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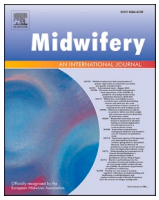

Tailoring midwifery care to women's needs in early labour: The cultivation of relational care in free-standing birth centres

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ABSTRACT

Aim: To understand and interpret the lived experience of newly qualified midwives in their first year in a free standing birth centre caring for women in early labour.
Background: Women who present in hospital labour wards in early labour are encouraged by hospital staff to go home. This leaves women to navigate early labour without professional care, leaving them on their own to manage the transition from early to active labour. However, some women request care for this transition.
Design: This is a Heideggerian hermeneutic phenomenology study.
Methods: Three unstructured interviews were conducted with 15 newly qualified midwives in their first year working in a free-standing birth centre. This paper focuses on the research participants' lived experience offering care to women in early labour. The study was conducted from 2021-2024.
Findings: Three themes were revealed in analysis: "*Paving the way into labour*": Tailoring care to women's needs in early labour; "*Perhaps it was intuition.*": Experiencing deeper knowing as a newly qualified midwife; and "*She locked the door and wouldn't let me in.*": Navigating uncomfortable situations in early labour.
Conclusions: The lived experience of newly qualified midwives offering care in early labour shows potential for midwives to build trusting relationships with women in this phase.
Relevance to clinical practice: Prioritizing relational care over interventions in early labor can enhance trust and confidence between midwives and birthing women, particularly in settings where policies discourage early admissions.
Issue: Women presenting in hospital labour wards in early labour who are sent home are often discouraged, feeling that their concerns and embodied experiences have not been heard.
What is already known: When labouring women are admitted to hospitals in early labour, they are prone to receive a cascade of interventions.
What this paper adds: When newly qualified midwives began working in free-standing birth centres, they acquired skills and knowledge to accompany women in early labour who requested care. Relational care in early labour builds women's trust in their ability to give birth and does not rely on interventions to augment labour.

Introduction

For women in early labour, being at home with painful contractions can be upsetting, eliciting fear and worry (Eri et al., 2015). Coping with the uncertainty of labour progress and finding the appropriate moment to leave for the hospital is stress inducing. For women who present at the hospital hoping to be admitted, hearing from hospital staff that they will be sent home because they are not in established labour can leave them feeling abandoned, especially if they do not feel that their subjective experience has been acknowledged (Beake et al., 2018). An additional issue for women presenting in early labour is that definitions of labour onset vary and are subsequently often not communicated well (Beake et al., 2018; Gross et al., 2009). In Germany, the S3 Guideline for vaginal birth at term defines early labour as the time from onset of labour up to 4-6 cm cervical dilation (Abou-Dakn et al., 2022). One study conducted in 45 labour wards in Lower Saxony, Germany determined that women identified their labour onset earlier than midwives' diagnosis of their labour onset (Gross et al., 2009). This can be the case when women's

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embodied experience of childbirth diverges from clinical definitions (Stone et al., 2022). Midwives generally conduct a vaginal examination to check cervical dilation, cervical effacement, and cervical consistency as indicators to assess the stage of labour a woman is in, while women identify labour onset with the start of contractions, leaking membranes, and irregular pain (Cheyne et al., 2006; David et al., 2006; Eri et al., 2011; Gross et al., 2009). When institutional demands allow, spending time talking with women who present in a labour ward in early labour is one approach that midwives use to evaluate how women are feeling, in addition to conducting a vaginal examination, palpating the uterus during a contraction, and checking for bloody show (Cheyne et al., 2006; Shallow et al., 2018).

However, in busy labour wards, multiple factors influence midwives' decisions to admit a woman in early labour beyond these assessments, including the imperative to keep the workload manageable and hospital or national policies that suggest that women should stay home as long as possible (Eri et al., 2011; Shallow et al., 2018). When medical and policy definitions that demarcate the beginning of labour are privileged over women's lived experience and needs, women are left on their own to manage the transition from early to active labour (Beake et al., 2018; Gehling et al., 2023; Shallow et al., 2018). Studies of women's embodied experience of early labour show that they desire care in early labour and can benefit from this (Nyman et al., 2011), especially primiparas (Gehling et al., 2023).

