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Swedish midwives' experiences of collegial midwifery assistance during the second stage of labour: A qualitative study

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ABSTRACT

Background: There has been an increased focus on clinical practice that may reduce severe perineal trauma due to awareness of the associated morbidity. Knowledge regarding the best practice to reduce these injuries is limited. Collegial midwifery assistance during the second stage of labour that involves an additional midwife being present has recently been implemented into many Swedish birth units with the aim of reducing severe perineal trauma. However, no studies have been conducted to evaluate midwives' experiences and views of this practice.
Aim: The aim of this study was to explore midwives' experiences of collegial midwifery assistance during the second stage of labour.
Methods: A qualitative study was undertaken with five focus groups conducted with 37 midwives who were part of a multisite randomised controlled trial. The data was analysed with reflexive thematic analysis.
Findings: Four key themes were generated: (i) "challenging the professional role"; (ii) "a balancing act between different roles"; (iii) "not just why and how - but who"; (iv) "a potential arena for learning".
Conclusion: This practice enabled valuable collegial support and learning. The midwives' experiences were multifaceted and influenced by several factors, including norms and culture in the birth units as well as personal relationships and the midwives' views on their role and childbirth. Staffing should be adapted in clinical practice to optimise the conditions for collegial support and learning while avoiding unintended consequences.

Statement of significance

Problem or issue

Little is known of midwives' experiences of collegial midwifery assistance during the second stage of labour, which is a newly introduced clinical practice in Sweden.

What is already known?

To reduce severe perineal trauma, a new clinical practice with collegial midwifery assistance during the second stage of labour has been implemented in many Swedish birth units. Prior to the practice change, collegial midwifery assistance was requested when needed during the second stage of labour, but it was not routine.

What this paper adds

This study provides insights into midwives' experiences of the clinical practice and adds an understanding of how various factors influence their experiences. Staffing needs to be adapted to the practice to optimise collegial support and learning, and to avoid unintended consequences.

1. Introduction

In recent years, there has been an increased focus on clinical

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practices aimed at reducing severe perineal trauma due to a raised awareness of its associated morbidity for women [1]. Figures from the National Swedish Birth register indicate that about 4.6% of primiparas suffered from severe perineal trauma in 2019 [2]. With the exception of perineal warm compresses, there is still a lack of high-level evidence regarding the best practice to reduce these injuries [1,3,4]. A new clinical practice, "collegial midwifery assistance", has been adopted in many Swedish birth units. It involves an additional midwife being present during the last phase of the second stage of labour with the aim of reducing severe perineal trauma [5]. The additional midwife assists the primary midwife and supports the birthing woman when needed. Research on the effectiveness of this on severe perineal trauma rates is currently being carried out in a multicentre controlled trial (M-RCT) that includes five Swedish birth units [5].

A common definition of the second stage of labour is the stage that starts when full dilation of the cervix is reached and ends at the birth of the baby [6].This stage can be perceived as the momentous culmination of the birth, and it can be stressful and intense for the woman giving birth, the child, and the midwife [7]. Midwifery care during this stage involves not only ensuring the wellbeing of the woman and the child, but also providing respectful maternity care to the woman thereby contributing to a positive birth experience [8].

In Swedish birth units, a midwife is often responsible for a few women during a shift who will be in different stages of labour and is assisted by an auxiliary nurse. An obstetrician is available for a consultation if complications arise. Traditionally, a midwife will only request assistance during the second stage of labour when concerns arise regarding the woman's or baby's wellbeing, if labour is protracted, or if another complicated situation indicates the need for an additional midwife.

It is well known that the midwifery profession is currently experiencing a considerable shortage of midwives at a global level [9]. In Sweden, this trend is estimated to continue until the year 2035, and is partly due to a large number of midwives retiring [10]. Consequently, many birth units are understaffed meaning that midwives are left with a high workload and busy work environment. The prevailing situation has led to a significant number of midwives suffering from various degrees of burnout [11]. This is especially pronounced amongst midwives in the first 10 years of their career and has resulted in many midwives considering leaving the profession [11]. A recent systematic review found an association between burnout and reduced safety levels and an increased risk of medical errors [12].

