This is an electronic reprint of the original article. This reprint may differ from the original in pagination and typographic detail. Please cite the original version: Niela-Vilen H, Axelin A, Flacking R. The golden hour in Finnish birthing units - An ethnographic study published online ahead of print, 2020 Jul 7. Midwifery. 2020;89:102793.
https://doi.org/10.1016/j.midw.2020.102793 © 2020.
This manuscript version is made available under the CC-BY-NC-ND 4.0 license. To view a copy of this license, visit https://creativecommons.org/licenses/by-nc-nd/4.0.

The golden hour in Finnish birthing units - an ethnographic study

Abstract

Objective: To explore midwives' and parents' perceptions and actions as well as the culture surrounding the first hour after the birth of a baby – the golden hour.

Design: Short-term ethnographic study, which included observations, informal interviews and focus group interviews. Thematic network analysis was used to analyse the data.

Setting: Two birthing hospitals in Finland.

Participants: The first hour following 16 births was observed and informal interviews of attending midwives (n=10) and parents (n=3 couples and n=6 mothers) were conducted to supplement the observations. The 16 cases included both primiparous (n=8) and multiparous (n=8) women, as well as vaginal (n=12) and elective caesarean births (n=4). Furthermore, two focus group interviews with midwives (n=9) were conducted to deepen the understanding.

Findings: The over-arching theme Unchallenged hospital 'rules' comprised the two main themes of Safety-driven support by midwives and Silent voices of the parents. The hospital guidelines and practices guided the first hour, unchallenged by parents and midwives. Based on the guidelines, all the babies were given skin-to-skin contact early but not immediately. Midwives strictly followed the guidelines and performed many activities with the mothers during the first hour. Embedded power was present: midwives were in control but tended to listen to the parents. Although the mothers displayed a strong need to be close to their babies, their voices were silent in the units. The parents' compliance with midwives and parents' intense focus on the baby strengthened the midwives' embedded power.

Key conclusion: Care culture in birthing units was 'rule-based' and the guidelines and practices sometimes inhibited uninterrupted skin-to-skin contact without questioning. The golden hour was mainly controlled by the maternity care staff.

Implications for practice: Re-evaluation of hospital guidelines should enable more woman- and family-centred care. The golden hour is unique to families, and unnecessary separation and interventions should be avoided.

Keywords: birthing unit; ethnography; golden hour; midwife; skin-to-skin contact

Introduction

The golden hour—the first 60 minutes in human life— has some significant clinical and emotional consequences for both the mother and her baby (Moore et al., 2016; WHO, 2018). The golden hour concept has been adopted from adult emergency medicine, where the first hour seems to be critical for the survival of a patient. For an infant, the transition from intrauterine to extrauterine life is the most complex adaptation process occurring in human life. An infant's onset of breathing is one of the concrete signs of this adaptation process (Hillman et al., 2012). In addition, delayed cord clamping, thermoregulation and breastfeeding are essential components of the golden hour (Sharma et al., 2017). For sick and preterm babies, the golden hour is aimed at stabilizing their condition (Sharma, 2017).

For a new-born baby, being in skin-to-skin contact (SSC) with the mother is the most natural environment for the adaptation to extrauterine life; thus, immediate and uninterrupted SSC during the first hour after birth is strongly recommended (Moore et al., 2016; WHO, 2018). SSC supports the physiological stabilization of the baby (Bystrova et al., 2003; Marin Gabriel et al., 2010; Moore et al., 2016) as well as early bonding and mother-baby interaction (Bystrova et al., 2009; Flacking et al., 2012; Moore et al., 2016). Both immediate and continued breastfeeding is supported by SSC. Healthy babies provided SSC instinctively demonstrate certain behaviours resulting in breastfeeding within the first 1-2 hours after birth. Babies allowed to go through all nine instinctive stages without disturbance may later exhibit more optimal self-regulation (Widström et al., 2011; Widström et al., 2019). It is important to ensure that the practice of SSC is immediate and uninterrupted unless medically justifiable (Brimdyr et al., 2018).

From the perspective of birthing unit staff, some duties are necessary during the first hour. The time between birth and the delivery of placenta and membranes is called the third stage of labour. The

placenta should usually be delivered during the hour after a baby's birth. Checking the uterus as well as collecting and estimating bleeding is important after the birth to ensure the well-being of the mother. Perineum, vagina and vulva tears are also examined and repaired after the birth to minimize the risk of infection and blood loss. It is recommended to keep the mother and her baby in the birthing room for a minimum of one hour after the delivery of the placenta (NICE, 2014; WHO, 2015).

