Gross, Haunschild, Stoexen, Methner, & Guenter, 2003), or to come to an universal consensus on the definition of labour dystocia (Kjaergaard, Olsen, Ottesen, & Dykes, 2009). If the increased time on the labour ward from admission to birth for nulliparous women in 2012 was an indication of women expressing a need for labour support from the labour ward staff, or if it was a result of the reduction of augmentation of labour is a factor which requires further study. The objective of the regional systematic quality development project that this AR project was connected to, included to decreasing the time of each hospital stay. This approach does not however reflect the realities inherent in the physiology of childbirth, and results in a dilemma for the hospital based labour wards.

The third question in the model of improvement (Langley, et al., 2009) is: to answer what changes can we make that will result in improvement? We pinpointed one local problem area, use of admission CTG for low risk (healthy women, with a healthy pregnancy, a single live fetus in cephalic presentation, and with spontaneous onset of labour at between 37 complete weeks and – 41 weeks + 6 days gestations) with normal labour onset. An improvement in the routines for CTG monitoring for these women could be achieved by making changes to the local guidelines<sup>4</sup> which recommend that an admission CTG be administrated for about 15-20 minutes. The requirement of an admission CTG for 15-20 minutes seems to be a factor which often results in the CTG monitoring being extended to 60 minutes, and many times longer. The reason for this is often due to the initial encounter being cut short as a result of the midwife being needed elsewhere. A subsequent delay in their return to the woman and partner easily results in prolonged monitoring (paper I and IV).

My experience of doing this AR has taught me that we are not ready to take the admission CTG away completely, not even for the ‘normal labours’, this because of the fear of missing something and risking litigation. However, a change to the guidelines which allowed for an admission CTG at a reduced period of only 5-10 minutes (for low risk women who have a ‘normal’ CTG) would enable a satisfactory CTG to be achieved during the first encounter, before the midwife had to leave or was in fact called away. This would prevent unnecessarily long periods of monitoring increasing the risk for a caesarean section (Devane et al. 2012), and enabling the labouring women to be more ambulant while decreasing the work strain for midwives. If we were to decrease the duration of the admission CTG with only 15 minutes, it would save about 1625 hours per year of what are most often normal CTG traces. For the midwives who most often have more than one labouring woman to care for at the same time this would lessen the strain and time involved with checking the admission CTG from the midwives central station and prevent the shattered feeling that results from leaving one woman’s side to quickly check another woman’s CTG trace. We have about 6500 pregnant women passing through our system, and all of them require CTG monitoring. *Nobody dares to react (back off) somehow we do a lot of CTG traces*

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<sup>4</sup><https://alfresco.vgregion.se/alfresco/service/vgr/storge/node/content/21557/CTG,%20ST-analys.%20Foster%C3%B6rvakning%20under%20f%C3%B6rlossning.pdf?a=false&guest=true>

*and then you think that you maybe could wait and just listen (to the baby's heart) intermittently* (midwife, paper II).

Changes that could result in improvement on a general level need to include improvement in our knowledge of evidence-based care and skills. 'We have growing and extensive knowledge about safe and effective maternity practice, so research priorities must focus on filling in gaps and better understanding how to translate our knowledge into practice. With the will and the skill, we can seize these opportunities to enhance the well-being of mothers, babies, and families' (Declercq, Sakala, Corry, & Applebaum, 2007, p. 14). Also, childbirth care in Sweden has been described as being more attitude based than evidence based (Sandin-Bojöö & Kvist, 2008). Ekman et al. (2011) depict the conservative health care culture as an impediment to the development of a more person centred care (PCC) approach where we would need to move from medical and task oriented care to placing the person before the disease (or surveillance of normal labour). In the next section I attempt to explain the processes of creating collaborative learning and developing practical knowing in order to bring together action and reflection through linking theory and practice.

## **Methodological discussion**

In AR all types of data gathering methods can be included from a variety of perspectives using a variety of methods, including both qualitative and quantitative methods (Coghlan & Brannick, 2014; DeLuca, et al., 2008). The epistemological expectations in AR show a similarity to the lifeworld approach, where the objective of inquiry is a collaborative process including the researcher (McNiff & Whitehead, 2011; Van Beinum, et al., 1996).

What are the validity criteria in AR and how can we attain these values? The goals of AR are to: attain action oriented outcomes, educate both researchers and participants, and achieve results that are relevant to the local setting and to generate new knowledge through enactment of a comprehensive research methodology. The questions regarding validity are: 1) outcome, 2) catalytic, 3) democratic, 4) process, and 5) dialogic validity criteria (Herr & Anderson, 2005).

