# Being in an oasis: a restorative and reassuring place - women's experiences of a valuable antenatal diabetes midwifery consultation

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## Abstract

The prevalence of diabetes in the childbearing population is increasing globally. Pregnant diabetic women are considered to be at high risk, and thus require specialized, multidisciplinary prenatal care in which midwives play an integral part. These women's views and experiences of encounters with midwives during diabetes care have not yet been investigated. Our aim was to use an exploratory interpretive approach to investigate the experiences of pregnant women and their perceptions towards the meaning of prenatal consultation provided by midwives in the prenatal care team. A purposive sample was recruited from four hospital-based prenatal diabetes outpatient clinics in the urban areas of Norway: 10 pregnant women (5 primiparous, 5 multiparous) aged 28-45 and diagnosed with different types of diabetes. Data from semi-structured interviews were transcribed and subjected to thematic analysis. Three main themes emerged: being in an open atmosphere, being seen as a person, and being reassured. Together, these themes created a construct that we labeled *being in an oasis-a restorative and reassuring place*. The counterpoint of this view was a more negative perspective described as having insufficient time, feelings of being objectified and rushed, and disease-oriented care. The women valued the focus on surveillance in the consultations, although at their best, the midwife-woman encounters complemented and counteracted the iatrogenic effect of the biomedical focus in specialist prenatal care. However, the organization of care may have contributed to and created feelings of suffering, as these women had limited scope for addressing their concerns in the consultation. We conclude that these consultations are complex co-created activities in which interpersonal aspects of the midwife-woman encounters, such as the midwives' openness and responsiveness to the women, seem to be significant in developing a personal approach.

## Introduction

The prevalence of diabetes is increasing within both the general and the childbearing population, in Norway and worldwide.[1] Women with pre-existing diabetes as well as those with pregnancy-induced diabetes (gestational diabetes, GDM) are regarded as a high-risk group with concerns for maternal, fetal, and neonate outcomes.[2] In order to optimize their pregnancy outcome, these women are provided with centralized specialist care organized as diabetes teams within the prenatal outpatient clinics at obstetrics and gynecology departments. Midwives are routinely included in these teams, because they can provide the usual prenatal education and care in addition to diabetes management.[3] Nurse-midwives are supposed to focus on more than the illness; they also attend to the patient as a unique individual with specific personal health concerns and questions.

In this study, we therefore asked how these women perceive the care provided by the midwives in the prenatal team.

## Literature Review

Previous research has been conducted primarily in the context of maternal service for women in uncomplicated/normal pregnancies using one-to-one or focus group interviews, or large surveys with predefined questionnaires. A Norwegian study using qualitative, semi-structured interviews with 18 women in two urban health care centers[4] revealed that being seen, cared for, respected, and given time was of significance for the women. It was also important that the health care practitioner had extensive professional experience and up-to-date evidence-based knowledge. On the basis of these qualitative interviews, a quantitative questionnaire study was undertaken in a sample of 342 women and their partners. The findings suggested that an overall positive experience with pregnancy, birth, and postnatal care occurred when the women perceived that they had sufficient time with the healthcare provider, experienced continuity of care, and were provided with information. Though the researchers did not report the reasons behind this, prenatal care with a midwife was considered to be more positive than the corresponding care provided by a general practitioner (GP).[5] Raine *et al.*[6] showed that during pregnancy, women had diverse communication experiences with health care professionals (HCPs) including GPs, midwives, obstetricians, and sonographers. Ineffective communication, identified as *inadequate information* and *a lack of a person-centered dialogue*, left women feeling rushed, ignored, and dismissed. The women valued communication styles in which HCPs demonstrated personal contact and empathy.

An interview study among 40 pregnant women and their prenatal care providers[7] revealed that a trustful and meaningful relationship was important during prenatal care; this theme was recurrent throughout the data. A respectful attitude, emotional support, an approachable interaction style, and taking time were also important, as were information sharing, continuity of care, non-medicalization of pregnancy, and a woman-centered approach.

We found four relevant studies on women's experiences of prenatal care from a diabetes context in the UK and Sweden.

Stenhouse *et al.*[8] interviewed 12 women with pre-existing diabetes and 8 significant others, asking for their experiences of maternity care. The findings encompassed three

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themes: the need for an empathetic care focused on the pregnancy rather than on the diabetes, feelings of being judged by their HCPs, and the notion of expertise.