Despite strong evidence of the benefits and uniqueness of early SSC during the first hour after birth, hospital care practices vary (Widström et al., 2019). Worldwide, fewer than half of new-born babies experience SSC during the first hour (UNICEF, 2016). Few studies have been conducted regarding underlying routines or individual midwives' actions and habits influencing early SSC in hospital settings. In an Australian study, health professionals' actions concerning SSC following a caesarean section (CS) were influenced by their environment and institutional regulations (Stevens et al., 2018). By increasing our understanding about various care cultures and practices concerning the golden hour, it is possible to further develop guidelines and practices that promote SSC and potentially increase parent-infant closeness. The objective of this study was to explore midwives' and parents' perceptions and actions as well as the culture surrounding the golden hour in a birthing room.

Methods

Design

This study utilised a short-term ethnographic approach (Pink and Morgan, 2013). Short-term ethnography is a method characterized by forms of intensity; the research activities are undertaken in a shorter time frame than in traditional ethnography. Focused observation and accurate selection of informants are needed to successfully perform short-term ethnography. The research takes place in "natural" settings, where people's actions and accounts are studied in everyday contexts to elicit more obvious (explicit) and hidden (tacit) knowledge (Hammersley and Atkinson, 2007; Pink and Morgan, 2013).

Setting

The two birthing units in this study were located in a tertiary-level university hospital (about 4000 births per year) and a secondary-level central hospital (about 1500 births per year) in Finland. Both units had single-family rooms for women in labour. All rooms were furnished with a birthing bed and a rocking chair or armchair. One side of the rooms had a sink and a table for the baby. In each

room, there were lots of closets and drawers with equipment for the maternity care staff to use. Efforts had been made to "hide" some equipment to make the rooms cosier. However, the spotlights in the ceiling, oxygen tubes and infusion holders revealed the rooms to be part of a hospital. The rooms in the central hospital were spacious compared with those in the university hospital. Computers were present in each room, but only in the central hospital were the midwives supposed to work with the computers and fill in the hospital records. At the university hospital, the midwives completed the patient records in a separate office; the computers in birthing rooms were used to follow cardiotocography during labour. Lighting in the rooms was adjustable and was usually dimmed during the second stage of labour. The level of sounds changed according to the persons present. In addition, many parents listened to music or the radio during labour.

Midwives work rather autonomously at the public birthing hospitals in Finland. They are responsible for labour and birth, and an obstetrician will be present only if necessary; for example, to perform vacuum extraction. Early SSC is a normal care practice for healthy full-term babies. However, guidelines about the details of SSC are local for each Finnish hospital and may differ regarding, for example, the duration of SSC.

In the two birthing units, two midwives and/or a student midwife were present in the birthing room with the woman in labour and her partner, limiting the total number of people in the room. In vacuum extraction-assisted births, an obstetrician and sometimes a neonatologist were also present; thus, the rooms could be full of people opening and closing the door, coming and going during the first hour.

Sample and data collection

The short-term ethnography consisted of observations, informal interviews and focus group interviews in two birthing units in November-December 2017 and in November 2018. All observations and interviews were conducted by the first author, who had also worked as a midwife. The maternity care staff was informed in advance about the study; midwives who did not want to participate were asked to email the researcher. None of the midwives declined to participate. The researcher usually arrived in the unit in the morning and consulted the midwives about eligible participants. All pregnant women in labour were eligible for the study regardless of gestational week, parity or pregnancy complications. Only women and their partners whose baby had died in utero were excluded. Women in early stages of labour and their partners were preferred in order to provide time for them to consider their consent. Only one woman and her partner were recruited

near to the second stage of labour as the situation was calm. After receiving preliminary consent from the midwives, the researcher approached the families and provided verbal and written information about the study. If all persons involved were willing to participate, each of them (the midwife, the pregnant woman and her partner) was asked to sign a written informed consent.

Data were collected through observations during the first hour after birth in birthing rooms and were supplemented by informal interviews with the participants when relevant and feasible. The researcher entered the room just before the birth and stayed in the room during the first hour after birth; the level of the researcher's participation was low. Field notes were taken based on observations, using Spradley's (1980) nine-dimension framework for ethnographic observation as a guide. The framework includes perspectives of 1) space, 2) actor, 3) activity, 4) object, 5) act, 6) event, 7) time, 8) goal and 9) feeling. Following the observations, informal interviews were conducted with some parents and attending midwives after the first hour. The discussions were related to topics that emerged during observations, such as how the parent had experienced a certain event or the rationale for why the midwife had performed a specific activity. The midwives were interviewed in private spaces during the same shift when they had a free moment. The parents were interviewed immediately after the golden hour in the birthing room, or later in the postnatal ward. Privacy was always ensured. Some discussions were audio recorded, but in most cases, the researcher made notes about the participants' responses. Participants were always asked about audio recording; some declined, and in some cases, the researcher made the decision not to record because it would have disturbed the discussion. In addition, the guidelines concerning SSC practices in the units were included in the data.