The imperative to send women in early labour home may result in midwives, and in particular midwifery students, lacking the requisite experience to provide care in this phase. This could leave newly qualified midwives challenged to offer individualised care for women who could benefit from care in early labour. In addition to this, in most midwifery education programs, the actual delivery of the newborn is the primary focus (Vermeulen et al., 2018). Midwifery students' have called this process of collecting births "catches," and find "catching" the baby less beneficial for their professional development than gaining experience caring for women during labour (Licqurish, 2013; Schytt & Waldenstrom, 2013). One Swedish study showed that midwives in their first year post-qualification believed that they would have been better prepared for practice if they had gathered more clinical experience in caring for women during labour (Schytt & Waldenstrom, 2013). Currently, there is no research addressing the skills and knowledge required by midwives to care for women in early labour that do not involve sending women home or employing interventions associated with active management of labour such as artificial rupture of the membranes or the use of a synthetic oxytocin drip (O'Driscoll & Meagher, 1980), interventions that have been shown to be administered too early and without a medical diagnosis (Selin et al., 2009; Wei et al., 2013). The aim of this paper is to understand and interpret the lived experience of newly qualified midwives (NQMs) in their first year in a free standing birth centre (FSBC) caring for women in early labour.

Methodology and methods

Design

The data presented in this paper were collected as part of a Heideggerian hermeneutic phenomenology study entitled: *ASK a Midwife*, which was conducted over 36 months between 2021-2024 and funded by the German Federal Ministry of Research and Education. The aims of this study were to understand and interpret the lived experience of NQMs commencing work in FSBCs, as well as the lived experience of experienced midwives in FSBCs in Germany who train and support NQMs. The following research question was the focus of the overarching study: What is the lived experience of NQMs when they begin to work in a FSBC? For this article, the interviews with the NQMs were analysed and reflected upon using Van Manen's lifeworld existentials (1990/2016) with a specific focus on their lived experience of offering care to women during early labour, an aspect of care that they did not experience in their clinical training. None of the fifteen NQMs had experience caring for women in early labour in their clinical placements during their midwifery studies.

Recruitment and participants

Fifteen NQMs participated in the study and were each interviewed three times. The inclusion criteria were a) they had completed their midwifery training in Germany and were certified to practice midwifery in Germany; b) they were commencing their first job as a midwife since certification; and c) were in their first six weeks at the FSBC. After receiving ethics approval, FSBCs in Germany were contacted with the help of several cooperating partners in the study, including the Network of Birth Centres and the Association for Quality at Out-of-Hospital Birth. Additionally, information was sent by post to each FSBC that could be found through an internet search. The FSBCs and the NQMs were all self-selecting. Because anonymity was assured for the NQMs and FSBCs that participated in the study, detailed demographic information that could lead to identification of any of the midwives or FSBCs who participated in the study has not been provided. The following table provides information about the research participants (See Table 1).

Research sites

The research sites were FSBCs in Germany, which are all privately owned institutions. In 2021, when the study began, there were 107 FSBCs in Germany. The statutory health insurance companies cover all costs for women who receive antenatal and intrapartum care in a FSBC or with these midwives at a home birth. The statutory health insurance companies also reimburse the FSBCs for operating costs for each client who is cared for during labour and birth, as well as women who are transferred to hospital due to e.g., a request for epidural anesthesia, stalled labour, or an emergency. The FSBCs design their own internal structures, including how they orient and familiarize NQMs with the work at the FSBC. Eight of the NQMs who participated in the study worked in FSBCs that also offered home birth services (See Table 1). The FSBCs throughout Germany are located in large cities, as well as in small towns. Every woman labouring with FSBC midwives receives 1:1 care, and at birth 2:1 care. All the FSBC teams in the study had on-call schedules in which a 'first' or 'primary' midwife provided care during labour, who then called a 'second' or 'background' midwife to attend the birth with her. None of the NQMs interviewed in this study worked shifts with other NQMs in their first year at their FSBC.