In view of this, it is of the utmost importance that midwives achieve job satisfaction and professional pride in order to retain midwives in the profession [13]. To do so, clinical practice methods must be developed that take midwives' perspectives and way of working into consideration and that also improve on outcomes for women and their babies. To our knowledge, no published studies have explored midwives' experiences of collegial midwifery assistance during the second stage of labour. It is essential to gain knowledge and understanding of midwives' understandings of collegial midwifery assistance during the second stage of labour, as well as how they perceive and apply this in clinical practice. This will enable the development of effective and sustainable methods for optimising resources that benefit the profession and improve maternity care. Effective collaboration between maternity care providers is important for high quality, safe healthcare, but it has been shown that there are obstacles, which can make this difficult to achieve [14,15]. When implementing a new clinical practice, it is also important that it is not only accepted by women but also that possible unintended consequences are considered [16]. Therefore, the aim of this study was to explore midwives' experiences of collegial midwifery assistance during the second stage of labour.

2. Method

2.1. Study design

A qualitative descriptive study was conducted with five focus groups comprising of 37 midwives who were part of a multisite randomised controlled trial [5]. The data was analysed using reflexive thematic analysis developed by Braun and Clarke [17–19]. This is a theoretically flexible method, meaning that the researcher makes an active decision regarding what theoretical assumptions have been made throughout the research process. It belongs to a paradigm of qualitative research where research subjectivity is regarded as essential and used as a research tool in the process of analysis [19,20]. Reflexive thematic analysis is a method for identifying patterns of shared meanings (themes) across a qualitative data set [17]. This method was considered suitable as the aim of the research was to identify patterns in what the midwives said about their experiences of the clinical practice.

The use of thematic analysis in the present study was underpinned by a critical realist epistemological position [19]. The critical realist perspective was chosen, as the aim of the study was to understand the midwives' experiences of collegial midwifery assistance during the second stage of labour from the point of view of their lived realities [19]. This approach affirms that an objective reality exists but access to it is always viewed through the subjective lens of the participants, mediated by their social and cultural values. Although it is never possible to access reality in its true form [19,21], study participants' words provided access to their view on reality and the conversations in the focus groups were then analysed, partly filtered through the lens of the researchers. By using this approach, we took the midwives' accounts on how they made sense of and described the clinical practice at face value, taking the contexts in which they practiced into consideration [17,18].

The researchers have actively reflected upon the subjectivity and their role to achieve reflexivity [22]. We strived to capture the midwives' experiences and meanings of the clinical practice, ensuring trustworthiness in terms of credibility. Focus group discussions were chosen as the method of data collection as they are suitable when the aim is to elicit people's understandings, opinions, and views on a topic [23]. Our intention was that the interaction between study participants would allow them to elaborate on the topic in a broader perspective than what would be possible in individual interviews.

2.2. Setting

The focus groups included 37 midwives who worked at the four birth units used to recruit participants to an M-RCT evaluating whether collegial midwifery assistance during the last phase of the second stage of labour reduces severe perineal trauma [5]. The four birth units are located in southern and central Sweden with annual birth rates ranging from around 3200–5200. Collegial midwifery assistance involves the primary midwife being assisted by a secondary midwife during the active phase of the second stage, while standard care involves only the primary midwife being present. The instruction given for the intervention in the M-RCT was to follow existing prevention models to reduce perineal trauma. No other specific instructions or tasks for the secondary midwife's role were pre-decided. Three of the four study sites had implemented this clinical practice into their guidelines prior to the study, one only partially, while the fourth only practised standard care.

2.3. Data collection and participants

The data collection took place between March and November 2019. All midwives who signed the consent form for participation in the M-RCT had the opportunity to participate in the focus groups. An email

with information about the study was sent to all midwives asking for expressions of interest in participation. Participants were primarily selected using purposive sampling [24] in order to achieve a range of variation in terms of age, years of work experience, and type of shift work. A couple of respondents were approached and asked to participate just before the focus groups due to late dropouts.