A total of 16 golden hours were observed: 10 at the university hospital and six at the central hospital. Twelve births were vaginal and four were elective caesareans and all but one baby (born at 35 gestational weeks) were born at full term. Half of the mothers (n=8) were primiparous. The age of the mothers was on average 31 years (range 21-39 years) and for the fathers 34.5 years (range 25-60 years). Fifteen of the mothers were supported by a male partner during the birth, and one woman had no support person with her. Altogether,16 midwives were observed, and they had on average 13 years of work experience with a range of 0.5-30 years. Informal interviews were conducted with a subsample of parents (n=3 couples and n=6 mothers) and midwives (n=10) (Table 1).

To gain a more comprehensive understanding about the position of power and unit routines, two focus group interviews (one in each study hospital) with midwives were conducted. Head midwives were approached to set times for the interviews. Midwives who were working during the pre-planned date and time were invited by the researcher to participate, and written informed consent was asked for if the midwife was willing to participate. Two of the participating midwives had also participated during the observations of the golden hour as attending midwives. The interview questions focused on power issues between midwives and parents as well as routine care practices in birthing rooms. The focus groups lasted about an hour and were audio recorded (Table 1).

Ethical considerations

Approval from the Ethics Committee of the Hospital District of Southwest Finland was obtained before data collection. All individuals participated voluntarily and signed a written informed consent form. No incentives were used. A protocol for addressing potential observed unethical practices was created in the research group prior to data collection. No such practices were observed in this study.

Data analysis

The ethnographic data were analysed using thematic network analysis (Attride-Stirling, 2001) and involved the interpretation of the meanings, functions and consequences of human actions and institutional practices (Hammersley and Atkinson, 2007). The field notes and the recorded interview data were transcribed and transferred to NVivo Version 11. The thematic network analysis followed the three-stage process (i.e., breakdown of text, exploration of text and integration of the exploration) described by Attride-Stirling (2001). In the first stage, data were coded on the basis of the salient issues that were identified in the text. The first and second author, both Finnish speaking, read all the data and the first author did the initial coding. Through discussions with all authors, themes were derived from the codes and were grouped together to form basic themes, which were then clustered into organizing themes and summarized into a global theme, presented in a network (Figure 1). In the second stage led by the first author, the original text was explored once again but by using the basic, organizing and global themes as a lens. Preliminary network figures were used as a basis of the discussions. In the last stage, the network was summarized as a storyline grounded in the discovered patterns.

Findings

Unchallenged hospital 'rules'

A global theme of *Unchallenged hospital 'rules'* emerged from the data set. 'Rule-based' culture prevailed in both units and the guidelines or routine practices were not challenged. The two organizing themes that explained the unchallenged hospital 'rules' were *Safety-driven support by midwives* and *Silent voices of parents*. The basic themes that were discovered described how midwives *followed the hospital guidelines* and felt *a need to perform activities* to guarantee the safety of mothers and babies. Midwives genuinely wanted to provide the best possible care, but their *embedded power* meant that they were the ones who made the decisions on what was the best care. The midwives were also the ones who initiated and *led parent-midwife interaction* and subsequently held the power. The mothers displayed a strong *need to be close to their babies*, but their voices were silent in the units. Parents felt safe in the units and did not even consider confronting the guidelines but *complied with midwives* because they trusted them. *Being in a bubble* reduced parents' means to state their preferences and needs. (Figure 1.)

Safety-driven support by midwives

Early and continuous SSC until the end of first breastfeeding was stated in the care guidelines in both hospitals, and these ***guidelines were carefully followed***. Aiming for SSC was the priority in both study hospitals and was realized with all babies participating in this study; it was the main concrete action dominating the first hour. However, all babies in both hospitals were dried on beds or tables before SSC; thus, vaginally born babies were about two minutes old and caesarean-born babies 3–7 minutes old when placed on their mothers' chests. In the central hospital, the babies born by caesarean section were taken to a separate room next to the operating room (OR) to be dried and measured; the father/partner could participate in this. In the university hospital, the caesarean-born babies were dried in the OR, and the measurements were performed after the first hour.

Extract from the field notes (ID09, vaginal birth):
9:55 baby girl born, midwife dries the baby on the bed. Dad takes a picture, baby starts crying. Dad asks if the baby is a girl and midwife suggests dad to take a look himself. Dad sees that the baby is a girl. 9:56 baby stops crying and starts again, assisting midwife takes blood samples from the umbilical cord. 9:57 midwife lifts the baby onto mum's belly, baby calms down, dad takes pictures. Mum looks at the baby.

The fundamental goal for the midwives was to ensure the safety of the mother and her baby. From the midwives' perspective, the initial drying of the baby was very important to maintain optimal

temperature, and they also had instructions to take blood samples instantly after the birth from the umbilical cord. Further, midwives had ‘habits’ and they conformed to normative unwritten practices, which influenced what they did. Midwives did not think the SSC after initial drying as being delayed but as more convenient for the mother, because she could have a minute to take a break and possibly move to a more comfortable position.

