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The kaleidoscopic midwife: A conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth. A grounded theory study



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ABSTRACT

Background: The literature review reveals general information about a good midwife from a range of perspectives and what childbearing women generally value in a midwife, but there is a lack of information around mothers' perspectives of what makes a good midwife specifically during labour and birth, and even less in the context of different places of birth.

Aim: To conceptualise first-time mothers' expectations and experiences of a good midwife during childbirth in the context of different birthplaces.

Design: Qualitative Straussian grounded theory methodology.

Setting: Three National Health Service Trusts in England providing maternity care that offered women the possibility of giving birth in different settings (home, freestanding midwifery unit and obstetric unit).

Participants: Fourteen first-time mothers in good general health with a straightforward singleton pregnancy anticipating a normal birth.

Methods: Ethical approval was gained. Data were collected through two semi-structured interviews for each participant (before and after birth). Data analysis included the processes of coding and conceptualising data, with constant comparison between data, literature and memos.

Findings: The model named 'The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth' was developed. The model is dynamic and woman-centred, and is operationalised as the midwife adapts to each woman's individual needs in the context of each specific labour. Four pillars of intrapartum care were identified for a good midwife in the labour continuum: *promoting individuality; supporting embodied limbo; helping to go with the flow; providing information and guidance*. The metaphor of a kaleidoscopic figure is used to describe a midwife who is 'multi-coloured' and ever changing in the light of the woman's individual needs, expectations and labour journey, in order to create an environment that enables her to move forward despite the uncertainty and the expectations-experiences gap. The following elements are harmonised by the *kaleidoscopic midwife: relationship-mediated being; knowledgeable doing; physical presence; immediately available presence*.

Conclusion: The model presented has relevance to contemporary debates about quality of care and place of birth and can be used by midwives to pursue excellence in caring for labouring mothers. Independently from the place of birth, when the woman is cared for by a midwife demonstrating the above characteristics, she is likely to have an optimum experience of birth. Future research is necessary to tease out individual components of the model in a variety of practice settings.

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Introduction

In the light of the Changing Childbirth report (Cumberlege et al., 1993), there has been a growing interest in the last two

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decades in understanding what women want from maternity services in the United Kingdom (Séguin et al., 1989; Walton and Hamilton, 1995; Green et al., 2000a, 2000b; Avers and Pickering, 2005; CQC, 2010; Redshaw and Heikkila, 2010; Birthrights, 2013; Dahlberg and Aune, 2013; Renfrew et al., 2014). The National Service Framework for Children, Young People and Maternity Services (DH, 2004: 9) purpose is to 'promote high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families', ensuring that childbearing women 'are involved in decisions about what is best for them and have choices about how and where they give birth'. However, childbearing women's perspectives can vary widely and understanding what they expect from maternity care and midwives is a complex, multifaceted and constantly changing phenomenon. WRASM (2011: 1) states that 'a woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma'. Giving birth is such a significant event in a woman's life and positive experiences are more likely to be embedded in the memory if the midwife has been acting in a caring way (Halldorsdottir and Karlsdottir, 1996b). Recommendations for evidence-based practice are set and increasing attention is being paid to compassionate midwifery care by regulatory bodies (NHS, 2012; NICE, 2014; NMC, 2015); however, contemporary investigations of poor healthcare practice place a question mark on the quality and safety of maternity care services provided to women and their families. Examples of these in the UK are the recent Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and the Report of the Morecambe Bay Investigation (Kirkup, 2015).

The idea of what makes a good midwife inevitably evolved through the years in parallel with the social, cultural, economic, political and historical contexts (Borrelli, 2013). To establish the existing knowledge base, research in the area of interest over the past twenty-five years (1990–2014) was reviewed. The focus of the literature review was on what makes a good midwife (Borrelli, 2014). The databases used were Medline, Maternity and Infant Care, Applied Social Sciences Index and Abstract and CINAHL. A total of six papers explicitly investigate what a good midwife means from a range of perspectives (midwives, student midwives and childbearing women). Research approaches used are variously described as systematic integrative review (Nicholls and Webb, 2006), theory synthesis (Halldorsdottir and Karlsdottir, 2011), Delphi study (Nicholls et al., 2011) and qualitative thematic analysis (Byrom and Downe, 2010; Carolan, 2010, 2013). Participants involved in the empirical studies are midwives, student midwives, women and their partners. Although there is no agreement on the definition of what constitutes a good midwife, insights from contemporary literature reveal that a midwife should possess several attributes: theoretical knowledge; professional competencies; personal qualities; communication skills and moral values (Nicholls and Webb, 2006; Byrom and Downe, 2010; Carolan, 2010; Halldorsdottir and Karlsdottir, 2011; Nicholls et al., 2011; Carolan, 2013). The focus of the selected papers is on the midwife's role in general as they do not refer to specific professional duties in relation to different stages of the childbearing event (e.g. pregnancy, labour, birth, postnatal period or breast feeding). Women are included as participants in only one of the empirical studies; however, midwives and midwifery educators' perspectives are presented in the same paper and it is not possible to distinguish between women and professionals' views. It is therefore unclear from the review if what women value in a good midwife corresponds to the midwives' perception of themselves as good professionals.