For the convenience of the participants, all focus groups were held at the hospitals they worked in and at times when most of the participants had either finished a work shift or could come in before a shift. The moderators CR (FG 1 & 3), MEd (FG 3 & 4), and HT (FG 5) are registered midwives and thus familiar with midwifery care and the context of the study. They alternated between being a moderator and an assistant moderator in the different focus groups. The first author (HT) was working clinically at one of the study sites and therefore did not act as a moderator in that focus group. A topic guide (Table 1) was used as an aid for probing and to keep discussions on track and relevant to the aim of the study. The primary focus was on possible pros and cons, challenges, learning, and feedback on the clinical practice of having a secondary midwife present during the second stage of labour. However, as the ambition was to get a broad range of views, the topic guide was used with flexibility after the initial question "Can you tell me about your experiences of having another midwife present during the second stage of labour?".

The focus groups took between 1 h and 15 min and 1 h and 41 min (Table 2). They were audiotaped and the first author transcribed them verbatim, to ensure data accuracy. Each focus group had an assistant moderator who took notes on who talked the most, how the discussion flowed, and the tone of the conversation. The assistant moderator also supported the moderator by asking questions when needed. The moderator followed up on participants' comments by asking questions to confirm that participants had been understood correctly to enhance trustworthiness. Throughout the focus groups, the moderators allowed and encouraged all participants to speak. Efforts were made to build trust in the groups to facilitate disclosure and to make participants feel comfortable and secure in sharing their experiences. The data collection was ended after the fifth focus group, as substantial information and richness of data had been obtained with no new themes generated [25].

2.4. Data analysis

The analysis was performed using the software program NVIVO, 12th version. To identify patterns of shared meaning across the data set, an iterative analytic process in six phases was undertaken, as detailed by Braun and Clarke [17,19]. Phase 1 started with familiarisation to engage and gain insights into the whole data set. It involved listening to the audiotaped focus groups, reading and rereading the transcripts and taking notes, and an initial categorisation of the content. Data were then coded inductively in an open and inclusive manner, guided by the aim, primarily on a semantic level (phase 2). Candidate themes were thereafter developed (phase 3), starting with the examination, grouping, and collapsing of codes. They were then compared for similarities and relationships to identify a central organising concept, common through the range of codes. This was performed using thematic maps. The analytical work continued with reviewing, defining, and naming themes (phase 4–5). Throughout the research process, there were discussions between the authors until consensus was reached regarding the final themes. The last step of the analysis (phase 6) involved report writing where selected data extracts were included.

Table 1
Focus group topic guide.

Topics
• Pros and cons of having two midwives present during the second stage of labour
• Challenges and difficulties
• What you can learn when acting as the primary or secondary midwife
• Feedback – possibilities, obstacles and challenges
Example questions
• When does the secondary midwife enter the room?
• How do you act when entering the room?
• What do you do as the secondary midwife?
• Have you ever, during the second stage of labour, "corrected" a colleague (given feedback), for instance regarding perineal protection?
• Are there any hierarchies in the form of experience/status between different midwives?

2.5. Ethics

The study was approved by the regional Ethics Board of Lund University (2018/476) in July 2018. To obtain informed consent, all participants were informed prior to the focus groups about the purpose of the study and the interview process. The participants were informed that participation was voluntary, and that all data would be treated with confidentially and not be reported in such a way that participants could be identified. Names used in the presented citations are pseudonyms.

3. Findings

The analytic process generated four key themes: (i) challenging the professional role, (ii) a balancing act between different roles, (iii) not just why and how, but who, and, (iv) a potential arena for learning.

3.1. Challenging the professional role

Data analysis indicated that the new clinical practice could challenge the professional role from both the primary and secondary midwife's perspectives. Participants described an established image of the midwife as being strong and independent in her professional practice. This image was sometimes conflicted when a second colleague was present during birth.