Table 1
Newly qualified midwife-participants

Newly qualified midwives	Where does the FSBC offer care in early labour?	Does the FSBC offer planned home birth?	Did the NQM have an observational internship in a FSBC or at home births before certification?
1.	Home and FSBC	no	no
2.	Home and FSBC	yes	no
3.	FSBC	no	FSBC
4.	Home and FSBC	no	FSBC and Home birth
5.	Home and FSBC	yes	FSBC
6.	FSBC	no	FSBC
7.	FSBC	yes	FSBC
8.	FSBC	no	no
9.	Home and FSBC	yes	FSBC
10.	Home and FSBC	yes	FSBC
11.	Home and FSBC	no	FSBC
12.	Home and FSBC	yes	FSBC
13.	Home and FSBC	no	Home birth
14.	Home and FSBC	yes	FSBC
15.	Home and FSBC	no	Home birth

Data collection

Data collection methods used with the NQMs included unstructured interviews, instant 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 unstructured interviews with the NQMs. The first interview was held in the first six weeks of their orientation period, which generally involved observation of antenatal and intrapartum care, and, for some, the transition to autonomous antenatal care. The second interview took place when the NQMs had transitioned to offering intrapartum care either together with an experienced team midwife or unaccompanied. At the third interview, all the NQMs were offering autonomous antenatal and intrapartum care. Interviews were guided by Smythe's description of the 'research conversation,' whereby the interviewer asks questions that keep the research participants as close to their lived experience as possible. Smythe wrote: "*To stay close to experience itself is to recount the story itself. Questions therefore need to prompt such telling: "Tell me what happened?', 'And then what happened?', How did you feel?*"" (2011, p. 42). This means that the NQMs were not directly asked about their experiences with women in early labour, and yet, each NQM spoke about these experiences in their interviews. When being told these experiences, NIS followed this up with prompts suggested by Smythe (ibid). The interviews were recorded on a digital recording device and uploaded to MaxQDA. All interviews were conducted in German and transcribed manually by either NIS or a student assistant.

Data analysis

Data analysis was inductive and began with listening to the interviews and then doing reflexive writing after each listening session (Van Manen, 2014). While listening, it was possible to engage with the NQMs' expressive telling of their experiences, a facet of data analysis that often gets lost when reading transcripts (ibid). The interviews were then analysed using the approach outlined by Dibley et al. (2020) and Van Manen (1990/2016). In order to ascertain themes, Van Manen suggests holistic reading, followed by selective reading, whereby distinctive stories come to the surface (ibid, p. 94). In addition to this, the NQM's lived experience was analysed using Van Manen's notion of lifeworld existentials (1990/2016). The themes were discussed with several NQMs and with the second author. During this phase of data analysis, the NQMs' stories about early labour gained prominence because they described their efforts to integrate women's embodied experiences into the diagnostic procedures that they had learned in their clinical practice.

Reflexivity

A pre-understandings interview was conducted with the lead author by the second author before the study began. The aim of a pre-understandings interview in a Heideggerian hermeneutic phenomenology study is to facilitate reflexivity. Through questioning, the lead researcher's personal biases and presuppositions on the study's subject matter at the beginning of the study were revealed (Barrett-Rodger, 2022; Laverty, 2003) and were reflected on throughout the research process (Laverty, 2003; Smythe, 2011). The first author also kept a reflexive journal.

To enhance confirmability, all authors disclose their positionality as follows:

The first author is a registered midwife in Germany. After working nine years in a hospital labour ward, she worked nine years in a FSBC, after which she worked in a midwife-led team in a hospital. She believes that midwives need a skill-set specific to the setting they are working in. She believes that women should have choices when deciding where to give birth, and that, with skilled professionals, home birth and birth in FSBCs is safe. The second author has a psychology academic background and has been undertaking maternity-related research for over 20 years, with a particular interest in parental mental health. Her beliefs are that sensitive support during early labour can help women to develop a trusting relationship with her midwife and to cope with their physiological responses for a positive childbirth experience. The third author is a registered midwife and adult educator. She is head of a university midwifery study program (B. Sc.). Her aim is to find out more about the acquisition of knowledge and skills by midwives in order to implement suitable learning opportunities in the degree program.