In Sweden, Berg and Sparud-Lundin[9] conducted focus group interviews and individual interviews among 23 women with type 1 diabetes (T1DM), asking for their experiences of pregnancy and childbirth in relation to glycaemic control, wellbeing, and the care provided. These women valued the attention they received, the access they were given, and the competence of the HCPs in the prenatal care period. However, due to disconnected care systems, the women found themselves acting as messengers carrying information between the different HCPs. The women also stated that the HCPs had a strong focus on the baby's physical wellbeing at the expense of the mother's emotional wellbeing.

In another Swedish study, Anderberg[10] used a questionnaire in a sample of 156 women with T1DM and GDM to study the participants' views of their treatment and the information provided during pregnancy, childbirth, and the postnatal period. The women reported positive views in response to the items on accessibility, participation-responsibility-respect, and care at the prenatal clinic, but negative views in response to the item on information flow between the parties. The results indicated an overall satisfaction with care, but the women commented that there was a huge focus on diabetes which forced the issues related to normal pregnancy aspects into the background.

The abovementioned studies identify areas where improvement is needed in prenatal care in general, such as a continuity of care extended to the postnatal period, an increased focus on personal needs, and more time to talk, in order that women do not feel rushed during the consultations. For women with diabetes, a more personal approach during the consultations, with less focus on the disease and on the baby, seems to be of significance. However, the women in these studies reported on the care received from HCPs in general. To our knowledge, little attention has been paid to the specific contributions of the midwives in these teams, from the woman's perspective. Guidelines state that midwives should be in a special position to focus on and support the woman's wellbeing during the childbearing period, viewing it as a normal life event and providing holistic care. Hence it is of interest to ask what specific contribution the midwife makes to the wellbeing of women subjected to an extended prenatal diabetes team care program.

In order to promote the wellbeing of women with diabetes, it would be helpful for the diabetes team and service to be aware of the women's needs and concerns in relation to this specific health condition. Hopefully, this knowledge could contribute to a deeper understanding of midwifery in prenatal diabetes care, and help identify areas for improvement both in the midwife-woman relationship and in the way the team care is organized.

The aim of this study was therefore to explore and elucidate pregnant diabetic women's experiences of midwife encounters in prenatal care consultations, with a special focus on the interpersonal factors influencing their perceptions and experiences of their wellbeing and the prenatal care received.

## Materials and Methods

This study had an explorative and intepretive design. We chose to use qualitative interviews to gain insight into what pregnant women found to be valuable in the midwife-woman encounter. The settings were four outpatient prenatal clinics at the obstetrics and gynecology departments of hospitals in urban areas of Norway.

Women with insulin-treated diabetes such as T1DM are referred directly to the clinic as soon as they are found to be pregnant. They may change to a different insulin regimen to achieve good blood sugar control, and are therefore scheduled for frequent appointments with the endocrinologist during pregnancy. Women with type 2 diabetes (T2DM) may change their treatment from tablets to insulin, and are also subject to frequent endocrinology appointments. The care is tailored to the needs of the individual, but in general, women with insulin-dependent diabetes are scheduled for approximately 17-19 appointments with the endocrinologist, 12-14 with the midwife, and 9-10 with the obstetrician. Women with diet-controlled diabetes such as GDM may have a combination of consultations with their own GP, the midwife at the clinic, and the obstetrician, and hence visit the clinic less frequently than women with insulin-dependent diabetes.

The women in our study were scheduled to meet the team every week or fortnight. The team consisted of an obstetrician, an endocrinologist, and a midwife, each of whom had specific tasks and responsibilities. On the appointment day, the women usually first saw the midwife, who would do all the paperwork, follow-up and recording the test results from the laboratory (*e.g.* blood sugar, HBA1C), taking blood pressure, weight measurement, urine sample, and symphysis-fundus measurements (midwives in Norway are nurses by virtue of their midwifery education. Very few have an extended education specializing in diabetes nursing). Women with insulin-treated diabetes then met the endocrinologists, for assistance with the continuous insulin adjustments in pregnancy. The obstetrician would monitor the fetal growth with ultrasound and the circulation with umbilical artery Doppler ultrasound. Women with insulin-treated diabetes would also be given an additional ultrasound check of the fetal heart, checking for abnormalities and congenital defects.