A subsequent thematic analysis was conducted with the aim of exploring what childbearing women value in a midwife specifically during labour and birth during the past twenty-five years

(1990–2014). The inclusion criteria were: qualitative studies; focus on women's experiences of the midwife specifically during labour and birth; women as participants (no limit on sample size); studies conducted in high-income countries; time window 1990–2013; English language. Six articles were included in the thematic analysis, with a sample size varying from 6 to 61 participants. Research designs are phenomenology (Kennedy, 1995; Berg et al., 1996), grounded theory (Walker et al., 1995) and descriptive/exploratory qualitative studies (Mackey and Stepan, 1994; Fraser, 1999; Brown et al., 2009). Key-themes emerging from the thematic analysis are: midwife's presence; providing supportive and individualised care; establishing a trusting relationship; giving appropriate information and possibility of choice (Mackey and Stepan, 1994; Kennedy, 1995; Walker et al., 1995; Fraser, 1999; Berg et al., 1996; Brown et al., 2009).

The literature review and thematic analysis reveal general information about a good midwife from a range of perspectives and what childbearing women generally value in a midwife, but there is a lack of information around the mothers' perspectives of what makes a good midwife specifically during labour and birth, and even less in the context of different places of birth, though this is likely to be an important influencing factor. In fact, the planned place of birth might shape both women's expectations and experiences of birth, with impacts on maternal satisfaction (Waldenstrom and Nilsson, 1993; Dahlen et al., 2010; Overgaard et al., 2012; Birthrights, 2013), clinical outcomes and medical interventions (Hodnett et al., 2010; Sutcliffe et al., 2012; Sandall et al., 2013).

In regard to the sample population, most researchers include women of mixed-parity (Fraser, 1999; Kennedy, 1995; Walker et al., 1995; Berg et al., 1996; Brown et al., 2009). However, nulliparous women's experiences are of particular importance as the first birth experience is known to shape future reproductive choices (Hauck et al., 2007). The majority of the studies presented as part of the thematic analysis are retrospective, as they explore women's experiences of birth in the postnatal period (Mackey and Stepan, 1994; Kennedy, 1995; Walker et al., 1995; Berg et al., 1996; Brown et al., 2009). The only longitudinal study was conducted over fifteen years ago by Fraser (1999), who interviewed women at three stages: during pregnancy, in the early postpartum period and a couple of weeks after birth. Given that perceptions inevitably evolve through the years (Green et al., 2000a), the exploration of childbearing women's expectation before and after birth will offer useful information about current maternity care provision, with potential implications for midwifery practice.

According to the gaps in the evidence demonstrated, the aim of the study was to explore and explain first-time mothers' expectations and experiences of a good midwife during labour and birth in the context of different planned places of birth. This paper reports the conceptualisation of women's perspectives of a good midwife by presenting the model entitled 'The kaleidoscopic midwife: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth'.

Methods

Study design

A qualitative grounded theory methodology was adopted. There are various and conflicting answers to what makes a theory grounded and three main common schools of thought exist: Glaserian or classic (Glaser and Strauss, 1967; Glaser, 1992, 1998), Straussian (Strauss and Corbin, 1998) and Charmazian or constructivist (Charmaz, 2006). The choice of a Straussian approach was based on the following criteria: (1) aim of the study and

research questions; (2) compatibility with contemporary thinking and actual midwifery debates; (3) flexibility; (4) pragmatic issues related to doctoral work.

Straussian grounded theory is an iterative and inductive process based on the constant comparison between the literature, collected data, codes, categories and memos. It is not a linear process as data collection and analysis proceed simultaneously in order to constantly check that developing insights are grounded in all parts of the analytical process (Strauss and Corbin, 1998). The purpose of grounded theory is to generate theory that seeks not only to explore but also to explain a phenomenon of interest, going beyond descriptive data (Birks and Mills, 2011; Rees, 2011: 52). Grounded theorists acknowledge the importance of theoretical sensitivity, meaning that the researcher should enter the fieldwork with a general awareness of the topic, but without any prejudice about what might be discovered (Strauss and Corbin, 1998). The philosophical underpinnings of this research combined constructivist ontology with interpretivist epistemology. Trustworthiness of data was guaranteed by the four central criteria of a well-constructed grounded theory: fit, understanding, generality and control.

