Labour onset and early labour

An exploration of first-time mothers' and midwives' experiences

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Abstract

This dissertation is about how women experience waiting for the onset of labour, and how first-time mothers and midwives communicate during the early phases of labour. Most women in Norway give birth in public hospitals, which is the context used for this study, with the experiences explored within a scientific tradition of lifeworld research.

Seventeen women and 18 midwives participated in the study. The empirical material stems from diaries, observations of admissions and in-depth interviews with the women, in addition to focus group discussions with the midwives. The women were recruited while attending childbirth education classes either in the hospital or in a public health clinic. The inclusion criteria were that they were expecting their first child, had a healthy pregnancy with no pathological conditions and were able to communicate in Norwegian. The midwives who participated in the project were currently practicing in either one or the other of two delivery units in the hospital.

The dissertation includes three papers that address three different research questions. Paper I explores first-time mothers' experiences of the contact with the labour ward before hospitalization, and mainly draws on the in-depth interviews carried out in the weeks after giving birth. The observation of three women's admissions yielded additionally valuable information to the analysis of the material. One of the central discoveries made in this paper is that the women had to negotiate their credibility in order to obtain access to the labour ward. They negotiated with the midwives through the requisite pattern of regularity, although the demanded pattern did not always match their experiences. This paper reveals the women's vulnerability in their attempts to avoid being sent home from the hospital because it was "too soon" to be admitted.

Paper II explores first-time mothers' experiences of waiting for the onset of labour. This paper draws on the diaries written by the women during the last days of their pregnancy, as well as the retrospective reflections on the experience of waiting given in the interviews. The paper shows that the estimated date of delivery, which was calculated with the help of ultrasound scanning, played a pivotal role in shaping the women's experiences. The

participants entered a state of active waiting, the so-called “waiting mode”, in the days around the estimated due date. Before the study participants got to the waiting mode, they hesitated to relate bodily changes to labour, and rarely interpreted new bodily signs as indications of labour onset. When the pregnant women entered the “waiting mode”, there was a marked change in the way the interpreted their bodily sensations. The women experienced being in a state of constant bodily alertness, their bodies felt all-consuming and they experienced themselves as being “more and more body”.

Paper III explores midwives’ priorities and strategies in communicating with first-time mothers in early labour by phone and during check-ups. The material includes three focus group discussions with both experienced and less experienced midwives working in the labour ward. The paper indicates that the midwives’ overall strategy was to encourage women to remain out of the hospital for as long as possible “for their own good”, in order to “protect” the women from unnecessary interventions and complications.

All three papers contribute to a discussion on the various aspects of contemporary childbirth paradigms and knowledge traditions surrounding childbirth, and how these understandings may shape and influence the women’s experiences and midwives’ practices. The thesis argues that the researched context of women’s experiences and encounters between birthing women and midwives in hospital-based practice is a field that seems to create paradoxes and dilemmas with no apparent solutions. The dissertation does not yield clear indications of the best way to arrange for the care of women in early labour, but hints at the complexity of the research area and at acquiring a broader understanding of how first-time mothers and midwives on the labour ward communicate. Somehow, the communication between the two parties seemed to be “mismatched” in the way that neither of them “achieved the goal”. Many labouring women wanted to come in, whereas many midwives wanted them to stay home. Paradoxically, both reasons for this action seemed to be embedded in a biomedical paradigm; the women wished to go to a safe place where the medical system could take care of their labours, while the same system produces the likelihood of interventions and complications that the midwives wanted to “protect” the women from. The findings of this study call for reflections and extensive discussions within the midwifery profession in hospital-based contexts. It seemed as if the midwives tacitly accepted the “execution” of the

task of being the gatekeepers of the labour ward, without seriously exploring the underpinnings of their professional decisions. It appears to be a bit strange that they persuaded women to stay home for as long as possible, rather than questioning their own professional role in trying to reduce the high intervention rate for women admitted in early labour. The dissertation may have implications for how antenatal care is organized and how women are prepared for labour. Pregnancy is managed and surveyed by "the experts", and women seem to internalize this type of knowledge as being *the* authoritative knowledge. There is no indication that women do not want to maintain the medical services, but the question is whether it is possible to support women in other ways in order for them to be better prepared for labour and its onset.

List of publications

I Eri, T.S., Blystad, A., Gjengedal, E. & Blaaka, G. (2010) Negotiating credibility: first-time mothers' experiences of contact with the labour ward before hospitalisation. Midwifery **26** (6) e25-e30

II Eri, T.S., Blystad, A., Gjengedal, E. & Blaaka, G. (2010) 'The waiting mode': First-time mothers' experiences of waiting for labour onset. Sexual & Reproductive Healthcare **1** (4) 169-173

III Eri, T.S., Blystad, A., Gjengedal, E. & Blaaka, G. (2011) 'Stay home for as long as possible': Midwives' priorities and strategies in communicating with first-time mothers in early labour. Midwifery doi:10.1016/j.midw.2011.01.006

Contents

1. Introduction

This thesis is about “labour onset” and “early labour”. The study explores the experiences of primiparous women around the time of the onset of labour and in the early part of labour up until the time they are admitted to the hospital. The main foci are women’s experiences of waiting for the onset of labour and of the communication and contact with midwives on the labour ward during this time period. The study also looks at what hospital-based midwives prioritize in their daily practice when they encounter and communicate with women who are going through labour for the first time. Moreover, the thesis attempts to understand how women’s experiences and midwives’ practices are embedded in and influenced by contemporary childbirth paradigms and discourses.

“How will I know that my labour has started?”, “Is this really it?” and “When should I contact the hospital?” These are crucial questions for women who are about to give birth for the first time. For the midwives on the labour ward, the critical questions are: “Is this woman in labour?” and “Should this woman be admitted?” During my years as a midwife in antenatal and intrapartum care, I have answered hundreds of phone calls and encountered many women with the question: “Is this really it?” I can still feel the burst of excitement about who I was going to meet when answering the call. Most of the time, I really enjoyed this task; it challenged my whole idea of professionalism, and I had to adopt all my midwifery skills. Within a very short time I had to assess the situation in front of me, knowing that my decisions and subsequent advice could have a great impact for the woman who was going to give birth. I have always had a fascination and curiosity in this part of midwifery in regard to the encounters during early labour and the challenge of finding out what each woman needed. During my clinical practice I started to feel a lack of knowledge about this part of labour, and realized that midwives mostly relied on their own clinical experience in these encounters. After starting my academic career, it became evident to me that systematic knowledge about the onset and the early part of labour was almost non-existent, which became the vantage point for this thesis.

This study is limited to exploring the experiences of women who are giving birth for the first time, not because those who have given birth before do not need any attention, but because nulliparous women are a unique group with unique needs. The first birth lays the

basis for a woman's subsequent "birthing career", and there is a growing awareness about how important it is for women to experience their first labour in a positive way. More multiparous women report that a bad experience during their first labour is the reason for asking for a caesarean section for their second birth. In Norway, approximately 61,000 women give birth every year, with more than 40% of these giving birth for the first time. Where do women in Norway give birth? The vast majority (99%) give birth in a public institution, while the other 1% have planned or unplanned homebirths or labours that take place on the way to the birthing facility. More than 70% of the institutionalized deliveries take place in hospital labour wards with more than 1,500 labours every year, 17% give birth in units handling 500 to 1,500 births per year, less than 10% of the women have their deliveries in the smallest hospital units, and under 1% give birth in an independent midwifery-led unit.

Midwifery in Norway is regulated, and authorization as a qualified midwife is granted after two years of post-nursing studies. According to The Health Personnel Act, the profession holds an independent and autonomous position when caring for healthy women and their babies in antenatal, intrapartum and postnatal care. The autonomous position implies that the profession is not subject to directions or instructions from the employer or other professional groups when performing within its field of competence and scope of practice. Midwives in Norway primarily work in labour wards in state hospitals (ca. 75%) and in public health clinics (ca. 25%), whereas some combine these two fields of practice. A few work in free-standing midwifery-led units, and some midwives run their own private practice. The latter might involve a range of services such as antenatal care, childbirth preparation, homebirth assistance and contraceptive counselling. In public health clinics, midwives mostly perform antenatal care and childbirth preparation, while some also offer various forms of counselling related to reproductive health. In the midwifery-led units midwives do antenatal, intrapartum and postnatal care. Depending on their size and organization, midwives in public hospitals might care for women with complicated pregnancies in addition to the main tasks of intrapartum and postnatal care.

Outline of the thesis

In Chapter 2, the context and background for the study are spelled out in a focused literature review. The main themes are perspectives on labour and labour care, first-time mother's experiences of labour onset and early labour, as well as midwives' viewpoints and experiences. The chapter ends with the research questions of the study. Chapter 3 follows with an account of the research process, including the scientific approach of the study. Chapter 4 comprises a summary of the findings of the study, and Chapter 5 offers a discussion of both methodological issues and the main findings of the study. Lastly, some implications of the findings and suggestions for future research close the thesis.

2. Contextualization of the study

The intention of this chapter is to present research which is the background for the study, and to help clarify concepts and ideas which have been important for planning and conducting the project. In the first section perspectives on labour and labour care will be described, starting with the concepts of "labour onset" and "early labour". How are these concept defined and understood today? We will have a look backwards at the origin and development of the knowledge and systems of concepts surrounding labour and labour care, which is important in order to be able to understand what is taking place in the field today. A few "snapshots" of research and work which have been influential in the field will be shown, starting with Friedman's graphic analysis of labour. His texts have had a great impact on the perception of labour and its time limits, and subsequently on the provision of care for women in labour. After the historic glance research about care and various forms of management in early labour today will be laid out. The second section presents the first study group: the first-time mothers and research on their experiences in relation to labour onset and early labour. The third section in the chapter concerns the second study group: the midwives and their perspectives and experiences with first-time mothers in early labour.

2.1 Perspectives on labour and labour care

Labour onset and early labour

How and when does the process of labour begin? What characterizes the onset of labour? How does a woman know that her labour has started? A complex physiological cascade triggered by the removal of inhibitory effects is supposed to initiate the transition from pregnancy to labour and the subsequent occurrence of regular uterine contractions, thus leading to the progressive effacement and dilatation of the cervix, and ultimately to the delivery of a child. The physiology of labour onset however is not the main focus in this dissertation. The focus is on labour onset and early labour as it is lived, experienced, understood and acknowledged by women and clinicians. As will be revealed in the subsequent section, research on labour has not paid much attention to the onset of labour

until the turn of the century. Different points in time have been defined as the onset of labour in various trials, such as the time when a woman is admitted to the labour ward (Hemminki and Simuka 1986; McNiven, Williams et al. 1998; Gross and Keirse 2002) or the time when she is included in a trial (Fraser, Marcoux et al. 1993; Ohel, Gonen et al. 2006). Blix et al. (2008) performed a review of scientific papers and textbooks for medical and midwifery students and found that the description of the onset of labour and the duration of the latent phase of labour differed to a great extent, and that in several of the reviewed texts the onset of labour was not discussed. The term "arbitrarily" seems to characterize how labour onset has been defined in research and textbooks, which may indicate at least two points: firstly, the lack of a simple, reliable definition of labour onset, and secondly, a limited interest in addressing this phenomenon. As will be shown in the subsequent sections and literature review, the concern about labour onset is an important research subject on the rise.

Labour is traditionally classified into three stages, and the first stage is further divided into the latent and the active phase (see Fig. 2.1). Yet, the precise demarcation between pregnancy and labour, or the stages and phases of labour, is unclear. Labour may also be seen as a continuous, smooth process and as a seamless transition from pregnancy to labour and delivery. The term "early labour" is used in a somewhat similar manner as the term "latent phase of labour". However, early labour signals a view on labour as more fluctuant and less fragmented then the terms "latent" and "active", both of which refer to the dilatation of the cervix in the first stage of labour. In this sense, the term early labour has a more open meaning by accentuating the process of labour as lived and as more than just biology. The term "established labour" corresponds to "active labour" in a similar way, thereby creating a pair of concepts that reflect labour as lived and experienced. Still, this terminology is not consistent throughout all the presented papers.

What is the "problem" of women in early labour? The International Early Labor Research Group stated in their roundtable discussion:

These women (who are not in established labour) are not deemed to be in need of hospital care, but the women themselves may feel otherwise as they struggle to understand the sensations they are experiencing. Until relatively recently, little research effort was expanded on early and latent phase labor, reflecting, perhaps, the assumption that it is just a gentle and relatively straightforward preamble to "the real thing" that can easily be dealt

with by keeping mobile, leaning over furniture, or doing the ironing. Because early labor is not seen as needing a health professional's input, the message is that it is unimportant (Janssen, Nolan et al. 2009: 332).

This extract from the roundtable discussion underlines a two-sided challenge, both for the women experiencing early labour and for the health professionals responsible for the management and provision of care. Recent research is challenging the view of early labour as unimportant, reflecting a growing awareness that this stage of labour merits consideration in its own right, which will be emphasized in the following sections.

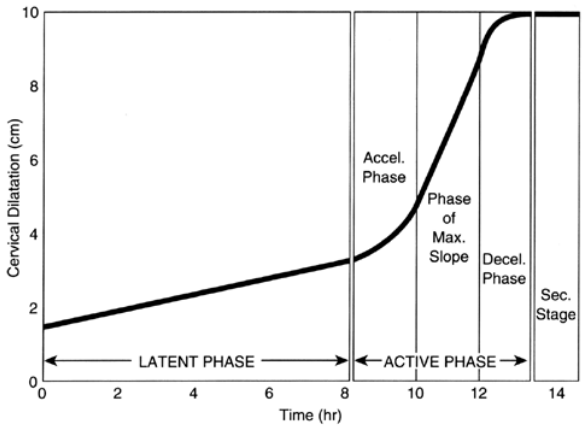
A retrospective glance

It is out of the framework of this dissertation to give a full historical review of the research, concepts and ideas that have lead up to contemporary childbirth management. Three "snapshots" provide glimpses into some of the most influentially relevant research and development of authoritative knowledge from the latter half of the 20th century. It is equally important to point out the lack of interest and acknowledgement that the onset of labour and the early phase of labour are given in the presented texts.

In 1954, an article called *The graphic analysis of labor* was published. The purpose of the study was to find a simple, reproducible, and relatively objective method of recording and comparing progressive changes in the course of labour (Friedman 1954). In this article the results of a study of 100 women were presented. In 1955, a second article followed, *Primigravid labor: A graphiostatistical analysis*, which included a total of 500 primigravid women (Friedman 1955). The articles give a graphic portrayal of the course of first stage labour, in which cervical dilatation is plotted against the elapsed time from the onset of regular contractions. Even so, Friedman may not have discovered anything really new about the course of labour. What he did do though was to define labour in a way that lent itself to quantitation and thus to standardization (Pitkin 2003). According to the rate of cervical dilatation, the first stage of labour was divided into two main phases, which are a latent and an active. The latter consists of three subdivisions: the acceleration phase, the phase of maximum slope and the deceleration phase. Based on the calculations, the slope of dilatation was described and an average duration was suggested for the different phases. The

calculated means were 8.6 and 4.9 hours for the latent and the active phases, respectively, with the statistical maximums of 20.6 and 11.7 hours (Friedman 1955). Through this calculation, the distinction between normal and pathological progress was set for the next few decades. Friedman's work became very influential; the "Friedman curve" (fig. 2.1), or some variation thereof, has been incorporated into clinical settings and adapted into teaching material for the education of midwives and doctors up until today, and contemporary textbooks still refer to Friedman's work (Blix, Kumle et al. 2008). In relation to the scope of this study, it is worth noting that Friedman did not pay much attention to the onset of labour in his publications. In the article published in 1955 he stated: "The latent phase extends from the onset of labour, *taken arbitrarily from the onset of regular uterine contractions*, to the beginning of the active phase." (italics mine) (Friedman 1955: 569). In 1972, Philpott introduced the precursor for what we know as the partogram with the alert and action lines which was based on Friedman's curve (Philpott and Castle 1972a; Philpott and Castle 1972b). It is worth noting that this work was originally aimed at rural carers in a context in which transfer of women in labour could take hours or even days. The alert and action lines were designed as a guide to when they should be considering, and then taking action on, an abnormally slow labour. This model was then exported to Western hospitals in which transfer times to a higher level of care are much less critical, often taking only minutes. Despite this, the use of one version or another of the partogram based on the work of Friedman and the researchers who followed him is now nearly universal in most intrapartum settings (Downe and Dykes 2009).