Rigour

The quality of qualitative research can be increased by achieving rigour through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was achieved through prolonged engagement with the NQMs throughout their first 9-12 months in their FSBC (Morse, 2015). During each visit, there was adequate time reserved for talking about the previous interviews and discussing the interpretations of these by the research team (member checking). Transferability has been attained in this article through providing longer excerpts of the interviews. Their stories provide thick descriptions of their experiences with women in early labour so that the reader can determine if the results can be transferred to their context (Freeman, 2014). Dependability was demonstrated through triangulation, in that each NQM was interviewed three times, in addition to leaving voice messages. The first author kept an audit trail in the form of a reflexive journal, writing entries during the data collection and analysis processes, an aspect of dependability and confirmability (ibid).

Ethical approval

Ethics approval for this study was obtained the Ethics Commission at the Protestant University of Applied Sciences Berlin. The FSBCs and NQMs interested in participating in the study were visited in-person and received verbal and written information prior to enrolling in the study. All study participants gave written informed consent.

Findings

The stories that NQMs told about caring for women in early labour revealed three themes. "*Paving the way into labour*": Tailoring care to women's needs in early labour; "*Perhaps it was intuition.*": Experiencing deeper knowing as a newly qualified midwife; and "*She locked the door and wouldn't let me in.*": Navigating uncomfortable situations in early labour.

1) "*Paving the way into labour*": Tailoring care to women's needs in early labour

In their orientation period, which was between 3-12 months, most of the NQMs observed their colleagues before they progressed to taking on a more active role in the care of labouring women. During this period, the NQMs' experienced colleagues were fielding phone calls from women who wanted contact with a midwife and then calling the NQMs to accompany them to home visits or meetings at the FSBC, depending on what actions had been agreed with the women.

While all the FSBCs that participated in this study had a quality management system with protocols for e.g., premature rupture of the membranes, post term pregnancy, and transfer during labour, deciding when a woman should be admitted to the FSBC was the decision of the midwife who was on-call. The NQMs, none of whom had experience caring for women in early labour before starting at the FSBC, sought balance in these situations and described the need to learn to be present without dominating the situation. NQM 10, interrupted her story about a woman who had given birth quickly to point out the following:

My issue is not with the women who give birth quickly, but with the women who call when they aren't in the active phase of labour—women who are in the latent phase of labour. My question is: How can I give them ideal care so that they feel I am meeting them where they're at—but am not too present, not taking over—as if I would sort of pave the way for them to really go into labour? NQM 10, third interview

For the NQMs, discovering a preference for when and where to meet with women was essential when they took on shifts as primary midwife, and was a cause of consternation. NQM 14 talked about how it was difficult for her to evaluate a woman's stage of labour from a phone conversation, especially those in early labour. Her approach was to let the women decide if they want a home visit or if they want to get checked at the FSBC. She said:

If clients want to come to the birth centre, I don't try to talk them out of it, I let them come. This means that a lot of the women I meet at the birth centre are in early labour, like their cervix is only dilated 2-3 cm. I find it difficult to gauge what direction the labour is going in from just a short time together at a home visit or a short conversation on the phone, and I don't want to make the decision for the women, even if they are obviously in early labour. NQM 14, third interview

For the NQMs, acquiring an understanding of the unique progression of a woman's labour was deemed essential, as they had previously only developed skills to assess labour using cervical dilation and contractions. They had not yet learned to integrate these assessments with women's embodied experience. This explains why NQM 14 put her focus on the lived experience of women in her care in early labour, particularly their ability to cope with pain, which was key for her to make decisions about further care. She needed time for this, so she did not put a time limit on her meetings with women in early labour. She felt that one of her aims was to help women in early labour cultivate patience. NQM 4 spoke about creating a space for women that engenders trust:

For me, it's really important that the women have the feeling that they are being well cared for, and if that means that I stay longer than 30 minutes at a home visit with a woman in early labour, then I'll do that. I saw in my orientation here that, if the women are given a safe space, especially at the beginning of labour, then they'll be able to let go and trust better—and they'll feel that we take them seriously. We get used to each other and gain each other's trust this way. NQM 4, second interview

NQM 4 stated that she stayed longer than 30 minutes at home visits. In general, the NQMs described needing more time than the experienced midwives to interpret the labour dynamic of a woman in early labour because this was new. They had not acquired experience during their clinical placements to assess women in early labour. NQM 1 described a home visit where she had an opportunity to care for a woman at the very beginning of her labour, describing how their relationship was built through care.