“Well, I’ve always kind of tried to do it, so I dry the baby first and then I hand it over to mum. I mean, I’ve never really done it so that I’d give baby straight to mum, because, well, I dunno who it benefits really when it’s all wet and slippery…”(midwife, central hospital).

“And then we got blamed for it getting cold, like some paediatrician said ‘Do you give it straight to mum all yucky and slimy?’ But that’s quite rare, but I’ve got that kind of feedback as well. Sometimes I ask mum if she wants to take it, but it’s quite rare that they dare hold the baby; but, then, obviously, if mum wants to take it, she can, and I try to get in between and dry it. But it’s mostly just drying baby, measuring the blood gases, then giving to mum, and, if she’s been in some other position, then mum gets into a better position so she can hold baby and catch her breath for a second” (midwife, university hospital).

SSC was supposed to be maintained until the end of the first hour but was interrupted in cases of compromised baby health. An incubator was seen as a safer environment than SSC for a baby who had breathing difficulties. Further, at the central hospital, SSC was interrupted while the umbilical cord was clamped; the baby was removed from SSC and placed in a bed for a few minutes. The midwives justified this by the baby’s position on the bed being more firm, making the cord easier and safer to clamp and cut, especially if the father/partner did it. In addition, the baby was easier to check—for example, for the number of fingers and toes as well as the palate. At the university hospital, the umbilical cord was always clamped during SSC, and the midwives did not see any reason to change this practice. Delayed cord clamping was the practice in both hospitals.

“I dunno, it’s probably just one of those things. I mean, some do it that way, that the cord is cut in skin to skin, and others want to put the baby on the bed while messing around with the scissors, and it’s usually dad that cuts the umbilical cord then” (midwife, central hospital).

As midwives knew about the importance of SSC for breastfeeding, the initiation of breastfeeding during the first hour was encouraged by the midwives. The importance of the first breastfeeding

was also mentioned in the units' guidelines. Almost all babies latched and started to suckle at the breast during the first hour. There were five exceptions: a preterm baby, two whose births had been assisted by vacuum extraction, a baby born by caesarean and one whose mother had given birth vaginally without complications. By the end of the first hour, these five babies were in SSC and practised suckling. In both hospitals, the official policy was to let the baby crawl to the breast without additional help, and based on the interviews, the midwives were aware of the nine stages of the new-born by Widström and colleagues (2011). However, in practice, the midwives often touched the baby and changed the baby's position to help her/him access the nipple.

During the first hour, the midwives displayed and described ***a need to perform many activities*** with all mothers; removal of the placenta, suturing of the perineum, assessing uterine tonus and measuring bleeding were seen as essential parts of care. In addition, the midwives took samples from the umbilical cord and/or placenta, carried away the used instruments, cleaned the room and the bed, provided sanitary towels and underpants to women, and observed the new-born babies. Sometimes, these routines filled the whole hour, for example, if the perineum laceration was demanding. Based on the observations, midwives usually had more to do with primiparous compared with multiparous mothers, as the latter hardly needed any stiches and they acted more independently due to their previous experiences. Midwives wanted to provide privacy for the families and aimed to minimize inconvenience for the parents, but the routines were seen as a fundamental part of their job. *"The midwives are busy doing their job while the family can focus on each other" (midwife, university hospital).* Optimal golden hours included a healthy baby, moderate maternal bleeding and no hassle. If these goals were achieved, the midwives were satisfied.

Both families and midwives impacted on the tone of the first hour, but midwives were the chief conductors of the 'orchestra' playing in birthing rooms and the ***embedded power*** was evident. For example, it became evident that when the SSC was interrupted, the decision was always made solely by the midwives. They usually consulted the parents about whether it was acceptable to take the baby, but usually it was done when they already had hands around the baby, and the parents consented. However, the intent of the midwives' decisions was good and they aimed for the well-being of the babies and the families. The midwives were aware of the existing power, but they did not want to use it unless they were forced to, to ensure safety. Midwives thought they were justified in using power in the case of compromised baby health.

"I'm of the opinion that we should do everything together, but then if there's some kind of, like, some kind of problem, then it's one of them—yeah, the doctor and the midwife—that make the decisions there" (midwife, central hospital).

"I think that, like, if there's, like some kind of, like, problem, foetal distress, well, that's when the midwife takes a more active role, so it's then that it maybe changes but not otherwise" (midwife, university hospital).

Although midwives were able to make almost all the birth and baby related decisions, they genuinely tried to listen to and share the decision-making with the mothers and their families. The midwives stated that birthing culture had changed during the past decades; previously, the midwife had true authority, and women in labour just obeyed midwives' orders without questioning. Today, care is more woman-centred, and the wishes and desires of the pregnant woman (e.g., pain relief) guide labour and birth. Many mothers had lists of their wishes with them. Some of the midwives with long careers described how the culture had dramatically changed from one extremity to another; however, the change process had not been easy.
"Yeah, [childbirth today is] all about choices and a journey of discovery" (midwife, central hospital).