Fourteen women's expectations and experiences of a good midwife during childbirth were explored in the context of three different planned places of birth (home, Freestanding Midwifery Unit and Obstetric Unit). Data were collected through two semi-structured interviews for each participant (before and after birth). Data analysis included the processes of coding and conceptualising data, with constant comparison between data, literature and memos. The setting, sample, ethical considerations, recruitment strategy, data collection, data analysis and reflexive accounts are reported in more depth in the following sub-headings.

Setting

The research sites were three National Health Service Trusts that offered different birth settings: home, Freestanding Midwifery Unit (FMU) and Obstetric Unit (OU). The FMU was purposively chosen instead of an alongside midwifery unit (AMU), because women choose this birth environment during pregnancy, unlike some AMUs where women are allocated if they are low risk at the onset of labour. The hospitals were intentionally selected without an AMU for the same reason.

Sample

A purposive theoretical sampling strategy was adopted and the sample size was determined by data saturation, which was achieved for both antenatal and postnatal interviews independently from the place of birth. The study participants were 14 women, with five women planning to give birth at an OU, seven at a FMU and two at home (one of these was undecided between home and the FMU). The difficulty in recruiting first-time mothers planning to give birth at home resulted in only two women recruited within this group.

The inclusion criteria for the first interview were that women were first-time mothers in good general health with a straightforward pregnancy (single fetus) anticipating a normal birth and a minimum age of 18. Participants needed to be able to read and speak English sufficiently to understand the information leaflet and to participate in the interview. The average age of the participants was 29 years (range: 19–43 years) and the average gestational age at the time of the first interview was 38⁺³ weeks (range: 36⁺¹–40⁺¹).

The second interview was conducted irrespective of whether a change from planned place of birth occurred. In fact, what women think is a good midwife has to incorporate the experience of

transfers between sites and models of care because that is the reality for a number of women, especially nulliparous. For this reason, more women were purposively recruited from the free-standing birth centre to include a variety of experiences at the time of the second interview (e.g. same place of birth as planned, change of place of birth during pregnancy or labour). In regard to this, no intrapartum transfers occurred, but a change of place of birth happened for seven of the nine women that were planning to give birth at home or in a FMU due to clinical reasons during the third trimester of pregnancy. All women participating in the second interview gave birth to healthy babies at term, with eight vaginal births and four caesarean births.

The exclusion criteria for the second interview were the woman's withdrawal or serious complications for the mother or the newborn (stillbirth, neonatal death, neonatal or maternal intensive care). Two out of fourteen women recruited and interviewed during pregnancy did not participate in the follow-up interview. One woman did not return the signed informed consent for the second interview; one participant withdrew because her newborn was admitted to hospital few weeks after birth.

Ethical considerations

Ethical approvals were obtained from Multicentre Research Ethics Committee and the respective Research and Development services for the three NHS Trusts before entering the research sites. Regarding individual informed consent, permission to conduct and tape-record interviews was obtained from each woman, after a detailed explanation of the study by the researcher. Women were free to decline participation or to withdraw at any time. Women were offered the possibility of receiving a summary of the findings on conclusion of the study. Pseudonyms are used in any reports, data were kept securely and data held on PCs or laptops are password protected.

Recruitment

The recruitment process lasted five months, from June to November 2013. Women were approached to participate in the study during the third trimester of pregnancy by the community midwives involved in their antenatal care. The midwives were fully informed about the study and were asked to help by giving brief information about the study to women and their families, providing them with the participant information sheet. The principal investigator's contact details were available in case of need for clarification from both midwives and women. People who wanted to participate in the study could contact the researcher by telephone, text or email. Otherwise, the woman could leave her contact details with the midwife using the participant's contact details form; in this case, the principal investigator telephoned the woman to talk about her involvement in the study and to arrange a suitable time to gain the first informed consent and do the interview.

As the period following the birth of their babies is a time when women were making the transition to motherhood and had other priorities, the participants were given the possibility to contact the researcher after childbirth in order to arrange a suitable time and place for the second interview. The women were sent a reminder letter two to three weeks after the birth and a stamped address envelope was provided for the second interview consent.

Data collection

The data collection period lasted seven months, from June 2013 to January 2014. Two audio-recorded face-to-face semi-structured interviews for each woman were planned. The first interview took

place in the third trimester of pregnancy; the second took place four to ten weeks after childbirth. A total of twenty-six interviews were conducted by the principal investigator, comprising fourteen interviews during pregnancy and twelve after birth. The time and place for the interviews were arranged with each participant, guaranteeing privacy and confidentiality. The researcher was as flexible as possible, in relation to participant's needs and requests. Twenty-five interviews were conducted at the women's own homes; one interview was done in a café. Before conducting the interview, the researcher summarised the study objectives and presented herself not only as investigator but also as a midwife by background.