There was a primipara whom I cared for starting from the latent phase—if I can call it that—well, from the beginning of when her contractions came and throughout cervical dilation—I was with her the whole time. She gave me permission to do a vaginal exam. The cervix was 1cm dilated, and the fetal heartbeats were good. I decided to stay with her a bit and see if there was anything I could do for her, since her husband had retreated to the kitchen. He wasn't ready for her to be in labour. I had a chance to find out what kind of care she liked. It was good to do this in the early dilation phase, so I could learn from her how much physical interaction she wanted. NQM 1, third interview

Early labour was seen by these NQMs as a chance to create a safe space for women in early labour and to have a positive effect on their transition to the next phase of labour. They also used these meetings to build a bridge between themselves and the women, fostering trust between them and facilitating the women to trust themselves and the process of giving birth.

2) "*Perhaps it was intuition*.": Experiencing deeper knowing as a newly qualified midwife

The observation period at births introduced the NQMs to the tools that their experienced colleagues used to assess women in all stages of labour. Especially with women in early labour, this included chatting with the women, palpating their abdomen using the Leopold manoeuvres, listening to fetal heartbeats, and paying attention to the rhythm of the contractions, as well as the woman's physical gestures and vocalizations during the contractions. The NQMs had positive experiences utilizing these tools, some of which, especially abdominal palpation, allowed the NQMs to make a connection between themselves, the unborn baby, and the woman. NQM 11 said:

When I make home visits, I palpate the woman's abdomen and wait until I feel the baby move. That gives me and the woman a good feeling for the baby. I also listen to fetal heartbeats and to the woman's pulse. If all of those things are normal, and the woman is feeling good, then it's a good way for me to confirm that mom and baby are doing well. I don't just rely on fetal heartbeats and a vaginal exam. NQM 11, second interview

None of the NQMs had a protocol to follow regarding when to conduct vaginal examinations. They had all learned in their midwifery education that results of vaginal examinations were the gold standard for making decisions. In their interviews, NQMs spoke about learning during orientation to explain to the women why they wanted to conduct a vaginal examination and wait for her consent. They also learned to downplay the results of these examinations, while integrating their intuitive feelings into the subjective experience of the labouring woman. NQM 10 said:

Of course, I learned in my practical training to make decisions based on the results of vaginal exams. Here (at the birth centre), I add my gut feeling into the mix when I'm making a decision—perhaps you could call it intuition. There are births that simply have a slow start, and everything is okay. The woman is feeling great, and she is full of energy, but it takes time for her to reach active labour. NQM 10, second interview

NQM 7 also talked about an experience where she let her intuition guide her. She explained:

I went to the birth centre to meet with a woman who said that she had some contractions. She was actually the client of a colleague (who was busy at a home birth), so I was meeting with her for the first time. I chatted with her a bit to get to know her before I started my assessment, which included listening to fetal heartbeats and doing a vaginal exam. She could easily converse with me, and she was really feeling positive about the birth. I did a vaginal exam after getting consent, but only to get a feeling for where we were starting. Her cervix was dilated 3 cm, the consistency was firm, it was still very sacral, and the head was still above the pelvic inlet. Well, one could easily say that she was in early labour, but I was certain that she wasn't. My feeling—I would call it intuition—was that she would give birth quickly. Three hours later her membranes ruptured, forty-five minutes after that, she gave birth. NQM 7, third interview

The midwives spoke about having intuitive leanings mostly in situations where their use of measurable diagnostic criteria was counter to a deep inner knowing that emerged in relationship with the woman.