The 1) outcome validity, to achieve action oriented outcomes was about moving participants toward successful outcomes of the research project (Herr & Anderson, 2005). The new local knowledge progressed to practical action in the form of changes to routines as shown in paper IV. Paper I and IV describe the project's generation of actionable knowledge. It is difficult to ascertain whether midwives have changed on an individual level as to 'how they are when they do' during an encounter. It is a question of taking responsibility for using one's own knowledge and competence to achieve a caring encounter, or responding to a facial expression from the other (Dahlberg & Segesten, 2010), or 'not let the other alone' (Lavoie, et al., 2006). The decrease in usage of unnecessary interventions during normal labour was valuable, and provided a counterweight to the otherwise continuing increase in the routine use of unnecessary medico-technical and pharmacological interventions for healthy women and babies (Begley, 2014; Scamell & Alaszewski, 2012; Walsh, 2011).

Many action researchers quit when they encounter the problem of there being no single solution to fit the multiple situations which have arisen during the AR (Dickens & Watkins, 1999). This is evident in the difficulties inherent in proving to peers and academics that a development involving accomplished reflection for improvement has transpired. Many action researchers abandon the AR approach for this reason. For me this was most challenging around the second year of this project, described further in paper III.

When it comes to 2) catalytic validity the question is; did the research process focus on energising participants toward reflecting on reality in order to transform it (Herr & Anderson, 2005). My answer would be yes. More about this process is described in paper II. Most of those involved in the AR did to some extent deepen their understanding of the issues involved, mostly through their involvement in everyday dialogue. However, answering the question if we have been successful in developing our 'bemeeting' towards the woman and partners, and towards each other is an ongoing action, and has not been evaluated for the purpose of the third audience yet.

The 3) democratic validity (Herr & Anderson, 2005) refers to how the results are relevant to the local setting and if the research has been done collaboratively. Paper II and III describe how the multiple perspectives have been taken in to account through the use of collegial dialogues. The initiative to do this AR was mine, which could be seen as undemocratic. However, as I am a member of the community and not in a managerial position the project initiation acquired a bottom up perspective, implying that consensus among the members was a prerequisite to make things happen. The issue under study, the improvement process that emerged from the context and the solutions could be said to be appropriate as they matured as a result of the processing. I did the writing during this AR project including the development project's process as part of my doctoral studies, and as the leader of the NLP group, which was an implicit assignment. An AR process moves at its own pace and in its own way through real time. Paper III describes some of the bumps that were encountered on the way.

The 4) process validity means to include multiple voices and guards from viewing the activities in a simplistic or self-serving way (Herr & Anderson, 2005). The use of a variety of methods and several sources of data allowed for ongoing learning. This is revealed in the different papers and will hopefully be informative for the reader. The use of a lifeworld perspective in order to explore the parent's experiences, followed by qualitative elucidation of the midwives reactions and reflections as a way to include multiple voices in order to illuminate the phenomenon under study and to explore and improve management of childbirth.

In lifeworld research the researcher adopts an open stance throughout the study and maintains an interest in how human beings understands and relate to and interact with the world (Dahlberg, et al., 2008; Merleau-Ponty, 1962). I used both individual and focus group interviews in paper I. In focus groups the inter-subjectivity that is generated can provide a greater understanding of the phenomenon under study (Bradbury-Jones, Sambrook, & Irvine, 2009). Meaning-making is a subjectively shared interpretive activity, and not an individual enterprise (Gadamer, et al., 2004a) and individual lived experience and opinions can be preserved within a group context. Focus group

interviews enabled a clarification of both similarities and differences in experiences through a sharing, acquiring and contrasting process (Krueger & Casey, 2000; Lehoux, Poland, & Daudelin, 2006).

The 5) dialogic validity criteria asks if the research is disseminated to a broader audience. Paper III is concerned with learning about learning, otherwise called meta learning (Argyris, 2003) with the goal to further elucidate the approach of AR. Describing the processes from the first person perspective, and from partaking in practice in the second person inquiry of implementing change. The first person (paper III) and the second person (paper II) perspectives are the twin imperatives for the third person practice, the dissemination to the broader audience (Coghlan, Shani, Roth, & Sloyan, 2014). During this AR the dissemination of theory to praxis has been a topic for discussions at staff meetings through collaborative discussions about 'bemeeting' and whether routine interventions are substantiated by evidence based knowledge.