The semi-structured interviews were characterised by open-ended questions in order to encourage participants to share their perspectives on the characteristics of a good midwife. However, they also enabled a balance between making the interview open and focusing on significant areas (Rose, 1994; Rees, 2011). Some key topics developed from the literature and agreed by the research team were discussed with every participant, including the definition and most important attributes of a good midwife; expectations and experiences of a midwife during childbirth; midwives' professional competencies versus personal qualities; place of birth with links to midwife; gap between expectations and experiences of a good midwife. According to grounded theory, the interview topics were also guided by preliminary data analysis, which allowed the continuous adjustment of the interview guide, according to the identified categories and topics meaningful to the participants. Before meeting with the woman after childbirth, the interviewer re-read the transcript of the first interview. At the time of the second interview, references were made to the topics previously discussed with the participant, stimulating the comparison between expectations and experiences. The average duration of the interviews was 40 minutes.

Each interview was labelled with a reference code indicating the planned birthplace for first interviews and both the planned and actual birthplace for second interviews. The acronyms used were: OU for obstetric unit; FMU for freestanding midwifery unit; HOME for home. For instance, W1-HOME indicates an interview conducted with a pregnant woman planning to give birth at home; W2-FMU-OU refers to an interview with a mother that was planning to give birth in a FMU but ultimately gave birth in an obstetric unit. Labels assigned to the first and second interviews are listed in Table 1.

Data analysis

The interviews were listened/re-listened to, fully transcribed and analysed before undertaking the next fieldwork. The data were collected, coded and analysed by SB. DW and HS fully reviewed the first few interviews and emerging themes were discussed regularly throughout data collection to determine what data to collect next, with the aim of developing a theory grounded on the participants' priorities (Glaser and Strauss, 1967; Strauss and Corbin, 1998).

The analysis of data was manually performed and memoing was used as a complementary analytical technique. Memos were kept to record analytical thoughts, insights and ideas that emerged during the fieldwork in order to interrogate data with the aim of developing concepts for the construction of theory (Glaser, 1978; Strauss and Corbin, 1998).

The data analysis was undertaken on the basis of the following phases identified by Strauss and Corbin (1998): (1) open coding; (2) axial coding; (3) selective coding; (4) development of the theory. The various steps of grounded theory are not necessarily taken in sequence and do not form a linear process (Strauss and Corbin, 1998). Open coding aimed at identifying, naming, categorizing and describing the phenomena. Each line, sentence and

Table 1
Interview labels.

Planned place of birth	First interview (label)	Actual place of birth	Second interview (label)
OU	W1-OU	OU	W1-OU-OU
	W2-OU	OU	W2-OU-OU
	W3-OU	OU	W3-OU-OU
	W4-OU	/	/
	W5-OU	OU	W5-OU-OU
FMU	W1-FMU	FMU	W1-FMU-FMU
	W2-FMU	OU	W2-FMU-OU
	W3-FMU	FMU	W3-FMU-FMU
	W4-FMU	OU	W4-FMU-OU
	W5-FMU	OU	W5-FMU-OU
	W6-FMU	OU	W6-FMU-OU
	W7-FMU	/	/
HOME	W1-HOME	OU	W1-HOME-OU
	W2-HOME/FMU	OU	W2-HOME/FMU-OU

paragraph was read and re-read, repeatedly asking questions of the data: What is this about? What is the participant referring to here? Axial coding allowed the fulfilment of categories, characterised therefore by richness and density in terms of crucial properties, dimensions and associated relationships (Strauss and Corbin, 1998). Through the process of selective coding, the researchers selected the core categories, which were systematically related to other categories and sub-categories (Strauss and Corbin, 1998), allowing the development of theory.

Theoretical sensitivity and constant comparison between codes, categories, memos and literature were maintained throughout all the stages. According to the adopted grounded theory methodology and the related constant comparison, the literature was used as a secondary source of data. The Straussian approach considers the literature as a stimulus for theoretical sensitivity, by providing concepts and relationships that are compared with actual data. Moreover, it might inspire interesting questions during the analysis process (Strauss and Corbin, 1998). Following the exploration of women's expectations and experiences of a good midwife, the findings of the study were therefore compared with the existing evidence and brought to the next level of data conceptualisation in order to answer the research question: *how can first-time mothers' perceptions of a good midwife during childbirth be conceptualised?* Data from first and second interviews were firstly analysed separately and then compared during the phase of data conceptualisation. Consensus of final interpretation of themes was reached before data dissemination.

Reflective accounts

The principal investigator (SB) is a midwife and was undertaking a PhD in Health Sciences at the time of the study. The co-authors (DW and HS) were midwives by background, experienced researchers and academic supervisors of the principal investigator; they contributed to the design of the study protocol and provided significant insights during all project stages.