Although the interaction and communication between the midwives and the families and being on the same wavelength (or not) played a major role during the first hour after birth, ***interactions were midwife-led***. Personalities and communication between parents and midwives seemed to guide whether the atmosphere in the room was extremely quiet and peaceful, loud and passionate or something in between. Midwives considered their own roles important, especially during the first minutes after birth. They felt responsible for how the atmosphere developed and how the parents reacted and felt after their babies were born.
"Yeah, I somehow thought, like, how does it all get going, like it's really important […] I need to stay calm, that it's, like, their moment, that I shouldn't start getting involved and making a terrible fuss, and that, after all, it's a moment, and you somehow feel that, of course, the parents will also start getting caught up in the stress of it, so you remind yourself to calm the situation down and then the parents usually relax, too" (midwife, university hospital).

In most cases, the midwives and parents seemed to have good relationships. They discussed, for example, postpartum issues, the family's other children or the course of labour. Some midwives

acted very energetically, talking constantly while doing some procedures such as sewing. They wanted to provide advice about the postnatal period and baby care at the same time to be able to give the family more private time. Most of the midwives always seemed to be calm and wanted to create peaceful atmospheres during the first hour, but loud and lively labour support persons had also a big impact on the feel of the birthing room.

Silent voices of the parents

Most of the mothers had a very strong ***need to be close to the baby***. Immediately after the birth, many mothers tried to reach their babies, who were being dried on the foot of the bed. However, none of the mothers asked to have the babies immediately for SSC but waited for the dried babies. The mothers started to look for an eye contact with the babies during SSC.

In addition, the mothers talked to the babies or just enjoyed the closeness and seemed relieved after a painful labour.

Extract from the field notes (ID02):

12:34 baby born, quickly starts crying. The midwife dries baby on top of the sheets. The mother gasps, beginning to reach for the baby lying between her legs to calm it. Dad is moved and talks to mum. 12:37 baby is placed skin-to-skin with mum and is soothed, mum starts talking to baby.

The fathers were usually more cautious and hesitated to touch the babies, immediately taking a step back if maternity care staff members approached the babies and the mothers. Sometimes, a midwife asked the father to come closer, take a seat and touch the baby. Fathers had their own place beside the birthing bed on a chair; most of the fathers kept that position during the first hour. Some fathers focused on their phones and sent messages or called the grandparents or other relatives. Phones were also used to take photos of the babies. Some families completely focused on the moment, seemed very happy, were close to each other and looked at and touched the baby, seeming to ignore all other persons and occasions. The parents also chatted with each other about the baby's characteristics and how she/he looked.

Parents' ***compliance with midwives*** strengthened the embedded power of the latter. The parents trusted the maternity care staff and the Finnish hospital system, felt safe, and did not want to confront or challenge midwives. The parents' trust to midwives was rarely explicitly said, but they carefully listened to the midwives' advice and let the midwives conduct all procedures with the mothers and babies. A couple of the mothers commented about the trust toward midwives or hospital system:

"I was nervous in advance, but not anymore there [at the birthing unit]" (mother, university hospital)
"Yeah, I don't think I would've needed anything more... Somehow everything turned out well in the end. I reckon that the system is pretty good in Finland." (mother, university hospital)

The most evident sign of trust and feeling safe was that the parents hardly ever criticized the decisions or activities of midwives. One mother though, described afterwards at the postpartum unit a negative experience related to breastfeeding and a nipple shield at the birthing unit:
"Like when we put baby on the breast and the nurse came in and shoved the boob in its mouth and put a nipple shield when it didn't work right away and...it was kind of hectic, and then I remember that I'd been stitched and my husband had gone to get some flowers..." (mother, university hospital).

Another reason for parents' silence was that, although some knew what was going to happen immediately after the birth, parents were seen by midwives as "***being in the bubble***", unable to focus on anything else other than their new-born baby. Hence, parents lacked the capacity to argue or discuss their views and needs. Based on the interview data, multiparous mothers had previous experiences about the first hour and SSC, and some of the primiparous women also knew about early SSC, as it was discussed in parent training groups. However, one mother having her first child assumed that she would have SSC with her new-born for a moment. She did not know that she was allowed SSC during the whole first hour and beyond. Some of the midwives in birthing units did not provide any advice about the postpartum period in advance. The responsibility to start the discussion about the postpartum time was on the pregnant women and families; one midwife said that if the family brought up the topic, she would talk about it.

Being in a bubble resulted for many mothers in having pleasant but quite vague memories about the first hour after birth. They could not identify the exact events. The fathers' memories were sometimes more accurate, especially regarding times and the order of the things that happened. In general, the parents were really pleased with the time after birth in birthing units and had mainly positive memories.
"Mmmm, [I remember from the first hour] well, at least from when it was searching for the boob [laughter]… but, yeah… yeah, I dunno, she was pretty overwhelmed somehow, all caught up in the moment" (mother, university hospital).