Fig. 2.1 "The Friedman's labour curve"



Active management of labour is yet another text which has had a major influence upon medical practice with regard to birthing women in the latter part of the 20th century (O'Driscoll, Meagher et al. 1993). Active management of labour (AML) implicates an obstetric involvement in all labouring women's "management", with the term "active" referring to the actions taken if the labour does not progress at a certain speed. The novelty of this approach was that the diagnosis of labour in first-time mothers is accepted in the presence of regular uterine contractions occurring at least every 8 minutes and a cervical effacement of at least 80%, even if the cervix is only 1 cm dilated. Consequently, the distinction between the latent and active phases of labour is seen as unimportant, as either the diagnosis of labour is made or it is ruled out according to the AML principles. Once a diagnosis of labour is made, the cervix is expected to dilate at a speed of at least 1 cm per hour. The artificial rupture of membranes is routine and oxytocin augmentation is begun if the cervix does not dilate at the expected speed. Where the model was incorporated in the management of labouring women, one of the results was a reduction of the average time duration of labour, which led to an expectation that no labour would last more than 12 hours. According to Boylan (1990), this effect is due to reducing the duration of the latent phase because AML had no effect on the duration of the active phase of labour when compared with Friedman's curve. O'Driscoll et al. state that labour is defined as "the numbers of hours a woman spends in the delivery unit, from the point of her admission until the time her baby is born", adding that "no allowance is made for time spent in labour at home" (1993: 32). The principles of AML have been incorporated into many clinical settings, including modified forms.

The last historical 'snapshot' to be presented is not a benchmark work in the way that Friedman and O'Driscoll have influenced the views and management of labouring women. Nevertheless, it is important because it is the first of a few studies which have been influential for the planning of care and management of women in early labour. In 1986 a study with the purpose of establishing the relationship between the timing of hospital admission and the progress of labour in primiparous women was published (Hemminki and Simuka 1986). The authors hypothesized that early hospital admission may be harmful in terms of intervention rates. This was a retrospective study conducted in Finland of the records of 591 healthy women who had been admitted to the hospital, of whom 436

approached the labour ward because of contractions and were found to be in labour at the time of admission. The main criterion for labour was regular contractions occurring at 5-10 minute intervals as well as effacement of the cervix. In this study, women were classified as early or late comers if they reported that the contractions had lasted for four hours or less, or for more than four hours, respectively. In addition, the dilatation of the cervix at admission was seen in relation to the period during which regular contractions had already occurred, hence establishing "the intrinsic speed of labour". Furthermore, the intrinsic speed of labour was compared to a curve
of an average dilatation of the cervix which was adapted from those given by Friedman and O'Driscoll. When the intrinsic speed of labour was taken into account, the women who come early had more interventions during labour and more caesarean sections than those who come late, although none of the results were significant. Thus, the authors conclude that the hypothesis that early hospital admission may be harmful obtained some support in the study. The authors underscore that they cannot prove that better results would have been achieved if the women had come later because it could as well have been that the factors which caused them to come early also caused the problem, independent of the admission time.

Management and care in early labour today

The interest in the relationship between the time of admission and obstetrical interventions and complications was rising around the turn of the century. Due to the escalating numbers of labour interventions caused by dystocia, which lead to more oxytocin stimulation and caesarean sections, research about possible relationships escalated. Several studies found a correlation between cervical dilatation at the time of admission to the hospital and the subsequent progress of labour; here, three important publications will be presented: Two retrospective studies specifically explored the relationship between cervical dilatation at which women presented in labour and the subsequent likelihood of a caesarean section (Holmes, Oppenheimer et al. 2001; Bailit, Dierker et al. 2005). The first study (n=1168) showed that significantly more nulliparous women presenting with 0–3 cm dilation at the first vaginal examination experienced a caesarean section compared with those presenting

with 4–10 cm dilation. There were also significantly greater frequencies of oxytocin use and epidural analgesia in women presenting earlier in labour (Holmes, Oppenheimer et al. 2001). The second study (n=3088) described significant differences in caesarean section rates between the two groups of nulliparous women, and they also reported increased rates of obstetric interventions and infections (Bailit, Dierker et al. 2005). The authors of the latter study propose two possible explanations as to why women arriving in early labour had higher caesarean delivery rates: either women who presented in the latent phase had an inherently higher risk of dysfunctional labour at baseline, or an increased exposure to the medical system conferred risks that were not present at admission. The authors answer the question by referring to a study conducted by McNiven et al. (1998), suggesting that it is the exposure to the medical system which is responsible for the increased number of caesarean deliveries, and epidural and oxytocin rates.

The third study which explores the relationship between the time of admission and obstetric complications was a randomized, controlled trial with the purpose of determining the effectiveness of early labour assessment in reducing caesarean birth rates for primiparous women at low risk (McNiven, Williams et al. 1998).A total of 209 women who presented themselves to the hospital in spontaneous labour were randomly allocated to either the early labour assessment group (experimental group) or the direct admission to hospital group (control group). In addition to the usual assessments performed on arrival, the intervention included support, encouragement and advice if the woman was not found to be in active labour. Women in the experimental group were transferred to the delivery unit when they had progressed to the active phase of labour. The determination of active labour was based on the presence of regular, painful contractions and cervical dilatation greater than 3 cm. The women allocated to the control group were sent immediately to the delivery unit without any instruction or advice and were admitted directly, receiving normal intrapartum care in the labour ward. Unfortunately, the paper does not give information about the cervical status of the women in the control group at the time of admission to the labour ward, thus making comparisons between the groups unreliable. Still, the authors claim that the duration of labour and the use of analgesia and oxytocin stimulation were significantly reduced when women were assessed before admission to the delivery unit. Women in the experimental group rated their labour and birth experience more positively than those admitted directly to

the delivery unit. The authors of the paper conclude that early labour assessment has the potential to reduce the number of women receiving oxytocin augmentation and epidural analgesia for pain relief, and to improve women's evaluation of their labour and birth.

The three papers presented in this section have been cited and drawn upon in numerous publications in the field, and have gained almost iconic status. Accordingly, a relationship between early admittance and negative labour outcomes was accepted and established through these trials. Moreover, it was indicated in the study performed by McNiven et al.(1998) that women in labour, however not surprisingly, rated the attention they received from caregivers positively. Which clinical changes and new questions emerged in the wake of these trials? A policy of delayed admission to avoid the "risk" of primiparous women presenting in early labour is one of the effects of the presented trials. Labouring women, who are found not to be in active labour, are asked to remain outside the hospital to await further progress. This policy of delayed admission therefore established a need for effective strategies to keep women out of the hospital during early labour in order to reduce the number of interventions. In the following section, five studies that were designed to compare and explore various strategies to delay admission will be presented.

Strategies to keep women home

Early labour assessment and support at home versus telephone triage was tested in two randomized controlled trials in Canada: firstly, with the rate of epidural analgesia as the primary outcome measure (n=237) (Janssen, Iker et al. 2003), and secondly to compare caesarean delivery rates in nulliparous women (n=1461) (Janssen, Still et al. 2006). It is not clear though as to whether the former study concerned first-time mothers only, or both primiparous and multiparous women. When women sought advice about when to come to the hospital they were randomized to one of the two groups, and were either provided with advice by telephone, or had a hands-on assessment in their homes. The assessment at home was identical to that done over the phone, but in addition an assessment of maternal vital signs, abdominal palpation, auscultation of the fetal heart rate, assessment of contraction and an examination of the cervix were performed. In the first study the authors conclude that early labour assessment and support at home are associated with a decrease in admission to the delivery unit of women in the latent phase of labour, as well as a reduced use of narcotic

analgesia. Furthermore, women who received home visits rated their early labour care more positively than women receiving support via telephone. Both studies demonstrated a reduction in the number of visits to the hospital in the latent phase, but did not prove any impact on caesarean delivery rates among healthy labouring women. The authors conclude that once the women were inside the hospital, there was no difference in the rates of interventions between the two groups.

The Early Labour Support and Assessment (ELSA) trial was conducted across clinical sites in the UK, including 3.514 women (Spiby, Green et al. 2008). The aim was to determine the impact of a policy of offering home visits by midwives to nulliparous women in early labour at term, compared with standard care and an assessment in hospital in a randomized controlled trial. The primary outcome measures were caesarean section and instrumental delivery rates. Among others, the secondary outcomes were labour duration, interventions and complications. The findings indicate that home visits did not reduce the operative and instrumental deliveries that had been the focus of the trial, nor did such visits delay the stage of labour at the point of final admission. The authors conclude that the hypothesized effect of home visiting against the cascade of interventions during labour was not achieved. Women evaluated home visiting positively, and were also significantly more satisfied with the time spent at home during early labour, reporting they felt as if they were treated as an individual and with respect at this time. Women in the home visiting group reported fewer episodes of admission followed by a discharge home than women in the standard care group.

A multicentre trial, including hospitals in Canada, the United States and the UK, with a total of 5.002 primiparous women was performed by Hodnett, Stremler et al. (2008). The objective of the study was to determine whether a complex nursing and midwifery intervention in hospital labour assessment units would increase the likelihood for spontaneous vaginal birth and improve other maternal and neonatal outcomes. One of the outcome measures was women's views of their care. It is interesting to note the shift in perspectives compared to the other studies presented, with the main focus in this study being on "positive" outcome measures. The interventions were performed in the labour assessment units in which the purpose is to determine whether a woman should be admitted to the labour ward or sent home to await active labour. After a basic assessment of labour, the women

were randomized to the experimental group or the usual early labour care group. Women in the experimental group immediately received one-to-one care during a minimum of one hour by a nurse or midwife trained in structured care. Women assigned to the control group received care by a nurse or a midwife who had not been trained in structured care, and who had also given her attention to other tasks. In both groups, the decision on whether to admit women to the labour ward or to send them home was made as per usual hospital policy, and only the nature and content of the nursing or midwifery care in the labour assessment unit varied between the groups. The results of the study show that structured care did not significantly improve clinical outcomes, but did improve some elements of the women's experiences and satisfaction with their care such as the amount of attention they received and helpfulness of the staff. Nevertheless, the approach was suggestive of a modest increase in the likelihood of spontaneous vaginal birth.

The last study to be presented regarding strategies to keep women out of the hospital until they are in active labour has explored the use of an algorithm to assist midwives with the diagnosis of active labour in primiparous women (Cheyne, Dowding et al. 2008; Cheyne, Hundley et al. 2008). The authors state that a possible reason for the higher rate of intervention in women admitted early is that clinicians do not make an accurate distinction between women who are in active labour, who are not yet in labour or who are in the latent phase, thus admitting women "too early". An estimate showed that between 30% to 45% of women admitted to the labour wards in the United Kingdom are subsequently found not to be in labour (Cheyne, Hundley et al. 2008). Even higher numbers being reported in a study from Canada (Raby, Helewa et al. 2005). The algorithm for diagnosis of active labour in primiparous women was tested in a cluster randomized trial in 14 participating maternity units in Scotland. The objective was to compare the effectiveness of the algorithm with standard care in terms of maternal and neonatal outcomes with the use of oxytocin for augmentation of labour as the primary outcome. Secondary outcomes were interventions in labour, admission management, and labour outcomes. In the experimental group (n=1029), midwives were asked to use the algorithm during the admission assessment of women to assist in the diagnosis of active labour, recording their judgement on the algorithm. Women who were identified as not yet being in labour were encouraged to return home or were admitted to an antenatal area, depending on the local maternity unit policy. Women in the

control group (n=1291) received normal care, comprising an admission assessment by midwives using clinical judgment alone. Although standard care varied between control units, none had any guidelines or protocols for diagnosis of labour at the time of the study. The results show no significant difference in the percentage of oxytocin use attributable to the application of the algorithm. Neither could the study demonstrate significant difference between groups for any of the labour interventions considered, mode of delivery, or maternal complications. A significant higher amount of women in the control group remained in the labour ward until delivery after their first admission, whereas women in the experimental group were more likely to be discharged home, thereby resulting in significantly more admissions before labour. Despite this, there was no significant difference between groups for the duration of active labour, or the time from the first labour assessment to delivery. The results of this study may imply that the higher rates of interventions in women admitted early cannot be fully explained by a failure to distinguish between the latent and active phases of labour, and that the policy of delayed admission may be an over-simplistic approach that does not meet the needs of women in early labour. Merely sending women home did not produce a clinical benefit, and may have contributed to negative experiences for the women in question (Cheyne, Hundley et al. 2008).

Summary

In this section we have taken a retrospective glance, looking at studies which have strongly contributed to an authoritative knowledge within the field. They have shaped the views on how to understand the progress of labour and its time limits for half a century. Additionally, research which established a relationship between the timing of admission and negative labour outcomes has been presented, demonstrating an association between early admission, caesarean sections and obstetrical interventions. This has led to a need for strategies to delay hospital admission, particularly for women waiting for their first child. Five studies which explored various strategies were subsequently presented, but none of the trials demonstrated any significant reduction in caesarean section rates. What is demonstrated through some of the trials though is that increased support from professionals in early labour improves women's experiences of labour, and that early labour support at home may have a positive effect in the way that it reduces episodes of admission followed by a discharge home.

2.2 First-time mothers experiences of labour onset and early labour

As emphasized at the beginning of this chapter, the focus of the dissertation is on labour onset and early labour as it is lived, experienced, understood, and acknowledged by women and clinicians. The research which has been presented so far has thus focused on the background for how care and management have evolved over the past years, and on the exploration of strategies to keep women out of the hospital in early labour to contextualize first-time mother's experiences in early labour. It has been necessary to show the 'backdrop' into which the lived experiences are embedded. In the coming section, studies related to how first-time mothers experience labour onset and early labour in their homes, and how they perceive contact with the hospital and professionals, will be presented.

Recognizing the onset

As we have already seen, the time for the beginning of a woman's labour has often been set arbitrarily in research trials and very little information has been available on women's own perceptions of labour onset. In clinical practice a regular contraction pattern over a period of time is a well-established indication of labour, with or without ruptured amniotic membranes and "show". The first study to examine women's recognition of the onset of labour at term was conducted in Germany (Gross, Haunschild et al. 2003), indicating that women perceive the beginning of labour in more differentiated ways than in relation to regular contractions only. This was a study conducted to examine women's assessments of how and when labour started. A total of 235 women retrospectively answered a semi-structured questionnaire concerning when their labour had started and what symptoms they experienced at that time. Additional questions asked about relief of discomfort and the rupture of membranes. All but 18 of the 235 women reported a definite time for their onset of labour, with a 60 % of the primiparous women reporting recurrent pains, both regular and irregular, as a characteristic feature of their onset of labour. There was a diversity of signs and symptoms reported by the women in addition to pain, including watery loss, blood-stained loss, gastrointestinal symptoms, emotional upheavals and sleep disturbances. Some women referred to signs and symptoms that had occurred over a period of a few days preceding the onset of labour. The authors state that the data indicate that the onset of labour is a concrete event for most

pregnant women, albeit with a wide individual variation occurring in the signals that are perceived to characterize this event.

The findings of this study were confirmed in two later trials. The first objective was to assess whether the ways in which women experienced the onset of their labour influenced the duration of their labour (Gross, Hecker et al. 2006), while the and second objective was to assess the time of labour onset and its symptoms as perceived by women in labour and their midwives (Gross, Burian et al. 2009). In the former study, a sample of 651 women recorded how and when their labour started. The majority recorded several signs of labour onset, and the answers were assessed by a structured content analysis that used eight predefined categories similar to those in the study conducted in 2003. In this sample, more first-time mothers reported recurrent or non-recurrent pain as one of the signs of labour onset. The duration of labour in this sample varied greatly, a few women recorded labour onset several days before the baby was born, and the labours ranged up to 5.8 days in primiparae. Despite this, the median of the intervals from women's reported onset was 12.2 hours. The authors concluded that the ways in which women experience the onset is not predictive for its duration, with the exception of women who reported loss of amniotic fluid as the only reported sign of labour having a significantly shorter duration. In the latter study, women answered two standardized questions and selected the applicable sign of labour onset from a list of eight categories. Most women became aware of the onset of labour as a result of contractions, leaking membranes, and irregular pain. The median of the duration of the first stage as determined by the first-time mothers themselves was 11hours, and seven hours as assessed by the midwives. The median time interval between perceived symptoms and the onset of labour determined by the midwife varied greatly, from 1.5 hours for those experiencing watery fluid loss, to 2 hours for women reporting contractions to 11.5 hours for the women who reported sleep alterations as the first sign of labour. The authors concluded that the perceptions of women in labour are important in determining the duration of the first stage of labour and should be taken into account in intrapartum care.