Openness to data and theoretical sensitivity were considered throughout the study. This recalls the participants' attitude of *going with the flow*, having expectations but at the same time preserving an open mind about what may happen next. Similarly, during data collection and analysis the researchers remained open to *go with the flow* of ideas, expectations and experiences disclosed by the women interviewed, trying to limit pre-conceived thoughts - though 'midwifery lens' were inevitably used in reading the data. When building properties, sub-categories and categories from codes, the investigators reflected on the entire stories recounted by women rather than considering individual quotes 'detached'

from the woman's expectations and experiences as a whole. According to grounded theory approach, different incidents were constantly compared within the same and different interviews. In this way, the interview's components were put into context and *grounded* in the whole data. Although the main focus of the study was exploring and explaining what makes a good midwife, it was not automatically assumed that participants encountered good midwives during labour and birth by default and the interviewer remained open to listen to both positive and negative experiences. As the investigator declared that she was a midwife before the first interviews, it was acknowledged that women may have had difficulties in sharing negative experiences about their midwives. However, this was disconfirmed by quite a few participants recounting midwives' undesirable language and manners. Disconfirming data and subtleties were sought and the model was designed keeping in mind the nuances and dynamism needed to address individual women's expectations and experiences of a good midwife in the context of each specific labour.

Findings and discussion

The model named 'The *kaleidoscopic midwife*: a conceptual metaphor illustrating first-time mothers' perspectives of a good midwife during childbirth' is the end-product of the conceptualisation of findings in the light of literature data. The model identifies the intrapartum care priorities that enable first-time mothers to feel supported and assisted by midwives who fit the criteria of good during labour and birth across different birth settings. The synthesis of the attributes, roles and behaviours of a good midwife included in the model allow the woman to trust that the carer is focused on her as an individual, is competent and conveys respect. If any one of the model's features is absent or underdeveloped, there is the potential for the woman to feel that the care provided by the midwife was not ideal. The model is dynamic and woman-centred, operationalised as the midwife should adapt to each woman's individual needs in the context of each specific labour, irrespective of the birth setting. The model is represented in Fig. 1.

Each side of the external square indicates one of the four pillars of care provided by a good midwife in the labour continuum. The central part of the figure portrays the different coloured sections that form a kaleidoscopic figure, which is the metaphor used to describe a good midwife's characteristics, roles and types of presence. Each coloured section indicates one of the main elements encompassed in a good midwife highlighted by the findings of this study. The central circle includes the labouring woman as she is considered as the starting point for the midwife to balance her characteristics and presence and to shape intrapartum care on individual needs. The harmonisation and balance between different characteristics and types of presence is pointed out by the arrows between the coloured circles of the kaleidoscopic figure.

Pillars of intrapartum care

The four pillars of care that should be provided by the midwife in the labour continuum derive from the identified first-time mothers' needs during labour and birth which were: being treated as individuals; solving their sense of uncertainty about childbirth; being able to 'go with the flow' and receiving accurate information and guidance about the labour progress. Therefore the following elements should be taken into account by the midwife in the labour continuum: *promoting individuality*; *supporting embodied limbo*; *helping to go with the flow* and *providing information and guidance*. These are essential to meet first-time mothers' needs and feelings during childbirth and to maximise the potential of her

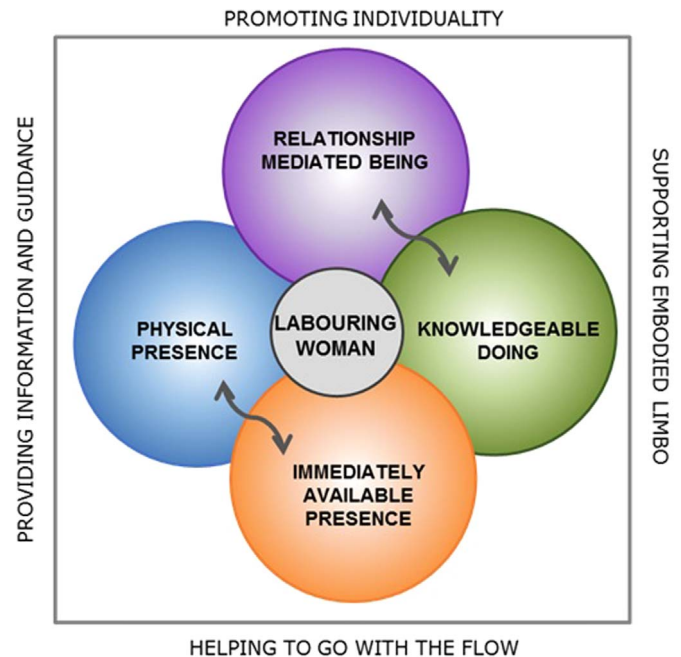


Fig. 1. The kaleidoscopic midwife.

having an optimal birth experience whatever the setting and the circumstances.

