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The phenomenon of intrapartum transfer from a western Australian birth centre to a tertiary maternity hospital: The overall experiences of partners

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ABSTRACT

Aim: the aim of this Western Australian study was to describe the overall labour and birth experience of partners within the context of an intrapartum transfer occurring from a low risk midwifery-led, woman-centred unit to an obstetric unit.
Design: a descriptive phenomenological design was used. 15 male partners were interviewed in the first 8 weeks post partum between July and October, 2013 to explore their experience of the intrapartum transfer.
Setting: a midwifery-led birth centre set on the grounds of a tertiary maternity referral hospital.
Participants: partners of women who were transferred from the birth centre to the onsite tertiary hospital due to complications during the first and second stages of labour.
Findings: five main themes emerged: (1) 'emotional roller coaster'; (2) 'partner's role in changing circumstances' with subthemes: 'acknowledgement for his inside knowledge of her' and 'challenges of being a witness'; (3) 'adapting to a changing model of care' with subthemes: 'moving from an inclusive nurturing and continuity model' and 'transferring to a medicalised model'; (4) 'adapting to environmental changes' with subthemes: 'feeling comfortable in the familiar birth centre', 'going to the place where things go wrong' and 'Back to comfortable familiarity afterwards' and (5) 'coming to terms with altered expectations around the labour and birth experience'.
Key conclusions: partners acknowledged the benefits of midwifery continuity of care, however, noted that as partners they also provided essential continuity as they felt they knew their woman better than any care provider. Partners found it difficult to witness their woman's difficult labour journey. They found the change of environment from birth centre to labour ward challenging but appreciated that experienced medical assistance was at hand when necessary. Being able to return to the birth centre environment was acknowledged as beneficial for the couple. Following the transfer experience partners asked for the opportunity to debrief to clarify and better understand the process.
Implications for practice: findings may be used to inform partners in childbirth education classes about what to expect when transfer takes place and offer the opportunity for them to debrief after the birth. Finally, themes can provide insight to maternity care professionals around the emotions experienced by partners during intrapartum transfer to enhance informed choice, involvement in care and empathetic support.

Introduction

Childbirth choices for women in Western Australia (WA) consist of one of four options. Women can choose care under a private obstetrician or GP obstetrician, with their birth taking place in a private or public hospital or care under a public hospital consultant with care provided by the medical and midwifery team. Alternately, they can select a midwife-led birth centre or home

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birth care provided by a midwife (either through a government funded programme or in independent practice) with medical collaboration as necessary. Of the 30,843 women who gave birth in 2010 in WA, 763 (2.5%) were booked for midwife-led birth centre care (Joyce and Hutchinson, 2012).

Prospective parents choosing to birth in a birth centre setting often do so due to a desire to have control over the management of their pregnancy and birth; where the right to make choices is encouraged (Laws et al., 2009). However, when transfer in labour takes place the choice is no longer with the parents. The midwife, depending on the situation, usually makes the decision in conjunction with a senior obstetrician. This scenario complicates the labour experience for partners, which is known be stressful, even when progress is still normal (Nichols, 1993; Somers-Smith, 1999; Dahlen et al., 2010).

Generally the woman's partner offers support in order to help her achieve the labour she planned for, which can be a challenging task (Laslett et al., 1997). Parents choosing to birth in a birth centre have reported feeling more involved in the care (Waldenstrom, 1999) and this involvement contributes to increased satisfaction with the experience (Hildingsson et al., 2011; Johansson et al., 2012). During the antenatal period prospective parents ideally have discussed their hopes for the labour and birth in detail, developed a birth plan and made decisions about labour choices. The partner may experience unanticipated emotions when events do not ensue as expected and the birth journey takes an altered pathway; however, we have no evidence to support this assumption within a birth centre context. Even when labour progresses normally the partner has been found to experience a range of emotions, which include feelings of uselessness and helplessness (Johansson et al., 2012; Kululanga et al., 2012; Draper and Ives, 2013), anguish (Steen et al., 2011), being sidelined or kept in the dark (Hildingsson et al., 2011), needing to be supported and involved and having trust in the professionals (Backstrom and Wahn, 2011). When the labour ends with an operative birth or other interventions take place, these sentiments can still occur but have also been found to escalate to emotions such as extreme anxiety (Johansson et al., 2013) and fear (Steen et al., 2011).