> "…but I think it's the image one has of a midwife…. Is just this strength, like, as if reliable and… can manage by herself'. (R 11, FG 2)

The image of the midwife as being strong and independent could be held by the individual midwife but also influenced by the "culture" at the maternity unit. At one of the units, some midwives were hesitant about the secondary midwife being present and reported heated discussions before the practice was introduced.

> "There were colleagues who just said…. – Oh, this will never happen. Nobody is let into my room. No one will come in at all". (R 18, FG 3)

Preserving the view of the midwife as independent seemed to be important during the second stage of labour to show responsibility and be in charge of problem solving. Some of the participating senior midwives claimed collegial assistance to be a potential hindrance to the independence of junior midwives.

> "You know the newly qualified midwives are like students…. And they don't dare do anything……". (R 1, FG 1)

Even when scepticism was expressed and participants seemed somewhat reluctant about the practice, they considered themselves strong together in situations when they had asked for assistance.

> "Maybe a little more to preserve, like, the course [of labour] uh, [to be] normal and uh, like we can handle this. Are we sure that we can manage it, or do we need a doctor? No, we can strengthen each other in it. That we can do it". (R 31, FG 4)

Participants emphasised the importance of deciding for themselves whether they had a colleague present in the room or not, since involving a colleague also meant sharing the responsibility of the birth with

Table 2
Details of the focus groups and characteristics of participants.

Focus group	Month and year of focus group	Number of participants (n = 37)	Age range of participants (years)	Average age (*median*)[a]	Years of work experience at birth units (range)	Duration of focus group (minutes)
FG 1	March 2019	9	31–59	44 (*42*)	<1–16	101
FG 2	April 2019	6	27–46	36 (*36*)	1–10	91
FG 3	May 2019	9	26–52	36 (*31*)	<1–9	74
FG 4	September 2019	8	37–64	49 (*47*)	2–24	80
FG 5	November 2019	5	28–55	37 (*32*)	1–21	76

[a] Rounded up to nearest year.

someone else. For some of the more experienced midwives, the new practice of having a colleague present could be like a professional loss of control.

> "…This thing with responsibility, who is responsible…. I want to be in control and have the responsibility, I think". (R 14, FG 2)

The new practice could also result in a feeling of being observed and assessed. For some midwives, this created uncertainty about not living up to expectations from others. In some cases, they reported that a colleague's presence interfered with their midwifery practice and that they consequently handled the situation differently from if they had been the only midwife in the room.

> "[I am] often a little stressed because someone is there watching and I wonder: does she think that the CTG trace is a little worse than I think? Perhaps I should hurry. In 99% of cases, when I have another midwife with me, I deliver [the baby] a contraction faster [earlier] than I normally would". (R 30, FG 4)

When the question about giving feedback to a colleague was brought up, participants stated that it was either seldom given or given on a more general level. The reason for this was to avoid situations where the primary midwife risked being questioned:

> "I don't do that, turn to someone and criticise her work, I would never do that…. Then we would be on thin ice". (R 31, FG 4)

The difficulty of giving feedback was especially pronounced among the junior midwives participating in the study, some of whom felt that they did not really have enough authority to give advice or offer help to a senior colleague. It seemed to reflect an unspoken hierarchical order that justified experienced midwives giving feedback or correcting less experienced midwives, but not vice versa. This could sometimes, paradoxically, mean that senior colleagues who valued feedback did not get it.

> "And I would really like to get feedback too, but it's not as easy when you are one of the more experienced. to get feedback from someone who is less experienced". (R 18, FG 3)

3.2. A balancing act between different roles

Participants described how the secondary midwife took on different roles in the birthing room depending on mutual expectations and how the situation was interpreted. The presence became a balancing act, on the one hand in acting as if they believed it was needed, and on the other hand trying not to disturb the woman or the primary midwife. When the secondary midwife was present or gave support when required it was seen as supportive. This sense of support sometimes pertained to various practical tasks, but the ability to gain a second opinion and confirmation of decisions was also seen as valuable. A colleague's involvement could also mean assistance was available in times of uncertainty, that responsibility could be shared, and help could be asked for when making decisions. This was expressed as particularly valuable by the more inexperienced midwives.

