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'Bringing forth' skills and knowledge of newly qualified midwives in free-standing birth centres: A hermeneutic phenomenological study

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Abstract

Aim: To understand and interpret the lived experience of newly qualified midwives (NQMs) as they acquire skills to work in free-standing birth centres (FSBCs), as well as the lived experience of experienced midwives in FSBCs in Germany who work with NQMs.

Background: In many high-, middle- and low-income countries, the scope of practice of midwives includes autonomous care of labouring women in all settings, including hospitals, home and FSBCs. There has been to date no research detailing the skills acquired when midwives who have trained in hospitals offer care in out-of-hospital settings.

Methods: This study was underpinned by hermeneutic phenomenology. Fifteen NQMs in their orientation period in a FSBC were interviewed three times in their first year. In addition to this, focus groups were conducted in 13 FSBCs. Data were collected between 2021 and 2023.

Findings: Using Heidegger's theory of technology as the philosophical underpinning, the results illustrate that the NQMs were facilitated to bring forth competencies to interpret women's unique variations of physiological labour, comprehending when they could enact intervention-free care, when the women necessitated a gentle intervention, and when acceleration of labour or transfer to hospital was necessary.

Conclusion: NQMs learned to effectively integrate medical knowledge with midwifery skills and knowledge, creating a bridge between the medical and midwifery approaches to care.

Implications: This paper showed the positive effects that an orientation and familiarization period with an experienced team of midwives have on the skill development of novice practitioners in FSBCs.

Impact: The findings of this study will have an impact on training and orientation for nurse-midwives and direct-entry midwives when they begin to practice in out-of-hospital settings after training and working in hospital labour wards.

Patient and Public Contribution: This research study has four cooperating partners: MotherHood, Network of Birth Centres, the Association for Quality at Out-of-Hospital Birth and the German Association of Midwifery Science. The cooperating partners met six times in a period of 2 ½ years to hear reports on the preliminary

research findings and discuss these from the point of view of each organization. In addition, at each meeting, three midwives from various FSBCs were present to discuss the results and implications. The cooperating partners also helped disseminate study information that facilitated recruitment.

KEYWORDS
crafted stories, free-standing birth centre, hermeneutic phenomenology, midwife, physiological birth, skill acquisition

1 | INTRODUCTION

In high-income countries (HICs), midwives can hypothetically offer care during labour and birth in all settings, including hospitals, free-standing birth centres (FSBCs) and in women's homes; however, the scope of practice of midwives may be limited by government or health policy regulations. (ICM, 2017; Stone et al., 2023). The scope of practice of midwives internationally according to the International Confederation of Midwives (ICM, 2017) definition includes the skills to 'conduct births on the midwife's own responsibility and to provide care for the newborn and the infant'.

Each setting—hospital and out-of-hospital—requires the midwife to have a skill-set specific to that setting (Cronie et al., 2012). Midwives practicing in hospital labour wards have a skill-set that includes working with and monitoring women at high-risk for complications during labour and birth, while midwives working at home birth and in FSBCs work with women at low-risk (O'Connell & Downe, 2009; Stone et al., 2023). Home birth and FSBC midwives specifically need expertise to perceive and assess variations in normal physiology in a low-tech setting, with the ability to identify early signs of pathology and initiate a timely transfer, when necessary. O'Connell and Downe's (2009) metasynthesis of midwives' experiences working in hospital labour wards revealed that midwives experienced birth primarily as a clinical event. In this metasynthesis, it was shown that appropriate skills for the hospital environment included '*the ability to manage birth actively in an often busy environment, (and the ability) to use technology and intervention in the care of labouring women … These competencies were more valued than providing a woman-centred approach to care or keeping birth interventions at a minimum*' (ibid, 2009, p. 11). In a meta-ethnography of skills and knowledge of midwives at home birth and in FSBCs, it was shown that, when midwives switched settings from hospital to home and/or FSBC, they needed to learn to 'see things in a new light' (Coddington et al., 2020, p. 3; Stone et al., 2023).

2 | BACKGROUND

In most HICs, the place of birth moved rapidly from the home to the hospital beginning in the 1950s (Macintyre, 1977; Schumann, 2009). While home birth dictates one-to-one care for labouring women, midwives in hospital labour wards usually care for more than one woman at a time and commonly practice protocol-based care, whereby labour and birth are managed (Reiger & Morton, 2012; Rycroft-Malone et al., 2009). In the sociological research of childbirth commencing in the 1970s, the medical model of care practiced in hospital labour wards was described as antithetical to the midwifery model of care practiced in out-of-hospital settings (Adams, 1994; Davis-Floyd, 1992; Rothman, 1984; Treichler, 1990). Sociologist Rothman's (1984) research highlighted the core principles of the midwifery model of care, which acknowledged the female body as its own norm and embraced variations among individual women, emphasizing that pregnancy is not a disease. The midwifery model approached care from the standpoint of 'watchful expectancy', trusting that birth was a natural process, advocating interventions only when necessary (Adams, 1994).

Conversely, the medical model of care, exemplified by 'active management', quickly became normalized in the 1960s (Macintyre, 1977). In the medical model of care, the female body is treated as if it were defective (Davis-Floyd, 1994). Through induction and acceleration of labour by means of artificial rupture of the membranes and intravenous synthetic oxytocin, for example, obstetric physicians believed that the labour process could be improved upon and risks inherent to childbirth could be reduced (Macintyre, 1977). Although these practices were heavily disputed at the time and remain at present a source of contention (Boie et al., 2018; Macintyre, 1977; Selin et al., 2019), they have become ritualized and anticipated as taken-for-granted practices in hospital birth culture (Davis-Floyd, 1994). The application of 'watchful expectancy' as an approach to care for labouring women is predicated upon fostering trust, engaging in collaborative decision-making, and removing labour and birth from restrictive timetables (Simonds, 2002). This approach can be seen as incongruent with a medicalized approach that tends to objectify and impose standardized protocols on women's physiological processes (Adams, 1994). According to Downe and McCourt (2008), when bodies are standardized and expected to conform to and function according to medical paradigms, other ways of experiencing bodies are concealed for midwives, obstetricians and labouring women. The body thus becomes dominated by medical assessments that often discount women's subjective experience, whereby women lose authority over the process and the procedures (Duden, 1993).

