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The paradoxes of communication and collaboration in maternity care: A video-reflexivity study with professionals and parents

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ABSTRACT

Background: Research on maternity care often focuses on factors that prevent good communication and collaboration and rarely includes important stakeholders – parents – as co-researchers. To understand how professionals and parents in Dutch maternity care accomplish constructive communication and collaboration, we examined their interactions in the clinic, looking for "good practice".
Methods: We used the video-reflexive ethnographic method in 9 midwifery practices and 2 obstetric units.
Findings: We conducted 16 meetings where participants reflected on video recordings of their clinical interactions. We found that informal strategies facilitate communication and collaboration: "talk work" – small talk and humour – and "work beyond words" – familiarity, use of sight, touch, sound, and non-verbal gestures. When using these strategies, participants noted that it is important to be sensitive to context, to the values and feelings of others, and to the timing of care. Our analysis of their ways of being sensitive shows that good communication and collaboration involves "paradoxical care", e.g., concurrent acts of "regulated spontaneity" and "informal formalities".
Discussion: Acknowledging and reinforcing paradoxical care skills will help caregivers develop the competencies needed to address the changing demands of health care. The video-reflexive ethnographic method offers an innovative approach to studying everyday work, focusing on informal and implicit aspects of practice and providing a bottom up approach, integrating researchers, professionals and parents.
Conclusion: Good communication and collaboration in maternity care involves "paradoxical care" requiring social sensitivity and self-reflection, skills that should be included as part of professional training.

Statement of significance

Problem or issue

Researchers and policymakers have explicitly called for better communication and collaboration between and among maternity caregivers and parents.

What is already known

Six intertwined factors promote communication and collaboration: "explicit" factors ("doing together") – expertise, partnership and context – and "implicit" factors ("being together") – attitude, trust, and communication style.

What this paper adds

Studying practicing effective communication and collaboration among and between caregivers and parents, led to the identification of informal strategies that facilitate being together: "talk work" – including small talk and humour – and "work beyond words" – including familiarity, use of sight, touch, sound, and gestures. Our research underscores the importance of "paradoxical care": e.g., concurrent acts of "regulated spontaneity" and "informal formalities".

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1. Introduction

Maternity care represents a dynamic and complex field in medicine [1], where professionals from different disciplines must work together to achieve their shared goal of healthy mothers and babies. Maternity caregivers have different professional cultures and philosophies of care, generated in part, by their historical and educational backgrounds [2], which can lead to miscommunication, tensions and a dis-integration of care. Reviews addressing communication and collaboration in maternity care [2–4] often consider these concepts to be multi-layered and overlapping and emphasize the need for better interprofessional communication and collaboration (hereafter C&C) to provide woman-centred care over the course of childbearing.

In maternity care, the quality of C&C between parents and professionals has shown to be vital to the health and well-being of mothers and babies [5]. Recognizing this, Dutch policymakers have called for a system of integrated care ("integrale zorg") that puts the woman at the centre of care ("de vrouw centraal"). They recommend better interprofessional integration between community midwives and the hospital care team and better integration between all maternity caregivers and parents. In order to realize the goals of encouraging shared decision making and empowering women, policymakers explicitly call for better C&C between maternity caregivers and with parents [6].

Effective C&C in maternity care requires the identification of the elements that generate positive interactions. In a preparatory scoping review, we discovered that much of the existing research in maternity care focuses on the barriers rather than the facilitators of C&C, with scant attention given to opinions of parents [7]. We also found that research on the integration of maternity care services tends to focus on the structural aspects of integration, not on how integration is realized on the work floor [7]. In this article, we examine how professionals accomplish effective C&C in everyday maternity care practice. We designed our study to learn from good practice – from what goes well, rather than from what goes wrong. Our review of the literature [7] provided "sensitizing concepts" for our fieldwork. We identified six main, intertwined factors relevant for good C&C. These factors fell into two categories: those that are "explicit" – Expertise, Partnership and Context – and those that are "implicit" – Attitude, Trust, and Communication style. The "explicit" factors are about "doing things together" and are often part of written regulations, such as the distribution of workload. The "implicit" factors are about "being together", personal characteristics or preferences of groups or individuals, such as respect among colleagues.

In this article, we present the findings of our ethnographic study of the implicit, but crucial, ways of working that establish and preserve constructive connections of "being together" between and among professionals and parents in Dutch midwifery practices and obstetric units. To understand how professionals and parents actively achieve a sense of "being together", we focused on their interactions and on learning from what goes well [8]. We included parents and professionals as functioning co-researchers in our study. In other words, we studied the actual practices of effective C&C between and, importantly, with all the parties involved in everyday maternity care practice, integrating our research with the work of professionals and parents in the care team.