> " Sometimes when you're by yourself and thinking: -Yeah but that looks good. Doesn't it? Almost like you only want to be validated…in my decisions that I make in there". (R 13, FG 2)

Participants also described situations where they wanted confirmation or new energy in the room to help women experiencing a prolonged second stage of labour. In these cases, presence or support from a colleague was appreciated. However, participants also described occasions when they had been passive and just observed their colleague in their role as the secondary midwife. From their descriptions, the expected role of the secondary midwife seemed to be largely task oriented in character. Thus, mere presence and observation could be perceived as superfluous.

> Sanna: "I had one with you. I thought I was disturbing you. I didn't say anything…" (R 19)
>
> (Participants laugh).
>
> Linda: "I know". (R 24)
>
> Sanna: "But you were, you were just doing fine and then I came in there and… you just stood like that and looked at me, because then they looked up". (R 19)
>
> Linda: "Yes." (R 24)
>
> Sanna: "So I just: -Hi. My name is Sanna, I'm just going to stand here. So… I tried as much as. The dad just stood there and looked at me all the time. I felt like… I didn't know what to say. " (R 19) (FG 3)

Participants expressed that they had previously assisted each other only in complicated situations and when it was obvious which roles and actions they should take. Thus, they expressed a need for specific guidelines on the secondary midwife's role, and how to act with regard to the new clinical practice. Furthermore, they experienced that the workload made it difficult or impossible to plan in advance who the secondary midwife would be, and what kind of support the primary midwife wanted. Some participants felt that it required more time to get acquainted with the situation in the room than was often available. They expressed a need for information about the woman giving birth to be able to support their colleague in preventing perineal trauma.

> "Uhm, but then, like if you really are going to be able to prevent tearing then you kind of need to know who this woman is. Like how long has she been fully dilated? How long has she been pushing? (R 17, FG 3)

There was an agreement among participants that the last phase of the second stage of labour is an extremely sensitive period when the woman giving birth could easily be disturbed. Both the situation and the prevailing atmosphere in the room were some of the factors mentioned that contributed to the role of the second midwife becoming disturbing. There was also agreement that entering the room during the last minutes of pushing, when the birth was imminent, was not fruitful and only increased stress and a sense of being disturbed.

> "Because something is interrupted.… Sometimes you can almost feel how the women tenses up a little when new people come in…the

room. I can feel it. It is almost as if you can feel it down there where we work (laughs)…that oh, now there's a change because you almost have a bubble you live in… when you're standing by, at a birth. And that, that is easily broken that, that magic in a way". (R 31, FG 4)

3.3. Not just why and how, but who

Participants expressed that the relationship with their colleague who was the secondary midwife was important. Differences in views on childbirth regarding management were claimed as a hindrance for a successful collaboration and these could result in a locked position when opinions conflicted with each other. The personal chemistry between midwives was further described as influencing the mutual interplay between colleagues.

"I think sometimes it probably has to do with personal chemistry, because you work differently together, with different people. So you work better with some. And worse with others…" (R 33, FG 5)

Relationships between midwives was also reported to affect the atmosphere in the birthing room. The midwives stated that the woman giving birth could easily get a sense of whether the colleagues enjoyed working together. The communication between the midwives could take place in silence when there was a close relationship that had been built up over time by working together on several occasions.

"… when you have talked to some you want, like, for example, Sara and I. We have had a number of deliveries together. You go in and say hello. Let's say that I am the second midwife. I think it has been an advantage because it's…But then we communicate with our eyes, I see what you are thinking……". (R 29, FG 4)

Having had the opportunity to work together during many births meant that there was a mutual understanding of how the other person was thinking, which influenced the interaction between them. This was pointed out as important to promote optimal teamwork. Organisational factors could, however, appear as an obstacle. For instance, the midwives reported that a large maternity unit made it difficult to build trusting collegial relationships.