As the process of approaching the forthcoming birth experience is inevitably accompanied by personal and subjective expectations and beliefs, the midwife is called to promote individuality by acknowledging the uniqueness of each woman's needs, beliefs, expectations and events occurring during labour (Halldorsdottir and Karlsdottir, 1996a; Fraser, 1999; Larkin et al., 2009; Berg et al., 2012):

Getting to know the person, what the person is like. Just having that boundary with your client and making it personal to them (W2-OU-OU).

They don't just talk at you but they listen to what you are saying and they take on board your feelings and what you think and what you like (W1-HOME-OU).

The uncertainty about childbirth that characterises first-time mothers is ongoing through the entire duration of pregnancy, labour and birth; a good midwife supports the woman's *embodied limbo* (defined as a period characterised by uncertainty while awaiting childbirth), especially in regard to insecurity about the labour progress, and care for her throughout the emotional and physical reactions during childbirth (McNiven et al., 1992; Seefat-Van Teeffelen et al., 2011; Haines et al., 2012), including her ability to cope with pain (Kannan et al., 2001; Hodnett, 2002):

Because it's my first time I don't know what to expect. It's just all sort of ifs and buts or maybes... until I am there I don't know because I've never done it before (W6-FMU).

I don't know what to expect and that's worrying. I don't know when it's going to happen and how I am going to handle it. [...] That's the worst thing, not knowing (W7-FMU).

As there is often a gap between the woman's expectations and experiences of childbirth, the midwife should help the woman to go with the flow, following the labour events and constantly adapting ideal expectations to the actual birth experience:

I just went with the flow! I just let my body take over and I listened to my body. That's the best advice anyone have ever given

me. Because if you fight the feeling I think I would have been more in pain. Definitely, just let it happen (W2-OU-OU).

Helping the woman to 'go with the flow' should be accompanied by providing appropriate information on labour progress and guidance on how to go through the labour journey, supporting her to actively participate in the childbirth experience. The reassurance resulting from information provided on the normal progression of labour is highly appreciated by women ([Mackey and Stepan, 1994](#); [Kennedy, 1995](#); [Walker et al., 1995](#); [Fraser, 1999](#); [Brown et al., 2009](#); [Dahlen et al., 2010](#)):

She spoke through everything that was going on, she told me what was going to happen, what just happened, what she could see so she kept me up to date very well (W2-OU-OU).

The kaleidoscopic midwife

The metaphor of a kaleidoscopic figure is used for the central part of the model, where the key features of a good midwife that underpin the four pillars of intrapartum care mentioned above are represented. As a kaleidoscopic figure, a good midwife should be 'multi-coloured' and ever changing in the light of the woman's individual needs, expectations and labour journey (e.g. stage of labour and events occurring during childbirth). In relation to these factors, as a beautiful kaleidoscopic shape is always created as a result of the turning movement of a kaleidoscope, a good midwife is required to constantly adapt her role, characteristics and types of presence to the labouring woman and her childbearing event. The *kaleidoscopic midwife* should therefore constantly reshape her way of supporting the woman in the light of the changes of her needs, intrapartum events and labour stages in order to create an environment that enables the mother to move forward despite the uncertainty and the expectations-experiences gap. The following elements are encompassed by the *kaleidoscopic midwife*: *physical presence*; *immediately available presence*; *relationship-mediated being*; *knowledgeable doing*.

Physical presence and immediately available presence

For a midwife to engage with a labouring woman, she must provide some *physical presence*, especially at transitional points such as the early labour phase (transition between pregnancy and labour) ([Cheyne et al., 2007](#); [Janssen and Desmarais, 2013](#); [Iannuzzi and Borrelli, 2014](#)) and the second stage of labour (transition between labour and birth) ([Anderson, 2000](#)):

Initially when you're first going into labour and you don't know what it's going to be like so... You know, when you're first going into labour you're kind of gauging from them 'Is this normal? Is this alright? Am I... is everything okay? And then as long as they check you sporadically through your labour to make sure everything is okay (W1-HOME-OU).

I'd probably say at the pushing stage because that's when it's harder and you start to get a bit worried then. So for them to be there and talk you through it (W1-OU-OU).

Diverse supportive behaviours might be valued by women according to different labour stages. For instance, they may appreciate a calm and friendly midwife that puts them at ease and stays in the background during the early phase of labour and a more proactive midwife in the pushing stage:

She was calm and sat right away watching and when it came the time to do the business they were quite hands on and anyone knew what to do (W1-OU-OU).

Authors have reported that the midwife's constant presence in the labour room is an important aspect of support ([Probst et al.,](#)

[1994](#); [Tumblin and Simkin, 2001](#)) and the notion of continuous support has become an established requirement of gold standard maternity care ([Cumberlege et al., 1993](#)). However, in this study the majority of participants valued more a midwife 'being there' for them if needed, thus being intermittently present but easily accessible. Once a trusting bond is established between the midwife and the woman, reassurance that the midwife is free of other direct care responsibilities and therefore *immediately available* if needed helps the woman maintain a sense of support ([Bowers, 2002](#)). Women often consider birth partner(s) as the persons that should provide continuous presence during labour:

I don't think it needs to be with me cause I've got my husband with me so there'll be that support. [...] but it would be nice to know they were sort of coming in every once in a while just checking everything was okay. I suppose it's just knowing that they were there just down the hall as well if you needed them (W3-FMU).