The three trials conducted by Gross et al. (2003; 2006; 2009) are significant contributions to knowledge concerning women's perceptions and the validation of women's experiences related to labour onset. They are important demonstrations of the individual variation of women's perceptions of the beginning of the labour process. Nonetheless, it has

to be taken into account that all data were reported retrospectively, at a point in time when the women were confirmed to be in labour and could therefore be certain about the onset. For that reason, the conclusion that the onset of labour is a concrete event for most women might be too definite, though still leaving the question of women's recognition of labour onset in real time unsolved.

Early labour experiences

Women's recognition of labour onset was explored in an ethnographic study conducted in the United States with the purpose of investigating the phenomenon of early labour prior to hospitalization from the perspective of first-time mothers (Beebe and Humphreys 2006). The authors starting point was that many women plan for and idealise the awaited event, and may not be fully prepared for the various decisions associated with early labour management. Data were largely derived from interviews conducted during a previous study and supplemented by additional data collected in relation to this study. Twenty-three women with uncomplicated term pregnancies who began spontaneous labour outside the hospital were interviewed about their experiences and management strategies during labour prior to hospital admission. The central theme that emerged from this study was confronting the relative incongruence between expectations and experiences, which was evident within the five supporting categories; expectations, identifying labour onset, managing the experience, supportive resources, and decision making about going to the hospital. Immense importance was assigned to the task of properly diagnosing labour among the participants, and women's expectations about what labour would feel like influenced their ability to recognize its onset. Retrospectively, participants could describe the details about the beginning of labour with ease, although most participants recalled an uncertainty about labour onset as it was happening. The decision about when to go into the hospital during labour was very important for the women in this study, and involved a number of factors and usually other people as well. An often-cited reason for delaying hospital admission was the fear of going in "too soon", and for those who did go in because they believed to be in labour and returned home without delivering, the thought of repeating that pattern was even more distressing. Many women stated that if they had known what their progress in labour had been, they would have stayed home longer before entering the hospital.

Aspects of experiences related to the decision about when to go to the hospital are explored in a few more studies. In the U.K., Cheyne, Terry et al. (2007) conducted a qualitative exploratory study to determine the main themes and issues surrounding women's early labour experiences and factors which influenced their decision making processes in relation to when to go to the hospital. Twenty-one women participated in the interview study, of which 16 were giving birth for the first time. The data analysis revealed two main themes, "preparation for labour" and "being in labour", both of which comprised a number of sub-themes. Uncertainty was a sub-theme running through the women's narratives, and pervaded much of the women's experiences of first-time labour at home. The feelings of uncertainty were related to whether their labour had started, with their ability to cope and the decision making processes in regard to when to go to the hospital. The women's narratives indicated that it was often the anticipation of impending pain, as well as current levels of pain, which was the key factor in deciding when to go to the hospital.

Women's perceptions of the transition to the birth facility was the focus of a qualitative study conducted in the United States, which presented women's perspective with concern to the process of identifying the "right" time to transfer to the birth setting (Low and Moffat 2006). Twenty-four women who had given birth for the first time were interviewed after their birth experience. Three major themes related to the transition from home to the birth environment were identified from the analysis. The first theme reflects the potential tension between being asked to correctly identify the signs and symptoms of labour when the diagnosis of labour is based on the healthcare provider's assessment of dilatation in response to contractions. Being in pain, which the women thought was an indication of labour, was not necessarily enough to gain admission. The second theme refers to how women interpreted their bodily experiences if these did not meet the medical definitions they were given in their instructions on how to know they were in labour. If they did not match it was understood as being abnormal by the women, or there was a denial of the bodily experience of pain. The last theme was marked by a confidence that what the woman was experiencing actually was labour, despite the medical definitions and potential response from her healthcare provider. The authors conclude that much of the dialogue about when to come to the hospital was framed by a "risk" of being sent home if a woman was not advanced enough

in her dilatation. They further indicate the need for acknowledging pain as the primary basis for women coming to the hospital as opposed to cervical dilatation.

A Swedish study explored the experiences of women who were admitted to the hospital when they were still in the latent phase of labour, in addition to their reasons for seeking care (Carlsson, Hallberg et al. 2009). Eighteen women, of whom 11 had a first child, were interviewed after their birth experiences. The central theme of "handing over responsibility" describes women's experiences of security and control as they entered the hospital and someone else took over the responsibility for their labour, the well-being of the unborn baby and for themselves as individuals. However, the women's respective need to hand over responsibility varied from a total release of control to partial participation and active decision making. It was deemed important among the participant that they were given the opportunity to either partially or totally hand over responsibility. If not, they experienced feelings of loneliness and helplessness. One of the five subcategories, "having difficulty managing the uncertainty" was specifically related to the first-time mother's experiences. The uncertainty was based on not knowing when labour would start, what a true onset of labour should feel like or if it had really started. Early labour was described as a stage in which strength and weakness co-existed like a pendulum oscillating from powerfulness to complete powerlessness. Support from caregivers or partners was described as crucial during periods of powerlessness, as it helped them regain strength. Feeling powerless contributed to a sense of helplessness, and in these cases caesarean section was contemplated as a legitimate way out by letting somebody else take over the responsibility for the labour. The authors of the article conclude that the experiences left women with the sense that the latent phase of labour was traumatic. This in turn influenced the total birth experience negatively, even to the extent that some women expressed doubts about having more children.

Several studies about first-time mothers' experiences in early labour in various contexts have now been presented. The studies exhibit a diversity of experiences and feelings among women in this phase, but at the same time there are some common traits which are important to highlight. Feelings of incongruence between women's expectations and their actual experiences concerning labour onset are mentioned in several studies, as well as the problem of interpreting experiences which do not match their expectations. It seems as if the

women participating in the studies were very concerned with the task of 'diagnosing' labour correctly and that making the subsequent decision about when to approach the hospital was framed within a risk of being sent home. Finally, feelings of uncertainty about recognizing the onset of labour and when to leave for the birthing facility were reported in several of the presented studies.

Experiences of remaining or returning home

As a consequence of the policy of delayed admission women are asked to remain outside the hospital as long as possible, or were requested to return home if they approach the birthing facility 'too early'. A couple of studies which have specifically explored women's perceptions of staying home after telephone contact or returning home will now be presented. Women's experiences of following the advice to stay home in early labour were explored in a qualitative study in the U.K (Nolan and Smith 2010). Eight women who contacted a triage unit by telephone in early labour and were advised to remain at home were interviewed. Seven of the women had given birth to their first babies and one to her second following an elective caesarean section for her first child. Four themes were identified in the transcripts; "reassurance", "uncertainty about early labour", "pressure from women's families to go to hospital" and "seeking permission to come in". The women in the study told about the need to have their experience of early labour validated by health professionals since they did not trust their own judgement. Contact with the hospital and acknowledgement from the midwives that their labours had begun reassured the women and gave them shortly relief from uncertainty and the sense of not knowing. To a great extent, the uncertainty the women experienced related to the question of when was the right time to go to the hospital, and this question was a major factor in their restlessness while at home. The women's anxiety levels while they were at home were exacerbated by the presence of partners and mothers who put pressure on them to go to the birth facility at an earlier time than they felt was needed. Some of the women had rung the triage unit or visited the hospital on several occasions, seeking to be admitted. The reasons for visiting the hospital could be lack of understanding the progress of labour, not knowing what was happening, a concern about making the journey to the hospital or pressure from relatives. The women reported that the decision about admission was ultimately made by the midwifery staff. An overarching category which subsumed all

the themes and provided a conceptual framework in which the experiences of the women could be understood reflects the women's sense that the advice to stay home was a professional rather than a woman-centred response to early labour. The authors conclude that advice from midwives to stay home in early labour may be insufficient to reassure women who lack trust in their own ability to interpret what is happening in labour, and who depend on health professionals. Additionally they state that the findings of this study shed some light on why interventions to help women stay at home, such as telephone triage and home visits by midwives, have not been successful in either reducing the time women spend in the hospital or the number of interventions they receive.

Barnett, Hundley et al. (2008) conducted a study which explored the factors that influence a women's decision to go to a maternity unit in latent labour and the impact that being sent home "not in labour" may have on her and her family. Twenty-one primiparae who approached one of the participating maternity units and were diagnosed as "not in labour" and subsequently sent home agreed to participate in the study. They received a self-complete semi-structured diary in which they were asked to record their experiences. Only six women returned the diary after their delivery, of whom five consented to have a follow-up interview. Five main themes were identified in the analysis: "influence of others", "reassurance", "coping/pain", "sleep deprivation" and "undervaluing the latent phase". As in the previously presented paper (Nolan and Smith 2010), the women were strongly influenced by others in making the decision about when to go to the hospital. The strong need for reassurance from the health providers that their labours had started is also a similar finding between the two studies. In this study the women experienced that reassurance was sometimes enough to reduce their anxiety, although for some being sent home only served to increase it. They all reported that the pain they experienced in early labour was far worse than they had expected or been prepared for, and they had problems coping with it despite pain relief medication and advice given by the hospital. They also listed pain as their major reason for going back into the hospital the second time. A lack of sleep was reported by the majority of the women as being a major problem while they waited for labour to establish. The authors' main conclusion was that women were strongly influenced in terms of when to go into the hospital by the anxiety of family and partners, and that most women sought reassurance, while being sent home made them feel unsupported and may actually have

increased their anxiety. It is worth noting that four of the six women participating in the study had a baby in the occipital posterior position which is associated with prolonged painful labour and increased risk of assisted delivery. Eventually, these four women had some form of instrumental delivery. To make a comparison, the incidence of the occiput posterior position was reported to be less than 3% of all deliveries in Norway in 2008. The authors indicate that the women who returned their diaries and agreed to take part in a follow-up interview were particularly unhappy with their labour experiences, which could have led to more negative findings.

Contact with health professionals

From the previously presented studies of first-time mother's experiences in early labour we can infer that contact with health professionals is very important with concern to how women manage labour at home. Only one study has been found that explicitly explores women's contact with health professionals, a website survey comprising 2.433 women, of whom 1.634 were primiparous (Nolan, Smith et al. 2009). The purpose of the study was to learn more about how women feel about their contact with triage units in early labour and about their experiences of early labour. The respondents were divided into two groups; women having a spontaneous vaginal birth and women having an assisted delivery. In the questionnaire, women were asked a series of questions about their first and on-going contact with health professionals during what they perceived to be early labour. A large number of women reported that the contact with a health professional had no effect on their level of anxiety, although there were no significant differences between the groups. In terms of how useful women found their first contact with services to be, more women in the assisted delivery group reported that the person to whom they spoke had made no suggestions about how they might cope at home. Women were asked whether they had visited the hospital in early labour and been sent home again because they were not judged to be in sufficiently strong labour; significantly more women who later had an assisted birth reported having visited their intended place of birth at least once during labour than women who later had a straightforward vaginal birth. Finally women were asked whether their experiences of early labour had been as they had expected it to be; significantly more women in the vaginal birth group answered the question positively. In a similar vein, significantly more women who had

a vaginal birth chose positive adjectives to characterize their experiences. The authors suggest that women who experienced early labour in accordance with their expectations, and who experienced it as a happy event, were more likely to have a straightforward vaginal birth. Moreover, they reflect that it was not clear whether having realistic expectations or having happy expectations is the key to later normality.

Summary

In this section we have presented studies about first-time mothers' experiences of labour onset and early labour, both at home and when having contact with health professionals at a hospital. We have seen that the first trials which explored women's' views about when labour started concluded that women perceived labour onset in far more divers ways than was previously suggested, thereby challenging the established time limits of labour. Qualitative research exploring women's early labour experiences indicate some common traits such as feelings of incongruence between expectations and actual experience, and feelings of uncertainty about "diagnosing" labour and the subsequent decision as to when to leave for the birthing facility. The experiences of remaining home after telephone advice, or returning home when approaching the hospital "too early", show that reassurance from the midwives only gave short relief from anxiety and uncertainty. Furthermore, the strong influence of partners or others staying with women in early labour on the timing of seeking contact with the birthing facility is indicated in these studies. Women's experiences of contact with health professionals in early labour reveal incongruence between expectations and actual experiences, particularly for the women who experienced an assisted birth.

2.3 Midwives' perspectives and experiences

Research which explores midwives' perspectives and experiences of labour onset and early labour are scarce. We have a couple of studies which looked into how midwives made "the diagnoses" of labour, i.e. the decision of whether a woman is in labour. In order to understand and frame the decision making process involved in early labour, literature on midwifery decision making in a clinical setting concerning the birthing process as a whole will also be presented. The decisions that midwives make are located within a certain

practice and embedded within professional discourses. We will therefore first present research which explores midwives' perceptions of hospital practice in a contemporary context that have relevance for the focus of the dissertation.

Midwifery in contemporary contexts

In 2005 we conducted a study among midwives practicing in a centralized and specialized labour ward responsible for approximately 5.000 births per year, with the aim of describing how skilled midwifery in a Norwegian high-technology labour ward was conducted (Blaaka and Schauer Eri 2008). The focus was on how skilled midwives experience their daily work between a biomedical and a phenomenological belief system. The theoretical approach of the paper was based on how the female birthing body is understood within the two paradigms. In a biomedical belief system, the female body's organic order may be grasped in a logical, unambiguous order. The body is capable of failure at any moment, even in low risk groups. In the phenomenological tradition the focus is on the needs of the women in relation to the birthing process as a whole. Control over a women's birthing body is achieved by attending to her physical, emotional and social well-being. The essence of the midwives' experience was "being and doing with the woman", in addition to balancing different types of knowledge through wise midwifery judgement. The act of "being with" was described by the participants in the study as presence, not only in a mere physical way, but also with their head, heart, and hands and with an attitude of watchful expectancy. The act of "doing with" meant to build a relationship of mutual trust and confidence with the birthing woman, which supports and confirms her subjectivity and gives her the opportunity to concentrate on herself. Wise midwifery, as described by the participants in the study, requires both presence and time. The demand for being present is difficult to standardize, and is hence less appreciated within a culture that values action and measurable skills. The midwives were all afraid of losing the key values of 'doing and being with women' when the birthing process was tied to medical time. This study did not explicitly explore midwives' experiences of working with women in early labour, but nevertheless gives a glimpse into of how some midwives describe their challenges in everyday hospital practice. In this type of practice, communication and contact with first-time mothers in early labour is one of the most important tasks that midwives perform.

The next study is a methasynthesis of midwives' experiences of hospital practice in publicly funded settings (O'Connell and Downe 2009). The objective of the synthesis was to explore midwives' perceptions of hospital midwifery with a focus on labour ward practice to examine professional discourses around midwifery work in the current modernist, risk averse and consumerist childbirth context. The background for the study was an assertion that while midwives claim to have expertise in normal birth, the literature suggest that they generally comply to what Davis-Floyd (2001) describes as the technocratic approach to childbirth. In this interpretation both doctors and midwives accept high levels of interventions and readily adopt available technology in the belief that it will lead to the best outcomes for mothers and babies. The authors also link this to notions of a risk society and consumerist requirements for certainty and control, which they say characterizes modern society. The cultural norms of modern society pose significant challenges for professional groups whose identity rests on assumptions of autonomous decision making and of the individualization of practice. According to the authors of the paper, midwifery provides an archetypal case study for such groups, as in most countries midwives occupy a potentially paradoxical position that is seen by some as subordinate to medical power, but which has the autonomy of decision making protected in their legislative structures. Furthermore, international midwifery bodies claim that the core expertise of midwifery is to support women in achieving normal childbirth (International Confederation of Midwives, 2005). A methasynthesis compares and integrates findings from individual studies in order to generate consensus on a new description of the phenomenon of interest. Fourteen studies were included in the synthesis, among them the previously presented study by Blaaka and Schauer Eri (2008). Eight studies were undertaken in the UK, three in New Zealand and two in Ireland, but despite the differences, the issues that impacted on the midwives' practice in hospital settings were surprisingly similar to the authors'. Three overarching themes were identified: "power and control", "compliance with cultural norms" and "attempts to normalize birth in a hospital environment". "Power and control" refer to how the medical model of care, obstetric control, and the hegemony of the medicalized system were referred to in all of the included studies. The midwives in the studies tended to blame doctors, other midwives and even the women themselves for what is described in all of the studies as the medical model of care. "Compliance with cultural norms" refers to midwives' adaption to the practices of the unit, even when this differed

from their preferred approach to care. They were constantly required to meet the needs of the hospital rather than the needs of the individual women, in order to manage heavy workloads. Interestingly, the synthesis indicates that even though midwives complained about the medicalized approached to care, it seemed as if other midwives rather than doctors were the main influence on their practice. Another point regarding the midwives' compliance was the importance of the choices or expectations of intervention by the women themselves. The last theme, "attempts to normalize birth in a hospital environment", is about midwives' divided loyalties between their support for normal birth and their loyalty to colleagues who conformed to different philosophies of care. Despite the perception of a medicalized environment many participants in the included studies remained committed to normal birth, and reported that normal birth was more likely to occur on nights when doctors and senior midwifery staff were not around. The authors provide an interesting discussion of the findings, and indicate that the way midwives work in hospital environments appear to be mediated by a "street level bureaucracy" (Lipsky 1980), in which the actual determinants of midwifery practice are senior midwives and not obstetricians. According to Lipsky, street level bureaucrats are those who provide a public service which involves caring and responsibility. They are characterized by using their authority in a defensive way to manage an otherwise overwhelming workload. The nature of midwifery work is to provide individualized care, but the work setting and institutional imperatives make this difficult to achieve. Public service is therefore delivered through a system that promotes equity, as opposed to individualized treatment and care. The authors go on to discuss that midwives may have certain myths about themselves, maintaining that they wish to provide women-centred care while supporting normal birth they practice as if they are bound by power dynamics in maternity units which work against them achieving this. In the included studies, they found an acceptance that hospital-based maternity care is inevitably based on medical protocols and emerging technology, and as a consequence midwives accept intervention as a "normal" part of birth. The authors suggest that midwives perceive that they cannot take personal responsibility for the care they provide and that this disempowerment influences their practice.