### Participants and recruitment procedure

This is part of a larger study on midwifery-led prenatal diabetes consultation. The participants were drawn from the same population as in previously-published studies,[11,12] and selected via purposive sampling of the best available women who could provide data on the phenomenon under study.[13]

The inclusion criteria were that participants had to be over 18 years of age, be able to speak and understand Norwegian, and having a diabetes condition. The exclusion criteria were having been diagnosed with diabetes in ongoing pregnancy, co-morbidities of medical diseases, and severe complicated conditions in the ongoing pregnancy.

Thirty women (n=30) were asked to participate by letter; three were given the information letter by their midwife at the consultation, whereas the remaining 27 received their letters from the secretary of their clinic. Participation required that one consultation with the midwife (preferably in the 3rd trimester) would be audio-taped, and that the women would then be interviewed concerning their experiences with their midwives. It was desirable that the women should have experience of the phenomena under investigation. Ten women contacted the first author by phone or e-mail for more information and clarification. Arrangements for the audio recording of the consultation and for the follow-up interviews were made with each woman who agreed to participate, with a total of 10 women accepting the invitation. All participants gave their written consent to be interviewed individually post consultation. The present article is concerned with the interviews alone.

Data collection took place from April to November 2008; the women decided when and where to be interviewed. Six women were interviewed straight after the appointment at the clinic, in a nearby room at the clinic. One woman was interviewed a day before her appointment, at a *café*. Another interview was held over the telephone the day after the woman's appointment. One woman was interviewed in her own home 5 days after the appointment in her home, and finally one woman was interviewed at the first author's office 5 weeks after the appointment.

The interviews lasted between 20-90 min, were audio recorded. Two open-ended questions were used to initiate the interview: *i) In what ways is the midwifery encounter/consul-*

*tation valuable? ii) Do you have experience of a less valuable encounter/consultation? If so, please explain.* During the evolving conversations, follow-up questions were posed in order to elaborate the women's narratives. The women were encouraged to freely address and speak about their experiences of both being pregnant and what they considered valuable in the midwife-woman encounter.

## Data analysis

The consultations were transcribed verbatim from spoken Norwegian into a text by the first author without any dialectal distinctions. Each transcript was read and compared to the audio recordings, and revised appropriately to ensure reliability. The quotations chosen in this article for the purpose of illustrating the findings were translated into English. The presented quotations reflect only a proportion of the available evidence in the data.

Drawing on the work of Braun and Clark,[14] a thematic analysis was conducted on the entire data set. First, all transcribed interviews were read repeatedly to help acquire an overall first impression of the data. Next, the meaning units which encompassed answers to the interview question were extracted, manually coded, and grouped together to identify potential subthemes, representing some level of a patterned response or meaning within the data set. There were also examples of less positive encounters, which were included in the analysis as a contrast to the women's accounts of valuable experiences. Finally, an overall interpretation of the data was developed on the basis of the quotations, subthemes, and themes. The analysis was conducted by the first author, then discussed and validated by the co-authors, by reading the transcripts and discussing the subthemes, the themes, and the final interpretation.

## Ethical considerations

The study was performed in accordance with the Declaration of Helsinki[15] and the Northern Nurses' Federation's Ethical Guidelines for Nursing Research in the Nordic Countries,[16] and was approved by the Norwegian Ethical Committee (No. 013/08). The participants were informed that they could withdraw from the study at any time without the need for any explanation, and that confidentiality was guaranteed. Audiotapes were kept locked away from unauthorized persons, and the quotations in this article have been labeled with anonymous identity codes in order to protect the anonymity and confidentiality of the participants.

## Findings

The women were aged between 28 and 45 years, and represented all three types of diabetes diagnosis. Eight women were treated with insulin, and two with dietary restrictions. At the time of the interviews, the women were in gestational week 26-36 and had experienced between five and seven midwife encounters, but only three women had met the same midwife at each appointment. Five of the women were expecting their first baby, and the other five were expecting their second, third, or fifth baby. The data comprised vivid and rich descriptions of experiences of encounters with midwives and other health care professionals. All women gave examples from recent encounters, and multiparous women also described encounters deriving from previous pregnancies. However, for the present study we singled out the midwife/women encounters and used other encounters only as contrasting examples (Table 1).

We first present the three themes: being in an open atmosphere, being seen as a person, and being reassured. Following this, in the last section we present our interpreted understanding of the meaning of the midwifery contribution to the women's wellbeing, developed through the analysis of the theme Being in an oasis: a restorative and reassuring place, developed in three sub-themes (Figure 1).