In addition to the change in setting and the adjustment of midwives' skill-set and approach to care when they moved from home to hospital, technological apparatuses such as ultrasound sonography and foetal heart monitoring were rapidly integrated into care for pregnant and labouring women. These supplanted the hands-on evaluation performed by midwives and obstetric physicians (Stone et al., 2022; Weir, 1996), marking a loss of physical contact and connection between the caretaker and the pregnant woman (Duden, 1993; Mitchell, 2001; Stone et al., 2022). Concurrently, a subtle undercurrent of concern persisted that, with the increased use of ultrasound sonography and foetal heart monitoring (CTGs), midwives and obstetric physicians were becoming de-skilled (Cowie & Floyd, 1998). Dibley et al. (2020, p. 23) wrote '*…women in labour may be managed via monitors rather than physical assessment by a midwife, removing an awareness of the essential nature of the labouring experience and the human expression of that experience, and potentially de-skilling the midwife*'.

Because midwives in many HICs are permitted to offer birth assistance in hospitals, FSBCs, and in women's homes after receiving certification, it is crucial to ascertain which skills are developed, as well as the situations that support skill development when midwives begin to offer care at home and at FSBC births. This is especially important when their practical training has predominantly taken place in hospital settings. A systematic literature search was conducted before beginning the study. The search confirmed that there have been no studies conducted to date that described skill and knowledge acquisition of midwives at home birth and in FSBCs. This knowledge could help elucidate the individual, intrapersonal and organizational mechanisms that are needed for midwives to acquire the skill-set needed for home birth and FSBC settings.

3 | THE STUDY

3.1 | Aims

The aims of this study were to understand and interpret the lived experience of newly qualified midwives (NQMs) commencing work in FSBCs, as well as the lived experience of experienced midwives in FSBCs in Germany who work with NQMs. The research questions were as follows:

1. What is the lived experience of NQMs when they commence work in a FSBC?
2. What is the lived experience of experienced midwives working with NQMs in their orientation period in a FSBC?

This study is a postdoctoral study funded by the German Ministry of Research and Education from May 2021 to April 2024.

3.2 | Design

The philosophical underpinning of this study is Heideggerian hermeneutic phenomenology. Although Martin Heidegger did not intend for his philosophical oeuvre to be translated into a research method, it has been utilized frequently in the fields of, for example, nursing, midwifery and psychotherapy to explore, interpret and understand the lived experience of phenomena (Bradbury-Jones et al., 2010; Dibley et al., 2020; Little, 1999; Smythe, 2010). Hermeneutic phenomenology as a methodology seeks to capture the lived experience of participants to reveal how phenomena show up for them in their day-to-day encounters (Van Manen, 2014). The researchers have adhered to the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

3.2.1 | Philosophical underpinning: Heidegger's notion of technology and *bringing forth*

In 1954, Martin Heidegger published a written essay based on a lecture that he delivered in 1953 entitled 'The Question concerning Technology' (Heidegger, 1977). According to Heidegger, the objectives of technology are to unlock energy and accelerate processes, while maximizing output and minimizing input. As the use of technology grows and becomes more complex, the demand of human beings to gain and retain control over it increases, according to Heidegger.

The etymological root of the word technology, *techne*, conveyed artistry and skilled craftsmanship in its original sense. For Heidegger, it encompassed the notion of revealing, whereby form was given to something that could not emerge independently. Heidegger elucidated that, when *techne* is employed to reveal a finished product, it can be interpreted as an act of 'bringing forth' (*Hervorbringen*). Nature, expressed by Heidegger (1977) as the Greek *poiesis*, also brings forth, as in the blossoming of a flower. For Heidegger, modern technology likewise reveals and brings forth, but not in the sense of *poiesis* or *techne*. With technology and the application of a technological mode of thinking, nature is 'challenged forth' and becomes a tool of modern industry. Optimization and efficiency are pursued as goals in and of themselves, prioritizing them over the well-being of human beings and the environment. The manner of bringing forth that Heidegger witnessed in technology has the qualities of imposition and manipulation. Dreyfus wrote:

> Heidegger's concern is the human distress caused by the technological understanding of being, rather than the destruction caused by specific technologies. The danger, then, is not the destruction of nature or culture but a restriction in our way of thinking— a leveling of our understanding of being. (Dreyfus, 1995, p. 26)

Employing Heidegger's concept of bringing forth, this article will show how the NQM's orientation period in the FSBCs brought forth the skills and knowledge necessary for their work in that setting. In addition to this, the NQMs learned to evaluate and interpret women's labour dynamic with an approach that was closely

aligned with the notions of *poiesis*, *techne*, and a technological mode of thinking, which contributed to the skill-set specific to care in FSBCs.

3.3 | Philosophical underpinning: Heidegger's notion of attunement

Heidegger wrote that 'Understanding is never free-floating, but always goes with some attunement' (state-of-mind) (Heidegger, 1962, p. 389/339). For Heidegger, just as human beings always find themselves in the world, they are already always attuned and embedded in the world (ibid). Emotions, or more specifically moods, which Heidegger referred to as *Befindlichkeit*, are not merely subjective phenomena, but are fundamental to shaping our understanding of the world (Heidegger, 1962). Attunement is our way of being-with (*Miteinander*), since moods are what make it possible to think about and understand the world (Heidegger, 1995, p. 67). The attunement or mood is already there and is not a result of our behaviour, emotion or thinking, but is a pre-supposition for it (ibid 67–8). In the findings, it was shown that learning to care for labouring women in FSBCs encompassed learning to attune to the mood in the birthing room.