Midwifery and decision making

In this section we have so far looked into research that explores midwives' perceptions of practicing in contemporary childbirth contexts, without explicitly focusing on early labour. The reason for providing these studies is to "frame" midwifery practice within a certain setting before presenting research that explores more explicit phenomena within hospital-based midwifery and early labour. To make decisions pertaining to the diagnosis of labour seems to be a pertinent task for midwives, which is the focus of the two studies we have found about midwifery in early labour. Before presenting those two studies which explicitly explore midwives' experiences related to early labour, we will take a look at a literature review about midwifery decision making and birth (Jefford, Fahy et al. 2010). The focus of this paper was on factors which influence the processes that midwives use when engaged in clinical decision making during birth. Only four small studies were found that met the inclusion criteria in the review, of which three studies involved qualified midwives and one student midwives. Two studies were undertaken in England, one in Scotland and one in Sweden. The outset of the review is the authors' claim that decision making in midwifery holds a certain position because of the woman-midwife partnership, in which the woman is the ultimate decision maker. This position is said to not correspond with either nursing or medical decision making, but nonetheless has its origin in the more medically accepted term of clinical reasoning, which is a form of hypothetico-deductive logical thinking. Clinical reasoning has been criticized as being too linear and reductionistic since it focuses on details and chains of causal relationships. The authors state that clinical decision making is a broader concept that allows for both reductionism and holism at various points in the process, thus being in harmony with contemporary ideas in midwifery. The major finding synthesized from the review is primarily that decision making in midwifery is socially negotiated, and involves hierarchies of surveillance and control. The surveillance tended to reduce or regulate the midwives' ability to function autonomously. Three of the reviewed studies indicated that midwives' confidence in their own clinical judgements was limited and that validations were sought from within a hierarchical system. It is clear that when the decisions also have to be negotiated with the woman, this is a complex process. The latter point however is not discussed in the literature review by Jefford et al. (2010) instead, the

authors point to the lack of studies on the influence of the negotiation with women in midwives' decision making in birth.

"Diagnosing" labour

One of the reviewed studies in the above presented paper is a qualitative study undertaken in Scotland that examines midwives' perception of the way in which they diagnose labour (Cheyne, Dowding et al. 2006). The authors claim that the common institutionalized birth setting requires a clear-cut distinction between women being in labour, and therefore being admitted to hospital, or not being in labour and staying at home. The midwives in the focus groups described information cues which could be separated into two categories, those arising from the woman and those from the institution. As well as assessing the physical cues and other factors arising from the woman herself, the midwives had to work within the framework of the institution. They had to negotiate a number of organizational factors, especially in relation to the pressures of the workload, including a lack of beds and a shortage of staff. Another organizational factor was the clinical guidelines, together with the need to justify their actions to others. The authors suggest a model of decision making which is divided into two distinct stages: the diagnostic judgement (is this woman in labour?) and the subsequent management decision (what is the appropriate management for this woman?).The diagnostic judgement is usually made first, and is based on the physical signs of labour of which painful contractions and cervical changes were seen as being essential. The management decision will be clear-cut when a woman is in active labour. However, when the midwife's judgement is that the woman is not yet in labour, the management decision would be made by considering a series of competing cues such as: the woman's level of coping, her expectations and those of her family and requirements of the institution. An interesting finding of the study was the interaction between the woman, the midwife and the institution, all of which appeared to strongly influence the management decision. If a midwife judged a woman to not yet be in active labour, negotiation was needed between clinical judgement, pressure from the woman seeking admission and pressure from the institution to keep her at home. The authors conclude that the findings of the study suggest that midwives may experience more difficulty with the management decision than with the initial diagnosis.

The last study to be presented in this section is a qualitative study whose purpose is to find out how midwives diagnose labour onset and furthermore to create a model of this knowledge (Burvill 2002). The study had the premise that midwives' diagnostic cues have been subsumed by the biomedical approach, and the author thus sought to provide a woman-centred holistic approach to labour onset diagnosis by developing a midwifery discourse. Major themes were brought out in the focus groups, and the themes were subsequently elicited in a "knowledge elicitation process" with an expert midwife. All the midwives in the study felt that the medical diagnosis of labour, as defined by cervical dilatation and contractions alone, did not represent the experience and reality for all the women. The final model is presented in three parts:

1) the reactions of women, 2) external signs, and 3) internal signs. The model is presented in a form that represents the progression of time and evolvement of the cues over various phases or stages, as it is impossible to determine a precise moment in time when labour starts. Even so, the author emphasizes that timing is extremely variable, and the use of the timeline in the model is therefore to be understood merely as a general representation of time passing.

The timeline looks like this:

Late pregnancy cues→latent/pre-labour cues→early labour cues→early active labour cues→active labour cues

The model shows how reactions of the woman, observable external signs and the internal signs changes along the timeline. The author asserts that the data demonstrate the difficulty in distinguishing between latent and active labour, stressing that the stage of labour must be based on observable events and women's experiences and not cervical dilatation alone. It is additionally indicated that cervical dilatation is not required to diagnose labour onset in the majority of women; midwives should be able to watch, listen, and interpret the cues provided without physically interfering with a woman's body and birthing process. This paper proposes a distinction between "the medical diagnosis of labour" and "the midwifery diagnosis of labour", reflecting the underlying knowledge paradigms and models of care. The author urges midwives to be vigilant that future midwifery ideology is not rooted in a purely biomedical model because the model undervalues indeterminate midwifery knowledge and women's experiences by over-emphasizing medical technical knowledge.

Summary

In this section we have first framed hospital-based midwifery in a contemporary context in order to highlight the professional discourses surrounding this practice. Midwives had to balance between two belief systems, and seemed afraid of losing their key values of "doing and being with women" if the process was too connected to medical time. Midwives were seen as typical representatives of a profession which has the autonomy of decision making tied to their practice, but at the same time are being seen by some as subordinate to medical power. Midwives were complaining about a medicalized approach to care, though it seemed as if other midwives rather than the doctors were the main influence. There seems to be an acceptance among midwives that hospital-based maternity care is inevitably based on medical protocols and that midwives accept intervention as a normal part of birth. A literature review of decision making during birth indicated that the process is socially negotiated and involves hierarchies of surveillance and control, and that the surveillance tended to reduce or regulate the midwives' ability to function autonomously. When midwives made the decision of diagnosing labour they had to negotiate organizational factors in addition to assessing the women, thus leading to a model of decision making divided into two distinct stages: the diagnostic judgement and the subsequent management decision. A model of how midwives diagnose labour based on signs and cues in the women is proposed. It is also suggested that cervical dilatation is not required to diagnose labour onset in the majority of women, and that midwives should be able to interpret cues without physically interfering. Furthermore, a distinction between "the medical diagnosis of labour" and "the midwifery diagnosis of labour" is proposed.

2.4 Closing remarks and research questions of the study

At the outset of this chapter, a question was posed indicating the problem area of the study: "What is the problem of women in early labour?" The "problem" of early labour seems to be a problem not only for the women waiting for or experiencing labour onset or the beginning of labour, but also for the midwifery profession in hospital-based practice that communicate with and care for women in labour. In other words, there seems to be an interplay between several "actors" on a certain "scene". Hence three main themes have provided the

subheadings of this chapter: perspectives on labour and labour care (the scene), first-time mothers' experiences of labour onset and early labour (actor one), and midwives' perspectives and experiences of working with women in early labour (actor two). It is indicated that authoritative knowledge within the field is embedded in a biomedical paradigm, and further that trials which had the purpose of exploring strategies to delay women's admission to the labour ward did not achieve the expected results in decreasing the rates of caesarean sections and other labour complications. It was shown that trials which are designed to measure cause and effect are too simplistic towards the complexity of human experience. Women's lived experiences in the time around of labour onset and in the early phases of labour were shown to be nuanced, diverse and complex, but nevertheless had some common traits. Their experiences are "played out" and understood by themselves and their healthcare providers against a backdrop of various knowledge traditions. These traditions were very evident in the presented research about midwives' experiences of hospital-based practice and decision making in labour, among which diagnosing labour is believed to be crucial.

The aim of this study has been twofold: firstly, to explore how first-time mothers experience onset and the early phase of labour, and secondly, to discover how midwives in a hospital-based practice communicated with women who were giving birth for the first time. The aim is sub-divided into three research questions:

- How do first-time mothers experience contact with the labour ward before hospitalization?
- How do first-time mothers experience waiting for labour onset?
- How do hospital-based midwives communicate with first-time mothers in early labour on the phone or during check-ups?

The broader aim of the study has been to contribute to a discussion of different aspects of contemporary childbirth paradigms and knowledge traditions surrounding childbirth, and how these may shape and influence women's experiences and midwives' practices.

3. The research process

In this chapter, the scientific approach that influenced the studies will be presented. The research design, including the setting of the study, the recruitment of the participants, the procedures for data collection, the description of the data material and the approaches for analysing the material are accounted for. At the end of the chapter, ethical issues connected to the study are considered.

3.1 Scientific approach

The aims of the study were to gain insight into first-time mother's experiences during the end of pregnancy and on their journey into labour, and to further explore midwives' priorities and strategies in their communication with women in early labour. To have a research approach means to make explicit ontological and epistemological assumptions to underpin the study (Bengtsson 1999). This clarification will form the basis and rationale for the methodological choices.

I will start by briefly describing some aspects of the notion of "lifeworld", which is the account of human engagement with the world (Moran 2000), or "the daily experienced reality in which we live our daily lives with other human beings, a world we mostly take for granted" (Bengtsson 1998: 18). In a study of women's and midwives' experiences, the concept of "lifeworld" partially captures both ontological and epistemological stances; thus, I claim to have a lifeworld approach. The German philosopher Edmund Husserl is said to be the founder of what is called modern phenomenology (Dahlberg, Dahlberg et al. 2008). Husserl sought a sound, philosophical ground which could overcome relativism and be the starting point for all knowledge, leading to what is known as "transcendental phenomenology". His intention was to philosophically examine the lifeworld as a tacit ground for science. The lifeworld is pre-scientific and pre-reflective, meaning we are "always already" present in a world which is always there and which we cannot escape (Bengtsson 1999). Husserl's work was further developed by Martin Heidegger, another German philosopher. He was critical of elements in Husserl's work, claiming that he remained too

"Cartesian" and "intellectualistic" in his account of human engagement with the world. Heidegger emphasized the reciprocity between the person and the world, hence making his work more of an ontological project. As opposed to Husserl's pure consciousness, Heidegger's notion of "being-in-the world" is pointing at a concrete existence, an existence which is fundamentally social, historical and situated, a world in which humans "find themselves thrown" (Moran 2000). The French philosopher Maurice Merleau-Ponty was inspired by both Husserl and Heidegger when he further explicated the lifeworld theory, emphasizing the lifeworld as "being-to-the world" (Bengtsson 1999) . He is known as "the philosopher of the body" because of the centrality of the subjective and lived body in his understanding of the human world. Merleau-Ponty's theories are as much a theory of the body as a theory of the subject (Bengtsson 1999). The bodily subject is one's own 'lived body', thus there is no opposition between body and soul, as they build an integrated whole. Merleau-Ponty was concerned with the perceiving bodily subject and how the surrounding world becomes meaningful for us through bodily experiences, i.e. the lifeworld is a world of perception. In Merleau-Ponty's own words: our body is "a nexus of living meanings" (Merleau-Ponty 1995/1945: 151). A fundamental feature of the lifeworld according to Merleau-Ponty is the circularity between subject and world, a constant reciprocity in which the subject and the world influence each other.

Another central theory which contributes to the basis of the scientific approach upon which this thesis is based is hermeneutics, which is the philosophy of understanding gained through interpretation. Hermeneutics goes back to the Greeks, who were engaged in interpreting texts, and was further related to interpreting the Bible during the Renaissance. In our time, hermeneutical theory has been further developed by Heidegger and then Hans-Georg Gadamer among others (Fjelland and Gjengedal 1994). Heidegger made it clear that the essence of human understanding is hermeneutic, that our understanding of the everyday world is derived from our interpretation of it and that all new things encountered in our lifeworld are related to previous experiences. Gadamer pointed to the authority of tradition, meaning that we are in the world as historical beings and always connected with our past, which is shown as our "prejudices" in relation to the present context (Dahlberg, Dahlberg et al. 2008). The terms historicity and pre-understanding are frequently used in hermeneutics to describe how human consciousness is embedded in our lifeworld. Pre-understanding is the

implicit knowledge within us that gives us a lifeworld, making it possible for us to understand the world we live in when we are in the natural and everyday attitude. There is a difference between the natural attitude and the scientific interpretation, as scientific interpretations are explicit and reflective methodological interpretations (Dahlberg, Dahlberg et al. 2008). The hermeneutic circle is the "method" for interpretation. We enter the circle with our pre-understanding, and in the encounter with what is being interpreted our pre-understanding moves so that we will never be at the same point of departure within the circle. Bengtsson (1998) claims that in modern hermeneutics, the hermeneutic circle concerns the relationship between meaning and context. Traditionally, qualitative research is said to be inductive. However, to acknowledge the researcher's pre-understanding as a valuable "tool" has consequences for the scientific approach, and the term "abductive" reflects this position (Mason 2002; Thagaard 2009). An abductive approach underscores the dialectic relationship between theory and data, and how research can never be completely "data-driven". This strategy is associated with the interpretive tradition; the researcher's theoretical background and foundation gives perspectives for the interpretation of the data.

In this empirical study, we wanted to explore how pregnant women and midwives perceive certain aspects of their lifeworld. To be able to gain knowledge about other persons' lifeworlds we needed a data material based on subjective and bodily experiences. To reach this goal implies reflections on design and methodology, which is further accounted for in this chapter.

