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ORIGINAL RESEARCH – QUALITATIVE

The birth bed: A qualitative study on the views of midwives regarding the use of the bed in the birth space

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ABSTRACT

Background: There is a growing body of evidence to show that the birth environment can influence women's experiences of labour and birth as well as midwifery practice. A common feature of the modern birth space is the bed. Knowledge about how the use of the bed shapes clinicians' perceptions and attitudes is limited.
Aim: The aim of this paper is to describe midwives' perceptions of the birth bed.
Method: Qualitative descriptive design. Fourteen midwives from one Queensland maternity unit participated in digitally recorded and transcribed interviews. Thematic analysis was used to analyse the data set.
Findings: Four themes were identified. The first, described beliefs that using the bed formed part of women's childbirth expectations. A second theme, captured midwives' perceptions that the bed was also an object required to safely undertake their work. The third theme described how others commonly worked to ensure the woman stayed off the bed. Lastly, there was evidence that whilst wanting to avoid the use of the bed, some were reluctant, fearing potential reprimand.
Conclusion: The themes highlight differences in how the midwives conceptualised the use of a bed within a birth space. While some avoided the use of the bed altogether others would only conceive of women moving off the bed if everything was 'normal'. How the bed was culturally constructed appeared to dictate clinical practice. Reflecting on the meaning of an object, such as the bed, is important if clinicians are to fully understand how the birth environment influences their practice and thus women's experiences of labour and birth.

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1. Introduction

Giving birth is a unique life event that creates enduring memories for every woman. Although there are certain aspects of the physiological process of labour and birth we are yet to fully understand, we do know that one to one support during labour makes a significant difference to a woman achieving a normal birth.[1] Likewise we now understand the benefits afforded to women who have access to a 'known midwife' across their entire childbirth journey.[2–4]

In resource rich countries, such as Australia, investigating models of care and their association with maternal and neonatal outcomes, especially rising rates of intervention or the lack thereof, has also led researchers to question the role the birth environment may play in how a woman feels and responds to her labour and subsequently perceives the experience.[5–10] The interplay between the birth environment (or space) and a woman's hormone response to her labour is something that many working with childbearing women have traditionally 'sensed' to be true. However it has only been fairly recently that the semiotics of the space (the meaning associated with space) have started to receive focused attention.[11–13]

Work by Australian researchers has yielded important insights into birth suite design and the features that are likely to support physiological birth.[14–16] For example, natural materials, dim lighting and the use of sensory materials, create a more relaxing calming place. In turn the ability of women to remain relaxed and in the moment helps the production of their own natural pain relieving endorphins and oxytocin. Conversely this work identified features that possibly hinder normal birth. For example, poor way

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finding, lack of warmth in the colour scheme, use of stainless steel, no ability to control lighting and temperature, doors that were left open, exposed equipment, limited place and space for families and women's belongings and no ability to access water immersion.[16] In addition, the team identified that the 'bed' remained a dominant and central feature of most Australian birth rooms. Certainly, the results of a large maternity survey conducted in Queensland, Australia,[17] support this assertion. In this study 88.3% of women who had a vaginal birth reported giving birth on a bed with 43.3% stating they did so flat on their backs.

Davis and Walker[18] have previously described the 'standard' hospital labour room as a place that conveys to women and their supporters that they are vulnerable and undertaking somewhat of a dangerous journey; "a woman at risk of peril and death rather than a woman in rapture to birth and life" (p. 386).[18] Likewise, Fahy and Parratt described the common clinical 'bed dominant birth space' as lacking privacy and one that is associated with a sense of 'surveillance'.[11] In comparison these researchers found 'home like' birth spaces resonated comfort, calmness, security and safety thus becoming a woman's 'sanctum'. Indeed Hodnett et al.'s[19] Cochrane review, which compared women using a standard hospital room vs a ambient clinical environment, found that 86% of women labouring in standard rooms spent at least 75% of their labour on the bed. Conversely, the majority of the women (65%) in the ambient room did not use the bed. The review also noted that there was an increase use of syntocinon for augmentation in women in the standard room compared to the ambient room.