2. Methods

2.1. Design

Studying everyday practices in maternity care is necessary for gaining insight into the origins of good C&C and learning from what goes well. This shift in focus towards learning from available strengths, instead of learning from mistakes or problems, requires "exnovation": explicating existing implicit and informal competencies [8,9]. Exnovation pays attention to the mundane routines of care, which, over time, have become invisible but are critical for promoting quality. With its focus on implicit ways of working, video-reflexive ethnography (VRE) is an ideal tool for exnovation. VRE facilitates exnovation by filming everyday practices, editing footage, and using clips for co-analysis in reflexive meetings with the involved professionals and other participants [10]. Watching this footage allows them to see, relive, and experience things they forgot, took for granted, or ceased to see. Different from linguistic or numerical data, video offers an immediate connection with the 'here and now' and shows the multiple layers of work, including the connectedness of people, spaces, and their technologies [11]. Moreover, the visual and audible, in combination with the familiar nature of the recorded situation, provides an affective dimension: the participants hear, feel, think, and question the taken-for-granted [12]. This is more than simply "showing the world as it is" because the making of, and the reflection on, the footage is a co-constructive process [13]. Through this process of reflexive discussions and analysis, professionals can identify their own strengths (exnovation). Different from most video-based methods, VRE takes one more step and considers participants as co-researchers [10].

VRE has proven useful for facilitating exnovation in other fields of health care [10,13–17], but has rarely been used in maternity care. Scarce examples are the Birth Unit Design (BUD) project [18] and a study on learning packages for maternity care staff [19]. The different parties in maternity care have their own versions of what they perceive as "best" care [20]. Therefore, to enable learning from all perspectives and to co-create knowledge about effective C&C, we included all parties as co-researchers in our study.

2.2. Settings, co-researchers, and ethics

Dutch maternity care is organised into primary (midwife-led) care and secondary/tertiary (obstetrician-led) care with professionals working alongside and complementary to each other [21]. Community-based midwives work autonomously and are responsible for the care of 89% of women at the start of antenatal care [22]. Some midwives work as salaried employees of hosptials, caring for women in the clinical setting [23].

Our observations and reflexive meetings took place from January 2013 until January 2015 in two regions of the Netherlands. In one region, the maternity care department of the university hospital and five collaborating midwifery practices participated, and, in the other region, the general hospital and four collaborating midwifery practices participated. In these regions, respectively, one and two practices were not able to participate because of time constraints. All locations are learning locations for maternity care professionals in training.

The co-researchers in our reflexive meetings were parents (mothers and partners), community-based midwives, hospital-based midwives, obstetric nurses, obstetricians, and nursing aides. They were eligible if they were able to communicate in Dutch and were aged 18 years or older.

The process of recruitment was carefully arranged to avoid any feelings of coercive participation. We informed the professionals about the study via presentations and information letters to allow an informed choice about participation. For the same reasons, all parents received written information in a timely manner in the waiting rooms, on websites, and verbal information from their care provider and the researcher. At any time, parents could consult an independent medical doctor and independent professionals from the hospitals' patient services desks about the study. Observations of parents and their care providers took place after their freely

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given verbal informed consent. Everyone who agreed to be filmed and all co-researchers in our meetings freely gave written informed consent. Consent forms highlighted the steps used to preserve confidentiality, emphasized that the decision to (not) participate would not disadvantage potential participants, and confirmed that all participants had the freedom to terminate involvement in the project at any time with no negative consequences. We ensured participant confidentiality in all presentations of the data. The Medical Ethics Committees of the involved hospitals approved our study. According to their requirements, all data are stored in a secure location for 15 years or until analysis is completed, whichever comes last.

2.3. Observations and reflexive meetings

During the first round of observations and reflexive meetings (2013–2014), the ethnographer performed observations and filmed for five days in a two-week period in each of the locations in both regions. During the second round (2014–2015), she performed observations and filmed for five days in each hospital and three days in each midwifery practice. The ethnographer focused on observing interactions – face-to-face and by phone – during pregnancy, childbirth, and postpartum between parents and professionals and among professionals, including antenatal visits, postnatal home visits, interdisciplinary professional consultations, handovers, staff meetings, medical rounds, and medical procedures. Formal interdisciplinary meetings to discuss and make organizational agreements, such as protocols and guidelines, were not observed. The care providers assisted in involving parents in the project and in getting their approval if they anticipated that a video clip of their interaction would visualize “good” C&C and if they expected that filming would not be intrusive.

We held 16 reflexive meetings: eight for professionals only and eight for parents and professionals. During the two-hour meetings we created an informal atmosphere by using first names, sitting in a circle, serving coffee and sweets, and inviting professionals not to wear uniforms. Furthermore, our focus on why things go well stimulated all our co-researchers in speaking freely during the reflexive meetings. Moreover, we consistently first invited parents to express their experiences to ensure that they felt they could speak freely in the presence of professionals.