### ***Limitations***

As shown in paper I, many women and their partners declined participation understandably as having your first child requires ones complete attention, especially during the first weeks after birth. Furthermore, the women and partners could have thought that participating in a focus group exclusively to talk about the first encounter was not interesting enough, for them to travel to the hospital. Hence there is a risk that those who wanted to participate were less satisfied with their first experience, and that this was mirrored in the results.

The interpretative description (ID) (Thorne, 2008) research approach was used in paper II to specifically illuminate and interpret practical insights that could be clinically beneficial, by using my theoretical and practical knowledge as the 'scaffold' during data gathering and in the interpretation. Being an insider researcher, familiar with the context could also be a barrier for me to glance beyond my own horizon, and therefore miss valuable information.

Within this organisation there is a long history of health care assistants working together with the midwives. Whilst all midwives and health care assistants working on the labour ward played a part in the improvement process, a limitation of this study was that we did not recognise the health care assistants' valuable knowledge and experience. My intention at the beginning of the AR was to illuminate the clinical physicians' reflections, my feeling being that they could contribute with much valuable information. Some physicians did in fact participate in the planning phase of the process work, but they soon left the process due to a variety of reasons. Knowledge about physicians' participation in clinical based development work is exposed by Baathe et al. and Lindgren et al. (2013; 2013). My position in the organisation as a novice action researcher, may have affected my ability to mobilise involvement of the health care assistants and physicians in the process. This was further complicated by the limited time frame available for doctoral studies.

The attainment of an informed consent to participate in an AR is impossible because of the evolutionary nature of AR (Herr & Anderson, 2005). Therefore, the manage-

ment of interpretations or outcomes that could be perceived negatively by the organisation could be a sensitive matter. When writing paper II and III I had to balance the dual roles of organisational membership and researcher with the function of inquiring in ways that might be seen as challenging by my colleagues. Despite standard precautions for protection of data confidentially, the citations used in paper II could be recognised by the individual midwives. This was a fact I considered when writing the papers. This may have influenced some of the accounts given in the participants' interviews. It also shows that AR is political with ethical responsibilities (Coghlan & Brannick, 2014).

AR involves not only understanding and describing a situation but also to change (Reason & Torbert, 2001). I was an actor taking action in the context and setting of my own organisation and I logged my feelings and reflections as they occurred (Coghlan & Brannick, 2014) (paper III). My log is comprised of instant reactions and reflection which reflects my natural attitude, thereby, my experience as I perceived it (Dahlberg, et al., 2008). The meaning of the text always exceeds the author and therefore understanding the log text and the 'existential context' hermeneutically is not a reproduction but a reflective open productive approach (Gadamer & Melberg, 1997). I tried to question my own experience of the experience of doing AR in my own organisation, in order to see beyond my horizon, my prejudiced memories and anticipations. When analysing there was a shift from the natural attitude (Husserl, 1970) to a phenomenological scientific attitude (Dahlberg, et al., 2008). However, it does not have to mean that the productive moment is a better understanding (Gadamer & Melberg, 1997). Understanding is not something one does, it is the way of existing, meaning that it is not possible to find correct or true interpretations (Dahlberg, et al., 2008).

Before and after studies (paper IV) are known to overestimate the effects of quality improvement, and they are often criticised due to the possibility of other changes making it difficult to establish if observed changes are result of the intervention (Eccles, Grimshaw, Campbell, & Ramsay, 2003). The major problem with observational studies is how to deal with confounding factors. On the other hand, in AR, the intention is to achieve change in every day practice, by explicitly involving 'confounding factors' as contributors to improvement. This makes the whole process interdependent with other possible effective interventions. The attribution of effect is therefore controversial.

Finally, I agree with Hans van Beinum whom 1999 stated that: 'In action research one starts in the middle and ends in the middle', and this thesis described what happened on this labour ward during the 'middle'.