3.2 Research design

Aspects of theories which are important for the theoretical position of the project and the scientific approach of this study have implications for the methodological choices. As mentioned earlier, to have a lifeworld approach means that some methods may be included, whereas others are excluded. To start, having a lifeworld approach implies having a qualitative design. In qualitative research, decisions about design and strategy are ongoing and are grounded in the practice, process and context of the research itself (Mason 2002). Bengtsson (1999) encourages "methodological creativity" and stresses the advantages of different methods in the same study in order to acquire knowledge of the complex and

multifaceted lifeworld. This study had an open, flexible design. Openness and flexibility mirror the nature of qualitative research, and reject the idea that decisions about design and procedures can only be made at the very beginning of the research process. We designed the study before commencing it, but constantly reflected on the data generated and made the necessary decisions and changes along the way. The study was planned with two different study groups and various data collection procedures:

Study Group 1: First-time mothers

- Diaries from 39th week
- Observations on arrival to the labour ward
- In-depth interviews after birth

Study Group 2: Midwives

- Focus group discussions with midwives at the labour ward

3.3 Setting

The study was conducted in connection to a university hospital in Norway. The hospital serves both rural and urban areas, and close to 5,000 women give birth at the hospital annually. The hospital's services for labouring women comprise two separate labour wards that are situated on the same floor, a post-natal ward and rooms for post-natal care in the patient hotel across the street.[1] The clinic offers free childbirth preparation classes one afternoon a week, which is conducted by the midwives on duty.[2]

Labour Ward A is the biggest unit and handles approximately 3,500 births every year, both normal and ones that are more complicated. This unit is a typical "high-tech" labour ward, with equipment available for epidural analgesia and obstetric emergencies and an operating room at the heart of the ward. It is a busy place, with staff and patients constantly on the move. The ward has an area dedicated to assessing women on arrival, consisting of three assessment rooms with the necessary equipment and a work station for the staff. The ward has eight delivery rooms, in addition to rooms for inductions and surveillance if

[1] Due to construction of the building and organisational issues the hospital has reorganised the wards after the material was collected.

[2] The childbirth preparation classes stopped immediately of economic reasons after the first recruitment period.

needed. Women who give birth in Ward A either move to a post-natal ward 2-4 hours after birth or to a patient hotel four hours after birth. In the latter case, they can bring their partner.

Labour Ward B is smaller and calmer, and has a more "home-like" interior. Medical equipment is barely visible in the delivery rooms, and the unit does not offer epidurals for pain relief. Healthy mothers with uncomplicated pregnancies may give birth here, and women who give birth at this unit can be accompanied by their partners for the entire stay; after the delivery, they move to a "family room" inside the ward where they can stay for two days. There is no separate assessment area here; women who arrive go directly to the delivery rooms for assessment.

Women are instructed to call the "admission number" when they think they are in labour. The wards take turns answering the phone; every second week the portable phone either stays in Unit A or Unit B.[3] Ward B is staffed with three midwives at all shifts who have to carry the portable phone with them at all times. Ward A does things differently because they always have a minimum of six midwives on duty at all times. As a result, the phone can stay in the midwives' station since there is always someone present who can answer. When women call, they are usually asked if they have made a choice as to which ward they want to give birth in, and if it is considered necessary, they will be asked to meet there for an assessment.

3.4 Recruitment and participants

The process of recruiting the participants and the descriptions of the two study groups will be described separately.

Study Group 1: First-time mothers

The recruitment process was purposive; we wanted to recruit women for the study who would yield diverse information about the research questions (Mason 2002; Silverman

[3] Today, this is arranged differently; one midwife answers the phone and maintains an overview of admissions at both wards.

2010). The aims and research questions of the study were the starting point for setting up the inclusion criteria, which were the following:

- Women who were expecting a first child
- Women who had a healthy pregnancy with no pathological conditions
- Women who were expecting a physiological labour
- Women who were able to communicate in Norwegian
- Women who were informed about the study and had given their consent to participate

At the time the study began, the clinic offered childbirth preparation classes every week. The classes were organized as one afternoon session, and were conducted on a rotation by the midwives on duty. The number of participants was usually limited to six women, together with a companion. Although the classes were not restricted to first-time mothers, the midwives' experiences were that very few women who had previously given birth would participate. Thus, these classes were perceived to be a feasible arena for recruiting women for the study.

In order to obtain access to the classes, I approached the midwives who would be responsible to ask for permission to be present.[4] I informed them about the study at the beginning of the first session, and provided all couples in attendance with written information about the project (attachment 4). The participants in the classes were encouraged to read the information and approach me during the breaks or after the classes if they wished to participate, or if they wanted further information about the study. They were also given the possibility of notifying me within a week if they wished to participate. After being present at some afternoon classes without recruiting more than a small number of informants, I decided to be more active. The couples were contacted during breaks or at times when the groups were walking around the labour wards, and were asked if they had considered participating in the study. I realized that many women felt that writing in a diary sounded challenging in some way, and that they were unsure if they would be able to do it the "right" way. Some women also had more questions about how the observations should be carried out. These were aspects which the women obviously felt too shy to discuss in front of an entire group of strangers. By having an informal talk with each couple separately, all their concerns were addressed and more women decided to participate in the study.

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[4] All midwives had received information about the study via e-mail on several occasions beforehand (attachment 3).

During the recruitment period, the clinic decided to stop the childbirth preparation classes. I therefore established contact with midwives in an ante-natal clinic outside the hospital. In this clinic, they offered childbirth preparation classes that were somewhat similar to the ones provided inside the hospital, except that the classes were conducted during the day, and no partners were present. I also established contact with a midwife who was conducting ante-natal classes for single mothers, and obtained permission to be present and recruit women during these classes as well. The recruitment period lasted from November 2006 until November 2007. See Table 3.1 for an overview of the recruitment period.

Table 3.1 Overview of the recruitment and data collection period, Study Group 1 (n=17)

	Recruited	Birth	Interview
Nov-07	A,B,C	A	
Dec-07		B,C	**A**
Jan-08	D,F		**B,C**
Feb-08	I	D,F	**D,F**
Mar-08	G,K	I,G	**D**[5]
Apr-08		K	**I**
May-08	E,M,N,O,T,V		**G,K**
Jun-08	R,S	T,N,O,R,V	**I**[6]
Jul-08		E,M	**E,M,N,O,R,T,V**
Aug-08			
Sept-08		S	
Oct-08			**S**
Nov-08	L		
Dec-08		**L**	**L**

I was present in 10 childbirth preparation classes at the hospital, in two classes at the ante-natal clinic and in one class for single mothers during the time period mentioned. Twenty-four women agreed to take part in the study; one woman withdrew from for unknown reasons, one woman moved to another part of the country before delivery and five women dropped out of the study because they did not experience spontaneous labour at term.

[5] Second interview

[6] Second interview

Lastly, 17 first-time mothers participated in the study. See Table 3.2 for a further description of the participants.

Table 3.2 Description of the participants in Study Group 1, (n=17)

Marital status:	**Married/cohab.: 15** **Single: 2**
Age:	21-25 years: 4 26-30 years: 9 31-36 years: 4
Education:	High school: 2 College/university: 15
Current occupation:	Student: 3 Employed: 14

Study Group 2: Midwives

The recruitment process for the three focus groups started with an e-mail to all the midwives employed at the hospital (attachment 5). We sought a purposive sample of midwives who were working at the labour wards and it was important to recruit participants from both labour units, as well as with a variation in the length of their working experience. The e-mail contained information about the study, and an invitation to midwives who were currently active in one of the two labour wards to take contact for further information and possible inclusion. Only one midwife responded to the first e-mail. The procedure was then repeated after a few weeks, in combination with a more personal approach, as I spent time with the midwives at the wards and initiated talks about the study. This was an opportunity to clarify questions about the study directly with the midwives. Some midwives responded positively and were given more information. A few wanted to think it over, and gave their consent either by phone or by e-mail within a week. In total, 18 midwives agreed to participate in the study, seven from Unit A and 11 from Unit B. Four midwives attended the first group, while seven midwives attended the second and third groups, respectively. See Table 3.3 for a closer description of the participants.

Table 3.3 Description of the participants in Study Group 2, (n=18)

Age	**29-39 years: 7** **40- 49 years: 5** **50-59 years: 3** **>60 years: 3**
Working experience as midwife	1-5 years: 3 6-10 years:6 10-20 years: 4 >21 years:5
Currently employed	Unit A: 7 Unit B: 11

3.5 Procedures and data collection

The procedures and empirical material will be described separately for the two studies.

Study 1: Diaries, observations and interviews

Bengtsson (1999) underscores the importance of "methodological creativity", and goes on to further emphasize the benefits of using multiple methods in one study. In order to obtain as much information as possible about first-time mothers' experiences, we applied and combined various methods for collecting data such as diaries, observation and interviews. Diaries are used as research instruments to collect detailed information about behaviour, events and other aspects of individuals' daily lives (Corti 1993; Elliot 1997).

This proximity of the present, the closeness between the experience and the record of experience means that there is the perception at least that diaries are less subject to the vagaries of memory, to retrospect censorship or reframing than other autobiographical accounts (Elliot 1997: 2).

The advantages of combining diaries and interviews, "the diary-interview method", have been described by Zimmermann (1977) and Elliot (1997), and the potential for accommodating different response modes for the same time span is emphasized. We decided to expand "the diary-interview method" to "a diary-observation-interview method". We

hoped that a combination of these techniques would hold an even greater potential for collecting detailed and in-depth information about the women's experiences.

The diaries

When the women had agreed to participate in the study, they obtained a notebook and were personally informed about how to use the diary. Instructions were given that it was not the mode of writing, but rather writing as often as possible, which was of importance. They were encouraged to write freely about their experiences, although a few topics were suggested such as bodily sensations, emotions they were experiencing, interaction with other people, daily activities and so on (attachment 6). The information was written on the first page of the notebook, together with my phone number and instructions to call me when they decided to leave for the hospital. The women were asked to start writing their diaries when they entered the 39th week of their pregnancy. Some started writing earlier, while two women who gave birth before the 39th week had not started to write at the time of giving birth, and therefore did not have a diary. The informants were asked to continue writing until they were admitted to the hospital for labour.

A few women started to write earlier then the 39th week, although the majority started when I reminded them by text message at the agreed point in time. The diaries varied, both in terms of the size of the written material and in the form of writing. Some women made many entries every day for several weeks, whereas others wrote once or twice every second day for a shorter period of time. The entries varied from being relatively short statements of the activities of the day to longer reflections on being pregnant and waiting for the birth of their child. Thoughts and concerns about the baby were also quite common entries in the diaries. A few women had written in the diary after their labour as well, thereby providing me with information about both the delivery and the baby.

The observations

The women were instructed to call me, regardless of the time of day, when they decided to leave for the hospital. I would then attempt to go to the hospital and conduct observations related to their arrival at the labour ward. Unfortunately I was only able to be present on three occasions. The observation sequences were relatively limited in time, as I planned to stay

with the women until their admittance was confirmed or until they returned home because they were not yet in labour. I wanted to observe the interaction between the midwives and the women, and possibly her partner if present. I paid attention to what was said, what was not said, and to which questions were asked. I also paid attention to the possible examinations that were carried out, and the "tone" in the interaction.

I started to write field notes during the observation, e.g. if a woman was resting, I took the opportunity to take some brief notes on situations which seemed important or essential. I did not take extensive notes, as I attempted to keep my attention focused on the observed situations. As soon as possible after the observation, I wrote and sorted my field notes. The notes were structured under three different categories: observation notes, theoretical notes and methodological notes as described by Fangen (2004) . The first category was a description of the situation, in which central moments were described in detail. The second category contained reflections, associations and assumptions of diverse things related to the research focus. The third focus was related to critical reflections on the fieldwork, as well as notes on how to do better the next time.

Because of the limited number of observations, we feel that the field notes should not be analysed in detail. Nevertheless, the observations and field notes were important when preparing for and conducting the interviews with the three women who I observed. Additionally, they added valuable insight for analysing the rest of the material; one example of this is how one observation, in combination with the interview with Oline, started an analytic track which is described in more detail in Chapter 5.1.

The interviews

All the women notified me by either phone or text message when they were leaving for the hospital, and kept me informed about when their child was born so we could arrange for the interview. All of the participants chose to do the interview in their homes, which were carried out within one to six weeks after giving birth. Two women were interviewed twice because their babies needed considerable attention during the first interview, and they were therefore unable to concentrate on what was being discussed. The interviews lasted between 60 to 180 minutes, with most of them taking approximately 90-100 minutes, and all were tape recorded. On six occasions, the woman's partner was also present. Their partner's

degree of involvement varied from being in the background and making coffee or taking care of the baby, to sitting in and being a part of the interview (two times). On three occasions, I also met the woman's mother while visiting the home.

The type of interview I conducted is described by Kvale (1997) as "the semi-structured lifeworld interview". He says that the purpose of the interview is "… to gather descriptions of the lifeworld of the interviewee with respect to interpretation of the meaning of the described phenomena" (Kvale 1997: 21). A guide which comprised the themes for the interviews was set up as a starting point (attachment 7). Before each interview the woman's diary was read for preparation, and the guide was adjusted to accommodate each individual woman. I noted interesting statements in the diary which I wished to encourage the woman to elaborate on. Through the diaries, I felt that I 'knew' the women and their stories to a certain extent. The lack of knowledge became very visible and gave me another basis when I was in the interview situation with the two participants who did not complete their diary. In the preparation for the interviews with the three women who had been observed on admittance at the hospital, the field notes from the observations were also included in the preparation. The interviews took form of a conversation, with the interview guide serving merely as a reminder for the themes. At the start of the interviews the women were encouraged to tell the story of their labour and delivery. After narrating their story we returned to their experiences of the onset and early part of labour for further clarification and in-depth discussion. If needed, I asked follow-up questions throughout the interview process to elicit their experiences. The women varied quite a bit in terms of the degree of articulation of their experiences; most of them told their stories without too much interruption from me, although a few of them needed concrete questions and requests to "go on" or "tell me more". After each interview I immediately wrote "research notes" to secure non-verbal information which I deemed important. The notes also served as reflections of my own role during the interview, and on how to potentially improve the next interview. Each interview was transcribed before the next interview was conducted in order to help start the analysis and reflect on the findings.

The empirical material from Study Group 1, i.e. the first-time mothers, comprised:

- Fifteen diaries (13 handwritten, two computer written)

- Field notes form three observations: 12 pages, single spaced
- Nineteen interviews: 363 pages, single spaced

See Table 3.4 for an overview of the data material.

Table 3.4 Overview of the data material in Study Group 1

Participant	Dairy	Observation	Interview
A	X		X
B	X	X	X
C	X		X
D	X		X X
E	X	X	X
F	X		X
G	X		X
I	X		X X
L	X		X
K	X		X
M	X		X
N	X		X
O	X	X	X
R			X
S	X		X
T	X		X
V			X

Study 2: Focus groups

We also wished to investigate midwives' priorities and strategies when communicating with first-time mothers in early labour. Focus groups are thought to be ideal for exploring people's experiences, opinions, wishes and concerns. Kitzinger (1999) further claims that focus groups are particularly well suited to the study of attitudes and experiences around specific topics, and how points of view are constructed and expressed. Three different focus groups were set up during November 2008. Four midwives attended the first group, whereas seven midwives attended the second and third groups, respectively. The groups were mixed with participants from both units (see Table 3.5 for a further description of the groups). Each group met once in a suitable room outside the wards but still inside the hospital, with each meeting lasting for approximately 1.5 hours. Upon arrival, the midwives signed consent forms, provided some demographic details and were offered a light snack and drinks during

the discussions. When all the participants had settled in around the table in a way that made it possible for everyone to see each other, the purpose of the study and the focus groups was repeated from the written information. I then also briefly introduced the nature and "rules" of the group. I was the moderator and facilitated the groups, with the help of an assistant who differed from group to group. The group sessions were tape-recorded, and the assistant took written notes to ensure that any information that was not audible was secured.

Table 3.5 Description of the groups

	Group one	Group two	Group three
Participants	4	7	7
• **Unit A**	1	2	4
• **Unit B**	3	5	3
Mean age (years)	46 (35-60)	40 (29-54)	48 (35-62)
Mean experience (years)	18 (7-33)	9 (1-28)	17 (6-38)

During the groups, the intention was to ensure that the participants talked among themselves, rather than only interacting with the moderator. A guide with questions was prepared to help facilitate and direct the discussions within the groups (attachment 8). The guide was planned with different categories of questions in accordance with what Krueger (1998) calls "Qualities of good questions and a good questioning route". Barbour recommends starting with unthreatening general questions in order to ease one's way into the topic of choice (Barbour 2007), and continue with transition and key questions before going to the ending questions, hence bringing closure to the discussion. I opened the discussion by asking the participants to talk about how they answer the phone when someone calls. An example of a transition question was when I asked if the midwives enjoy this part of their job. A typical key question would be: What do you know about research on early admission and the consequences for labouring women? To close the discussion, I asked the participants: If you were in control of making the decision, what do you think would be the optimal care for first-time mothers in early labour?

The participants were encouraged to engage in a conversation in response to each question, and I used prompts and follow-up questions for clarification and elaboration. It was easy to get the discussion going, so it was a challenge to allow enough time for discussion

and spontaneity on the one side, while moving on to the next question on the other. The challenge was sometimes solved by the group members themselves, who reminded each other of the actual question. To ensure that all group members contributed to the discussions, I sometimes asked the participants to share their opinions with the others, especially the least experienced midwives, who tended to be quieter during the discussions.