The ethnographer was moderator, and one of the other researchers took notes and assisted with audiotaping. In all meetings, the moderator showed short video clips or pictures of interactions in the locations and used an interview guide to solicit comments. The footage allowed the co-researchers to reflect on their different experiences in everyday interactions, and to identify and explicate their strengths. During and at the end of the meetings the moderator gave oral summaries and invited elaboration, feedback, and verification (member check) [24].

To evaluate the project’s feasibility and progress we also held eight project meetings with key persons among the co-researchers. This led to decisions about what type of interactions called for more observation and reflexivity. Furthermore, we decided to involve the co-researchers in the preparatory stage while selecting the footage for the video clips for the reflexive meetings. This resulted in nine preparation sessions in which the ethnographer and different co-researchers chose topics and video clips that they thought would be most relevant and helpful for stimulating reflexivity. Our co-researchers were actively involved in collecting and analysing the video footage, making sense of practices as embedded within their contexts [25].

2.4. Analysis

We began the iterative process of content analysis using constant comparison [26] immediately after the first observations and reflexive meeting. All authors, combining expertise from maternity care, social science, and ethics backgrounds, discussed their findings and identified areas for further in-depth exploration directly after and in between the reflexivity meetings (debriefing). The first three authors analyzed all verbatim transcripts of the audiotaped meetings and the field notes from observations and debriefings, through reading and re-reading and developing a coding scheme. We identified themes and patterns within and among these themes by coding the data using a software program for qualitative analysis and grouping the coded material. We based the categories on the research question, scoping study [7] and the data itself, and we restructured and refined them through sequential and retrospective searching of the data. We compared and contrasted the categories within and among transcripts and field notes. A native English speaker assisted in translation of the quotes.

We applied accepted strategies to ensure trustworthiness in qualitative research [24,27]. Credibility was ensured by our prolonged engagement and persistent observation in the settings, transcripts, field notes and debriefings (methodological and data triangulation), member checks, and reflections on the project (investigator triangulation). By carefully describing the context of our work, we enable readers to evaluate whether our findings are transferable to other care contexts. We also kept a logbook of the proceedings, including reflections on the researchers’ roles, allowing our findings to be checked for trustworthiness [27].

3. Findings

In 16 reflective meetings, a total of 88 co-researchers participated: 62 professionals and 26 parents. Professionals varied in age and work-experience, and most professionals were female (Table 1a). The parents varied in age and experience with birth, all lived in a relationship, and no parents had a low educational level (Table 1b).

We present the findings of our observations and reflexive meetings as descriptive summaries and interpretations of the key themes. We support and illustrate our findings using quotes from the conversations between co-researchers in the reflexive meetings. We included identification numbers for the co-researchers (1–88), and identification numbers (1–16) for the reflective meetings of professionals (P) and the meetings of parents and professionals (PP).

3.1. Ways of working

Professionals use different strategies for enhancing C&C, some formal (e.g., protocols and emergency team training) and some

Table 1b
Characteristics of co-researchers in reflexive meetings: parents (n = 26)[a].

Parents (n)	All 26	Mo 19	Fa 7
Age in years (range)	22–45	22–38	27–45
Living in relationship	26	19	7
Lower educational level	–	–	–
Intermediate educational level	11	9	2
Higher educational level	15	10	5
Homebirth at least once	3	2	1
Hospital birth at least once	18	12	6
No birth	5	5	–

[a]MO: mothers; FA: fathers.

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Table 1a
Characteristics of co-researchers in reflexive meetings: professionals (n = 62).[a]

Professionals (n)	All	CM	HM	ON	OB	NA
	62	24	3	11	17	7
Age in years (range)	23–59	25–52	24–51	25–57	23–59	41–58
Work experience in years (range)	1–35	3–31	2–20	5–33	1–34	2–35
Female	56	24	2	11	12	7
Male	6	–	1	–	5	–

[a] CM: community-based midwives; HM: hospital-based midwives; ON: obstetric nurses; OB: obstetricians; NA: nursing aides.

informal (e.g., small talk and gestures). The combination of formal and informal ways of working allows for "smooth" C&C. During our observations and reflexive meetings, we identified several informal, mostly taken for granted, ways of working that promoted effective C&C. These strategies were small talk; humour; familiarity; use of sight, touch, sound; and non-verbal gestures. Moreover, our analysis shows how these strategies were used.

3.1.1. Small talk

We identified the ways small talk promoted C&C. For example, a mother explained how chatting about non-medical issues enhances trust:

> PP12-Mother: "When someone is genuinely interested, then, a talk can be personal, rather than just the medical things: is the nursery ready? Have you thought about baby clothes? You don't have to talk about these things, but if you do, it builds the trusting relationship you need for working together. Especially, the non-medical questions about how you really are doing, [show] that someone is sincerely interested." [MO77]

During our fieldwork, we noticed that when professionals shared personal experiences with parents about, for example, being tired when working nights, parents' feelings of being understood were enhanced. They felt free to express their worries, normalizing their concerns. Professionals also regularly made positive informal remarks as antidotes for possible feelings of stress.