3.4 | Participants and recruitment

The study participants were experienced midwives who were currently working at a FSBC, as well as NQMs in their orientation period in a FSBC in Germany. The midwives at the FSBC where the NQM worked were not required to participate in a focus group. Inclusion criteria for the NQMs and experienced midwives participating in focus groups were that they had completed their midwifery training in Germany and were certified to practice midwifery in Germany. The inclusion criteria for experienced midwives were that they had worked for ≥3 years in a FSBC and had worked with a NQM in her orientation period. The inclusion criteria for NQMs were that they had not worked elsewhere as a midwife after their state examinations and were in the first 6 weeks of their orientation period in a FSBC. All of the participants in the study were >21 years old. Participation in the study was voluntary. None of the midwives or FSBCs received compensation for participating in the study.

After receiving ethics approval, FSBCs were contacted postally and with the assistance of Q.U.A.G. (the Association for Quality in Out-of-Hospital Births). FSBCs in Germany are required to transmit perinatal data to Q.U.A.G for all women registered at FSBCs whose birth began there; therefore, it was assumed that all the FSBCs in Germany received study information and had the possibility to participate in the study. The FSBCs also received a request to pass information on to any NQM who would begin working with them in the following 24 months. The FSBCs and the NQMs were all self-selecting. Detailed information concerning the size and location of the FSBCs and information that could lead to identification of any of the midwives who participated in the study has not been given, as anonymity was assured. For this reason, demographic data will not be provided, as the midwives and FSBCs could be identified.

3.5 | Research sites

The research sites were FSBCs throughout Germany. When the study commenced in 2021, there were a total of 107 FSBCs. FSBCs in Germany are privately owned institutions, each of which maintains their own quality management handbook. Each FSBC determines how NQMs will be oriented to and familiarized with the work in the individual FSBC. The FSBCs differ in many ways, including geography (city or rural, region of Germany), number of births per year, number of midwives and type of care (team care or caseload care). Almost half of the FSBCs where the NQM-participants worked offered home birth in addition to births in FSBCs, meaning that NQMs in those FSBCs were also getting familiarized with care at home births. In all of the participating FSBCs, all of the women received 1:1 care during labour by a 'primary' or 'first' midwife. During the final phase of labour, also called the expulsion phase, a 'second' midwife was present. Members of other professions were not present at births in the participating FSBCs.

3.6 | Data collection

Data collection methods included focus group interviews, unstructured interviews, digital capturing (voice messaging through Signal), journaling and rapid ethnography (3–4 day observation periods in FSBCs). For this paper, the authors have included the findings from the focus group interviews held with the experienced midwives and the first interviews with the NQMs. Only the first interview was chosen for analysis for this article since it best revealed the NQM's lived experience in their initial period in the FSBCs. The later interviews included stories of settling in, as well as coping, managing and handling increased responsibility. The complete data set will be used in future publications. The focus group and unstructured interviews with NQMs were recorded on a digital recording device and entered into MaxQDA. All focus groups/interviews were conducted in German and transcribed manually by either NIS or a student assistant.

3.7 | Focus group interviews

Thirteen focus group interviews were conducted. The focus groups comprised 2–5 experienced midwives working at the same FSBC. The purpose of the focus groups was to understand the lived experience of experienced midwives training NQMs. While the implementation of focus groups in hermeneutic phenomenology studies is controversial (Bradbury-Jones et al., 2009), in these settings, orientation of NQMs was accomplished by the team as a whole. The intention was for the team to share their individual

experiences with NQMs, as well as the experiences they had together, as Little (1999), have described. Regardless of the number of midwives participating in the focus groups, their interviews were transcribed as one voice, since most of the teams told stories together. In practice, this meant that each midwife added details to a particular story and sometimes finished the sentences that a colleague had begun. The focus group interviews lasted between 47 and 90 min.

3.8 | Interviews with NQMs

Fifteen NQMs participated in the study. Each NQM was interviewed at three different times in the first year of her orientation. The first interview was conducted in the first 4–6 weeks of their orientation, while the second and third interviews were conducted when the NQMs informed the first author that they had entered a new phase of their orientation, for example when they reached a new level of independence in work assignments. This included the independent provision of antenatal care or being the first or primary midwife at births.

3.9 | Data analysis

The goal of analysis in hermeneutic phenomenology is to interpret the stories of lived experience told by the research participants, thereby revealing the meaning of phenomena (Adams & van Manen, 2017; Dibley et al., 2020; Smythe, 2011). While there are no rigid structures to adhere to in the analysis of data in a hermeneutic phenomenology study, there are processes to follow that have been described in the research literature (Dibley et al., 2020; Little, 1999; Smythe, 2011). For this study, data analysis was undertaken through the following steps outlined by Dibley et al. (2020) and Smythe (2011): (1) Getting familiar with the data through listening to the interviews several times; (2) reading and re-reading the interviews; (3) writing memos about the interviews to aid in uncovering meaning; (4) reading about the topics that arose in the interviews, especially in philosophical texts; (5) going back to the written transcripts and crafting stories; (6) reading and discussing the crafted stories with the other members of the research team; (7) discussing the crafted stories with the research participants; and (8) composing the analysis.

Approaching the data with openness, understanding that all experience is embedded in the world, and reflecting on the relationship between the parts and the whole are components of analysing data (Suddick et al., 2019). As analysis in hermeneutic phenomenology research is iterative, data analysis involved going back and forth between listening and reading, moving between the individual stories in the data and the whole of the stories, and using phenomenological writing as a tool to interpret the data (Adams & van Manen, 2017; Crowther et al., 2014; Crowther & Thomson, 2020). Crowther et al. (2017) and Adams and van Manen (2017) explain this process as seeking themes in the lived descriptions, a type of analysis that is different from line-by-line coding in thematic analysis. Meaning making arose through interpretations of lived experiences, intertwining the interpretations with discussions with the research team and with research participants.