Discussion

The golden hour in Finnish birthing units was led by unchallenged 'rules' comprised of hospital guidelines and practices. All babies were placed in early SSC, although not immediately, and the early initiation of breastfeeding was encouraged with "hands-on" support. The midwives displayed and stated needs to perform tasks to ensure the safety and well-being of the babies and their mothers during the first postpartum hour. Furthermore, the midwives usually initiated the interaction and communication with the family. Parents' voices in birthing units were more silent. Although mothers displayed a strong need to touch and be close to their babies, they did not ask, for example, for immediate SSC. Parents were compliant with the midwives, which strengthened midwives' embedded power. Because parents felt like they were in a bubble, they had fewer resources to argue their case, and their memories from the first hour after birth were vague.

None of the babies in this study had immediate SSC with their mothers; the babies were dried on the bed or the table first and were a couple of minutes old when they received SSC. In many cases, SSC was interrupted without any medical reason because of hospital practices, as has been found in other studies (Niela-Vilen et al., 2017; Brimdyr et al., 2018). The international standard emphasizes immediate or early continuous and uninterrupted SSC for at least one hour. Term babies should be placed in SSC immediately or within five minutes after birth (WHO and UNICEF, 2018); this standard was mostly met in the study hospitals. However, the skin-to-skin implementation algorithm (i.e., the golden standard related to the first hour), such as continuous and uninterrupted SSC as well as compliance with the instinctive behaviours of babies, was not achieved (Brimdyr et al., 2018). The instinctive behaviours of full-term babies, also known as Widström's 9 stages, were not always facilitated by the midwives in this study, although they were aware of them. A change in attitude is probably needed to let new-born babies lead the first hour instead of trying to expedite the initiation of breastfeeding by transferring or repositioning the baby. The resting stage in particular can be misinterpreted as a failure to accomplish the 9 stages, because resting can be repeated throughout all stages. The first hour is a unique and sensitive period for both baby and mother, and they need to be supported and protected by evidence-based practices (Widström et al., 2019).

Decisions about continuing or interrupting SSC with parents were made by the maternity care staff and guided by hospital routines and practices. For example, interrupting SSC due to cord clamping exemplified how unwritten hospital routines overrode individual needs. Parents seemed to very compliant with the care provided and had high trust in the hospital system and in midwives, who

have a high status and are valued and respected in Finland. This compliance to medical knowledge and thus the medical authority is not unusual in maternity care (Larsson et al. 2009, Sinivaara et al., 2004). Starting with Michel Foucault (1975) many authors have explored the potential for recipients of health care in institutions to be rendered powerless by professionals who are gatekeepers of knowledge. The power dynamics of surveillance in institutions have recently been discussed by Newnham et al (2017), who suggest the focus on safety in the culture of contemporary maternity care can override efforts to promote normal birth practices. In this study, midwives suggested that the focus of parents on their baby in the immediate hour following birth, described as "being in a bubble", was an extra factor that overrode any impetus to challenge actions that were seen as routine hospital practices or 'rules'.

A midwife is a woman's primary carer in a birthing room and probably has an impact on the woman's birthing experience. Borrelli (2014) explored the definition of a good midwife, establishing several attributes, such as theoretical knowledge, professional competence, personal qualities, communication skills and moral/ethical values. Based on the literature, however, childbearing women want support, power over decisions, a feeling of control and information. It seems that the definition of a good midwife depends on the perspective (Borrelli, 2014). In this study, midwives were convinced of their professional competence and had strong professional identities and therefore might have had such roles as 'chief conductor' in the birthing room (Blix-Lindström et al., 2008; Larsson et al., 2009). The intent of the midwives was good, and they wanted to provide the best possible care and support women individually; it is suggested that more woman-centred care models would be preferred (Sinivaara, et al., 2004; Wennberg et al., 2015; Lundgren et al., 2019) but midwives might feel that their role is becoming limited by the pressure of other professionals, organizations and changing society (Larsson et al., 2009; O'Boyle, 2014).

Limitations

Observation as a method might have influenced the trustworthiness of this study. The researcher's level of participation was as low as possible (Spradley, 1980), but her presence might have impacted on the behaviour of the people studied. The observed period was extremely sensitive, and some of the families declined to participate, which might have threatened the trustworthiness of this study. The researcher had previously worked in a birthing unit; thus, her experiences might have had an influence on the observations and analysis. However, before data collection, the researcher reflected on her thoughts about the first hour to identify her preconceptions. Credibility was further enhanced through discussions with other researchers who are not midwives and had no previous

work experience in birthing units. In addition, data extracts and direct quotes were used to illustrate the data and analysis. The data were collected only in two birthing units, which may limit the transferability of the findings; however, this study could be used as an example to promote discussions about the golden hour after birth as well as the effects of power dynamics in maternity care.