> PP4-Obstetrician: " . . . you say the whole time, "beautiful", "wonderful", "good", "nice" (. . .) giving the continuous feeling of, well, it just looks very normal, very good, nothing special, it is going according to the book." [OB4]

A mother explained that small talk creates an informal atmosphere that makes it easier to share vulnerable or embarrassing information and to ask questions:

> PP12-Mother: "It was always relaxed, informal. You feel OK, you know? You don't feel shy about asking questions." [MO80]

Professionals also noticed that sharing informal information with colleagues provides the opportunity to interact socially and facilitates working with colleagues. Chatting during breaks or quiet moments, or asking about one's weekend creates an informal atmosphere, making it easier to ask for help, admit a mistake, or give feedback.

3.1.2. Humour

We observed a lot of laughter in the consultation room. Making jokes provided moments that break with the seriousness of the context by adding informality and creating feelings of being together in the situation.

> PP12-Father: "Humour is a binding factor in strengthening a relationship . . . trust between a midwife and the woman during childbirth. You need that in any case, because in vital moments, you might need to look each other in the eye and say: what do we do now?" [FA81]

Humour facilitated getting to know someone better, important for building the relationship necessary to respond to the uncertainties of pregnancy and birth. Professionals also used humour in their contacts with parents to break the ice, to put them at ease at potential stressful times, to comfort them after difficult events, to support them in opening up, and to allow them to express worries or thoughts on sensitive topics such as sexual behaviour.

> PP16-Mother: "The talks with midwives and obstetricians that are a bit informal, a little joke, those were pleasant experiences. [At my workplace] I try a bit of informality in my teams, because it often creates a connection." [MO82]

Remarkably, humour was also deliberately used for communicating serious business, as explained by a professional who commented on the value of these "serious" jokes:

> PP12-Obstetrician: "A little joke, how you communicate, helps to get your messages across better. They are remembered better than when you just sum up: you can do this or that or you can not drink, and eh . . . " [OB18]

Humour was also important for the relational work between professionals when providing care and participating in interprofessional meetings. In our reflexive meetings, we heard that humour enhanced sharing and supporting each other, letting go, recovering from tensions, and preparing for the next encounter or topic.

For both parents and professionals humour played a significant role in connecting. It could buttress "bonding practices" in maternity care by "breaking the ice", creating a comfort zone to reduce feelings of stress and embarrassment. Furthermore, it could help parents relax, and, simultaneously, provide professionals a pleasant break with their busy, stressful, everyday working routines. Yet, there is a problem here. Using humour could help getting to know someone, but making the right joke at the right moment requires that you already know that person.

> P9-Obstetrician: "You do that mainly with people you know, all day long. A kind of confirmation that you are good colleagues, that you have a friendly relationship, can make jokes, and that you understand each other. Sometimes it doesn't really work out, or has an adverse effect, and then you make it up again by touching each other for a moment or hugging each other." [OB12]

Professionals used humour for many reasons and in different ways, depending on the context, their counterparts' characteristics, and the nature of their relationships with colleagues or parents. As we shall see, this predominantly verbal strategy intertwined with other, nonverbal, strategies.

3.1.3. Familiarity

Professionals and parents acknowledged familiarity as a distinct strategy for connecting. They regularly reflected on the importance of professionals being familiar with the parents they care for.

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PP8-Mother: "The personal [approach] is very important, that your family situation is considered. What you consider important as a person, what your partner considers important, and that this is addressed." [MO70].
PP2-Midwife: "That is precisely our strength as midwives, that you form such a special bond with the pregnant woman." [CM38]. Obstetrician: "Yes, of course." [OB3]. Midwife: "And that you can give her one-to-one contact. That you are there, and that she knows you." [CM38]. Obstetrician: "Yes." [OB3].

Simply spending time together facilitated becoming familiar. Familiarity was enhanced by using the opportunity of physical proximity to ask parents about their personal contexts, experiences, expectations, and wishes, and by giving attention to accompanying partners, children, or significant others. Thorough handovers over the phone or the presence of referring professionals during childbirth in the hospital allowed the receiving professionals to prepare themselves and to become familiar with the referred parents.