3) *"She locked the door and wouldn't let me in."*: Navigating uncomfortable situations in early labour

In this theme, the difficulties are described that NQMs had when they were with women in early labour and did not feel confident. These were situations that demanded a level of expertise that they had not yet reached. In the following story from NQM 9, she was thrown into a situation that was distressing for her and for the woman she was caring for. NQM 9, who was in the first 6 weeks at her FSBC, told this story:

My very first client was a woman in her 20s who called me when her membranes ruptured. She asked if she should come to the birth centre. I asked my mentor, who told me it would be better to visit her at home because she didn't have contractions yet. When I arrived, I monitored the fetal heartbeats (with a portable CTG) first. After that, I did a vaginal exam. The cervix was 1-2 cm and rigid. I asked if she wanted to go into the bathtub—she said yes, and then I suggested she go to the toilet first, since she hadn't gone for hours. While she was on the toilet, her contractions suddenly got so strong that she totally checked out, started to scream, cry, and hyperventilate. She had locked the door and wouldn't let me in. …she finally came out of the bathroom. She was in a lot of pain and wasn't managing well. I told her that she should think about going to the hospital for the birth to get an epidural. She agreed to this. NQM 9, first interview

When telling the story, NQM 9 mentioned the lack of trust that she and the woman had for each other, coupled with her own discomfort in being in a home where she did not feel welcome. Her client was in the home of her boyfriend's parents, who were watching television in a neighbouring room. The NQM did not see any other solution in the moment besides encouraging the woman to continue her labour at the hospital. As such, she felt that she had not included the woman in the decision-making process to go to the hospital.

In the next story, NQM 4 made a home visit on her own since the other colleagues on call were at a birth. She had not slept much in the previous two days, which she said contributed to her miscalculation of a vaginal exam.

(I visited a) woman, a primipara, (who) was in the bathtub when I arrived. Her mother and her partner were there with her. She had regular contractions and was focused on her breathing during each one. She seemed to me to be in labour from the way she was breathing and moving. I checked the fetal heartbeats with the fetal doppler and did a vaginal exam. I thought I was good at checking cervical dilation, but I must have gotten it wrong. I told her that I thought she was 4 cm dilated. A few hours later, she came to the birth centre, and, soon after, her membranes ruptured. I did another vaginal exam and again, wasn't certain at all. I asked my colleague to check and I was shocked when said that her cervix was only dilated 1 cm. I had told her at home that it was 4—now we had to tell her it was only 1 cm. I felt so bad. NQM 4, second interview

Facing uncertainty as an NQM can be unsettling. In this situation, the labouring woman made an impression on the NQM as if she would be further along in labour. The NQM misinterpreted the woman's labour dynamic, believing that she would eventually reach 4 cm, even if that was not the case at the moment. Having difficulty correctly assessing cervical dilation was addressed by most of the NQMs in their interviews. If they were uncertain, they could ask an experienced colleague for help—an option available to all NQMs, even at night, as each FSBC always had 2-3 midwives on call 24 hours a day.

Despite the availability of an experienced on-call colleague, there were situations where NQMs felt unable to reconcile their aim of allowing women to labour undisturbed and knowing when to call their second midwife to the birth. This was NQM 14's experience:

During one of my shifts, there was a woman who I was going to have to transfer to the hospital after having ruptured membranes for over 36 hours if she didn't go into labour. I thought it could be good if she spent the night at the birth centre, that maybe she would go into labour. In the early morning hours, from one moment to the next, she got strong contractions and felt a bearing down, saying that she felt rushes, real hormone rushes. I thought that she was going to give birth really quickly and didn't want to bother her with a vaginal exam. I decided to call my second midwife to come to the birth. By the time she arrived, the woman had barely any contractions. I checked her at that point because I was going to have to transfer her to the hospital. She was 2-3 cm dilated. My colleague was less than enthusiastic. NQM 14, third interview

NQM 14 offered her client a space to enter into labour, which seemed to her to have a positive effect. However, in choosing not to bother the woman with a vaginal exam, she created an uncomfortable situation with her colleague. While the NQMs in these final stories felt that they were making decisions with and for women, they, and arguably the women, felt unsatisfied with the consequences.