A further step in working with the data for this article was crafting stories from the interviews. When crafting stories, the words of the research participants were used verbatim, as well as paraphrased. In some cases, sentences were re-ordered to confer flow to the story, as Crowther et al. (2017) and Caelli (2001) have described. After the lived experiences were crafted into stories, they were translated into English by the first author, who is fluent in both languages. Lastly, throughout the research period, the first author revisited FSBCs and discussed preliminary findings with the NQMs and the experienced midwives. In doing this, the first author was often gifted the phenomenological nod, '*when subtle and nuanced experiential meanings that only a phenomenological description can evoke through descriptive and evocative means are recognized*' (Van Manen, 2014, p. Loc 4738).

3.10 | Rigour and trustworthiness

According to Lincoln and Guba (1985), the key strategies to enhance trustworthiness are credibility, dependability, transferability and confirmability. Data triangulation, which enhances credibility, was achieved through engaging with both NQMs and experienced midwives in the FSBCs (Morse, 2015), which facilitated a deeper understanding of the phenomenon (Lincoln & Guba, 1985). Moreover, credibility was reinforced by interviewing the NQMs three times throughout their orientation period in the FSBC in their first year. Dependability in qualitative research refers to the possibility that the study could be recreated and would result in the same findings (Morse, 2015). This cannot be expected with hermeneutic phenomenology, since the crafted stories are open to multiple interpretations by the authors (Crowther et al., 2017). However, dependability was improved through the first author's use of an audit trail in the form of interpretive memos that were shared with the other researchers in the team. Discussing the findings with the research participants, as well as disseminating preliminary research results at international conferences strengthened dependability, as well as improving the transferability of the research results, since feedback could be used in the interpretation of the data. Including midwives from 17 FSBCs aided in achieving confirmability, since the diversity of the FSBCs was an additional form of triangulation (Morse, 2015). Consequently, the researchers were able to achieve a profound understanding of the experience of NQMs orientation and familiarization with FSBC care (Van Manen, 1990).

3.11 | Positioning the authors

In a hermeneutic phenomenology study, credibility can be strengthened through the authors' dual commitment to reflexivity and transparency through articulating their own positioning. (Crowther & Thomson, 2020).

NIS: Before proceeding with data collection, a pre-suppositions interview was undertaken with GT to help NIS identify her positioning, beliefs and biases concerning the research topic (Barrett-Rodger., 2022; Dibley et al., 2020). NIS has been a practicing midwife in Germany for 22 years, both in hospital labour wards and in a FSBC. When switching from the hospital to the FSBC, she went through an orientation period to learn the approach to care at the FSBC. Before commencing this postdoctoral study, NIS completed two research studies in FSBCs in Germany and has been immersed in FSBC care as an academic and practicing midwife (Stone, 2012; Stone et al., 2022; Stone & Downe, 2023).

GT has a psychology academic background and has been undertaking perinatal-related research, predominantly with parents, since the 1990s. GT is also a parent of three children, with all births taking place in a hospital setting. She believes that midwives need to have the knowledge, confidence and capacities to advocate for women's needs, and as a non-clinician, holds no firm opinions as to how best this should be achieved.

DT has been a midwife since 1986 and has worked in midwifery education since 1999. Since 2022, she has been head of the study programme in midwifery at the Rostock University Medical Center. DTs experience with birth care is limited to the clinical setting. With regard to the study of midwives, DT believes it is important to identify the training and skill-sets that midwives need in the different work settings.

3.12 | Ethics approval

Ethics Approval for this study was obtained by the Ethics Commission at the Protestant University of Applied Sciences Berlin in July 2021 (project number EK 2021-01). The study was explained to all interested in participating in the study. All participants provided written informed consent prior to enrolment in the study.

4 | FINDINGS

Fifteen NQMs participated in the study (see Table 1), as well as 45 experienced midwives in 13 FSBCs. Table 1 shows that seven of the 15 NQMs were oriented to offer birth assistance at home births, as well as in FSBCs. In addition to this, eight of the NQMs worked in FSBCs that visited women in early labour at home, before arranging for them to come to the FSBC. Three areas that illustrate how NQMs' competencies and skills were cultivated, drawing on the Heideggerian notion of '*bringing-forth*', are presented in this section. They are as follows: '*I watched everything the midwife did and learned to think it through*': *Bringing-forth* skills for individualized care of labouring women; Sensing what cannot be seen: *Bringing forth* embodied interactions, and '*Opening up to the deep calm*': *Bringing-forth* attunement.

4.1 | Theme 1: '*I watched everything the midwife did and learned to think it through*': *Bringing-forth* skills for individualized care of labouring women

In most of the FSBCs that participated in the study, NQMs had an orientation period that included 3 days to 3 months of observation at antenatal care appointments and at births. Observing experienced midwives gave NQMs the opportunity to emulate skills and to experience the conduct of their colleagues. Amelia, one of the NQMs

TABLE 1 Newly qualified midwife participants.

Newly qualified midwives	Pseudonym	FSBC with planned home birth	Home visits in early labour	Programme of study in years[a]
1	Toni	No	Yes	3.5
2	Laura	Yes	Yes	3
3	Nina	No	Yes	3
4	Theresa	No	No	3
5	Sally	Yes	Yes	3
6	Tara	No	No	3
7	Felicia	Yes	No	3.5
8	Annabelle	No	No	3.5
9	Nanette	Yes	Yes	3
10	Sheila	Yes	Yes	3
11	Patricia	No	No	3
12	Bianca	Yes	Yes	3
13	Caroline	No	No	3
14	Amelia	Yes	Yes	3.5
15	Dana	No	No	3.5

[a]Bsc = 3.5 years. Non-academic training = 3 years.

who participated in the study, talked about being present at her first home birth with her colleague, Erica. Amelia told this story:

> I was still in my observation period. Erica, who was on-call as the first midwife, called me early in the morning and asked me if I wanted to go to a home birth with her. The woman was having her third baby, so Erica decided to visit her and get a picture of the situation for herself. When we got there, the woman seemed distracted by family and didn't have many contractions. She wanted us to stay, so we set up our things in the kitchen. I sat at the kitchen table with Erica and really just observed what she was doing to get ready, chatted with her, and waited patiently for the woman to ask us to come. It was an incredible bonding experience for me with Erica. She told me so many good stories about previous births at the birth centre. Anyway, hours later, the woman called to us to come upstairs. I wasn't watching the woman; I was watching Erica. I realized that, in this part of my orientation, I'm not there to watch births; I'm there to watch the midwife at birth. It's like—what is the first midwife doing? And what will I be doing when I'm in that situation as first midwife? And what else is happening in the room? (Amelia, NQM)

Amelia, engrossed in observation, experienced this birth as a process of *poiesis*, an unfolding of the labour dynamic that happened on its own, without any interventions. Erica prepared for the birth by setting up her instruments, ready to switch to a technological mode to intervene and accelerate the birth, if necessary, and then relaxed. For Amelia, calm concern, as well as the ability to wait patiently for the labour dynamic to progress on its own, was cultivated and brought forth at this home birth. In technological modes of thinking, usefulness is associated with actions and results, typified in manipulation and domination. At this home birth, being useful meant to sit and wait for the woman's labour dynamic to progress on its own. Amelia learned at this birth to respond to the woman with patience, calm and readiness.

One of the NQMs, Sally, described a situation where she was able to draw on her knowledge and skills from her midwifery studies to facilitate an intervention at a birth in the FSBC. This intervention was an application of midwifery skills akin to *techne*, utilized not to challenge forth and accelerate, but rather to bring forth the physiological progression of labour. Sally explained:

> I was still just mostly observing at births, not really doing much yet besides watching and documenting. I was at a birth which was not really moving along. Even though I was in my observation phase, my colleague, the first midwife, was really bringing me into the conversation. Every examination that she had conducted up until then told us that the baby was slightly dorso-posterior. The baby's head was still above the pelvic brim and not well positioned to progress into the birth canal. We then took a model of a pelvis and a doll and really thought through which positions we could guide the woman to take to encourage the baby to rotate into a better position. I had the theoretical knowledge from academic modules. From my training at the hospital, I had some experience in positioning women during labour to encourage the baby to rotate, but I never learned how to really think it through because the women there were always chained to the fetal heart monitor in bed, had an epidural and couldn't move much. At this birth, I really saw that I could take what I had learned, and, while I was thinking it through with my colleague, I could totally understand it and apply it, especially with the situation at the birth centre, where we listen intermittently to the fetal heatbeats and the woman is not attached to a fetal heart monitor. This woman was mobile, moving around, and open to trying everything. (Sally, NQM)

In the first story, where the labour had progressed on its own, as in *poiesis*, Amelia learned to wait patiently rather than to act or intervene. In Sally's story, caring for the labouring woman meant practicing midwifery as *techne*, understood here as skilled doing. In utilizing *techne*, the midwives believed that the labour was more likely to progress with the gentle actions that they took.

However, there were also moments for the NQMs in their orientation period where they observed that a woman needed her birth to be accelerated, necessitating a more intrusive intervention. Nina, a NQM, had an experience in the early part of her orientation where the midwives she was working with needed to accelerate a birth and did an intervention that she did not think would be necessary at births in a FSBC. She told this story:

> I had been at the birth centre all night with a colleague. We were caring for a labouring woman together. She was the primary midwife. At 8am, the midwife on call for that day came on duty. She was supposed to take over as the primary midwife, but the woman was fully dilated, the head had been at the pelvic floor for a while, and the woman hadn't been able to push the baby out yet. I actually wanted to have a conversation outside the door before the new shift started, but it was a critical point in the birth where we couldn't leave the woman alone. It wouldn't have been ideal for anyone to leave the room. My colleague asked out loud in the room if we should do an episiotomy because the baby was showing signs of stress. They both decided together with the woman that this was the right thing to do. I tried to somehow convey, without saying it directly, that I wasn't comfortable with it. We reflected later together, and I could understand them. They could

> also understand me. They noticed that I didn't think it was a good idea, but it was simply one of those moments where there was no other choice. I was aware of that, and I didn't like it, AND I also saw no other option. I believe that the more familiar I am with things here and with my colleagues, the more I'll see the whole picture. Of course, at the moment, I am more cautious. I'm curious to see how this will continue to evolve. (Nina, NQM)

This situation brought forth for Nina the necessity to shift to a mechanistic way of thinking about the birth of the baby, as the episiotomy was meant to quicken the birth. The observation period for NQMs in the FSBCs gave them the opportunity to get a comprehensive picture of how the experienced midwives worked, which sometimes confronted NQMs' aspirations that all births be free of interventions. Because every labour and birth does not proceed as *poiesis*, the skill-set for midwives in the FSBCs demanded that the NQMs learn when births needed to be accelerated and an intervention was necessary, as well as when attentive patience or gentle interventions were appropriate.

4.2 | Theme 2: Sensing what cannot be seen: *Bringing-forth* embodied interactions

As shown in the stories above, through observing their colleagues, NQMs could bring forth skills to care for labouring women and understand when they could let birth unfold without intervening and when an intervention was necessary. However, according to the focus group and NQM interviews, a skill that could not be learned through observation was embodied interaction and communication.