PP10-Obstetrician: "The average woman knows the midwife much better than she knows the doctor. If you always see the same care provider, that is, of course, much better. Fortunately, I see it in the records quickly, then, you've created a kind of click." [OB12]

Professionals want to create a kind of "instant familiarity" at a faster pace than in "real life", to make parents and themselves feel more at ease.
P11-Obstetrician: "I think that [familiarity] is what people, and probably I myself, need. It's of course a very personal profession, therefore I find it nice, even though I barely know people, to have a kind of personal connection." [OB4]

Professionals also appreciated that in most cases they can easily connect with colleagues at a personal level. Due to longstanding work relations, many professionals knew each other by face and by name, and recognized each other's voices over the phone. Furthermore, professionals stressed the value of informal gatherings after interprofessional workshops and meetings for enhancing familiarity. Moreover, working together in an intense and challenging care situation can create a life-long bond. Our clinical co-researchers recognized how spending time with each other at work can strengthen C&C.
P11-Midwife: "Some residents asked me if they could join me for one day in my practice. Then, you get to know them in a different way, which is very nice. That should actually be part of the obstetrician's training. Midwives have clinical placements with obstetricians and in the operating room to see what happens when you transfer [women], whereas obstetricians rarely have clinical placements in primary care to see how you handle things at home. It would be good if there were more time and, of course, budget." [CM38] Obstetrician: "I think it is very instructive for us, that you see how they work, and get to know each other better, very important." [OB18]

Knowing each other was important for valuing each other's work and for understanding a colleague's needs. Familiarity also increased mutual trust among professionals and the confidence that they can depend on each other.
P-Midwife: "You feel that . . . This is primary care and that is hospital care, there arises a grey zone . . . [There are] agreements, but sometimes there is a part where it is not very clear. If in doubt, I do not hesitate to ask them for help." [CM40] Obstetrician: "It matters that you know each other, it is very important that we know where we all stand . . . you basically stand for a common goal . . . others aren't there to stand in your way, but you work together towards a shared . . . you feel that very clearly." [OB4]

This mutual trust among professionals also increases parents' feelings of safety.
PP12-Mother: "I was actually very safe, in good hands. When I had to push, the midwife stayed with me." [MO80] Obstetrician: "When we get into the room, I also see that you have a good relationship with your midwife . . . I know her very well and if we do it together, it's fine. We do our medical thing. I try not to take centre stage. You can't create the same relationship in an hour, as you can with someone you've followed up for nine months." [OB1]

We also found that professionals tend to be cautious in their interactions with parents. They varied in how much of their personal life they were prepared to share and varied in their desire to protect their privacy. As the community midwives often actually live among the people they serve, they tended to see their lack of privacy as inevitable and acceptable, and valuable for building relationships with the families.

3.1.4. Use of sight, touch, sound

Professionals and parents used different senses for reading and addressing each other's non-verbal signals. Because professionals valued having eye contact with parents, they tried to go through the parents' records before each appointment and to minimize use of their computers during visits. In an urgent situation, making eye contact facilitated instant connecting.
PP8-Nurse: "Someone comes in for induction of labour or someone comes during the last phase of labour. That is a very big difference; you have to try even faster, especially to make eye contact." [ON33]

Professionals also combined different sensory techniques in vital situations. For example, making eye contact, using touch, and changing their tone of voice.
PP4-Obstetrician: "Taking a time-out at that moment to look at people and if necessary, to touch them, even though I do not know them, I notice that it calms them and that you . . . speak more slowly, more directly." [OB4]

Parents felt that these techniques had reassuring and encouraging effects, when, for example, coping with the contractions of labour.
PP12-Obstetrician: "Just put your hand on someone's hand or shoulder, even with someone you do not know at all, you do that . . . that is part of it, so, silence with body contact is very different from silence on its own." [OB4]. Mother: " . . . knew that I found it very stressful . . . a pat on the back, yes, it's calming, does a lot. [MO75]

Professionals often encouraged the women to make contact with the baby that is growing inside, and they involved the mothers' partners and the baby's siblings.
PP8-Obstetrician: "What I tell the father is, feel her tummy. Like this, and this is the womb." [OB26]. Mother: "Yes, at least he can also tell others, friends, so, yes, he [the baby] is in position." [MO69]. Obstetrician: "Here's a nice idea . . . give that device [Doppler] to the dad . . . Go find it [the baby's heartbeat]. It's a small effort actually." [OB26]

Some professionals felt that many maternity care providers almost intuitively understand and address parents' non-verbal signals. Others added that professionals should check whether they understood the parents, and that professionals would benefit from reflectivity and training. They stressed the importance of using "deliberate-spontaneous" body-language.
PP12-Midwife: "I think you can also increase your own awareness, that you can learn certain non-verbal techniques to spread more calmness, also through training." [CM38]

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Professionals and parents became aware of the pervasiveness of eye contact, touch, and tone of voice in their interactions and the importance of working with the senses for the feeling of 'being together'.

However, facial expressions can also be read in the wrong way: an otherwise innocent expression can disturb parents. For instance, concentrating during an ultrasound might result in a silence or a frown that parents could easily misinterpret as worrying. Being aware of this, professionals aimed to prevent parents' fears.