"…when you work like this close together because it is very, very close work and it's very, very important to understand one another. And you do with some of your colleagues, but definitely not with all. We can't do that…. How many work here? We can't be close to everyone". (R 31, FG 4)

In some situations, participants preferred a certain colleague to assist them on specific clinical issues, to help solve a problem. However, some junior midwives found it more stressful to work with a senior colleague due to their seniority. The less experienced midwives described it being easier to be transparent and open with each other, which facilitated communication and promoted good cooperation.

"And I find it can be easier to be with a colleague who is just as inexperienced as you are yourself". (R 17, FG 3)

However, the participants differed in their opinions on whether good cooperation had to do with the secondary midwife being a senior or not. Some claimed that it was the personality that came into play rather than seniority. The attitude and approach towards the colleague also contributed to how participants experienced the situation.

"Yes but like sometimes it is completely fantastic, you feel like the greatest team with the woman… like everything is just…perfect and you work very well together with this other person". (R 33, FG 5)

Participants reported that sometimes the primary midwife experienced a lack of respect in situations when the secondary midwife came in and took over. In these situations, feelings of disappointment over being disregarded by the colleague were described. Conversely, when the communication worked in a positive way, the midwife felt confident in expressing herself freely in front of her colleague, without the risk of being offended or having to defend herself and justify her actions.

3.4. A potential arena for learning

There was consensus among the midwives that collegial assistance could provide a valuable opportunity for the exchange of knowledge and learning. The knowledge transfer was not only from experienced to less experienced midwives, but less experienced midwives also shared new knowledge with more experienced colleagues, who otherwise would continue to work in the same way.

"Because I haven't had any input and I have not seen how the others work. That's what I'm …. missing. So this can be a good……possibility. A changed way of working, to see what others do and learn from…. others". (R 14, FG 2)

Being observed by a colleague and offered advice on preventive strategies as one way of learning was reported by the participants. In these situations, reflecting and discussing afterwards further contributed to an enhanced understanding and learning.

"So she stood there, but when I ….ehm, when the head was crowning, she pointed and said: -The hand a little higher up – she commented on how I was holding the perineal protection. I thought that was very helpful, so we talked afterwards about it…. and she showed me what I had done. ehm., What I could do better next time". (R 9, FG 1)

The learning situations described often occurred spontaneously, but sometimes the experienced midwives had the intention to teach something specific to an inexperienced colleague. It could, for instance, be an agreement to teach a colleague who needed more knowledge in a certain area, such as a specific birth position. Learning was further described as taking place when the secondary midwife observed the primary midwife during a birth. By attending many births with different midwives, new knowledge was incorporated into one's own. For example, one participant expressed how knowledge of perineal protection was conveyed through observation.

"Because when I observe I can learn a lot about how I deliver. How I can deliver in a way that minimises tears. How I can talk to the patient, what kind of communication I have. How I deal with a CTG that looks a certain way. What position. How I hold my hands. When I should start protecting the perineum." (R 17, FG 3)

Similar stories that reflected willingness and motivation to change after observing a colleague were told. Frequently, participants described it as a matter of moving away from active towards more passive management, less forced and more physiologically following the birthing women. Moreover, the presence of a colleague gave the possibility to reflect on how to be with women giving birth. In this way, a deeper understanding of the matter could occur. Despite this, some participants reported that important reflection and feedback were frequently hindered by a lack of time. Furthermore, the absence of an established structure and strategy to give feedback led to uncertainty regarding how to organize the conversations.

"Because we haven't had time for these reflections and actually it is more difficult to reflect than we maybe… would wish". (R 6, FG 1)

Occasionally, reflection was also hindered by the parties not feeling ready to open up in discussions. Hence, although not always present, fruitful feedback was described as requiring both will and active mutual commitment.