Relationship-mediated being and knowledgeable doing

Being physically present in the room with the labouring woman does not necessarily mean that the midwife understands how she feels or what her support needs are. It is the midwife's way of being that accomplishes this, explained here as *relationship-mediated being*. The notion of *relationship-mediated being* is defined as the combination of a midwife's *being* role and her personal, interpersonal and empathic characteristics. It is the *relationship-mediated being* that enables the establishment of a trusting relationship with the woman such that she feels listened to and understood ([Berg et al., 1996](#); [Fraser, 1999](#); [Lundgren and Dahlberg, 2002](#); [Dahlen et al., 2010](#)):

Good communication and adapt to the person. Good listener, understanding and give you support (W4-OU).
It helps when you've got somebody there that [...] understands it and is very compassionate and caring towards you (W1-HOME-OU).

The majority of participants valued when the midwife shared her own life and personality thus traversing traditional client-professional boundaries considering it as more important than knowing the midwife before labour:

I think I liked her telling me a bit more about her... that's kind of what I didn't expect but it was a nice extra to what I expect a good midwife to be (W1-FMU-FMU).

The *relationship-mediated being* includes also a respectful handover between the midwives. The midwife informs and prepares the woman for the shift change and introduces the new midwife to her. Notes should be passed over to the new midwife that is called to establish a new trusting relationship with the mother ([Fraser, 1999](#)):

[During the change I would expect them] to let me know, I wouldn't want just a midwife to go and not knowing that they've gone. It would be nice if they notify what is going on. Communicate with each other so that they know where and what stage I am at, what's going to happen. Introduce themselves, probably both of them being there at the same time just having a chat with me saying 'I have finished my shift, I am going to swap now, this is so and so' (W2-OU).

When trusting relationships are established between women and midwives, mothers are more likely to have positive memories of their childbirth experience, regardless of the birthplace:

As much as labour can be a good thing, I had the most amazing labour ever! I was very happy actually with the whole labour. The midwives were brilliant (W3-FMU-FMU).

I was concerned that the midwives in the hospital because they didn't know me they wouldn't give me the care, that they wouldn't really be bothered that much because they see so many different women. But they were all brilliant! I couldn't have asked for better care than I got (W1-HOME-OU).

In addition to personal and interpersonal qualities, a good midwife should possess also *knowledgeable doing* competencies in order that the woman can be confident in the professional's abilities to provide safe care (Halldorsdottir and Karlsdottir, 1996b; Pope et al., 1998; Halldorsdottir and Karlsdottir, 2011). The concept of *knowledgeable doing* is defined as the combination of a midwife's doing role and professional competencies. *Doing* is identified as the provision of clinical tasks by the midwife. The *knowledgeable* element designates the midwife's adequate theoretical knowledge, capability and expertise to provide labouring women with good clinical care during childbirth. The midwife's knowledge is often considered by women as a 'given', guaranteed by academic and NHS standards:

I guess if you have been assigned a midwife then you assume automatically that they would have been trained at certain standards. So you assume that when they are allocated to you they're fully trained and that's it! (W1-HOME).

The *kaleidoscopic midwife* properly interprets knowledge, recommendations and guidelines in the light of each woman's individual preferences, providing woman-centred care rather than procedure-centred care:

A midwife who advises me [...] 'how about trying this?', lets me try it and then works with me to say 'ok, how about trying this?' rather than say 'this is what you must do (W3-OU).

The midwife must also use her professional competence to accept the uncertainty typical of childbirth and employ a behaviour of 'watchful waiting' (Carlson and Lowe, 2014: 514). A certain degree of flexibility, intuition and tolerance of events happening in different ways is needed to do this.

Harmonisation of characteristics, roles and types of presence

Although constantly maintaining the pillars of care in the labour continuum, the *kaleidoscopic midwife* is dynamic and continuously adjusts the balance between *physical presence* and *immediately available presence* for each woman in the context of the specific labour. Moreover, a good midwife aims at harmonising the spheres of *relationship-mediated being* and *knowledgeable doing*. It is important that the *kaleidoscopic midwife* considers all the aspects together to provide care that meets the woman's physical and emotional needs throughout childbirth.