The moderator and assistant discussed the session immediately after the group had finished, paying particular attention to the groups' process. I transcribed the recordings of the discussions word for word, with the assistant's written notes as a supplement. The empirical material from Study Group 2, i.e. the midwives, comprised:

- Three focus group discussions: 63 pages, single spaced

3.6 Analysis of the material

In qualitative research projects, analysis means creating patterns or structures and coherence in the data material in order to create meaning from the data (Kvale 1997; Haavind 2000). To account for the process can be demanding, because a qualitative data analysis is not a straightforward process that takes place in clear, easily distinguishable steps. The process of analysis differed between the two data sets, but nevertheless I had the same basic approach, which can be said to be systematic. A systematic approach means that the researcher is reflective with concern to important decisions, not only in the analysis of course, but throughout the entire research process. Thagaard (2009) argues that in combination with sensitivity, a systematic approach captures various aspects of the qualitative research process. I will try to recount how I worked analytically with the data material in a process in which I moved forwards, backwards and sideways, while still continuously attempting to achieve a broader understanding of the material.

Material 1: The diaries and the interviews

The analysed material is comprised of diaries and interviews. There are also field notes from three observations, but as mentioned earlier, they were not analysed in detail. Nonetheless, the field notes yielded valuable insight for analysing and understanding the rest of the material. The analytic process actually started during the data collection period; to get a sense

of the material as soon as possible, each interview was transcribed before the next interview was performed as well as continuous reflection on the topic and writing of the "research notes". It is important to stress the fact that even though analysis was going on throughout the entire research process, at one point in the process the "formal" analysis commenced, which I attempt to describe here. The material was analysed twice in order to be able to answer two different research questions, though the first phases were quite similar. The first stage of the analysis implied intense reading; the diaries and the interviews were read continuously to give a sense of the content of the material. I considered several open questions while reading: What is the content of the material? What are the essential themes running through the women's experiences?

The first analysis

I moved on to read the interviews and diaries with the more specific research question in mind: How do women experience their encounter with the hospital? It appeared that the women did not write very much about these experiences in the diaries, therefore leaving us with mostly just the transcribed interview texts for further analysis. The work of organizing, sorting and structuring the data was started by marking all text, which in a broad sense revealed something about the encounters in one way or another. This is not entirely a practical or technical task, as the distinction between sorting the material and building analyses and interpretations can be blurred (Mason 2002). The process of sorting out the parts of the material which seemed relevant started with the creation of a shorter text concerning each woman. The result of this condensation was to create a structured text for analysis and the generation of meaning. It was important not to rush through the material, but to dwell long enough in each interview text to be able to get into a position to uncover the statements that implied something about the experiences of the encounters with the hospital. For example, I was struck about how concerned the women were about the timing of the contact with the hospital, and it was also surprising to realize that what the women told the midwives on the phone did not seem to match well with their actual reason for calling, as was revealed in the interviews and diaries. Findings of what seemed to be experiences of rejection and embarrassment among the women when they were in contact with the midwives in the labour ward also led to further investigation. The next step was to "label"

pieces of text which were perceived as meaning units with an appropriate name that could imply something about what the data meant or represented. Questions such as: Why is this statement here? Why not something else? What does this statement mean in this context?" were explored further.

Through reflective and critical examination, we looked for thematic patterns and commonalities that seemed to characterize the women's experiences of contact and communication with midwives during early labour, in addition to the individual variations within these experiences (Miles and Huberman 1994). The analytical process, including the mechanism of interpretation, was performed by regarding it as a process of logical inquiry and reasoning, rather than one of strict procedures (Kvale 1997; Haavind 2000; Thorne, Reimer Kirkham et al. 2004). The findings, i.e. our best suggestion for the interpretation of the data, are presented in Paper I: Negotiating credibility: first-time mother's experiences of contact with the labour ward before hospitalization.

The second analysis

The material, which was comprised of the diaries and interviews, was approached for a second analysis. It was interesting to see how the material emerged as "new" when I started over again with another question: How do women experience waiting for labour onset? I moved from the phase of intense reading to organizing and sorting the material. Phrases that seemed essential or particularly revealing in terms of the experience of waiting for labour were marked. I also worked with the material by writing a condensed text for each woman. The text included entries in her diary and her own retrospective reflections on the experience of waiting. During the work, we became aware of how important the estimated date of delivery was for the women's experience, and this topic guided us further. The analysis can be understood as an interpretive dialogue within the texts, which is a process that implies a systematic movement between the whole and the parts and a new whole. The dialogue arrived at an identification of thematic aspects that formed the basis of the findings in the study, which were explored through various tentative interpretations. This part of the analysis involved both creativity and imagination, in order to make sure that the interpretations did not stop at too early a stage (Dahlberg, Dahlberg et al. 2008). The interpretations, a text that takes the form of a story which aims at telling something particular while really addressing

the general (van Manen 1997), are presented in Paper II: 'The waiting mode': First-time mothers' experiences of waiting for labour onset.

Material 2: The focus groups

The material here is comprised of transcribed text from three focus groups. In this analysis, the groups themselves became an object for analytic purposes. The tape recordings were transcribed as soon as possible after the group discussion in order to initiate the analysis. By doing it that way, I had the possibility to adjust the questioning guide for the next group if needed. After reading through the entire data set, the questioning guide was the starting point for organizing the data. Each piece of data was labelled with a code that related to the content of the text and corresponded to the guide for the focus group discussions. Certain segments of text were given non-exclusive codes at different levels, which referred to both major topics and sub-topics in the guide. Since the emphasis at this point was on inclusiveness, the codes were quite broad and general and initially included all possibly relevant material (Frankland and Bloor 1999; Halkier 2008). An example of a major heading was "the phone call", and sub-headings were given codes such as "how to ask" or "when the partner makes the call". The next phase in the analysis was to cluster the codes into themes by processes of reflection, comparison and the identification of meaningful patterns, which could be then be interpreted as priorities and strategies that the midwives applied when they communicated with women who were in labour for the first time. The analysis of the group discussions revealed that the midwives prioritized the elements of their encounters in relatively similar ways when they talked to first-time mothers. We identified five major themes that seemed to constitute the key elements in the communication and which are presented in Paper III: "Stay home for as long as possible": Midwives' priorities and strategies in communicating with first-time mothers in early labour.

3.7 Ethical considerations

The study plan was approved by the Regional Committee for Medical Research Ethics (attachment 1) and the Ombudsman for Privacy in Research at the Norwegian Social Science Data Services (attachment 2). Voluntary and informed participation is an absolute principle

in research in relation to human participation, in addition to the right to confidentiality and the protection of privacy. These principles have been addressed to a certain extent in the papers, though here I will elaborate on two issues: 1) To what extent research participants can be fully informed, and 2) Protection of the participants' privacy. I will also discuss a few considerations concerning the interview situation.

The principle of information requires that potential participants have knowledge of all aspects of a research project before they consent to take part in it. However, this principle presupposes that the researcher has a full overview of the entire process, which is rarely true for studies with an explorative design. How then should this principle be observed? Rather, one must work from the vantage point that the information must be adequate, be in a quantity sufficient enough for the potential participants to make a decision and include all relevant information that the researcher possesses at a certain point in time. Thus, the researcher needs to inform the potential participants about the "uncertainty" inherent in the design and which possible changes one can foresee. Both study groups in this research project were informed step by step before they consented to participate. By doing it in this manner, they had the possibility to prepare questions about their participation that were not clear to them after receiving the first piece of information about the project. The pregnant women and their partners initially received oral information about the study in the childbirth preparation classes. The next step of information was written (attachment 4), and those who considered participation received additional oral information and were offered the possibility to ask questions before they gave their written consent. The participants needed detailed information about the data collection procedures, which yielded yet another possibility for information and questioning when we went through the details. My phone number was written on the first page of the diary, together with an invitation to call me if they had any questions about the study. Study Group 2 had a somewhat similar, though not quite identical, line of information about participation in the study which is clarified in Section 3.4.

Protection of the participants' privacy involves storing the data material in a safe way to ensure that the participants cannot be identified. Generating data from focus groups challenges the researcher's ability to protect the participant's privacy due to the nature of the method (Barbour 2007). The researcher does not have a guarantee that group members will keep information about other group members to themselves. Although the research topic was

not particularly sensitive, I found this especially important since the participants were all colleagues at the same hospital who worked together on a daily basis. I addressed my concern during the introduction to the group discussion, inviting the participants to share their opinions freely, while asking them to make sure that the information was kept within the group.

The ethical challenges of the qualitative research interview have been pointed out by several authors (Fog 1994; Kvale 1997). The interview bears a strong resemblance with an ordinary informal conversation, but differs with regard to the unequal relationship between researcher and interviewee. One important challenge with in-depth interviews is how the openness of the researcher and the trust she/he establishes in the interview may "seduce" the interviewee into revealing more personal information then she is confident with, or which is not relevant to the interview. In our study, however, the topic was not considered to be particularly sensitive and the possibility for the above mentioned situation taking place seemed to be low. Nonetheless, in order to open up for the participants' thoughts, we had a sequence of "debriefing" after each interview. When the interview was over, the tape recorder was turned off and we had a discussion about the experience of being interviewed. None of the participants reported any negative feelings with the interview situation or the information they had shared. To the contrary, both women and men emphasized the positive experience of talking through the complete experience of labour and delivery.

4. Summary of the findings

Paper I: Negotiating credibility: first-time mothers' experiences of contact with the labour ward before hospitalisation

The purpose of this study was to explore Norwegian women's experiences of communication and contact with midwives at the labour ward in the early phase of labour. The women faced two different types of encounters with the midwives - phone contact and personal encounters – both of which had different characteristics. The phone conversations were characterized by the midwife asking questions and the labouring woman answering the questions. The check-ups were characterized by objective investigations carried out by the midwife. Few questions were asked during the personal encounters, either by the labouring woman or her partner. Four themes seem to be central to how the labouring women decided to make contact with the birthing facility and how they experienced the contact with the midwives: "negotiating on two fronts", "avoiding being sent home", "searching for regularity" and "experiencing vulnerability".

The women negotiated with their partners about when to seek contact with the hospital. In many cases, the woman wanted to delay the call or trip but felt pressure from her partner. The women also negotiated with the midwives on the labour ward about whether they might be in labour and if or when it was time to come to the hospital. Communication and contact between the women and the midwives were framed within an unarticulated understanding that women often present too early at the labour ward; consequently, the women were very concerned about seeking admission at the proper time. Coming too early to the hospital and the subsequent return home was perceived as embarrassing by the women in the study, thus they tried to avoid such situations by being "ready" when they arrived. The interval and regularity of the contractions were spoken of and asked about in the phone calls. The more subtle signs of labour were not addressed in the same way during the encounters. The women tried to match their experiences to the expected rhythm of the contractions with five-minute intervals and a one-minute duration, and some hesitated to make contact, or even suppressed the signs of labour, if they did not match. The labouring women experienced themselves as being very vulnerable in their communications, especially during the personal

encounters with the midwives at the hospital. They also expressed a crucial need to be taken seriously when they contacted the hospital, whether by phone or in person.

Paper II: 'The waiting mode': First-time mothers' experience of waiting for labour onset

The aim of this study was to explore first-time mothers' experiences during the last days of pregnancy when they were waiting for labour onset, with a particular focus on the women's bodily experiences during this period. The main findings demonstrate that the participants moved towards or into a state of active waiting, "the waiting mode", in the days around the estimated delivery date. They all seemed to be aware of and anticipate the condition, even though some of the women did not enter this mode. The participants in the study fell into three "groups"; thirteen women described their transition into the mode, three women gave birth before they got to the expected date and one woman actively tried to avoid entering the waiting mode. The three women who gave birth two-three weeks before the estimated date had the common experience of anticipating a more intense period of waiting which they did not reach. Before the participants in the study got to the waiting mode they hesitated to relate bodily changes to labour, and did not interpret any new bodily signs as indications of labour onset. For the women who entered the waiting mode, there seemed to be a marked shift in the way they interpreted bodily sensations when reaching the estimated date of delivery, as they tuned in on new ways to interpret their own bodies. At that point, the experiences of bodily signs were transformed and given meanings as plausible indications of labour onset, and were matched against what cues they had learned to look for and be aware of. In the waiting mode, the bodily assessment was an ongoing task that the women performed; it was experienced as a state of constant alertness to the many potent possibilities within their bodies. The state of constant alertness was absorbing, their bodies felt all-consuming and they experienced themselves as being "more and more body". While in the waiting mode, waiting for labour onset occupied an increasing space in the women's lifeworld, and they felt a need to close the world out in order to be in their own bodies. This generated a sense of being enclosed in one's own body, intensely trying to identify the signs of labour onset. Through the experience of being enclosed in an all-consuming bodily attention, labour and

birth were more and more brought to the forefront of the women's awareness. Hence, being in the waiting mode seemed to draw labour closer in a manner that opened up for the birthing process, and helped the women to prepare for labour.

Paper III: 'Stay home for as long as possible': Midwives' priorities and strategies in communicating with first-time mothers in early labour

The purpose of this study was to explore the priorities and strategies that hospital-based midwives use in their communication with first-time mothers who seek contact in the early phase of labour. Because all labouring women call at least once before they come to the hospital, answering the phone took quite a bit of time. On a busy shift it could feel like a burden to answer the phone, and the midwives sometimes felt that the task disturbed them in their work. The participants emphasized that the way they conducted the talks and personal encounters was based on their individual judgement. The analysis of the group discussions nevertheless revealed that the midwives prioritized the elements of their encounters in relatively similar ways when they talked with first-time mothers. Five themes which constitute key elements were identified: "getting the picture", "normalizing the situation", "giving concrete advice", "letting the woman make the decision" and "staying home for as long as possible". The midwives' first concern when a woman called was getting the picture, which meant to obtain an overview of the woman's situation. Questions about the signs of onset seemed to be important to the midwives, and they asked about those signs in a concrete and simple way. If a woman approached the labour ward to have a check-up, they wanted to establish whether she was in labour with the help of the dilatation of the cervix. The next step in the communication, either on the phone or during a check-up, was to normalize the situation for the woman. The participants in the groups agreed that when many first-time mothers call, they want to hear that their experiences are normal. Furthermore, they thought that normalizing the situation would offer the woman a feeling of security and the reassurance they needed. Giving specific advice in concrete and easy to understand terms was the next element in the communication with the labouring women. The advice was often linked to concrete "tasks", such as having a meal, taking a shower or laying down to rest. One of the important issues in the midwives' communication with a labouring woman was

the decision as to whether she should come to the hospital, or if already there, return home. The midwives' strategy was to let the women make the decision themselves, or at least to agree with the decision. If the woman came to the ward for a check-up, they always prepared her for the possibility of returning home, but planned the management of the stay in such a way that the woman would find out for herself. The last theme was the very clear element of encouraging first-time mothers to remain at home for as long as possible "for their own good". They often made an offer to women who called to come in and have the dilatation of their cervix measured, but prepared them for going home afterwards if they did not meet the criterion of active labour. The midwives did not want women to be admitted too early because of what they perceived as an inherent anticipation of action in both the women and the system.

5. Discussion

This chapter is comprised of two main parts: First, a discussion of methodological topics such as pre-understanding, openness and the researcher's role will be reflected upon, followed by reflections on quality in qualitative research before providing a consideration of the generalizability of the findings.
The second part of the chapter discusses the main findings of the study, including such central issues as: a) the encounters between labouring women and midwives, and b) a discussion of the dominant paradigms from the experiences of the women who took part in the study. Thereafter some implications of the findings, and lastly suggestions for future research are indicated.