Discussion

Care provided by midwives in early labour is understudied, since most care in this phase is provided by friends and family (Janssen & Desmarais, 2013). While there is evidence showing how midwives in hospitals diagnose early labour, there is a dearth of evidence on descriptions of care in this phase (Allen et al., 2020). The NQMs in this study offered thick descriptions of their work processes within the FSBCs and women's homes, which were subsequently contextualized in this article through providing expressive and illustrative quotes (Younas et al., 2023). The findings in this study are novel and show the NQMs' approach to decision-making, as well as descriptions of their care of women in early labour. In this section, the findings will be considered using Van Manen's four lifeworld existentials: lived space, lived relations, lived body, and lived time to help illustrate how care during early labour can facilitate a positive experiences of connection and birth (Thomson and Feeley, 2019; Van Manen, 1998, 2014).

Midwives working in FSBCs provide 1:1 care to labouring women. Usually, the women have received antenatal care with the midwives at the FSBC, whereby mutual knowledge of each other has been acquired (Rocca-Ihenacho et al., 2021). The relationships between midwives and women that are forged through individualized care transform space from just a place—demarcated by walls, floors, and ceilings—to a lived space (Hammond et al., 2013). This provides a framework for considering space in terms of relationships and the effect this has on immediate sensory experiences (Van Manen, 1990/2016). The NQMs, through beginning each interaction in early labour with conversation, were able to explore their perceptions, allowing them to get a feel for the situation before beginning physical assessments. In the gap between contractions, the NQMs had the chance to pause and connect, since time slowed down, and there was nothing else to attend to but relationship (Crowther et al., 2015). Through having the space and time between contractions to calmly connect with the women (Hammond et al., 2013), the NQMs' perceptions and care were guided by the interaction, as opposed to institutional policies, allowing intuitive feelings to emerge (Davis-Floyd & Davis, 1996). Lived space is thus interwoven with lived relations, as well as lived body. According to a study by Carlsson, women seek a safe place in early labour, defined as a "*location that is constructed through the interactions between people and the physical environment*" (2016, p. 6).

When women's labour begins, their day-to-day experience of their body is interrupted. Receiving care from a midwife at the beginning of the transition from pregnancy to birth—early labour—can help some women to move positively into the liminal space of birth, if this care is in and of itself not disruptive (Reed et al., 2016). Van Manen wrote that people who need care from healthcare workers are often in "*need of finding a livable relation with their bodies*" (1998, p. 9), a need which women have expressed is overlooked when they are sent home in early labour after being assessed in a hospital (Allen et al., 2020). In this study, the NQMs were able, most of the time, to provide care that helped women to positively come to terms with their lived body during transition.

Lived relations refers to corporeal and emotional relations in shared space (Van Manen, 1990/2016) and in this study refers not just to NQMs' dialoguing with women, but also to e.g., the palpation of the woman's abdomen. This procedure had the dual function of checking fetal position, as well as connecting to the unborn baby and woman, enabling a deeper awareness for both the midwife and the woman (Stone et al., 2022). The trusting connection between corporeal and emotional relations was also developed through asking for consent before conducting vaginal exams and asking for consent in a way that gave women

the opportunity to reject the exam (Moncrieff et al., 2022). Creating connection before physical assessments and becoming mindful of women's emotions also lowers the chance of "othering" labouring women through disregarding their way of knowing (Downe & Stone, 2020; Thomson and Feeley, 2019; Van Manen, 2014). Seeking a balance whereby women's lived experience is honoured *and* examinations are conducted is an aspect of "judgement" that comes with experience (Downe et al., 2007).

Lastly, lived time for the NQMs was not bound by institutional time restraints. In busy labour wards, midwives often do not have adequate time to spend with women to conduct an in-depth, personal assessment (Cheyne et al., 2006), so that the nuances of early labour go unnoticed (Allen et al., 2020). Nyman et. al. (2001) wrote that, in their study of primiparas gaining entrance to the labour ward, women often felt that the midwives did not take time to listen to them. The construction of time in obstetric medicine is argued to equate time with risk, "*(binding) women by the clock instead of leather straps*" (Simonds, 2002, p. 568). Because the NQMs were less encumbered by institutional policies, the question of admission did not hold urgency. In its place, their central concern was to interpret the situation in order to offer the most appropriate care in the moment.