## CONCLUSION

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The goal of this thesis was to care for the parents and increase their wellbeing by focusing on our, the midwives behaviours and responsibilities. The project was initiated by using own practice and academic theory to improve care approach from the first and subsequent encounters between midwives and women and their partners. From the parents' point of view, expert monitoring, information and support were sought actively the point at which they experienced had an embodied sense of *being* in labour, based on the need for support as 'whole' persons. However from the organisation's point of view, carers focused more on *observed* signs of labour. To be compliant to technocratic norms and 'getting through the work' that midwives experience working in publicly funded settings was through this AR challenged. During the process midwives' reactions and reflections revealed that we are imprisoned in a hegemonic 'CTG faith', and rely on the medico technical surveillance for normal childbirth, but also that we were able to reflect and glance beyond the inherent routines. The concept of 'bemeeting' emphasises the behaviour and attitudes, how we as carers *are* when we do whatever we do in the encounters with others. The 'bemeeting' was also central for me to consider as well, when I was the change agent doing AR in my own organisation. The evaluation of routine interventions showed a decrease of unnecessary interventions in normal labour during this time. Whereas we as clinical professionals have been overly medicine and task oriented, in this thesis the midwifery philosophy, of working in partnership was applicable as a strategy when doing this AR. The 'bemeeting' towards others is central to all professions within health care and an essential component for the improvement of professionals' competence and capacity to practice.

## FUTURE RESEARCH

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We know that emotional and social support is shown to reduce the rate of caesarean section and operative vaginal deliveries, as well as the need for pain relief in childbirth. This thesis discusses the need to reflect on our 'bemeeting' towards women and partners, and on our actions and responsibilities as midwives. There is a need for further research on how to enable midwives to be woman or person centred, as an alternative to a task oriented and medicalised approach. Efforts to provide a respectable and empathetic 'bemeeting' to others in an asymmetrical power relation is often in the form of a subject included in health care education, describing care/caring. It should not be understood as an inherent quality that does not need continuous development. This indicates that our behaviours and attitudes must constantly be highlighted and developed through theoretical and practical knowledge. If we are to succeed, it requires that knowledge production in the 'swampy lowlands' (Schön), the knowledge that is of most benefit for daily care activities is undertaken by those who provide and receive the care. The knowledge produced on 'high ground' (Schön) is often too far away from the realities of everyday actions and difficult to translate and transfer into practice.

Ongoing evaluation is a critical aspect of a project and without adequate follow up and feedback many projects fade and disappear. This often results in unsatisfactory returns for the organisation in terms of the financial investment made for development. Hence, it is pivotal to continuously evaluate the rates of occurrence of interventions in normal labour in hospital based labour wards. Ongoing documentation of routines, reflection and of findings together with healthy debate can act as a counterweight to the increasing treatment of childbirth as a disease.

## SAMMANFATTNING PÅ SVENSKA

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*Bakgrund:* Barnafödande efterlämnar ett livslångt minne för kvinnor och deras familjer. Hur de bemöts av vårdpersonal under förlossningen påverkar deras förlossningsupplevelse. Därför är det av yttersta vikt att vårdandet är av optimal kvalitet i enlighet med kvinnans och partnerns individuella behov.

*Syfte* Det övergripande syftet var att undersöka och förbättra handläggningen av förlossning genom insider aktionsforskning med början i barnmorskans första möte med kvinnan och hennes partner vid deras ankomst till förlossningsavdelningen.

*Metodologi och resultat:* Som en del av ett lokalt projekt för att förbättra sjukhusbase-rad förlossningsvård genomfördes en insider aktionsforskning. För att identifiera och förstå mönster av betydelsen av förstagång föräldrars (n = 65) upplevelse av det första mötet på en förlossningsavdelning användes hermeneutisk reflekterande livsvärldsforskningsansats. Upplevelsen tolkades som betydelsen att *vänta på att få tillstånd att komma in i förlossningsavdelningens värld*. Det innebar i sin tur att *tajma det rätt*, att *vänta på att få information*, att *vara i en underordnad ställning*, och att *stå inför verkligheten med en mosaik av känslor* (artikel I). I följande studie användes tolkande beskrivning (Interpretive Description) som forskningsansats för att skildra barnmorskors respons på de överenskomna förbättringar som gjordes för det första mötet med kvinnan och partnern och beskrevs som *att se bortom eller vara fast i rutiner* (artikel II). Hermeneutisk reflekterande livsvärldsforskningsansats användes också för att beskriva insider aktionsforskarens perspektiv (artikel III). Detta innebar att som anställd på förlossningsavdelningen som novis aktionsforskare och doktorand försöka utveckla vården på förlossningsavdelningen. Den tolkande sammanfattningen var *att lära sig att kliniskt reflektera och att uttala den tysta kunskapen av vårdandet*. Det innebar tre tematiska betydelse: *att katalysera en motkraft till den medicinsktekniska fokusen*, *att stå ensam i den röriga frontlinjen*, och *att sträva för att få organisationen delaktig*. Aktionsforskningsprojektet avslutades med en observationsstudie där rutinhandläggning av förlossningen av friska kvinnor i fullgången tid utvärderades. Resultatet utvisade en signifikant minskning av längden på intagnings-CTG (cardiotocography), användning av fosterskalpelektrod samt användande av värkförstärkande dropp. Data visade också en nedåtgående trend i antalet amniotomier, dvs. att ta hål på hinnorna (artikel IV).