Conclusions and clinical implications

Care during the golden hour in birthing units is based on hospital guidelines and practices, which were not challenged. Early, but not immediate, SSC was routine practice, but babies were not allowed to accomplish the natural behaviours suggested in the literature. The care culture in birthing units has changed during the last decades, but midwives still have the power and parents adhere to midwives' decisions. A critical re-evaluation of hospital guidelines and unwritten practices among unit managers and midwives as well as obstetricians and neonatologists should be conducted. Pregnant women and families should be included in the development process to make care culture more equal and strengthen personalised care and shared decision-making.

References

Attride-Stirling, J., 2001. Thematic networks: an analytic tool for qualitative research. Qualitative Research 1 (3), 385–405.

Blix-Lindström, S., Johansson, E., Christensson, K., 2008. Midwives' navigation and perceived power during decision-making related to augmentation of labour. Midwifery 24, 190–198.

Borrelli, S.E., 2014. What is a good midwife? Insights from the literature. Midwifery 30, 3–10.

Brimdyr, K., Cadwell, K., Stevens, J., Takahashi, Y., 2018. An implementation algorithm to improve skin-to-skin practice in the first hour after birth. Maternal & Child Nutrition 14 (2), e12571. doi: 10.1111/mcn.12571.

Bystrova, K., Ivanova, V., Edhborg, M., Matthiesen, A.-S., Ransjö-Arvidson, A.-B., Mukhamedrakhimov, R., Uvnäs-Moberg, K., Widström, A.-M., 2009. Early contact versus separation: effects on mother-infant interaction one year later. Birth 36 (2), 97–109.

Bystrova, K., Widström, A.-M., Matthiesen, A.-S., Ransjö-Arvidson, A.-B., Welles-Nyström, B., Wassberg, C., Vorontsov, I., Uvnäs-Moberg, K., 2003. Skin-to-skin contact may reduce negative consequences of "the stress of being born": a study on temperature in newborn infants, subjected to different ward routines in St. Petersburg. Acta Paediatrica 92 (3), 320–326.

Flacking, R., Lehtonen, L., Thomson, G., Axelin, A., Ahlqvist, S., Hall Moran, V., Ewald, U., Dykes, F., 2012. Closeness and separation in neonatal intensive care. Acta Paediatrica 101 (10), 1032–1037.

Foucault, M., 1975. The birth of the clinic an archaeology of medical perception. New York: Vintage Books.

Hammersley, M., Atkinson, P., 2007. Ethnography: principles in practice (3rd ed.). London: Routledge.

Hillman, N., Kallapur, S.G., Jobe, A., 2012. Physiology of transition from intrauterine to extrauterine life. Clinics in Perinatology 39 (4),769–783.

Larsson, M., Aldegarmann, U., Aarts, C., 2009. Professional role and identity in a changing society: three paradoxes in Swedish midwives' experience. Midwifery 25 (4), 373–381.

Lundgren, I., Berg, M., Nilsson, C., Olafsdottir, O.A., 2019. Health professionals' perceptions of a midwifery model of woman-centred care implemented on a hospital labour ward. Women and Birth 33 (1), 60–69. doi: 10.1016/j.wombi.2019.01.004.

Marin Gabriel, M.A., Llana Martín, I., López Escobar, A., Fernández Villalba, E., Romero Blanco, I., Touza Pol, P., 2010. Randomized controlled trial of early skin-to-skin contact: effects on the mother and the newborn. Acta Paediatrica 99 (11), 1630–1634.

Moore, E.R., Bergman, N., Anderson, G.C., Medley, N., 2016. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews CD003519.

Newnham, E.C., McKellar, L.V., Pincombe, J.I., 2017. Paradox of the institution: findings from a hospital labour ward ethnography. BMC Pregnancy and Childbirth 17:2. doi: 10.1186/s12884-016-1193-4

O'Boyle, C., 2014. "Being with" while retaining and asserting professional midwifery power and authority in home birth. Journal of Organizational Ethnography 3 (2), 204–223.

NICE, 2014. Third stage of labour and Care of the baby and woman immediately after birth. Intrapartum care: care of healthy women and their babies during childbirth. NICE Clinical

Guidelines, No. 190. National Collaborating Centre for Women's and Children's Health (UK). London: National Institute for Health and Care Excellence.

Niela-Vilen, H., Feeley, N., Axelin, A., 2017. Hospital routines promote parent-infant closeness and cause separation in the birthing unit in the first two hours after birth – a pilot study. Birth: Issues in Perinatal Care 44 (2), 167–172.

Pink, S., Morgan, J., 2013. Short-term ethnography: intense routes to knowing. Symbolic Interaction 36 (3), 351–361.

UNICEF, 2016. From the first hour of life. Making the case for improved infant and young child feeding everywhere Part 1: focus on breastfeeding. UNICEF 2016. Available at: https://unicef.at/fileadmin/media/Infos_und_Medien/Info-Material/Ernaehrung_und_Gesundheit/FromTheFirstHourOfLife.pdf

Sharma, D., 2017. Golden hour of neonatal life: need of the hour. Maternal Health, Neonatology and Perinatology 3:16. doi: 10.1186/s40748-017-0057-x.