Although research has been carried out to discover partners' general experiences in labour and there are limited studies addressing their experiences when a high risk birth occurs, no research specifically has been undertaken addressing the experience of intrapartum transfer for low risk women attending a birth centre context. Therefore with no understanding of this experience from the partner's perspective, suggesting a gap in knowledge and the need for research, this study aimed to provide insight into the experiences of partners when intrapartum transfer from a low risk birth centre to a tertiary obstetric unit occurs.

Methods

Design and aim

In order to capture the lived experience of intrapartum transfer from the partners, a descriptive phenomenological study design was chosen (Polit and Beck, 2010) as it facilitates interpretation of meaning by exploring, explaining and describing phenomenon to 'make sense of them' (Taylor et al., 2007 p. 583). This choice was ideal as it focuses upon the subjective description from participants' words to gain rich data and insight into an understanding of human experiences (Liamputtong, 2010; Schneider et al., 2013) and enables description of the human experience, providing detailed accounts of various aspects of the event through seeing, feeling, remembering and evaluating (Polit and Beck, 2010). The phenomenon in this case is *the intrapartum transfer*, as described from the partner's perspective. The findings reported are part of a larger study designed to discover the lived experiences from three key players' perspectives; the woman who is central to the experience, the partner who observes and the midwife who facilitates.

Setting and participants

The study was conducted at the only midwifery-led birth centre in WA which, set on the grounds of a tertiary referral centre, provides separate midwifery care for low risk women. Families attending the birth centre (BC) are encouraged to be involved in the planning of pregnancy and childbirth in a safe, familiar setting in order to enable them to labour in a home-like environment so that stress hormones are reduced and labour is more likely to progress normally (Walsh, 2009; Brocklehurst et al., 2011). During antenatal clinic appointments and in childbirth education classes women and their partners are educated about the choices they can make around various management options. Couples are encouraged to write a birth plan which is discussed with the midwife at around 36 weeks' gestation. They are also encouraged to do their own research to support information already provided to facilitate informed choices. During labour woman are encouraged to use non-pharmacological comfort measures but nitrous oxide and oxygen and opiates are available if requested. If further pain relief such as an epidural is required or any other intervention beyond artificial rupture of membranes or cannulation for positive Group B Streptococcus (GBS) status, the woman is transferred to the OU. From July 2013 to June 2014, 609 women were booked to birth in the BC. Of these 259 (43%) were transferred antenatally to the OU for reasons such as Gestational Diabetes. Of the remaining 350 women, 118 (19%) were transferred in labour leaving 232 (38%) birthing in the birth centre (Midwifery Manager, 2014).

Women who book at the BC are allocated to a group of five midwives whom they meet during the antenatal period so when they arrive in labour they are familiar with the surroundings and the midwife who will be caring for them. The outcomes in the BC reflect existing evidence that women have lower rates of intervention, operative birth and pharmacological analgesia in a low-risk familiar setting (Rooks et al., 1992; Hatem et al., 2008; Brocklehurst et al., 2011).

The inclusion criteria for the study comprised of partners of women booked for BC care, who read and spoke English and whose women laboured in the BC but were transferred to the tertiary hospital during the first or second stages of labour, accompanied by the BC midwife. Ethical approval was obtained from the University's Human Research Ethics Committee (HR91/2013) and the Hospital Human Ethics committee (2013031EW).

Data collection and analysis

Recruitment took place from mid-July to mid-October 2013, with the first author approaching partners who met the inclusion criteria in the BC or hospital postnatal ward prior to discharge. Alternatively if the woman was discharged prior to recruitment taking place, the partner was contacted by telephone within four weeks of the birth. An information letter was provided to the partner and a consent form was signed. Following informed consent, demographic information such as name, contact details, age, educational level, their woman's parity, length of labour, reason for transfer and type of birth was collected from the partner or the woman's medical record.

Individual face-to-face interviews were deemed to be the most suitable method to understand the partners narrative of their experiences (Polit and Beck, 2010). Interviews began with a broad