4. Discussion

This study shows that several factors are at play and contribute to midwives' experiences of collegial midwifery practice during the second stage of labour. Prevailing norms and culture in the birth units shape how the practice is experienced, and this is further influenced by personal relationships, trust, and views on childbirth. Having the time to attend and getting to the birthing room on time for the last phase of the second stage of labour were also central to the secondary midwife's ability to assist in the birth. Furthermore, organisational factors were reported to affect available time for planning and familiarisation with the situation. Current workloads, expectations, and how the situation in the birthing room was perceived often determined the role of the secondary midwife. Study participants preferred a supportive role, but sometimes it turned out to be superfluous or even a disturbance that jeopardised the atmosphere of the birth. It also became evident that the clinical practice could challenge the professional role when it interfered with the midwife's autonomy.

This study demonstrated that having a colleague present during the second stage of labour can result in a loss of control and less independence than when working individually. It has previously been shown that autonomy and the ability to manage situations independently is central in midwifery [26]. Therefore, it is hardly surprising that a clinical practice that implies always having a colleague attending births, even if not requested, can be experienced as encroaching on the midwife's responsibilities and autonomy. Research has further shown that the professional role of midwives has been restricted due to the medicalisation of birth care [27–30], and that midwives perceived constraints on their occupational autonomy and professional practice [31]. Perdok et al. [32] described that decreased work autonomy not only leads to reduced work-related wellbeing, but also to a reduced degree of satisfaction with the care given. For midwives who were used to working in closed rooms, without having colleagues involved when everything progresses normally, this new clinical practice could be viewed as inconvenient and restricting.

It has been shown that asking for advice and assistance from colleagues is common in midwives' daily work, and furthermore, that communication with colleagues during birth can reinforce their capacity to take responsibility [33]. This could possibly be seen as contradictory with the midwife being autonomous, but not necessarily so. Some midwives in this study described feeling strengthened in situations when having a colleague present but wanted the decision regarding assistance to be their own. This is logical as having the ability to make individual choices has also been demonstrated to be important for managing work challenges and being resilient [31].

Midwives reported that when the prerequisites were in place and the secondary midwife's presence was wanted, the primary midwife was provided with valuable collegial support and confirmation, which also positively contributed to the birth process. This suggests that a collaboration between midwives has the potential to build capacity and strengthen midwifery care through shared problem solving [34] and the intention of keeping a birth normal and without the need for medical interventions. But it also stresses the importance of midwives understanding the rationale behind having a colleague present in order for the clinical practice to make sense to them. It could both metaphorically, and to a certain extent practically, be seen as the opening of a door that has previously been closed.

Another finding in this study was the valuable knowledge transfer that occurs between midwives during birth. Some of the midwives expressed a will and the motivation to change after observing a colleague during this new clinical practice. Åhlund et al. [35] similarly showed that getting the opportunity to work in a new way by participating in a study allowed midwives to view childbirth from a new perspective and to develop within their profession. Another study by Lundborg et al. [33] found that junior midwives tended to share newly acquired evidence based knowledge with their colleagues, whereas experienced midwives contributed their knowledge about variations in normal birth patterns and processes thereby facilitating normal births. This was demonstrated in the current study. Evidence is still lacking about whether collegial midwifery assistance prevents severe perineal trauma [5], but it is possible that the knowledge transfer associated with this clinical practice might contribute to a lower rate of severe perineal trauma in the long term. The results of the M-RCT will provide high-level evidence to confirm or refute this hypothesis. In addition to this, it is also worth considering that this practice brings with it a potential risk for learning bad habits or techniques from each other as well.

Participating midwives stated that women giving birth could easily be disturbed, especially if the secondary midwife arrived late in the second stage. Additionally, some midwives felt that some women became physically affected when a colleague suddenly appeared. Nilsson [36] concluded that women must be offered both emotional and existential safety to avoid having a negative birth experience. To accomplish this, midwives use strategies such as closing the door to the birthing room to make space for childbirth in a calm environment with privacy [37]. Research has shown that when colleagues show up uninvited in the birthing room, it results in a lack of privacy that alters the woman's hormones and consequently could slow down the progress of labour [38,39]. This corresponds with what was indicated by the midwives in our study, and it helps explain why midwives often strive to safeguard the woman from disturbances and to keep the birthing room a safe place. It also stresses the importance of informing women of the change in clinical practice if units are using this approach, so that they are not caught unaware when a second midwife enters the room at this pivotal moment of the birth.