*Diskussion och Slutsats:* Föräldrarnas egen upplevelse av att förlossningen har startat utgjorde grunden för att de sökte sig till förlossningsavdelningen. De önskade få sakkunnig information och stöd inte bara vad gäller det fysiska utan som människa i sin helhet. Från organisationens perspektiv fokuserades däremot oftast synliga tecken på om förlossningsarbetet hade startat. Genom denna aktionsforskning utmanades den teknokratiska normen som är rådande inom offentligt finansierad förlossningsvård, att det viktigaste är "att få arbetet gjort". Under processen visade barnmorskors reaktioner och reflektioner att vi är fast i en hegemonisk "CTG tilltro", och förlitar oss på den medicintekniska övervakningen av den normala förlossningen. Barnmorskornas respons visade dock också på förmågan och viljan att se bortom de egna inbyggda rutinerna. Utvärderingen av processen genererade ny kunskap om hur vi kan förbättra

förlossningsvården, dvs. bemötandet och den kliniska handläggningen av en förlossning. Dessutom framkom att en minskning av onödig inblandning i den normala förlossningen skulle kunna frigöra tid och möjlighet för barnmorskor att vara närvarande hos en födande kvinna och partner utan att intervensera i förlossningsförloppet.

Att åta sig att göra aktionsforskning i den egna organisationen är en utmaning, men trots det en effektiv metod för att tillsammans med kollegor försöka utveckla och minska gapet mellan teori och praktik. Det ledde till att vi talade om dagliga vårdrutiner vilket bidrog till att vi kunde undvika ytterligare ökning av onödig inblandning i det normala förlossningsförloppet. Ny lokal kunskap spreds bäst genom de vardagliga dialogerna på förlossningsavdelningen. För att kunna förbättra vårdpersonalens kompetens och kapacitet behövs fortsatt forskning om praxis inom hälso- och sjukvård i ett nedifrån och upp perspektiv i kombination med teoretiska kunskaper.

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**APPENDIX, Table 2**

<i>Time period</i>	<i>Led by/initiated by</i>	<i>Activity</i>	<i>Why</i>	<i>Effect/Significance</i>
2009 June	<i>Me, the Insider action researcher (IARr)</i>	<i>Meeting with the Head of the clinic</i>	<i>Discuss research topic and AR</i>	<i>Introduce AR on clinic</i>
2009 September	<i>IARr</i>	<i>Information to all staff on the clinic about AR.</i>	<i>Inform clinical staff about the research idea, care approach</i>	<i>Familiarise staff to AR and care approach routines</i>
2010	<i>Regional County Council and the local Women's clinic</i>	<i>Process based work on clinical level</i>	<i>To create a basis for development of cost effective care and to improve quality through processing</i>	<i>A process group was created about the Normal Labour Process (NLP)</i>
2010 First meeting held in March	<i>External management Representative, IARr and NLP group</i>	<i>NLP group was formed 11 meetings</i>	<i>Mapping of the NLP</i>	<i>September 2010 the NLP was divided in three parts A = Arrival, B =Birth and C=Care after birth</i>
2010 - onwards	<i>IARr</i>	<i>Communication with Head of unit</i>	<i>To keep her updated about the AR and Normal Labour Process (NLP)</i>	<i>Increased understanding of the NLP and AR lead to planning and workshops about normal labour</i>
2010 December - onwards	<i>NLP group</i>	<i>NLP topic on regular staff meetings</i>	<i>To inform staff as info travels slowly in a shift working staff group</i>	<i>To make the process going</i>
2010	<i>IARr</i>	<i>Two meetings with the head of the clinic</i>	<i>Update and inform about AR and NLP progress</i>	<i>Presentation for the clinical board about the research</i>
2010 October	<i>NLP group</i>	<i>Brainstorm on a staff meeting about content in the first encounter</i>	<i>Reflect on the care approach in the first encounters</i>	<i>Items defined and documented to the approach in the first encounter</i>
2010 November	<i>Clinic</i>	<i>Renovation of labour ward</i>	<i>Evacuation during November to April to a another ward</i>	<i>Less delivery rooms, less strain for staff</i>
2011	<i>IARr and NLP group</i>	<i>11 meetings in the NLP group</i>	<i>To continue planning for action about normal labour and first encounter</i>	<i>Planning led to action and emphasis on the care provision in the first encounter started in March</i>
2011 February	<i>IARr</i>	<i>Pilot focus group interview</i>	<i>To interview midwives former colleagues</i>	<i>I understood how and what to focus when interviewing current colleagues</i>
2011 February	<i>IARr</i>	<i>Meeting with CEO</i>	<i>Inform about the AR project and care</i>	<i>Dialogue about health care research</i>
2011 March - June	<i>IARr</i>	<i>Interviews with 37 midwives</i>	<i>To find out how midwives experienced the first encounter and to involve colleagues</i>	<i>Make time and space for reflection</i>
2011 March	<i>IARr</i>	<i>Focus group interview with NLP group</i>	<i>Evaluation of the AR process and my role in the group</i>	<i>I was informed about the NLP group members' view on connecting this AR to the NLP</i>
2011 - 2012	<i>Staff and NLP group</i>	<i>Daily reflection on the ward</i>	<i>'Set down' time before going home, reflect on job and cooperation</i>	<i>Worked well on the temporary ward during the evacuation, but not when back on regular ward</i>
2011 March-April	<i>IARr</i>	<i>Fieldwork approx. 60 hours</i>	<i>Facilitate change and interview midwives</i>	<i>I had time to interview when not part of the regular work</i>