Theorising the influence of the birth environment on women's physiological responses during labour has also led to questions about how this same environment may impact clinical practice. The New Zealand midwives in Davis and Walker's study[18] articulated how the 'highly obstetric' space made them fearful, changing the way they practised. In the Cochrane review[19] comparing standard and ambient birth rooms', midwives were noted to spend more time with women in the ambient birth space. Similarly Canadian midwives, when comparing working with women at home as opposed to hospital, also acknowledged how the different birth environments influenced their practice.[20] While the 26 midwives in this qualitative study acknowledged the less than ideal nature of the medicalised hospital environment, they also spoke of working hard to create a comfortable space for women as well as a hybrid work space for themselves. Hammond et al.[21] have similarly identified how Australian midwives are affected by the design of the hospital birth room. In this study midwives perceived that the way the room 'looked and felt' affected the quality of care they provided the labouring woman. Some of the midwives participating in this study admitted that a lack of space and comfort in the birth room commonly resulted in them spending less time in the room with the woman. The authors concluded that the current design of the standard 'hospital birth room' cluttered with equipment and with the 'bed' as a central feature was not conducive to current midwifery practice and the facilitation of normal birth.

Health care providers, particularly midwives, are in the unique position of being able to make decisions around how a woman's birth space is configured. Although the majority of Birth Suites continue to reflect in their design the dominance of a medical culture, there is room for clinician creativity. There remains limited understanding, however, of how clinicians think about birth space.

2. Aim

The aim of this paper is to describe midwives' perceptions of the birth bed. The findings were derived from interviews where midwives where asked to share their perceptions of the birth environment. This was part of a large programme of work exploring birth unit design [16,20].

3. Method

A qualitative descriptive approach was used. Descriptive approaches are considered an appropriate choice if the phenomenon is inadequately defined or conceptualised and typically incorporate an eclectic combination of methods in data collection and analysis.[22] Arguably the participants' subjective descriptions provide insight into understanding the human experience.[23–25]

3.1. Setting

The study took place at a regional Queensland public hospital. The Birth Suite had eight birthing rooms, each with shower facilities. Standard to each room was a bed that was surrounded by an abundance of visual medical equipment. There was minimal decoration. At one end of the Birth Suite were an additional two Birth Centre rooms. These rooms had been purpose built and each contained a large pool which was the central feature of the room. The beds were pushed to one side and covered with domestic-type quilts rather than hospital-type, white linen. The Birth Centre rooms were more aesthetically pleasing with wooden floors, artwork, dimmable lamps and all equipment hidden from sight. Only clients of the Midwifery Group Practice (caseload care) accessed these rooms. Interviews were conducted just prior to the hospital relocating to a new tertiary unit at the end of 2013.

3.2. Participants, recruitment and data collection.

Following approval from both hospital and university ethics committee's (HREC/12/QCG/51; NRS/52/12/HREC), planned as well as opportunistic, in-service information sessions were held for midwifery staff who worked in both the Birth Centre and Birth Suite to explain what the study was about. Participant information sheets and consent forms were distributed to interested staff. Once consent to participate was gained, a time and location, suitable to the clinician, was made to conduct a one-off, digitally audio recorded, unstructured interview.

At the beginning of the interview each clinician completed a short demographic sheet that collected information such as age and years of experience. The digital recorder was then switched on and participants were asked two broad overarching questions; "Can you share your perceptions of the birth environment and how you encourage women to use the birth space". As the interview progressed participants were asked to clarify and expand their responses as the need arose. Contemporaneous field notes were taken by the interviewer. The interviews lasted between 30 and 60 min.

Fourteen midwives agreed to participate in the interviews. One was a student midwife. To maintain confidentiality the student is considered as a midwife throughout this paper. All were female and aged between 25 and 61 years (mean 43). Some 17% had a Masters degree, 50% an undergraduate degree, 11% a diploma and 22% a midwifery certificate. Sixty-one percent of midwives had children of their own. Thirty-six percent of participants had worked in both the Birth Centre and standard Birth Suite whilst 57% had only worked in the standard Birth Suite and 7% only in the Birth Centre.

3.3. Data analysis

Interviews were transcribed verbatim and all identifying material removed. Thematic analysis and the techniques associated with constant comparison were used to analyse the data

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