PP12-Nurse: "When a doctor is doing an ultrasound: I tell them, the doctor is having some difficulty interpreting the screen properly. It doesn't mean anything." [N7] Multiple voices: "Yes." Nurse: "You try to be an intermediary between a doctor who is concentrating at the time and is not thinking about the mother's reaction . . . " [N7]. Midwife: Well, I think we should realize much better how our non-verbal [behaviour] influences people." [CM38] Multiple voices: "Yes, yes." Midwife: how your expression immediately creates a cascade of feelings in people." [CM38]

Professionals felt it was important to take care in order to prevent giving contradictory messages to parents and to regulate their spontaneity.

3.1.5. Non-verbal gestures

Professionals and parents reflected on how their physical gestures influenced their communication.

PP8-Midwife: "What we regularly do is a "high five", and, then, you can just continue." [HM32]
PP8-Obstetrician: "Very simple. You're busy, first in the birth suite, your administration, then, a cup of coffee or tea appears in front of you." [OB26]. Midwife: "Yes, yes." [HM32] Obstetrician: "Without words. That's also communication, right?" [OB26]

During the rounds in the hospital, some professionals chose to sit down beside the mother's bed to create a sense of having time and calmness for the benefit of parents and professionals, which might actually turn out to be time-saving and highly effective.

P5-Obstetrician: "I often sit down. I'm not in the room for longer, but people feel: "He takes time to sit down for a while", takes 5 seconds." [OB22] Midwife: "You are talking at the same level then." [CM62] Obstetrician: "It feels more personal. It also gives me some peace, you can order things . . . everyone should sit down." [OB1] Obstetrician: "If we all sit down in a row, next to the woman that looks weird." [OB25] Obstetrician: "Oh, I use to sit down with everyone. When you have to tell bad news, don't do that while standing." [OB22]. Obstetrician: "No." [OB25]

Some professionals further decreased the distance from the parent by leaning over or sitting on the bed to give their full attention and to invite parents to express themselves. Other professionals were careful to ask permission before touching the bed, because they did not want to intrude in the parents' personal space. A professional explained that by physically positioning herself closer to the parent, she actually created more intimacy.

PP8-Obstetrician: "[The CM] did very well with the postnatal woman. She just let her talk and talk . . . And she just sat quietly watching . . . she has to tell her story." [OB26] Interviewer: "She leaned a little on the bed." Mother: "I liked that very much. Just sit close . . . at eye level, not from a distance." [MO69]. Obstetrician: "Then you give them time." [OB26] Mother: "Really, take the time for you, indeed," [MO69] Mother: "Yes, I also like it." [MO70] Midwife: "That she sits down on the bed and not on the chair next to it or on that couch at a distance." [CM52] Mother: "That reduces the distance." [MO69]

The practice of sitting down also had advantages for interactions between professionals.

P11-Nurse: "You literally lean over that one file when you are sitting close together." [ON7] Midwife: "You get closer to each other the more background noise there is. Sitting together gives you more of a feeling of belonging than if you sit far opposite each other." [HM1]

By sitting down during their handover, professionals made time for a verbal exchange of the written reports and provided additional information when needed. To do so in an effective way, they also made a shared space by positioning themselves close to each other at the desk or by creating a quiet zone while standing in urgent circumstances.

P11-Midwife: "Sometimes, it is better to discuss things standing face-to-face, quickly, while you are in a hurry and are actually further with your thoughts." [CM40]

The observations and reflections of our co-researchers showed us how an ostensibly insignificant and small act of sitting down with one another could have big impact and promote connectedness and, thereby, contribute to better C&C.

Overall, reviewing our findings on ways of working in care teams, we found that informal acts "filled in" spaces where formal agreements and guidelines fall short. One obstetrician used the metaphor of "beads" to describe the value of formal and informal ways of working towards good C&C.

P7-Obstetrician: "These little things boost collaboration, yeah. A comparison: You have many big beads. Then, if you want to get a beautiful and smooth surface, you would have to fill it up with small beads." [OB26]

These "small beads", the informal ways of working we found, allow adjustment to the situated nature of the interpersonal encounters, characterised by variation in the behaviour and relational skills of professionals and parents and by the different settings that affect the flow of care.

4. Discussion

To understand how the implicit factors of the everyday work of maternity care facilitate connectedness, we examined how professionals and parents accomplish "being together". We found that small talk and humour – or talk work [28] – and the use of familiarity, sight, touch, sound, and non-verbal gestures – work beyond words – facilitate connectedness. Our observations and the data from reflexive meetings allowed us to identify these strategies, and to see how these strategies work and affect C&C in everyday care. For example, small talk often is regarded as irrelevant, and a way to avoid silences, but it can positively influence C&C [29]. Our findings confirm the relevance of these irrelevancies by showing how small talk and other informal strategies facilitated "bonding" among parents and professionals and "reduced stress" of caregiving and care receiving, and thereby enhanced connecting.