Sharma, D., Sharma, P., Shastri, S., 2017. Golden 60 minutes of newborn's life: part 2: term neonate. Journal of Maternal-Fetal & Neonatal Medicine 30 (22), 2728–2733.

Sinivaara, M., Suominen, T., Routasalo, P., Hupli, M., 2004. How delivery ward staff exercise power over women in communication. Journal of Advanced Nursing 46 (1), 33–41.

Spradley, J.P., 1980. Participant observation. Holt, Rinehart and Winston, Florida, USA.

Stevens, J., Schmied, V., Burns, E., Dahlen, H.G., 2018. Who owns the baby? A video ethnography of skin-to-skin contact after a caesarean section. Women and Birth 31, 453–462.

Wennberg, A.L., Hörnsten, Å., Hamberg, K., 2015. A questioned authority meets well-informed pregnant women – a qualitative study examining how midwives perceive their role in dietary counselling. BMC Pregnancy and Childbirth 15:88. doi: 10.1186/s12884-015-0523-2.

Widström, A.M., Brimdyr, K., Svensson, K., Cadwell, K., Nissen, E., 2019. Skin-to-skin contact the first hour after birth, underlying implications and clinical practice. Acta Paediatrica 108, 1192–1204.

Widström, A.M., Lilja,, G., Aaltomaa-Michalias, P., Dahllöf, A., Lintula, M., Nissen, E., 2011. Newborn behaviour to locate the breast when skin-to-skin: A possible method for enabling early self-regulation. Acta Paediatrica 100 (1), 79–85.

WHO, 2015. Childbirth: labour, delivery and immediate postpartum care. Pregnancy, Childbirth, Postpartum and Newborn Care: a guide for essential practice. 3rd edition. World Health Organization, Geneva. Available at: https://www.who.int/maternal_child_adolescent/documents/imca-essential-practice-guide/en/

WHO, 2018. WHO recommendation on skin-to-skin contact during the first hour after birth. Recommendation 2018. Available at: https://extranet.who.int/rhl/topics/newborn-health/care-newborn-infant/who-recommendation-skin-skin-contact-during-first-hour-after-birth

WHO & UNICEF, 2018. Implementation guidance. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-Friendly Hospital Initiative. Available at: https://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?ua=1

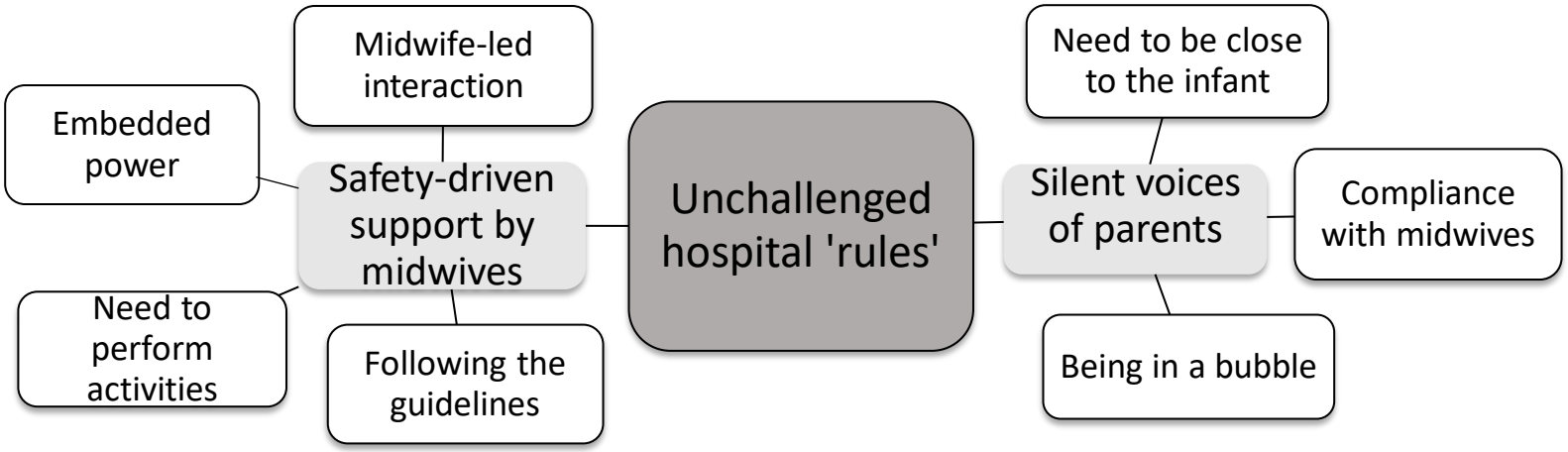

Figure 1. The global, organizing and basic themes illustrating the golden hour in Finnish birthing units