In the following story, midwives in Team 7's focus group considered how a midwife's ability to make more complex decisions about a woman's labour dynamic and the trajectory of birth could only be brought forth through experience:

> Right now, downstairs, there's a woman in labour. Her cervix is fully dilated, and the foetal head is in a good position, and everything is good—but the head isn't descending into the birth canal. And actually, the woman is in her head too much, intellectualizing everything. She's not in her body. She's using up all her energy trying to "think" her baby out, but you need to be in your body to give birth. The two midwives downstairs—the new midwife is one of them—well, they remind me of me when I started here. They're so motivated and are saying: we can try this, and we can try that. They asked me for advice and I told them: —yeah, I know this situation. At some point—and we all have that feeling as midwives—we are making such a huge effort that we are actually doing the work for the woman. I needed years to understand what it means when I make such a huge effort as the midwife. We have intense coaching sessions as a team so that we can learn to perceive where the woman is at in the moment and where I, as the midwife, am at. Am I only in my intellect? What's going on here right now? We try to get more and more conscious of how we're perceiving and interpreting situations. Maybe the woman isn't doing anything anymore—she's checked out, like the labouring woman downstairs. We need to be able to perceive that. The midwife has to properly be "in" the process with the woman, sensing the birth dynamic, and interpreting what the woman needs. She has to hold the space for the woman, not dominate it. The new midwife can observe another midwife doing this, but she also needs to experience it herself and reflect with one of us after the birth. (Focus Group, FSBC Team 7)

The midwives in this focus group were describing an embodied art of midwifery, referred to here as *techne*, whereby labour progress is supported through gentle interventions. As this story shows, gentle interventions can turn into domination of the woman and the labour dynamic without deeper reflection.

According to the experienced midwife participants in this study, NQMs can observe how experienced midwives enter into embodied dialogues with labouring women; however, without the actual experience of caring for labouring women at the FSBC, they cannot bring forth the necessary skills and develop the knowledge to do this. The wisdom to know when to utilize *techne*, the art of midwifery, to bring forth a change in a woman's labour dynamic required that the midwives have a physical, embodied experience of care.

The next story shows how Theresa, a NQM, stepped into her new role as the second midwife at births. During her studies in her hospital training, she came to realize that she had relied predominantly on her visual acuity to comprehend births and to guide her decision-making. At the FSBC, she was present at births where she had to bring forth other ways of sensing and interpreting the labour dynamic and the progression of labour. The following story from Theresa was told to me with pride:

> My first birth here—it was during the night—I was immediately, without question, the colleague. After I arrived (at the birth centre), I took off my shoes, went into the birthing room, and whispered: "Hi." Suddenly, I was simply sitting with the others in the same boat and was the 'second midwife.' Most of the time at births, I watch the midwife. Simply watching what she's doing. Sometimes, I don't actually "see" anything because it isn't in my line of sight. At my first birth, the three of them—the midwife, woman, and

her partner—were somehow in harmony with each other. So, I sat there with a bit of distance between myself and the others and was only partially "in the bubble" with them. I was doing the documentation and otherwise watching everyone as a whole. I didn't get up and move just to be able to see something better. I wouldn't do that. I don't need to do that. When I noticed that (I couldn't see everything anymore) I thought: Okay, I can't see if the (baby's) head is born yet—I have to hear it. That means that I watched for cues from the midwife and listened for changes in the woman's vocalizations. (Theresa, NQM)

Because Theresa was responsible for documenting the birth, she needed to write down what was transpiring, which she could not always visually perceive. Rather than experience the situation as limiting, she opened herself to a new way of sensing the situation. Being responsible for the documentation, while also being aware that moving around could disturb the others, brought forth a new, embodied skill that included interpreting auditory cues and her colleague's non-verbal cues. These two stories show the aspiration of the FSBC teams to facilitate an embodied knowledge of birth to NQMs.

4.3 | Theme 3: '*Opening up to the deep calm*': *Bringing-forth* attunement in the birthing room

When NQMs were invited to attend their first births at the FSBC, the experienced midwives expected them to be quietly present in the birthing room with the labouring woman, her partner and the primary, experienced midwife. Most of the NQMs expressed that they were often tasked with simply being there in the room and documenting the labour and birth as a story, which included the documentation of examinations (i.e. foetal heart rate and vaginal examinations), conversations between the labouring woman, her partner and the midwife, as well as the labouring woman's location, position and disposition. During long labours, the experienced midwives voiced in their interviews that it was difficult for the NQMs to remain present and attentive in the room. They explained that the NQMs went in and out of the room from time to time, often remarking that they were bored because nothing was happening. Team 1 told the story of a NQM who had difficulty remaining in the birthing room.

> There was a new midwife I was working with who was constantly leaving the birthing room and coming back in after spending time outside the room. At some point, I followed her out of the room and told her that she was disturbing the sacredness of the birthing room. There is a presence in the room that we can sense, and it is a protected space. And that, when the door opens and closes--when she is doing this-- the mood is disturbed and so am I. Midwifery students and even new midwives look so bored when their only task is to observe. And we can really tell if they are understanding what is happening in the room. Because, when there is very little midwife activity at a birth in terms of vaginal exams, and the fetal heartbeats are not continuously monitored (through a fetal heart monitor), then she has an opportunity to begin to understand and open up to the deep calm that is in the room and experience our affirming care of the woman. We absolutely notice if someone is receptive to that and is understanding what is happening in the room because, those who aren't getting it, are like a limp dishrag in the corner. (Focus group, FSBC Team 1)

According to the experienced midwives, the NQMs were sometimes not able to attune to the labouring woman and what the midwives referred to as the sacredness in the room. The NQMs were expected to orient themselves towards their colleague and the family and refrain from actions that disturbed the others. Coming and going repeatedly revealed to the experienced midwives that the NQM was not attuned to the mood in the birthing room.

In contrast to Team 1's story, the following story from Amelia shows her attunement to the birthing room before she entered. She said:

> Last week I was called to a birth in the birth centre. I rode my bicycle as quickly as I could to get there and arrived sweaty and out of breath. I changed my clothes and stood for a moment in front of the door until I was calmer. I then knocked ever so quietly, waited a moment, and slowly pushed down the door handle. I inched the door open and tiptoed into the room, careful not to make a noise. I found a small stool and sat down a ways away from the midwife, who handed me the documentation. I sat down, observed everything that was happening, and documented. I sat in the corner, in the 'second midwife' corner, where I could just silently watch and write. I felt so connected to everyone during that birth. (Amelia, NQM)

Amelia found that she needed a moment to switch from the exhilaration and anticipation that she felt on her way to the FSBC to the calm state she was expected to attune to in the room. Once in the room, she was able to bridge the physical distance between herself, the labouring woman and her colleague to develop a sense of connection through this attunement.