5.1 Methodological issues

Reflections on pre-understanding, openness and the researcher's role
In Chapter 3 the scientific approach for the study was briefly laid out, suggesting that the dissertation has a lifeworld approach. This scientific approach will have implications for the researcher's role, which I will reflect on in this section. Obviously, it is not possible to step outside the lifeworld to study other person's experiences because the lifeworld is our daily experienced reality in which we live with other human beings (Bengtsson 1998). When using a lifeworld approach, the researcher's pre-understanding is viewed as not only an inevitable, but also valuable part of what she brings with her into the project. The "personal me" has given birth to three fantastic children, and has encountered a few midwives during three complicated labours. The "professional me" is a trained midwife who has worked in the clinical field for approximately 10 years and presently teaches midwifery students. It is apparent that I investigate the research topic from a certain standpoint, and that the choices of procedures and what is determined to be meaningful depend on this starting point (Fontana and Frey 2000). The implication of the described position was that I perceived myself in the role of an "informed observer". There are problems with conducting research in one's "own culture" because it is easy to overlook the "taken for granted", thereby decreasing one's

ability to be surprised. On the other hand, the advantage of having professional knowledge should not be underestimated (Wadel 1991; Repstad 1998). This prior knowledge could lead to an immediate understanding of situations that researchers who do not possess this knowledge would not understand. One example of this emerged during one of my observations: I received an sms from one of the participants that she was about to leave for the hospital. She wrote that she was quite certain that she was not yet in labour since the due date was still a couple of weeks ahead, but she wanted to see a midwife to be sure that her baby was all right. Meeting her at the labour ward, I was surprised because her appearance told "the professional me" that she was in labour. This and other observations started the analytical track which led to a closer investigation of how women interpret signs of labour in relation to their estimated date of delivery.

I also want to draw attention to the role of the researcher during the interviews. The interview was perceived as a social encounter between the researcher and the interviewee, though it was not identical to a spontaneous daily conversation because it contained some methodological elements, and was perceived as one of several possible ways of talking about this topic. This was considered an arena for the co-production of data because both the interviewer and interviewee contributed to the production (Kvale 1997; Rapley 2001). The data generated can be regarded as an outcome of the collective meaning making created by the researcher and the study participants, but is nevertheless strongly dependent on the position and ability of the interviewer. In lifeworld research, there is a goal of openness, or the "bridling" of one's pre-understanding (Dahlberg, Dahlberg et al. 2008). My position as a trained midwife and an experienced birthing women had to be bridled so that I was able to really listen to what the women were telling me, so as to better be able to follow their tracks and "detours" when telling me the story about their labours. I found this challenging, particularly during the first interviews, when I was still tense and possibly too concerned about how to pose the next follow-up question in order to help the women talk about the things I wanted to hear about. After a few interviews, I became more relaxed and from a more informed sense came to realize that the quality of the interviews was dependent on our shared contribution. Most of the women were very talkative and eager to share their experiences and had an immediate understanding of the topics being discussed. Some of the participants needed to be steered toward a certain direction so I had to be more active during

the interview and pose direct questions and follow-up questions. As a result, it is likely that the quality of the interviews changed during the study, which was dependent to a certain degree on our shared contribution.

Quality in qualitative research – reliability and validity

The quality of the research may be assessed by applying the concepts of "reliability" and "validity". Kvale (1997) argues that validation is not a limited stage of the study, but ought to be an integral part of the research process as a whole. To be able to demonstrate validity, one also has to show that the methods applied are reliable and appropriate (Mason 2002; Halkier 2008; Thagaard 2009). Ultimately, the question is not about truth, but rather: a) Have I gained knowledge about the phenomena meant to be explored, and b) Are the interpretations valid? In order to establish reliability in this study, I have attempted to provide a detailed description of the processes of data generation and analysis because transparency enhances the reliability of the research process. I have attempted to show that the methods and procedures have been appropriate to the research questions, and were carried out in a thorough, systematic and conscientious way. As previously emphasized, we attempted to obtain knowledge through methodological creativity, or "method triangulation". In hindsight, it is important to reflect on the design and how it possibly could have been further enhanced. In Study 1, the design was complex, with three different methods of material productions. It did not work out quite as I had planned since I was only able to present and observe three women and their first encounter with the labour ward. With more observations, the data material could have been potentially richer and more nuanced, and could have yielded valuable information prior to the interviews with the women and the focus group discussions with the midwives. Even so, the empirical material collected is rich and nuanced, and I feel confident in saying that we have acquired some knowledge about the phenomena explored.

The methods employed for the generation of data are essential in relation to the quality of qualitative research. In the previous section the role of the researcher during the interviews was discussed, in addition to how the data generated can be thought of as an outcome of the collective meaning making created by the participant and the researcher. The researcher's openness and sensitivity in the interview situation was emphasized as well as how the researcher sought to "bridle" her pre-understanding. Sensitivity and openness

towards the participants are important factors in order to secure knowledge about the phenomena to be explored. Some would claim that having an interview guide is contradictory to the goal of openness. In contrast, a thematic interview guide helps the inexperienced researcher to stay on "track" within the scope of the conversation (Kvale 1997). During the first interviews, I had to consult the interview guide on several occasions; I was afraid that I had forgotten many of the themes we were supposed to talk about, though after a few interviews I became more relaxed, and did not feel the same need for the interview guide. Nonetheless, I always had a quick glance at the guide before we ended the interview to ensure that the topics I wanted to discuss had been covered. During the interviews, I wanted to be sensitive to more than what was being said; I also tried to "listen" to the women's body language and the way she was expressing herself, as body language adds important information to the spoken word (Fog 1994), which was noted in the transcription of the interviews.

Focus groups produce data that are seldom created through individual interviewing, and several authors have emphasized how focus group discussions have the potential to generate valuable and important data about group interaction and dynamics (Kitzinger 1994; Duggleby 2005; Kamberelis and Dimitriadis 2005). As such, data from focus groups may reveal unarticulated norms and normative assumptions that may allow the researcher to learn about the complex way in which people position themselves in relation to each other as they process questions, issues and topics in more focused ways. During the focus group discussions with the midwives, the dynamics in the interaction between the participants, both verbal and nonverbal, became apparent in many ways, which was noted by both the moderator and the assistant. The group dynamics were discussed immediately after the group sessions, and were also reflected on in "research notes", as well as being brought into the transcripts of the discussions, albeit not in a very systematic way. Nevertheless, it is not immediately obvious or visible how the group interaction has been a source of data in this study. To be able to claim that group interaction was part of the analysis, one must demonstrate a systematic and congruent methodological approach on this matter (Duggleby 2005). I will suggest that we have obtained some knowledge about the phenomena to a certain extent, while simultaneously acknowledging that a more systematical approach directed towards group dynamics during the data collection and analysis could have

potentially yielded valuable additional data and subsequently more knowledge about the researched phenomena.

The act of interpreting – taking something *as* something – presupposes that the researcher acts form a position. To assess the validity of the study implies that the researcher must make explicit how she positions herself in relation to the informants (Schwandt 2003; Thagaard 2009). However, a certain position does not automatically grant "epistemological advantages", although the researcher acknowledges how the position forms a basis for interpretations and conclusions (Mason 2002). In my account, I have made an attempt to position myself in general terms in the broader epistemological, ontological and professional field. I have further attempted to make my pre-understanding explicit, describing professional and personal experiences with the phenomena being explored. In the previous section, an example was presented as to how my position led to a certain understanding of an observation, and how this observation initiated an analytical track that initiated the asking of a specific set of questions. The importance of adopting a critical and reflexive stance towards one's own interpretations in order to enhance their validity is emphasized in the literature, as well as the need for additional review through a dialogue with others (Kvale 1997; Mason 2002; Fangen 2004; Dahlberg, Dahlberg et al. 2008). In the early stages of the analytical work, various interpretations of the material were tried and discussed with my co-researchers and other research fellows, which led to a rejection of some interpretations and a decision to follow up other tracks. One example of an analytic track that was left in the early stages was the "shameful female body", which we felt was not sufficiently substantiated. The interpretations were also viewed in light of other studies in the same field to compare the findings, as well as to achieve more insight and new understandings of the material. When the interpretive suggestions were more coherent and refined further into the analytical process, I had a discussion with my midwifery colleagues to see whether they recognized the interpretations of the material as being relevant and valid. The studies were also presented and discussed in scientific seminars and conferences, and to have the papers peer-reviewed in scientific journals further enhanced the quality of the research.

The question about generalizability or transferability of the findings

Generalizability involves the degree to which one can make some form of wider claim on the basis of the research and analysis performed. In qualitative research, different terms are frequently applied to make a distinction to "statistical generalizability". "Analytic generalizability" or "theoretical generalizability", which are used interchangeably, involve a justified assessment as to what extent the findings from one study may have the potential to explain other related situations (Kvale 1997; Mason 2002; Schwandt 2007). Some authors argue the position that in qualitative research, the "transferability" of findings is a more appropriate term (Seale 1999; Malterud 2001; Thagaard 2009). For the sake of simplicity, the term "generalizability" will be used consistently throughout this discussion. The question is whether interpretations that have evolved within the framework of one project may be relevant in other contexts or for other persons, and whether this study has contributed to acquiring an understanding of the significant traits of a given phenomenon. The way in which the research is designed will strongly influence how one can generalize the findings; In particular, the research question, the sampling strategy and the methods for organizing data lay the foundation for what types of generalizations one can make (Malterud 2001; Mason 2002; Dahlberg, Dahlberg et al. 2008). Kvale (1997) emphasises that the possibilities for generalization lie in providing the reader with a detailed description of the research findings and in making the arguments as explicit as possible, so that the reader can judge whether the knowledge presented may be relevant to other settings. Dahlberg et al.(2008) thoroughly discuss generalization in research using a lifeworld approach. They argue that generalization is clearly possible within this tradition; the fact that informants and their experiences are regarded as unique does not mean that generalization should be avoided. This viewpoint is grounded in the relation between particularity and generality, and uniqueness and sameness, which are natural paradoxes of the lifeworld (Dahlberg, Dahlberg et al. 2008). By being open to the wealth of meanings in these phenomena, we can see their particularities and what make them unique. In the infinite variations of a phenomenon, however, its general structures become more visible to us:

As humans we are at once both unique and irreducible, and similar to others with whom we share consensus about the lifeworld. Uniqueness is irretrievably coupled with sameness; humans are at once both much more alike than different and, singularly, us. We share

sameness insofar as we all exist as humans having lifeworlds, being part of the same world, the same "flesh", but we are unique through our choices about how to live that existence and see meanings of it (Dahlberg, Dahlberg et al. 2008: 119).

Moreover, Dahlberg states that the aim is to achieve a knowledge that goes beyond the specific individuals and their personal experiences. The findings are always contextual and are not to be understood as universal, but should be lifted above the level of the concrete and applied to new contexts.

In this study, I have attempted to provide a detailed and explicit description of the findings in the three respective papers. I have also accounted for the entire research process in a detailed way in order to enable the reader to decide to what extent one can make generalizations from the findings. I suggest that the findings of this study are somewhat applicable in the same context as the research, i.e. for midwives and labouring women at the labour wards of hospitals in Western societies. But do the research findings have meaning in other contexts and for persons other than those participating in the study? Has the study contributed to acquiring an understanding of the significant traits of the researched phenomena beyond this particular setting? I will argue that the findings presented in Paper I – the way first-time mothers experience contact with the labour ward – may also be applicable for other contexts in which communication about bodily experiences is crucial. The women said they felt very vulnerable, and were concerned about doing the "right" thing, i.e. presenting their case in a manner which granted them access to the services offered. These findings could be applicable and have meaning in for example a setting for acute health care, in which individuals have to present and explain their symptoms on the phone to health personnel. Likewise, the findings presented in Paper III – midwives' strategies and priorities when communicating with first-time mothers – could also be applicable in other settings in which professional health workers have to make important decisions based on the information they gather on the phone. The findings presented in Paper II - the waiting mode - have hopefully contributed to achieving a better understanding of the experience of waiting for an event that is inevitable but still uncertain in its emergence. The findings of the study reveal that a specific point in time organized women's perception of waiting, and that entering a new mode altered the way bodily signs were interpreted. These traits of the

phenomenon of waiting may expand the understanding of waiting in other circumstances as well.

5.2 Discussion of the main findings of the study

The purpose of this study was to obtain knowledge about women's and midwives' experiences in early labour, with the experiences of waiting for the onset of labour and communication between the women and midwives being focused on. The broader aim was to contribute to a discussion of the various aspects of contemporary childbirth paradigms and knowledge traditions surrounding childbirth, and how these understandings may shape and influence women's experiences and midwives' practices. The detailed findings of the study are presented and discussed in the three papers. This section focuses on the integration of the main findings of the study, which indicate that the researched context of women's experiences and the encounters between birthing women and midwives in hospital-based practice is a field that seems to create paradoxes and dilemmas with no apparent solutions. The discussion will highlight what we perceive as the most important dilemmas: "encounters between different paradigms of knowledge" and "women enacting and negotiating authoritative knowledge".

Encounters between different paradigms of knowledge

As shown in Papers I and III, women and midwives seem to have different views as to the proper time to be admitted to the hospital (Eri, Blystad et al. 2010a; Eri, Blystad et al. 2011). The women in the study had to negotiate their credibility in order to gain access to the hospital, and their best argument was the desired rhythm and pattern of contractions. Their actual reasons for seeking admission were often not that specific, but as a means to convince the midwives, the women translated more complex and subtle experiences into what they perceived as "acceptable" concepts. For the women, their individual experiences were the obvious starting point for the decision of when to seek admission. From the other side, the midwives seemed to base their strategies on what was seen as "normal" in relation to the meaning of "usual" or "most frequent". As revealed in Paper III, the midwives' overall strategy was to convince women to stay home as long as possible "for their own good". They

wanted the women to have a short stay in the hospital, and did not want to admit them before they had reached the active phase of labour. Their grounds for delaying admission were to avoid interventions and subsequent complications, which seem to be plausible arguments when looking at the "evidence".[7] This vantage point is based on trials which indicate that there might be a relationship between early admission and labour complications (Holmes, Oppenheimer et al. 2001; Bailit, Dierker et al. 2005). In many cases, the women in the study were unable to understand why they were not given the opportunity to be admitted and why they had to wait until they were in a far advanced stage of labour. The situation could be understood as a meeting between knowledge based on experience and knowledge based on evidence, i.e. a dilemma of "simultaneousness" of knowledge systems. Walsh (2009) states that contemporary childbirth is dominated by a variety of discourses such as medicalization, natural childbirth, androcentric models, women-centred models and risk models, all of which represent different lines of thought and different knowledge systems. The dominant paradigm in childbirth that subsequently holds authoritative knowledge is the biomedical paradigm (Davis-Floyd 2001; Downe and McCourt 2004; Hunter 2006). In practice, the edges of the discourses are blurred and it would probably be fruitful to take a look at van Teijlingen's (2005) critical analysis of a "medical model" and a "social model" as frequently applied opposites in the study of childbirth. The two lines of thought are contrasted by an emphasis on the possible medical risks versus pregnancy as a normal life event. In van Teijlingen's paper, the models of childbirth are separated into practical, analytical and ideological levels. At the practical or empirical level, the focus is on what people do in their daily lives, e.g. as maternity care practitioners or as health service users. Accordingly, the medical model harmonizes with an obstetrical practice and the social model with a midwifery practice, while at the ideological level with a biomechanical and woman-centred ideology, respectively. It is obvious that a clear-cut distinction and dichotomization between a medical and midwifery practice are applied for analytical reasons. In practice, an entire range of

[7] "Evidence" is often presented in a hierarchical way by ranking randomized controlled trials starting at the top, followed by controlled trials without randomization, cohort or case-control studies, the opinions of respected authorities, as well as descriptive studies or the reports of expert committees Stewart, M. (2001). "Whose evidence counts? An exploration of health professionals' perceptions of evidence-based practice, focusing on the maternity services." Midwifery **17**(4): 279-288.

combinations of the two ways of operating may be seen, and there will be a multitude of models of practice. Jordan's (1993) thoughts about who holds the authoritative knowledge is interesting in this case; she asserts that authoritative knowledge is not necessarily the knowledge of the elite, but rather the knowledge operating in a particular social context. She writes: "By authoritative knowledge I mean …. the knowledge that participants agree counts in a particular setting, that they see as consequential, on the basis of which they make decisions and provide justification for courses of action" (Jordan and Davis-Floyd 1993: 58). This quote illuminates what we may view as the meeting of different paradigms of knowledge in the communication and encounters between the labouring women and the midwives in the study.

The findings discussed in paper I and paper III indicate how the two parties try to find solutions to the dilemma which rises from the encounter; the women by accommodating their experiences to what they perceive as the desired concepts of regularity, and the midwives by encouraging women to stay home. As pointed to in paper III, the question of why midwives chose this solution does not have a simple or obvious answer. It emerges as odd that a profession which advocates a woman-centred philosophy seems to give in by choosing what might look like the easiest way out of the dilemma, in keeping women away by using the argument of evidence derived from the statistical chances for interventions and complications. It is pertinent to ask the questions of why the midwives do not problematize and try to reduce the number of interventions for women who are admitted to the labour ward in the early stage of labour. The question is even more important if we take into account the fact that during the focus group discussions, several of the midwives actually stated that they thought that many women in labour would have preferred to be admitted in the latent phase. Still, their overall strategy was that women should stay home for as long as possible, and that women should find out for themselves that this was the best solution.