## Being in an open atmosphere

This theme reflects a factor mentioned by most of the women; the importance of perceiving/experiencing an open atmosphere in the consultation, in which the woman feels invited to share her concerns as well as to acquire access to the midwife's knowledge. It seemed to be of relevance for the women to know the resources that would be accessible to them if needed. Other significant aspects included openness to the woman's expectations and feelings towards becoming a mother, as well having time for her.

## Being able to ask about everything

The diabetes team held different kinds of knowledge and provided the women opportunites to adress to the right person.

*…you see the doctors last; first [you go] to the midwife and then the endocrinologist and then the OB. In any case, you have different places where you can ask the [person]…things that the midwife can't answer I take to the OB (C10).*

## Openness to aspects other than the medical

The midwifery consultation served as a place where there was an openness to aspects other than the medical issues which framed the disease in the foreground. These women felt there was less openness to addressing the issues related to becoming a mother in some of the consultations.

*I believe that this, just being allowed… just being pregnant, not all the sickness, but that I am pregnant with all my expectations (C7).*

The following two quotations illustrate a *less-than-open attitude*, demonstrating less interest in the woman's perspective of her wellbeing in daily life and living. We interpret the words *soft things* as referring to a subjective orientation on the woman's experiences, compared to the physical focus on measurable objective signs of pathology such as blood pressure:

*It is very important to concentrate on the baby's [wellbeing], that he is well, but there's also* How are you? *Usually, this isn't something the doctor asks you about, as she [the midwife] is concerned about the soft things and not only the blood pressure and* thanks for today *(C1).*

However, the women appreciated the focus on surveillance and monitoring of their and their babies' physical health, even if this came at the expense of a focus on the normal maternity tasks:

*It is stressful to be pregnant and the joy has disappeared, everything gets technical and you lose a bit of the joy, [but] you should actually have a baby and that is the whole point… (C9).*

The notion of the consultation as a co-created activity is mirrored in the following quotation, in which the midwife is described as asking an open question about how the woman is doing. The woman herself takes the context into consideration in deciding whether to respond honestly to this question; she judges the situation before revealing her concerns. She needs to know that she will be listened to,

**Table 1. Participants.**

| Participants' characteristics | |
|---|---|
| Age | 28-45 (years) |
| Nulliparous | 5 |
| Primiparous | 5 |
| Diagnoses | |
| T1DM | 7 |
| T2DM | 1 |
| GDM | 2 |
| Educational level | |
| College degree | 1 |
| University college degree | 8 |
| University degree | 1 |

T1DM, type 1 diabetes; T2DM, type 2 diabetes; GDM, gestational diabetes.




**Figure 1. Being in an oasis: a restorative and reassuring place.**

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but an open question may be considered to be a rhetorical question.

*It's getting kind of technical here, looking at my glucose numbers, measuring the baby with ultrasound, so there isn't much time for talking, and I feel that is important, but they are very nice, polite and forthcoming, and we all know there is time pressure and they have to measure blood pressure and check my urine, so it really… and then they ask* how are you? *They don't have time to do more than write down [my results] and then I have to go to the next one [in the team] (C7).*

## Having enough time

None of the women blamed the individual midwives for not having more time to talk. Some of them had additional contact with a community midwife because their need to talk and their expectations of support were not met in the regular midwifery consultation:

*… but when I'm going to my midwife beyond this, I know that I can bring my concerns and worries and if I need to discuss something there is time for that, where there isn't time here… I know how the system works, so I've safeguarded myself by having access to an outside midwife (C6).*

## Being seen as a person

The content in this theme was confirmed by most of the women. It reflects an approach incorporating a valuable human connectedness in the consultation; this is achieved by being known to each other and then being remembered, which is a prerequisite to being previously known to each other. In such a personal relationship, the woman feels that she is listened to and invited to share her concerns in her meeting with the midwife. The theme also describes the significance of being responded to as a knowledgeable person.