4.1. Paradoxical care

At first sight, the informal strategies might seem just a matter of "being pleasant", but they require the use of certain skills and result in what we call "paradoxical care", as we will show. These strategies serve a higher purpose: enhancing connectedness. But, in listening to our co-researchers reflections on the video clips, we learned that these seemingly "ordinary" ways of working require

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the skill of deciding when, how, and how much "talk work" and "work beyond words" are appropriate. This expertise is crucial since inappropriate use of these strategies could backfire and destabilize relationships. Professionals in our reflexive meetings were aware of these pitfalls. For example, they agreed that humour could support building and preserving good relationships. Yet, they argued, knowing and understanding the other was necessary for the appropriate use of humorous remarks. Moreover, humour could promote a sense of belonging, but could also act as boundary marker for those who are connected and those who are not. To prevent confusion or feelings of exclusion, using humour requires checking and following up verbal and non-verbal responses and, on occasion, repair work. In line with this, the professionals stressed the importance of familiarity as it allows for interpreting non-verbal signals, tailoring communication, being open and honest, and feeling safe in exchanging feedback. In sum, informal strategies require sensitivity for timing, context, and other's values and feelings.

In our analysis, we distilled three skills used to avoid pitfalls and keep care on track: balancing, sensing, and dosing (i.e., the extent to which an informal strategy is used). Professionals put effort into creating a pleasant atmosphere. Because they were aware of potential problems, they adjusted their C&C by balancing, dosing, and sensing what they needed to say or do. When they used humour, they complemented informality with professional behaviour. They shared personal information with their colleagues or parents while staying professional. They acted relaxed while being strict. They were kind but decisive. Their balancing skill makes clear that a pleasant atmosphere is not enough. It contributed to togetherness, but professionals were not aiming for just any togetherness. They strived for togetherness that accommodates trust and safety, essential aspects of quality maternity care.

Beneath the surface, an understanding of the more formal aspects of relationships accompanied informal behaviours. Professionals tried to sense what could be said and done at what moment and place and in whose presence. For example, sitting on a bed to create a feeling of "we have time" might be experienced as intruding one's private space. Therefore, professionals tried to provide the right dose of formal and informal behaviour, laughter and seriousness, functional and attentive touch. Their goal is an optimal trajectory toward confident and well-prepared parents for childbirth. The oppositional character of the balancing, sensing, and dosing skills required for effective use of the informal strategies suggests that maternity care involves "paradoxical care". Paradoxical care is expressed in oxymorons: acts of "regulated spontaneity", "relevant irrelevancies", "serious jokes" and "informal formalities" all in the right dose at the right time and place. Paradoxical care is about apparently contradictory concurrent acts based on continuous probing and tailoring. This situational check requires high levels of social sensitivity and self-reflection.

Interestingly, the various strategies result in different modes of connectedness. For example, small talk acts as a social glue that supports bonding. A social glue [30] connects people in a way that is strong enough to hold and flexible enough to adjust. If everything is fixed, it becomes much harder to relate and link up. As a social glue, small talk helps to transcend different spaces and moments in time. In other words, it creates an illusion of permanency. In practice, this illusion is a strong aid to manage being together. During our fieldwork in the hospitals, we observed moments where professionals invited parents to take off their coat and sit down, and we observed doctors sitting on a chair next to the mother in the bed. These ways of acting create the illusion of time, taking out the haste and hurry, stretching the moment and slowing down time. Sharing laughter and joy can create an informality that assumes a relationship older than its actual existence.

Other strategies can be useful for loosening up a situation when needed. Breaking the ice by a well-chosen pun or nice joke at the right time can dissolve boundaries and frictions, softening the situation. This viscosity in the state of affairs enables professionals and parents to overcome tensions, anxiety, or frictions. Loosening up by using humour can also provide a transition zone that connects the different parties as they move between contexts, e.g., from waiting room to consultation room, from not knowing each other to getting familiar. In maternity care, informal ways of connecting are everywhere, and familiarity has a central position in relationship building. It creates the illusion of having a relationship that is more than being a client and a healthcare professional. The illusion of friendship creates an intimacy in which one feels safe to ask questions, discuss otherwise difficult issues, and express feelings of doubt.

These illusions might give the impression that the care experience is just a "happy ride". Professionals are trying to ease the potential tension and anxiety of what lies ahead but they need to use their social sensitivity and self-reflection skills to ensure that these illusions do not lead to unrealistic expectations.

4.2. Implications for education and care practice

We found that sensitivity to context, the use of informal relational skills, and the art of paradoxical care are required for good C&C. This finding is of utmost importance because guidelines, protocols, and fixed routines are not sufficient for good interprofessional C&C in the complex care given during pregnancy and childbirth [1]. Excessive reliance on rule-based and protocol driven healthcare can lead to a lack of concern for woman-centred care and to emotional burnout for healthcare professionals who can no longer provide the kind of caring that led them to choose their profession [1].