The NQMs in this study had the time to slow down and feel the magnitude of the beginning of birth (Crowther et al., 2015), enabling them to experience the intricate dynamics at play within women's unique personal circumstances and labour itself (Downe, 2006). The development of deeper knowing is arrived at through intention, through creating the circumstances to enlarge vision and perception. "*The way we see things is affected by what we know or what we believe… We only see what we look at. To look is an act of choice*" (Berger, 1972, p. 6). In embracing the complexities of women's early labor experiences, the NQMs forged a space where empathy, understanding, and mutual support came together, illuminating the profound interplay of lived time, lived space, lived body, and lived relations.

Strengths and limitations

This is a qualitative study that explored NQMs' experiences of getting oriented and familiarized with care in FSBCs in Germany during their first year post-qualification. A limitation is that the NQMs' experiences of caring for women in early labour cannot be generalized to other settings or to FSBCs in other countries, as, e.g., midwives in other countries have a different system for educating midwives and orienting them to practice in their first year. However, despite these differences, the use of phenomenology provided descriptive stories that may be relatable. It also presents an approach to care in early labour that could be modified for other settings in other countries, including hospital settings. A further limitation is that the study did not include interviews with women who received care from NQMs in early labour, therefore their lived experience of being cared for by an NQM could not be integrated into the findings. A key strength is that the NQMs were interviewed 3 times in their first 9-12 months in FSBCs, allowing for in-depth exploration of their lived experience caring for women antenatally and intrapartum in settings where midwife-led care is provided.

Implications and relevance to clinical practice

Facilitating midwifery students to offer relational care to women in early labor without contiguous intervention aligns with the growing recognition of the importance of client-centered care in obstetrics. In hospital settings, where policies often favor minimizing early admissions to labor wards, midwives should develop skills to provide meaningful support to women who request care. The benefits of spending time with women in early labor for building trust and rapport can lead to more positive birth outcomes. Integrating this understanding into clinical practice encourages a shift towards personalized care that considers women's individual experiences and needs, ultimately improving the overall quality of care provided during childbirth in all settings. For midwives in all settings, pressure to adhere to policies and standards that restrict care pathways and limit time spent in contact with labouring women, especially in early labour, obstructs the potential benefits that interactions and relationality bring.

Conclusion

Midwives working in hospital settings may lack experience caring for women in early labour because policies that seek to protect women from early admission impede meaningful interaction between women and midwives during this stage of labour. The findings from this study indicate that NQMs, in general, possessed minimal to no experience with women-centred, relational care during early labour. Within the FSBCs examined in this study, early labour was perceived as a significant component of the childbirth process, serving as a critical phase for building trust between midwives and women, and reinforcing women's confidence in their birthing capabilities. Early labour is experienced as a period of uncertainty for pregnant women and midwives, and a one size fits all solution—sending women home in early labour—is inappropriate, as studies of women's experiences in early labour have shown. Achieving the necessary connection and relationality to make a holistic assessment of women in early labour and to provide needs-appropriate care requires time and space for personal, trusting relationships to be built. This is an important first step towards including women's lived experience into clinical assessments and enacting mutual decision making.

Patient and Public Contribution: This research study has four cooperating partners: MotherHood (registered association), Network of Birth Centres (registered association), the Association for Quality at Out-of-Hospital Birth, and the German Association of Midwifery Science (DGHWi). 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.

Criteria	Author Initials
Writing original draft	NIS
Conceptualization	NIS, GT
Writing—review and editing	NIS, GT, DT
Gave final approval of the version to be published.	NIS, GT, DT
Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.	NIS, GT, DT

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CRediT authorship contribution statement

Nancy I. Stone: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Gill Thomson:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Dorothea Tegethoff:** Writing – review & editing, Supervision, Funding acquisition, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial

interests or personal relationships that have influenced the work reported in this paper.

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