## Being known to each other

The women gave examples of encounters in which they felt some kind of reciprocal connectedness with the midwives. Over time, the midwife gained a personal knowledge and personal memory of the woman. By knowing the woman, her personal story, and her preferences, the midwife could personalize general biomedical knowledge for the woman's own situation, making her feel that she was being treated as a unique person:

*Well, when I'm with the midwife, I experience her not just as the professional midwife, but as a person [name] who is the midwife, and after a while I realized how important this is for me when I come to the midwife… she [the midwife] doesn't talk about normal pregnancies, she talks about my pregnancy... she normalizes things, while at the same time she says we are all different. What you experience isn't normal or abnormal (C5).*

As a contrasting example, the same woman as above felt as if she had vanished into a world of numbers, with all the discussion and focus on the HB1AC and blood glucose numbers:

*The doctor focuses on the diabetes, on the impact it has on the pregnancy and how the diabetes affects the baby. He is not interested in me as a person, just in my numbers (C5).*

All the women had experienced a varied quality of interactions with different HCPs during this and previous pregnancies. The running theme in all the stories was the significance of the continuity of career. Being known to each other, with the woman knowing that the midwife knew her personal story, was of significance and a necessity for a trustful relationship to be built up; this also affected topics brought up in the encounter.

*The only thing that has been negative is that you don't see the same midwife every time… two midwives are OK, but when a third midwife comes into the picture… she knew very little compared to the other two, whom I had a relationship with and who knew me better. Having two different midwives was OK, but with a third it's different… it can get to be exhausting telling the same story all the time (C3).*

## Being remembered

The appointment day at the clinic was described as a hectic event. One woman used the metaphor of a factory, carrying connotations of line production and an efficiency-based clinic. However, being remembered in this context was a significant factor in feeling cared for as a unique person; continuity of care could help cushion the feeling of being part of a hurried factory-like process. A prerequisite for being remembered was having previously been seen and known by the midwife.

*Here, it's like a little factory where I'm one of a thousand patients, but I feel that I'm always being cared for as an individual. When I meet her, she has been such a friend, you feel very comfortable with her… I think it's important they follow up complaints they know I've been struggling with, remembering personal details, and it's then that you know they remember you as a person. I think that's very good (C2).*

## Picking up the woman's concerns in the dialogue

The woman quoted below points to the midwife's openness to aspects other than the physical and responsiveness to her unspoken concerns. However, in this quotation she refers to an encounter with a midwife in a primary care setting:

*She [the midwife outside the hospital] starts by asking how I have been doing so far, and encourages me to tell her; others say* tell me, *but they don't have the time to listen. I feel she has time for listening, it's not just a phrase,* tell - *while I am telling her what's happened since the last time, she can pick up things... And then I come to remember things I would like to ask, things that I'm worried and anxious about, and there is room for this. It's not* Can you wait with that or can we deal with it afterwards? *(C6).*

## Being responded to as a knowledgeable person

Midwives in daily practice encounter pregnant women with a variety of diabetes-related experiences, including women recently diag-




**Figure 2. Interpreted understanding of the value in a midwife consultation.**

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nosed with GDM in an ongoing pregnancy and women who had entered pregnancy with a diabetes diagnosis. Knowing the woman, her preferences, and her previous experiences is therefore crucial in order to adjust the communication as needed. As one woman commented, *Midwives in general were good at being on the same level (C1)*.

In such a relationship, where the parties came to know each other and shared each other's knowledge, the women felt knowledgeable and confident: *She doesn't have to translate everything to someone who has had diabetes for a long time (C2).*

### Being reassured

This theme reflects the women's experiences as well as their needs, while describing the consultations as an encounter that helped to relieve their concerns, in addition to possibly increasing motivation and addressing existential aspects of self-management. The women appreciated the midwives' ways of sharing and transforming different types of knowledge into their situation.

### Feeling safe and trusting in the continuity of the career

All women described the prenatal appointments as time-consuming activities; they would spend hours at the clinic waiting to see all the HCPs. However, being offered frequent checkups at the clinics provided relief of stress as well as the reassurance of knowing their glucose numbers:

*I am thinking of all the others who don't get this frequent follow-up. They must become so worried about this and that, while I'm checking my blood pressure every week (C2).*

The women received ultrasound and Doppler examinations at each appointment. Some of them referred to this as being too technical; but on the other hand, this high-tech outside approach to the woman's pregnancy and body, allowing her to actually see and hear the baby, served as a confirmation of her own successful diabetes self-management. We interpreted these moments as being valuable, as they made the women feel relaxed for a while, and helped them feel trust (or distrust) in their own bodies:

*The more I come here, the more focused I get, because if there's three weeks in between you get to be a bit relaxed… and after each ultrasound, I see it like a premium, why shouldn't we who work so hard be allowed to see the baby? (C8).*

### Feeling trust in the midwives' double gaze

All of the women in our study were employed. At the time of the interview, seven of them had already experienced work-related changes such as partial or full-time sick leave and job modifications. A few had been exposed to colleagues' comments about taking sick leave during early pregnancy, which was regarded as an additional stressor.