2011 February – onwards	<i>Clinic</i>	<i>Start of a web based survey</i>	<i>To find out how women and partners experienced their arrival to the labour ward</i>	<i>QS results were discussed on staff meetings including positive and negative feedback to staff about first encounter</i>
2011 November	<i>IARr</i>	<i>Meeting with the Head of the clinic</i>	<i>Update and inform about AR and NLP group's work</i>	<i>Important for me as the group leader and IARr to keep stakeholders informed</i>
2011 May	<i>IARr</i>	<i>Presentation of AR project to all 50 community/ antenatal midwives</i>	<i>Inform about the parents' experience of the first encounter on the labour ward</i>	<i>Essential to inform community midwives about ongoing research on institutional encounters and care approach</i>
2011 May	<i>NLP group</i>	<i>Mapping of NLP finished The first NLP evaluation report on staff meeting</i>	<i>Evaluation of NLP including routine interventions in labour</i>	<i>Presentation on staff meeting to show outcomes of NLP group's actions and to inspire to reflection on routines</i>
2011 December	<i>NLP group</i>	<i>Report on staff meeting about routine interventions in labour</i>	<i>Evaluation of NLP group's work including routine interventions in labour</i>	<i>Presentation to show outcomes of NLP actions and to inform midwives that were less involved in the processing</i>
2012 April	<i>IARr</i>	<i>Presentation of the AR process to all 50 community/ antenatal midwives</i>	<i>Inform about midwives experience of the first encounter on the labour ward</i>	<i>Essential to inform community midwives about the change process</i>
2012	<i>IARr and NLP group</i>	<i>4 NLP group meetings in 2012</i>	<i>To continue planning for actions about normal labour and first encounter</i>	<i>The NLP group was familiar to the process work and less meetings were needed</i>
2012 May	<i>IARr</i>	<i>Focus group interview with members of NLP group</i>	<i>Evaluation of the AR process and my role</i>	<i>I was informed about the group members' view on connecting this AR to the NLP</i>
2012 May	<i>IARr</i>	<i>Presentation of the AR to the Clinical board</i>	<i>Inform about the AR, NLP and parents experience of the first encounter</i>	<i>Updated stakeholders</i>
2012 May and December	<i>NLPG</i>	<i>Report on staff meeting about the evaluation of routines interventions in labour</i>	<i>Evaluation of NLP including routine interventions in labour</i>	<i>Presentation to show outcomes of NLP actions and to inspire to reflection</i>
2013 March	<i>NLPG</i>	<i>2 work shop with staff about normal labour care, app. 40 staff per session</i>	<i>Emphasise the routine management and care in normal labour</i>	<i>Reflection continued on normal labour and own routines on regular working shifts</i>
2013 May	<i>Head of unit</i>	<i>7 group discussions with staff (39 in total)</i>	<i>Evaluation of AR and my role as the action researcher, end of my data gathering, start of analyses of data</i>	<i>I was informed about staffs' feelings about participating in this AR and about my role</i>