The paradoxical care skills we identified are essential for coping with the messiness of real life. C&C are always situational: happening in a particular time and space, within a specific sociohistorical context [31]. This does not imply that professionals are at the mercy of the situation, they themselves also influence the situation [31]. The different informal strategies are aimed at aligning with the context (e.g. "laughing is inappropriate now", "a friendly touch is needed") to optimize the trajectory and the encounters that come about. At the same time, they create the context ("we are friends", "we have time"), facilitating "being together" in the best possible encounter. In other words, informal strategies are called up by, and simultaneously constitute, the same situation. The context directs the use of small talk or familiarity, and, at the same time, these strategies set the scene in which everything is happening. Studies on humour [32] show how humour both creates relations and reflects the closeness of the alliances between social groups. Exnovating paradoxical care skills – using what we learned in our research – will support professionals while operating in the maternity context and its "grey zone", where protocols are not available or are ineffective. Hence, professionals need training in the art of providing paradoxical care.

Recent studies in maternity care illustrate the contradictory cultural and ethical challenges professionals face in rapidly changing societal and health care contexts [33]. For professionals, key issues in their collaboration were competition, trust, the need to be valued, and the ability to help each other when necessary [34]. They faced dilemmas, for example, when confronted with women who choose homebirth against medical advice in complicated pregnancies [35] or women influenced by medicalization in the media [33]. They recommend building new professional competencies for providing good care through interprofessional practice, awareness, introspection, and

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reflection. Good maternity care is about recognition, about seeing women. Good care cannot exist without attentiveness [35], an art that requires professionals to be attuned to the needs and responses of the other [36]. Therefore, research in maternity care calls for interprofessional training in communication, shared decision-making, and in balancing values, and perceptions of risk [33,35]. Educators and practitioners should focus on supporting and role-modelling students in navigating dilemmas in practice and in promoting women-centred care and physiological childbirth care in communication with other professionals and with women [37].

Our study confirms earlier work that found relational continuity to be a key to positive birth experiences [38], but it also shows the value of relational continuity for interprofessional relations. Acknowledging and reinforcing the paradoxical care skills identified here will support developing new competences to address the changing demands of health care.

4.3. Strengths and limitations

As explained in the introduction we focused on "good practice" and the implicit, though crucial, ways of working that accomplish "being together" between and among professionals and parents. An important strength of our study is its examination of integration on the work floor. Following the suggestion of Goodwin [39], we studied "the 'inner workings' of care integration". Our use of VRE offers an innovative approach to studying the everyday work of integration, going beyond social network analysis [39], enlisting the participants in integrated care –parents and professionals – to help uncover the elements of good C&C. While we did not study the barriers to effective C&C, our use of exnovative methods and VRE facilitates learning from implicit, and good, practices [40]. We do not prescribe how professionals should behave. On the contrary, using "exnovation" focuses on informal and implicit aspects of a practice and it provides a bottom up approach, integrating researchers, professionals and parents. For comparing or elaborating on our findings in Dutch maternity care settings, we recommend VRE for future research in maternity care in other international and intercultural contexts.

5. Conclusion

This study of the actual practice of effective C&C with and between all parties in maternity care, revealed the use of different informal strategies to facilitate being together, a critical feature of integrated care [7]. Talk work – including small talk and humour – and work beyond words – including familiarity, use of sight, touch, sound, and gestures – were effective for bonding and reducing stress. Our research underlines the importance of "paradoxical care" expressed in oxymorons: acts of "regulated spontaneity" and "informal formalities". This type of care requires high levels of social sensitivity and self-reflection on the part of professionals, and therefore, attention to professional training.

Author statements

All authors have contributed substantially to the study conception and design, data acquisition, analysis and interpretation, and to drafting the article or revising it critically for intellectual content. All authors agree to be accountable for all aspects of the work related to the accuracy or integrity of any part of the work. All authors approved of the final version.

Authors' contributions

The conception and design of the study, acquisition of data, analysis and interpretation of data: IK, JM, IvH, RdV, MN.

Drafting the article or revising it critically for important intellectual content: IK, JM, IvH, RdV, MN.

Final approval of the version to be submitted: IK, JM, IvH, RdV, MN.

Ethics in publication

We have followed the Committee of Publication Ethics (COPE) guidelines.

Ethics approval and consent to participate

In November 2012, the Medical Ethics Committees of the involved hospitals approved our study (METC Atrium-Orbis-Zuyd, no.12-N-134). Informed consent was obtained from all participants.

Consent for publication

Consent for publication was obtained from all authors.

Conflict of interest

The authors declare that there is no conflict of interest.

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CRediT authorship contribution statement

Irene Korstjens: Formal analysis, Funding acquisition, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Jessica Mesman:** Formal analysis, Funding acquisition, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Isabel van Helmond:** Formal analysis, Investigation, Methodology, Writing - original draft, Writing - review & editing. **Raymond de Vries:** Funding acquisition, Methodology, Supervision, Writing - review & editing. **Marianne Nieuwenhuijze:** Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing - review & editing.

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Appendix A. Supplementary data

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