Participating midwives reported that not only personal relationships but also views on childbirth and hierarchy between midwives were important for a successful collaboration. Some of the junior midwives found it difficult to give feedback to their senior colleagues. A possible explanation could be a mismatch between evidence-based midwifery care and clinically proven experience. In a study of the emotional aspects of midwifery, Hunter [40] found two dissimilar, conflicting work ideologies with different perspectives and values: "with institution" and "with woman". Junior midwives, in particular, found it emotionally difficult when they were not able to work according to the "with woman" ideology. Correspondingly, Teijlingen [41] described two models of childbirth: "the medical model" emphasising risk and interventions with a focus on risk reduction with an active approach, and "the social model" focusing on normality and social support, where the woman is the active doer and giver of birth. Caregivers usually have a view that fits somewhere in between the two ends of this spectrum and views may change over time.

Our study indicates that the expectations on the assisting midwife's role during the second stage of labour seemed to be somewhat unclear. Participants reported difficulties with knowing how to act in this role due to a lack of specific, practical guidelines, and in real life mere observations were often considered to have a superfluous role. When the primary and secondary midwife endorse even slightly different models of childbirth, in accordance with Teijlingen [41], this might lead to different expectations on the role of the assisting midwife. It is not unlikely that an increased medicalisation of birth care [27–30] in a busy system may lead to a more "task-oriented" approach, where being active becomes synonymous with effectiveness. In such circumstances,

midwives would lean towards expectations to be active and to do something concrete and tangible. Hunter [40] showed that successfully completing tasks for achieving safety and focus on satisfying the needs of the institution was emphasised in the "with institution ideology". In this study, it may further have been affected by the fact that the clinical practice was initially aimed at reducing severe perineal trauma and therefore generally associated with practical "hands on" techniques by participants, despite a lack of high-level evidence supporting this.

The midwives in our study described that when organisational factors, such as staffing, were not adapted to the practice, it restricted their ability to discuss expectations, to make up a plan in advance and to be able to reflect afterwards. It has been demonstrated that workplace conditions in maternity units are not always aligned with ideal practice [31]. This suggests that even if the midwives have the desire to work according to the new practice, in line with their ideology, organisational factors can shape their work and restrict their ability to live up to it.

A limitation in this study is that the focus groups were held during, before, or after work shifts and that the environment was busy at times, which may have led to the midwives feeling somewhat stressed. Another limitation might be that no participants from one of the study sites were represented due to practical reasons. However, a strength is that the data collected were rich. A broad range of views from the midwives' experiences of collegial assistance, a previously unexplored topic, were captured. The authors considered the group dynamics during the focus groups as being positive and open, and the trustworthiness in the data has therefore most likely not been affected by inhibited disclosure. It is plausible that our findings are transferrable to units within a similar context outside Sweden, where they could be useful to consider when implementing this clinical practice in their settings.

5. Conclusion

This study shows that collegial midwifery assistance during the second stage of labour has the potential to contribute to valuable collegial support and learning. Participating midwives' experiences of the practice were multifaceted and were influenced by several factors, including the norms and culture in the birth units as well as personal relationships and their view on the midwife's role and childbirth. The findings suggest that to optimise the conditions for collegial support and knowledge transfer while avoiding unintended consequences, such as disturbance in the birthing room and dissatisfaction among midwives, staffing should be sufficient, with time for planning, clarification of expectations, and familiarisation with the situation in the birthing room. Further research will include studying women's experiences of having two midwives attending the birth of their children. Their perspective is essential to gain a deeper understanding of this practice and women's needs, though the results from the M-RCT will determine the effectiveness of the practice.

Conflict of interest

No conflicts of interest declared.

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