The women valued the diabetes-specific knowledge of the midwives, including their knowledge of the kind of obstacles that women with diabetes may experience in their working lives. Some of the women, especially those with type 1 diabetes, had to work hard to achieve good numbers; in some cases this could affect the routines of their daily working lives. Whereas the diabetes diagnosis had previously been something personal, as soon as the woman became pregnant her condition became an issue for the whole workplace. The mainstream understanding of pregnancy as a normal healthy condition was challenged at the workplace, but the midwife on the other hand supported the woman and helped her perceive her condition as a normal one.

The quotation below illustrates how a midwife reframed a situation from a disease orientation into an issue of normal maternal tasks; being concerned about the baby`s health. Diabetes self-management is work that takes place 24 h a day, but may be invisible to others. The midwife below confirmed the woman's priorities and her responsibility to her unborn child, after she had been told by her doctor to go on sick leave (an instruction which she initially did not comply with).

*I didn't want to go on sick leave, but then she [the midwife] said:* You have to remember that the reason for being well is that you have a great deal of work behind you, which isn't something an employer sees. *I never use the diabetes as an excuse or make a big deal about this at work, but now there is a another reason, there is another life involved (C2).*

### Interpreted understanding of the value in a midwife consultation

The interpreted understanding was developed through the analysis of the three themes: being in an open atmosphere, being seen as a person, and being reassured (Figure 2).

The midwife consultation, one encounter in a series with different HCPs, provides a special service for the pregnant woman with diabetes. At its best, it relieves some of the uncertainty and strain of being in a high-risk pregnancy. We therefore regard the consultation as a restorative place, and as an encounter which takes place in an open atmosphere, in a personal/professional relationship in which it is known that the woman is perceived as a normal pregnant woman, with a feeling of trust and reassurance.

We use the oasis metaphor because it has connotations of a physical place to rest and become strengthened (through professional support) before carrying on one's journey. The journey metaphor was chosen because for a pregnant woman, whether diabetic or not, the pregnancy period is an individual journey into motherhood. However, for women with diabetes, who are already in a pre-settled pathway, the journey is punctuated by a series of checkups with various HCPs. This surveillance, as well as information and emotional support from trusted professionals, is crucial for the woman. The midwife encounter seems to counterbalance the iatrogenic effects of the medical model of management, and by association the disease orientation and objectification of the woman. The personal and subjective orientation toward the woman in the midwife consultation may be viewed as a significant professional skill, a *being skill* which is required to facilitate person-centered care.

## Discussion

### Methodological considerations

This study aimed to explore and clarify pregnant women's experiences of valuable encounters in their midwifery consultations. We recruited 30 women, 10 of whom agreed to participate. We were unable to control which women participated, how many participated, or why women chose not to participate. Selection of the participants was carried out by the secretary or the midwives at the clinic. Based on the rationale that we did not want to use an interpreter, a limitation of the study was that we chose not to include women who did not speak Norwegian. The small size of the study population meant that we were not able to ensure saturation, but the data were rich in detail and served to answer the research questions in this study. However, further themes or a different pattern may have emerged in a larger data material, and different types of data (both experiences and meanings) might have been elicited if we had included women with other ethnic origins or socioeconomic circumstances. It should also be noted that the participants did not receive transcripts of the interviews they participated in, and so were not able to check the content. A final limitation is that only the perspectives of the pregnant women were obtained.

We speculate that participation in this study may have been perceived as an additional stressor in these women's lives. However, the participating women spontaneously commented that they were happy to contribute and share their stories and experiences in order to improve future diabetes practice. Since we asked for both valuable and less valuable experiences, the women had to define for themselves what they considered to be valuable. This small qualitative study reflects a particu-

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lar Norwegian perspective; the findings may not be transferable, due to global and cultural variations in the organization of prenatal diabetes care.

Our findings show no major differences from previous research into women's experiences of normal prenatal care. The personal approach was highlighted and perceived as a valuable aspect of prenatal care. The findings might contribute to an increased understanding of health care encounters in a wider context as well as under circumstances similar to those experienced by our participants.