The NQM Caroline also told a story of entering the birthing room with care and respect:

> The midwife that I was observing told me that I shouldn't come into the room until she came to get me. She told me to be silent in the room and to take care of the documentation. After she called me in, I went to the room and opened the door. Right at

> that moment, the woman got a contraction. I quietly closed the door and squatted down at the entrance to the room. I made myself as small as possible, practically hiding in the darkness that engulfed the space just inside the room at the doorway. The only light in the room was coming from candles that were burning near the woman. When the contraction was over, I quietly tiptoed over to a stool that the midwife had placed for me. Then, I sat down. (Caroline, NQM)

Caroline's response to the mood when she entered the room was an act of caring and was a stark contrast to the midwives in Team 1's story, who were like '*limp dishrags in the corner*'. Attunement was an integral aspect of observation and documentation in the early weeks of the NQMs' orientation.

5 | DISCUSSION

This study focused on skill and knowledge acquisition of NQMs in FSBCs, settings where midwives autonomously care for women at low-risk for complications during pregnancy, labour and birth, and postpartum. In their clinical placements, the NQMs had been taught to utilize invasive interventions to accelerate women's labour dynamic without a medical indication (Jordan & Farley, 2008), situations which can be described as intervening with 'too much, too soon' (Miller et al., 2016). As such, they had not learned to assess the individual variations in women's labour dynamic (Stone, 2012). In their first 4–6 weeks in the FSBCs, the NQMs were revealed to have learned to recognize birth in terms of *poiesis*, whereby birth progressed on its own, as well as when *techne* or 'gentle' interventions were needed. *Techne* refers to the midwifery practices or techniques that the NQMs observed in the first weeks of their orientation period and later carried out independently. Guiding the woman to move and try different positions to have an effect on the position of the foetal head, listening to foetal heartbeats intermittently instead of employing continuous foetal heart monitoring, helping women cope with pain, entering the room quietly and being mindful not to disturb the mood at birth were a few of these techniques (Crowther et al., 2014; Skeide, 2019; Stone, 2012). These skills are at the core of midwifery care in FSBCs and at home births (O'Boyle, 2014; Stone, 2012).

Because the NQMs had not developed knowledge of low intervention care at births, observation served as a key method to orient NQMs in the FSBCs, as is customary with students of midwifery, nursing, medicine and education during their clinical practice, as well as during their transition in their new work setting after certification (Begley, 2001; Kolb, 2015; Takase et al., 2015; Watling et al., 2012). Through observation, the NQMs learned to model their care on that of their colleagues, as well as to experience how midwives assess labour progress in the FSBC and at home births. This skill has been called by Rooney and Boud (2019, p. 443) 'reading the complexities of the practice domain'. Given that labour and childbirth are emotionally charged events in all settings, NQMs encountered a form of vicarious engagement simply by being present in the birthing room, particularly as their attention was directed towards the primary midwife (Bandura, 1978). The NQMs all recounted focussing on how the midwives prepared for and attended labouring women, and in particular how they negotiated difficult situations, such as a transfer to a hospital. As the NQMs became familiarized with the FSBC approach to care, reflection with experienced midwives helped them solidify their newly won skill to recognize physiology, pathology, and the correct moment for gentle, invasive or urgent interventions (Miller et al., 2016). The medical model of birth that they had observed and carried out in their clinical practice was not forgotten, but rather served as an underlying framework for the NQMs, providing them with the skills and knowledge to intervene when this was required (Stone et al., 2023).

Through observation, the NQMs began to grasp the nuanced communication between the primary midwife, the labouring woman and her birth companion, and began to develop a cognitive understanding of the situatedness of labour and birth in the new birth environments (Hammond et al., 2013). The spatial arrangement of those in the room and the ensuing interactions were understood and integrated into the care they gave as their orientation progressed. This went beyond just acquiring skills and knowledge for clinical assessment appropriate to the setting; it also encompassed achieving a deeper understanding of the social dynamics at birth, which facilitated their integration into the FSBC culture, as well (Lave & Wenger, 1991).

During observation periods, most of the NQMs were given the task to document the labour and birth in a detailed, story-like manner. This is a novel finding and will be discussed in-depth in a future publication. Documentation fostered their observation of the labouring woman, her partner and the primary midwife, bringing forth the ability to 'see birth in a new light' (Coddington et al., 2020, p. 3). The NQMs' attention was drawn to typical, everyday situations during labour and birth, whereby they immersed themselves in their colleagues' discourse, reasoning and reflections, adding this into the documentation, along with their standard observations and results of examinations. Documentation as a learning tool also compelled the NQMs to listen more attentively to the labouring women's vocalizations, expanding their sensory knowledge of labour and birth and their ability to interpret non-verbal cues from labouring women and their colleagues. This type of documentation facilitated what Davis-Floyd (2003, p. 1927) has described as a 'smooth articulation between knowledge systems'. The 'medical' story of birth was thus embedded in the complete birth story, but did not dominate it.

Further, when the experienced midwives included the NQMs in decision-making during a woman's labour, this exposed them to situations where they were able to bring forth knowledge of anatomy and physiology from their theoretical education, a positive finding in studies of NQMs in hospital settings, as well (Skirton et al., 2012; van der Putten, 2008). These discussions promoted experiential learning (Kolb, 2015), encouraging new ways to think about anatomy and physiology, such as the positive effects of movement on the labour dynamic (Davis-Floyd, 2018; Igarashi et al., 2014). The NQM was invited to think through situations

from an anatomical perspective and motivate women, for example to try different positions that were intended to re-direct the labour towards continued physiological progression (Jordan & Davis-Floyd, 1993). Knowledge and *techne* blended, helping the NQMs to work with and be a part of the bigger picture as a foundation for embodied knowledge.