Studies of midwifery in hospital settings can yield one indication of how we may best understand this practice. In a metasynthesis of midwives' experiences of issues that impacted on their practice in a hospital setting, several interesting points are raised which may underpin and help understand the findings of this study (O'Connell and Downe 2009). The paper is thoroughly presented in Chapter 2.3, in which a contextualization of the study is provided. One of the main points discussed in the paper is midwives' compliance with

cultural norms. The findings in the synthesis demonstrate that the midwives adapted to the practices of the unit even when this differed from their ideology and preferred approach to care. This is in concordance with van Teijlingen (2005) who claims that a working practice changes more easily and quickly than ideological perspectives. The ideology of the woman-centred approach asserts that every woman should be taken as an individual and not as a statistic in a given health care system. This ideology seems to be incommensurable with providing an equitable (though not individualized) service for all women, and managing the institutional imperatives as put forth in the metasynthesis of O'Connel and Downe (2009). We might ask if the midwives' solution of urging women to stay home as long as possible may be understood as an example of compliance to cultural norms in the practice environment. This argument is strengthened by the fact that there did not seem to be any difference between the midwives working in the two labour wards in terms of their strategies when communicating with first-time mothers in early labour. The two wards are situated on the same floor, but have differences as far as size, equipment and staffing. Unit A is a "high-tech" labour ward with equipment available for all emergencies, and handles approximately 3,500 births annually. Unit B handles 1,500 births a year, and offers its services for healthy mothers with no complications.

The individual woman experienced labour onset and early labour in their own and unique way, but at the same time encountered the midwives' normalization of their situation. Normalizing the situation was one of the most important ways that midwives calmed and soothed the women, both on the phone and in personal encounters. Furthermore, the midwives stated that they perceived that the desire to have the situation normalized was one of the important reasons for the women to establish contact with the labour ward. The women in the study confirmed the midwives' intention; their reason for seeking contact was partly because they wanted to know whether their labour had started and they also wanted to receive confirmation of their baby's condition. This may be understood as consenting to "normality" in the sense of an "absence of problems". Other studies in the field support the finding that women want their labour to be confirmed by the midwives (Cheyne, Terry et al. 2007; Barnett, Hundley et al. 2008; Nolan and Smith 2010). Simultaneously, several of the women felt that they were not being assessed according to their individual experiences and on their own terms, but rather that they were compared with an average or typical

progression curve. For several of the women in the study, this resulted in feelings of deprivation, embarrassment and a lack of acknowledgement as a "labourer". It seems as if the need for a confirmation that everything is well was intertwined with an urge to be seen as an individual, to be "special" in the sense of having a unique course of labour. Is it possible to be "normal" and "special" at the same time? One definition of "normal" can be regular, typical, ordinary or conventional. In a linear or dichotomized thinking, if you are not normal you have to be "abnormal", i.e. atypical, disordered or irregular (Kennedy 2010). This way of understanding appears to be analogous with the lines of thought in "the medical model" as outlined above. If contrasted with "the social model" and midwifery practice, it is implicit that there should be room for the complexity of human experience and for the possibility of being both normal and special. This is yet another example of the dilemmas which may arise in the encounters between the users and providers of health care in this type of setting, in which both parties have to relate to the various knowledge systems without it being problematized or pointed to.

Women enacting and negotiating authoritative knowledge

In Papers I and II, we explored the participating women's experiences when they were waiting for the onset of labour and contacting the hospital (Eri, Blystad et al. 2010a; Eri, Blystad et al. 2010b). As discussed in Paper II, we were surprised about the degree to which the estimated date of delivery impacted on the women's interpretation (or lack of interpretation) of the signs of labour. The women did not start to view bodily changes as possible signs of labour until they made the transition into the "waiting mode" in the days leading up to the estimated date. We were also surprised about how concerned the women were about "self-diagnosing" labour, and subsequently finding the proper time to leave for the hospital, preferably during the active phase. Arriving "too early" and not being admitted gave rise to strong feelings of embarrassment for several of the women. By contrast, they felt a strong need to have their labour confirmed by professionals. This seemed like a rather paradoxical situation for several of the women in the study. In the first instance, they did not trust their own bodies enough to interpret the signs of labour, while in the next moment they put a heavy demand on themselves, as far as knowing the correct time to transfer to the birthing setting.

Many authors point to the dominance of the development of maternity services and risk management within a medical paradigm which have given society, institutions and the professionals the right to manage birth, which is a process in which women have lost confidence in their own abilities and have become dependent on the professionals (Machin and Scamell 1997; Janssen, Nolan et al. 2009; MacKenzie Bryers and van Teijlingen 2010; Nolan and Smith 2010). Young (1998) asserts the claim that women's experiences in pregnancy and labour are often alienating because medical instruments objectify internal processes to such an extent that they devalue a woman's experiencing of those processes. The way time is portrayed in the practice surrounding pregnant women is a part of the medicalization of pregnancy and birth. Maher (2008) writes: "From the assigned moment of conception to the "due date", through the temporally regulated measurements of the foetus in utero during routine ultrasound to the timed birth stages, women experience pregnancy and birth in defined medical time-frames" (2008:130). She goes on to argues with Reiger and Dempsey (2006) that "…. cultural shifts around birthing are inscribed into the material reality of birth giving through institutional and interpersonal practices, which pushes us beyond an understanding of medical time as imposed to a recognition that these are conditions in which birthing occur" (Reiger and Dempsey 2006: 371). The authors point to what they see as the main paradox in this case, which may be fruitful to take into account in the discussion of the findings of this study; a decline in cultural and individual confidence in women's birthing capacity is apparent in spite of Western women's increased power, achievement and improved health and living conditions.

Ultrasound has undoubtedly improved maternity care, as conditions which need immediate action after delivery can be prepared for and lives can be saved. Nowadays, twins very seldom come as a surprise, and for some women it is important to know the sex of the coming baby. Ultrasound is also essential for the sake of calculating the estimated date of delivery. Only a handful of pregnant women in Norway do not chose to have the ultrasound scan around the eighteenth week of pregnancy. A current political discussion is circling around the question if pregnant women should have the possibility of two ultrasound examinations, the first in week 13 and the second in week 18. As far as I can tell, the main argument for introducing the so-called "early ultrasound" is that it will presumably give pregnant women a stronger feeling of security by confirming that the foetus is healthy. It is

worth noting that at this point in the pregnancy, women themselves rarely notice the movements of the foetus. We may question whether such a development will lead to an increase in women's dependence upon antenatal screening and the system established in order to monitor and manage pregnancy.

At first glance, it seems as though the women in the study depended heavily on the medical system. As suggested by Reiger and Dempsey (2006), another approach is to ask whether the culture has produced a normative frame of reference that has become internalized and enacted by individual women. This frame of reference signals that pregnancy and birth are potentially dangerous, and that pregnant women can neither manage these processes by themselves nor have confidence in the knowledge derived from their personal experiences. In this light, it makes sense that the participants in the study made the estimated date of delivery calculated on the ultrasound scanning into their main reference point for interpreting bodily sensations as signs of labour. Additionally, it makes sense that the women wanted to go to the hospital when they felt their labour had started to have the status of labour confirmed by the midwives, as this would be the safe environment where their labour could be properly managed. Several other studies of women's experiences in this phase of labour support the finding that women often felt insecure at home, and wanted to be admitted earlier to the hospital earlier (Beebe and Humphreys 2006; Low and Moffat 2006; Cheyne, Terry et al. 2007; Carlsson, Hallberg et al. 2009; Nolan and Smith 2010). Yet, it seems rather paradoxical that the women were so concerned with finding the right time to leave for the hospital by themselves. The embarrassment reported by several of the women who made a wrong judgement about how far advanced their labours were when approaching the hospital may be an indication of how important it was for them to succeed in this task. Somehow, the aspect of finding the correct moment does not "fit in" with that discussed above concerning how medical knowledge is materialized in the women's bodies, thereby underscoring the multifaceted and diverse experiences of labouring women. There seems to be a contrast between the internalized medical knowledge and dependence on the medical system versus a perception that they were supposed to automatically recognize the hallmarks of active labour emerging in their bodies. Or maybe there is no contrast, but rather more than one normative frame of reference in pregnant and labouring women's lifeworlds?

Labour and birth are processes which are often said to be "the most natural thing in the world", and pregnancy is sometimes pointed to as "the manifestation of nature itself". These claims seem to be in opposition to what is said to be the dominant paradigm in childbirth today, which I have discussed as being internalized and enacted by individual women. In many contexts, the notion of "the natural birth" is applied as being antagonistic to a "technological birth", thus reflecting the two opposite positions discussed in the previous section. A discourse of "the natural" seems to live side by side with the medical paradigm in pregnant women's public sphere (Noem 2000; Ravn 2004). The coloured press aimed at pregnant women maintains both views at the same time, praising the "natural" women who go through labour without pain relief or interventions, while also emphasizing the possible risks connected with pregnancy and childbirth. The notion of the natural is further maintained in society's view on sick leave in pregnancy: "Being pregnant is a healthy and natural condition, it does not mean that you are ill" (Fredriksen, Harris et al. 2010). However, the most outstanding example of the natural paradigm as it pertains to reproductive women in Norway belongs to the discourses about breastfeeding (Hörnfeldt 1998). Interestingly, breastfeeding has not undergone the same medicalization as pregnancy and labour, and the majority of women in Norway breastfeed their infants. Reiger and Dempsey (2006) considered the possibility that the cultural shaping of women's embodiment may become "written" into the physiological processes discussed above. We might consider if the cultural shaping not only concerns the biomedical imperative, but also the natural. Marander-Eklund (1998) suggests that the two aforementioned discourses are perceived by the women as being on a continuum, and that women are constantly negotiating the authoritative knowledge surrounding them. The paradox in the participating women's experiences outlined above may be more understandable if we take into account that there are more frames of references shaping their perceptions. The labouring women's experiences could be seen as oscillating between various influential discourses, therefore creating this seeming paradox. When the women were so concerned about finding the proper time to go to the hospital and be "ready" on arrival, this may well be an example of how the natural paradigm emerges in-between the medical paradigm, which nonetheless still seems to be the most dominant. This would be in accordance with Jordan's (1993) account that the authoritative knowledge is that which operates in a specific social context. The consideration of more than

one discourse being in play is fruitful for the discussion of the findings of women's experiences in early labour, and again underscores the complexity of these phenomena.

It is interesting to ask the question of why some of the women were able to interpret the signs of the body and go to the birthing facility at the right time, while some of the women had several trips and were constantly uncertain about exactly where they were in the labour process. Did they oscillate between the various discourses in quite divergent manners? How influential was the social context? Did some women have innate qualities which enabled them in a better way? A recently published study has explored how women who remain home until the active phase of labour experience the period from labour onset until admission (Carlsson, Ziegert et al. 2011). The central theme presented is the shared experience of the participants of having power when they entered the labour process and subsequently maintaining power throughout the process. The power is described as a driving force towards the goal of giving birth and motherhood. It was also expressed as possessing bodily and mental strength and a sense of their own authority over their bodies, in addition to a conviction that they had sufficient power and ability to go through the birth. To maintain their power, they shared their experiences with somebody else. This is an interesting finding, because both in our and other's studies (Barnett, Hundley et al. 2008; Nolan and Smith 2010) it seems as if having persons in the home environment sometimes had the opposite effect on the labouring women by urging them to go to the hospital earlier than they actually wanted to.

This discussion has focused on the main findings of the study, as well as on dilemmas and apparent paradoxes arising in labouring women's and midwives' experiences in early labour. In the next section some implications of the findings will be discussed, and suggestions for further research in this area will be given.

Implications of the findings and suggestions for future research

The discussion of the main findings of the study has highlighted a few of the dilemmas and apparent paradoxes arising when pregnant women are waiting for the onset of labour, and when the women and midwives communicate in early labour. Some of the dilemmas seem to appear in what we see as an encounter between different knowledge paradigms. In this

section, I will discuss a few issues related to the implications of the findings and subsequent areas for future research.

The findings of this study do not give clear indications of the best way to arrange for the care of women in early labour, but they do hint at the complexity of the research area and at acquiring a broader understanding of how first-time mothers and midwives on the labour ward communicate. Somehow, the communication between the two parties seems to be "mismatched" in the way that neither of them "hits the goal". Put in a simple though not very nuanced way, many labouring women want to come in and many midwives want them to stay home. Paradoxically, both reasons for this action seem to be embedded in a biomedical paradigm; the women wish to go to a safe place where the medical system can take care of their labours, while the same system produces the likelihood of interventions and complications which the midwives want to "protect" the women from.

In the roundtable discussion "Early Labour: What's the Problem?" (Janssen, Nolan et al. 2009), Mary Nolan argues that until women have confidence in themselves that they are the ones who "know", they will keep calling the hospital despite our efforts to provide other forms of care for women in early labour. Several studies that have explored various ways of supporting women to stay at home in early labour, whether by telephone or by home visit, seem to confirm this argument as they have shown that women still have the same number of interventions in their labours (Janssen, Still et al. 2006; Spiby, Green et al. 2006; Cheyne, Hundley et al. 2008). Nolan further argues that staying home would be acceptable if the culture of birth was different. She is not very optimistic with regard to the possibilities for such a change, as it "….requires a new breed of maternity care professionals……." (Janssen, Nolan et al. 2009: 334). I would add that it probably also requires "a new breed of labouring women", and these two groups that are allegedly dependent on each other could change the culture of childbirth reciprocally.

The findings of the study call for reflections and extensive discussions within the midwifery profession in hospital-based contexts. Midwives in Norway are authorized to take the lead in caring for healthy labouring women, and should reflect upon the foundation of their care and how this affects the women they encounter. In this study, it seemed as if the midwives tacitly accepted the "execution" of the task of being the gatekeepers of the labour ward without seriously exploring the underpinnings for their professional decisions. It

appears to be a bit strange that they persuaded women to stay home for as long as possible, rather than questioning their own professional role in trying to reduce the high intervention rate for women admitted in early labour. The notion "for the women's own good" was given as the justification with no confirmation that this resonated with women's perceptions of their needs. As discussed in the previous section, this rationale was based on statistical probability, not the "unique normality" of the individual woman (Downe and McCourt 2004). As such, the advice to stay home could be seen as a professional rather than a woman-centred response to early labour (Nolan and Smith 2010). Research should be designed to explore dimensions that support a women-centred response within the midwifery profession and within the context of hospitals in particular. In order to have a new breed of maternity care professionals, there is a need to explore ways to increase reflective actions within midwifery as well.

Moreover, the findings of the study imply that in order to individualize the care, a reorganization into more differentiated types of services for women in early labour is needed. We assume that for some women the best solution is to be admitted early (Carlsson, Hallberg et al. 2009), and that some have the power to stay home until they are in active labour (Carlsson, Ziegert et al. 2011). The main group of women, however, will probably need a form of care which is between the home and the hospital, in which they can profit from the best of both types of services. They may also wish to meet with a health professional, although this may not necessarily need to be within the hospital walls. Depending on geography and other conditions, this could be organized in a number of ways. An important area for research would therefore be to explore ways in which to identify the women who may need professional care, and how to individualize the services for primiparous women in early labour. This could be followed by an intervention study in which care in early labour is tailored to specific groups of women. Outcome measures in terms of coping, well-being and the likelihood for a delivery without intervention support a woman-centred approach to early labour.

The findings of the study may also have implications for how antenatal care is organized and how women are prepared for labour. As discussed, pregnancy is managed and surveyed by "the experts" and women seem to internalize this type of knowledge as being the authoritative knowledge. There is no indication that women do not want to maintain the

medical services, but the question is if it is possible to support women in additional ways in order for them to be better prepared for labour and its onset. Studies could be designed to explore how pregnant women can be empowered to have an increased trust in their own embodied knowledge when preparing for labour. One approach could be to explore whether "peer groups" with no professional participation or involvement, in which the exchange and discussions of expectations and experiences among women is the goal, could help to improve first-time mother's sense of coping with early labour. In order to bring up a new breed of labourers, one might consider how young women could be empowered to acknowledge bodily sensations as valid knowledge even before they are pregnant.

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