The first author collected and transcribed all the data. However, because of space constraints, we have not included the interviewer's contributions in the quotations; this would have provided insight into the interactional context of the interviews. Prior to the interviews, the women were informed by letter that the researcher was a midwife with an interest in communication during consultations. We were concerned that the women would therefore be reluctant to address negative aspects of midwifery encounters, as the researcher was a representative of the profession with which the women's relationships were under investigation. However, the women gave examples of negative aspects of consultations and encounters with midwives, as well as with other HCPs. When the women revealed feelings of being restricted from talking because of a tight schedule, in addition to feelings of being processed and objectified, we interpreted this as evidence that their humanity had been disregarded, and thus interpreted these situations as potentially being unintentionally morally offensive. The aim in this study was not a critique of professional practice; however, we believe that the presentation of contrasting examples is useful in addressing the circumstances under which these situations occurred. We critically examined our developed interpretations as well as our pre-understandings because we, the authors, are women and mothers, and thus have personal experience of the phenomenon under study.

## Discussion of the findings

The concept of a *birthing atmosphere*, taken from a midwifery model of care[17] developed through a synthesis of 12 previously published qualitative studies focusing on care during labor and childbirth, resonates well with our finding of the theme of an open atmosphere. According to the authors, the *birthing atmosphere* is a place that radiates feelings of calm, trust, and safety. The authors point to the fundamental basis of creating this atmosphere: the establishment of a reciprocal relationship. In our study we found that the context, the organization of care, and the interpersonal processes developed in the encounter all played an essential role in maintaining this type of atmosphere. One crucial feature was the perception that the midwife was actually listening to the woman, which helped her to open up about her concerns; this may be viewed as a prerequisite for the development of a participatory relationship.

The women also stressed that other HCPs often disrupted their conversations with the midwife. Being hurried and having a feeling of being processed may also contribute to this interpretation of having a limited amount of time. Similar findings were reported in a Finnish study of prenatal care,[18] where pregnant women who observed other women waiting in line and other patients in the waiting room felt that they were a burden on the midwife. Because of this, we suggest that in order to facilitate a more open and patient-centered approach in health care, it is not only interpersonal relationships that are of importance, but the entire context has to be taken into consideration.[19]

One of the main threads in our findings was *being known to each other*, which seemed to represent a facet of relationship-based care. We suggest that being known thorough many encounters may contribute to the development of personal knowledge about each other, thus helping a relationship to develop. This reciprocal knowledge of each other could be considered as a resource in the midwives' daily work, as it may facilitate the dialogue as well as ease the consultation in an effective way. Our results indicate that encounters with a variety of previously-unknown HCPs seem to produce feelings of being objectified and less satisfaction with the quality of care. Findings from a Swedish study showed that seeing two midwives rather than one did not affect satisfaction with prenatal care, but differences arose when three or more midwives were involved.[20]

The organization of prenatal care is of significance for relationships between the women and midwives, as well for relationships with HCPs which are still to be developed. A lack of continuity in care and a lack of time may negatively affect the care, which in the long run may be the origin of distrust in the system.

One woman in our study referred to this distrust *as having come to know the system*; she sought additional care outside the system on her own initiative in order, as she put it, to safeguard her midwifery care. This woman had previous experiences of midwifery care on a primary/community level, and could therefore compare her experiences between the systems. From a caring perspective, the main goal of care is to alleviate suffering and support the patient in maintaining good health. Instead, the system, through the organization of care, may create or even increase suffering, due to a discontinuity in care, a lack of time, and the perceived feeling of being restricted in talking. As a result, the woman may come to feel she is simply known as a number and not as a person. To better understand the results, below we introduce different perspectives of knowledge that may be significant in the clinical encounter.

## Levels of knowledge

Liaschenko and Fisher[21] proposed that different types of knowledge may be useful in nursing, and that knowledge in this context can be classified as case, patient, and personal knowledge.[22] Case knowledge usually represents biomedical knowledge, and knowing the woman solely in this way may position her as an object who becomes a passive recipient of care. The second level, that of knowing the woman as a patient, includes knowing her as more than a body knowing her story, and knowing something about her physical and emotional responses to treatment. The third level, personal knowledge, refers to knowledge of the woman in relation to how she is situated in the world and how she engages with the world.[23]

This resonates well with our subthemes of being known and trusting the midwives' double gaze, in which we have interpreted the integration of different types of knowledge as something which made the women feel confident and unique. This integration of different levels of knowledge is also mirrored in previous midwifery research, with Berg[24] pointing to the struggle to integrate both the medical and the *normal* perspective on childbearing issues in midwifery care. The challenge therefore seems to be that of integrating and balancing the medical perspective with the woman's perspective in the consultation, which can be seen as intertwining both an outside and an inside approach into these consultations.