In developing enhanced knowledge of applied anatomy and physiology in their orientation period, the midwives learned that there were limitations to the success of *techne* to support women who needed gentle interventions for labour to progress. The women registered to give birth at the FSBC or at home were not all expected to give birth according to *poiesis*, which was akin to natural birth. Therefore, attentive care, which included remaining in the room, was crucial, in order to perceive when the labouring woman, her labour dynamic and/or the foetus were diverging from physiology towards pathology. In these cases, they needed to recognize when a more invasive intervention or the use of technology was needed to accelerate the birth. This included learning when their scope of practice at the FSBC had reached its limit, and the woman needed to be transported to a hospital to complete her birth, an issue investigated in several previous studies (Meyer et al., 2017; O'Boyle, 2014; Stone, 2012).

Several reasons that NQMs in this study mentioned for the necessity to improve their skills in interpreting variations in physiological labour were the tolerance of pathology in their clinical practice in hospital labour wards due to the proximity of an operating theatre, as well as the routine use of interventions. This desensitized them to the uncertain or grey area between physiology and pathology (Skinner & Maude, 2016), preventing them from discerning the healthy variations in physiological labour and birth (Downe & McCourt, 2019).

Hospital labour wards have often been referred to as bustling, with midwives moving between rooms to care for more than one woman at a time (Kool et al., 2020; O'Connell & Downe, 2009). Working in the FSBC, where 1:1 care was offered, meant that the midwives had no additional tasks to tend to when they were caring for a labouring woman. In the mundane act of entering the birthing room attuned to the mood, the NQMs began to learn the importance of holding the space for labouring women (Hammond et al., 2013). Remaining there attentively helped the NQMs 'bear the stillness of hidden growth' (Heidegger, 1977, p. 84), an antidote to the dominant paradigm of acceleration in technological modes of thinking.

6 | CONCLUSION

In their orientation period in FSBCs, NQMs learned an approach to care that privileged the individual labour dynamic of each woman. In this approach, the woman's labour dynamic was understood through the lens of *poiesis* and *techne*, permitting the midwives to refrain from interventions that would accelerate the labour and dominate the labour dynamic, unless the situation necessitated a medical intervention. These skills were brought forth through observation, documentation, attuning to the mood in the birthing room and reflection on births with experienced midwives. These new skills were integrated into the theoretical and practical knowledge that they had acquired in their studies and was not, as such, a rejection of what they had previously learned, but an enrichment. Commencing work in a FSBC with a well-structured orientation period makes it possible for NQMs to have a positive transition in their first year.

6.1 | Implications

This study showed the positive role that an orientation and familiarization period with an experienced team of midwives can play in the skill development of novice practitioners in FSBCs. Further, in the past, approaches and models to care for labouring women have indicated a dichotomy between a medicalized model of care that is assumed to be typical in hospital labour wards, and a midwifery model of care that is assumed typical in FSBCs and at home births. The orientation period of these NQMs in FSBCs showed that they became familiarized with a model of care in the FSBCs that drew on medical knowledge and blended this with midwifery skills and knowledge, including the ability to transition to active management of labour when the circumstances warranted an intervention.

It is basic to birth assistance both in FSBCs and at home births that midwives refrain from intervening in labour without a medical indication, an approach which necessitates 1:1 care and continuous support in the birthing room. To effectively care for women labouring in hospital labour wards who request to labour without unnecessary interventions, it is imperative that the entire team comprised of midwives and obstetricians undergo comprehensive training. Giving birth without interventions is not analogous to letting nature run its course, which this study has shown. The care-delivery structure in most hospital labour wards demands that midwives care for several women concurrently throughout labour and birth, making skilled, watchful attendance of labouring women unachievable. Furthermore, there is a need for obstetricians, who often oversee hospital labour wards, to develop skills and knowledge that prioritize individualized and attentive care, shifting away from an approach that emphasizes active management. The needs of women must take precedence over institutional demands.

An interdisciplinary approach must begin with educating medical students and student midwives about the benefits of continuous labour support for women with high- and low-risk pregnancies and include clinical practice that encompasses being present in the birthing room throughout labour. It is essential to gain first-hand experience of the emotional and physical processes of labour and birth to offer quality care. However, requiring participation at births in FSBCs and at home births during midwifery and medical education is problematic in many countries due to the small number of births taking place in these settings. Nevertheless, placing a stronger focus on enabling and accompanying physiological processes in the curriculum is an urgent concern. In this way, both obstetricians and midwives can develop skills for low intervention care at labour and birth. Cultivating a skill-set appropriate to the requests of labouring woman, not to the needs of the institution, should guide care in every setting.

6.2 | Strengths and limitations

A limitation of the study is that it is likely not transferable to countries that have a different system of midwifery education since the focus in this study was on NQMs educated in Germany. Additionally, the FSBCs that participated in the study were self-selecting and do not represent all of the FSBCs in Germany, where other approaches to orient NQMs to FSBC care may be carried out. Further, in other qualitative methodologies, the justification for the sample size is to reach data or theoretical saturation (Charmaz, 2021). However, data saturation is not an objective in hermeneutic phenomenology studies (Van Manen, 2014). The goal of hermeneutic phenomenology is to achieve interpretations that are '*comprehensive*, *explicit and visible*' (Crowther et al., 2014, p. 22).

A strength of this study was the inclusion of NQMs and experienced midwives from FSBCs throughout Germany. This meant that the sample size was relatively large. While hermeneutic phenomenology studies often have small sample sizes, in this study, a large amount of data were collected. The authors consider this a strength since this is an understudied area. A further strength of the study was the commitment of the research team to refrain from polarizing discourses during data analysis. Through this attitude, the NQM's learning process and outcomes could be revealed without discrediting the medical foundation that they had acquired in their education and their ability to carry out interventions when necessary.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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