Implications of findings

The findings of the current study provide useful insights that should be considered when local, national and international maternity care guidelines and protocols are planned and developed. The care provided by midwives during childbirth should be constantly reshaped in the light of a woman's desired birth plan rather than fitting the woman's preferences around maternity care policies (e.g. in the case of change of planned birthplace). Monthly clinical case reviews where examples of a *kaleidoscopic midwife* and *relational-mediated being* are examined and discussed by practising midwives should be introduced. Midwives should also be able to modulate physical and immediately available presence in any birth setting, according to when the woman wants the midwife to be in the birth room rather than on the sole basis of

when the midwife thinks she should be there. The findings of this study highlighted that labouring women may prefer to have some privacy and time with their birth partners with no interference from healthcare professionals. In order to guarantee immediately available presence, it is recommended that midwives caring for a labouring woman are responsible for providing care only for one client at a time and free of other direct care responsibilities. The midwife should therefore remain available to help maintain a sense of support and connection, utilising the time outside the room to undertake activities which can be easily interrupted and restarted later (e.g. administrative tasks). It is acknowledged that this might be more difficult in busy OUs where task completion and time are key regulators (CQC, 2010). Although low staffing levels are felt to have a direct impact on the safety of care and midwives find it 'unacceptable to have to look after more than one woman in labour at a time' (Smith and Dixon, 2008: vii), workforce constraints often restrict time for direct care. In regard to this, some midwives feel they spend too much time on non-clinical tasks that could be undertaken by support workers; this may resolve some of the apparent staffing levels issues and allow more one-to-one provision of care from midwives (Smith and Dixon, 2008). In the absence of already embedded continuity of carer models in the labour continuum, respectful and efficient handovers between midwives were considered as crucial in guaranteeing a high level of continuity of care. Continuity of information at handover must therefore be done in such a way as to maximise information exchange and undertaken in a way that is respectful of the woman and the birth partner(s). It is suggested that the midwife dedicates 15 minutes to sit down with the woman and the new midwife having prompt questions for the woman to identify her needs from the current stage of labour onward with this new midwife. It is recommended that the new midwife dedicates the necessary time to establish a trusting rapport with the mother in a friendly manner, possibly over a cup of coffee or tea if the woman wishes to. The development of the attributes of a *kaleidoscopic midwife* should be promoted and discussed in undergraduate and postgraduate midwifery training and continuous professional education.

Limitations

This research was conducted in two regions in England and three NHS Trusts that provided home birth and free-standing midwifery units. In regard to the population characteristics, the study conducted did not include women from minority ethnic groups. Furthermore, women with a pregnancy in which pathology developed were not enrolled as they would be automatically referred to an OU for labour and birth and hence would not usually be offered a choice on where to give birth. Therefore the applicability of the findings to these groups is limited. Due to the fact that few first-time mothers usually plan a homebirth, the researcher managed to recruit only a limited number of participants planning to birth at home. Sampling was weighted in favour of women planning to give birth in an FMU. However, five women experienced a change to their planned place of birth during the third trimester. Only two women had a FMU birth (compared with ten women who experienced an OU birth), resulting in the difficulty of comparing women's experiences of diverse birthplaces in regard to the data collected in the second interviews after birth. Due to a high transfer rate of birthplace during pregnancy, it was not possible to explore the experiences of women giving birth where planned, both for home and FMU births. Finally, it is acknowledged that women might have expressed a preference for what was actually experienced, recalling the idea of 'what is, must be best' (Porter and Macintyre, 1984: 1197).

Conclusion

Independently from the place of birth, when the woman is cared for by a supportive caregiver, it is likely that she will be satisfied with her experience. Since there are numerous nuances in women's perceptions of a good midwife's role, behaviour and characteristics, midwives should acknowledge that each woman requires first of all the establishment of a positive rapport from which one-to-one individualised care can flow. This is fundamental to improving women's satisfaction with their caregivers during labour and birth. The model presented can be used by midwives to pursue excellence in caring for labouring mothers across different birth settings. As this is a dynamic model, midwives are called to adapt it to individual women, labour experiences, settings and contexts. The model is likely to have explanatory power when applied to similar contexts as the comparison with existing evidence allowed the constant connection of data with the ongoing international debates on the key topics.

This study raises questions for future research that is necessary to tease out individual components of the model in a variety of practice settings. The novel elements in the model indicate that it is worth investigating markers of *relationship-mediated being*. Research is also required to identify the strategies engaged by midwives to use their reflexivity and intuition to be *kaleidoscopic* and what are the factors that may contribute to and facilitate or hinder the midwife's continuous adjustment to the woman's individual needs, expectations and labour journey. Moreover, the exploration of the best ways to support students to develop *relationship-mediated being* during midwifery programmes is needed, including the understanding of whether relationship-mediated characteristics are easier to be cultivated in particular settings (e.g. home or Midwife-Led Units versus Obstetric Units) or models of care (e.g. caseholding schemes). More research is required to further explore the midwife's presence and characteristics at different labour stages, especially at transitional points such as the latent phase and the second stage of labour.

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