## The outside and inside approach

The technological surveillance approach to the consultations was highly valued by the women in this study. The significance of this approach, which we may refer to as an outside approach, is a finding that corresponds with the results of other studies.[10,25,26] We found that the women valued the visible and audible part of the consultation: being able to actually see their baby on the screen and hear its heartbeat with the Doppler. As noted by Berg and Honkasalo,[27] *women with a high-risk pregnancy more easily lose touch with their own body and accept objective knowledge that is more correct and valuable.* The frequent use of technology in monitoring both the baby's and the woman's health may overshadow the woman's *inside* approach - how it feels from the inside - which *may devalue her body knowledge*. [28]

Recent studies point to the importance of the identification of decreased fetal activity,

measured by the mother herself in counting the movements of her unborn baby, as this gives an indication of the health of the baby and hence increases the possibility for a healthy baby to be born.[29] Saastad[30] found that women who performed this fetal movement counting in their third trimester reported less concern about their baby's wellbeing than those in the control group where no such counting was encouraged. Rådestad[31] also addressed the importance of this kind of inside approach by introducing the concept of *mindfetalness* to be used in prenatal care. The introduction of this inside approach would be of particular significance for women with type 1 diabetes, who as a group have a threefold increased risk of stillbirth.[32]

One of our respondents valued the midwives' interest in *soft things*. We interpreted this as a subjective approach to the woman which consists of an interest in non-measurable phenomena, such as emotional wellbeing, which cannot just be measured from the outside. We therefore suggest that the inside approach of focusing on *soft things* could be seen as more than just a feel-good strategy for the women; it also offers an opportunity for the HCPs to better understand and follow the woman's experiences regarding emotional wellbeing in terms of early signs and symptoms of depression. According to findings from a Swedish study, one-third of postpartum depression cases start during pregnancy.[33]

When the women spoke about this valuable encounter they mentioned being in an open atmosphere, as well as being listened to, responded to, and encouraged to talk about their concerns. Being guided by the patient's experiences seems to be of significance in building a reciprocal participatory relationship, where both parties may develop a new understanding of each other. The midwives' engaging in listening and picking up concerns resonates with Friberg's concept *to follow and let oneself be followed* which underline *a situation where the health professional follows the patient, guided by patient experiences, and a need for understanding. At the same time, it means that following the patient's experiences creates possibilities for the health professional to reason and act in a way that the patient can follow.*[34]

One of our participants stated that *it's good for the midwives to be on the same level,* which may be an example of an interpretation of the professional midwife's interpersonal competence[35] at integrating different levels of knowledge as well as an empowering strategy. This is in line with Hermansson and Mårtensson's[36] concept analysis of empowerment in midwifery context; they refer to empowerment as an act *to meet the woman where she is, trying to understand her and respect her as a human being, and adapt to her conversation and communication.* Another aspect of an empowering strategy is seen in the context of when the women found accessibility to the midwives over the phone to be of importance. Knowing that support is available when needed seems to be a buffer in stressful situations.[37] This may be of significance to pregnant diabetic women, as they seem to have an extended need for emotional appraisal and informational support during their childbearing period, including pregnancy.[9]

In a collaborative multidisciplinary approach, the different professionals may contribute to a tailored care where different perspectives complement each other to ensure that the woman experiences the healthiest pregnancy possible. The midwifery contribution to the wellbeing of these women is grounded in the capacity to form personal and participatory relationships with them.

## Conclusions

We suggest that some prerequisites for pregnant diabetic women to manifest their concerns may be related to organizational as well as interpersonal aspects, both for the HCPs and for the pregnant woman. The important aspects are therefore: i) the continuity of the care; ii) the actual scheduled time for the consultation, and iii) the HCP's openness and responsiveness to the woman and the degree to which there is a narrative and personal approach in the encounter.

We suggest that prenatal care is a morally loaded practice. Although all the women in our study valued the medical focus, and believed that it benefited their and their baby's physical health, women may feel morally offended by being seen and treated as a physical object. Our participants also valued the contribution of the midwives, interpreted as a holistic focus on their pregnancy that included their emotional wellbeing, which seemed to counterbalance the medical focus.

Open, personal, and trustful relationships may help to facilitate and open up for women's voices to be manifest in the conversations, and thereby may contribute to wellbeing; the feeling of being in an oasis, in a restorative and reassuring place.

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