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The woman, partner and midwife: An integration of three perspectives of labour when intrapartum transfer from a birth centre to a tertiary obstetric unit occurs

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ABSTRACT

Background: When transfer in labour takes place from a birth centre to a tertiary maternity hospital the woman, her partner and the midwife (the triad) are involved, representing three different perspectives. The purpose of this paper is to explore the integration of these intrapartum transfer experiences for the birth triad.

Methods: Giorgi's descriptive phenomenological method of analysis was used to explore the 'lived' experiences of Western Australian women, their partners and midwives across the birth journey. Forty-five interviews were conducted.

Findings: Findings revealed that experiences of intrapartum transfer were unique to each member of the triad (woman, partner and midwife) and yet there were also shared experiences. All three had three themes in common: 'The same journey through three different lenses'; 'In my own world' and 'Talking about the birth'. The woman and partner shared two themes: 'Lost birth dream' and 'Grateful to return to a familiar environment'. The woman and midwife both had: 'Gratitude for continuity of care model' and the partner and midwife both found they were: 'Struggling to adapt to a changing care model' and their 'Inside knowledge was not appreciated'.

Conclusion: Insight into the unique integrated experiences during a birth centre intrapartum transfer can inform midwives, empowering them to better support parents through antenatal education before and by offering discussion about the birth and transfer after. Translation of findings to practice also reinforces how midwives can support their colleagues by recognising the accompanying midwife's role and knowledge of the woman.

Statement of significance

Problem or issue

Intrapartum transfer from midwife-led to obstetrician care is relatively common but there is little knowledge regarding the impact on women, their partners and midwives.

What is already known

Intrapartum transfer causes disappointment, trauma and stress for each individual party involved.

What this paper adds

There is no published literature comparing the experiences of the three involved parties. This paper makes comparisons between the three and offers insight into what each one is experiencing, how their journeys compare and how this knowledge can improve care.

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1. Introduction

The birth of a baby is a pivotal day in a woman's life with women stating they remember the highs and lows, the exhaustion, the despair and the exhilaration.[1] The overall experience changes if her birth plan is not realised due to problems occurring during labour.[2–4] Women who plan to birth in a low risk centre but are required to transfer to a tertiary referral unit experience a range of emotions including concern, fear and disappointment.[5,6] However, the woman's recollection and memory of this event is one perspective. Within the birthing room there are usually at least three people; the woman, her life partner and the midwife; the birth triad. Each of these participants approaches the birth journey independently and lives the experience in a different way. They are influenced by a variety of factors such as hormones, expectations, hopes, policies and legal requirements.[7–10] The three perspectives mean that the birth journey is viewed through lenses with individualised foci, however, because each participant is so immersed in their own journey they may have limited insight into the experiences of others.

The findings of this paper are part of a larger qualitative study in which the overall experiences of women, partners and midwives were independently examined when transfer took place in labour from a low risk birth centre to a tertiary obstetric unit.[7,10,11] The purpose of this unique paper is to explore the integration of the lived experiences of an intrapartum transfer within the labour journey for the birth triad (the woman, her partner and the midwife).

2. Literature review

Childbirth choices for women in Western Australia are divided into private or public care, within a variety of options. Women can birth in a private hospital with care being provided by a private obstetrician or a public hospital under a public hospital consultant, with care provided by the medical and midwifery team. Alternatively, women can select a birth centre or home birth with care provided by a midwife, either through a government funded program or independent practice together with medical collaboration as necessary. Of the 33,393 women who gave birth in 2012 in Western Australia, 324 (1%) were in a birth centre.[12] Couples who plan for birth centre care often do so in order to have some degree of choice and control around labour and birth decisions.[13] However labour does not always progress according to plan and women and partners can be confronted by the unexpected when intrapartum transfer becomes necessary.[2–5,10,14]

When transfer in labour from a low risk area, such as home or birth centre, to a referral centre occurs it has been identified that women experience a feeling of failure and disappointment. An English qualitative study[5], confirmed that these overwhelming emotions were experienced by 12 women. Another mixed methods Swedish study[14] concluded that women who were transferred described negative birth experiences. Feelings of negativity were also confirmed in two further English studies which discovered a perceived loss of choice, continuity and control, contributing to feelings of anger, resentment and not belonging.[2,3] The woman's partner, the second member of the triad, who generally aims to offer support in order to help achieve the labour that was planned for, is also affected by the labour experience.[15–17] Partners of women choosing to birth in a birth centre have been acknowledged as feeling more involved in the care[18] however, this increased involvement may contribute to the range of emotions that have been described when the anticipated path of labour changes.[10] Partners are known to feel sidelined and excluded when transfer takes place but believe that they could play an important and beneficial role because of their inside knowledge of the woman.[10]

In the antenatal period the midwife informs and educates the couple to enable planning for their desired birth. When intrapartum transfer occurs, the midwife, the third member of the triad, has to react in a timely fashion[19] whilst reassuring the parents and facilitating the transfer which can, according to recent American and English qualitative studies, cause stress[20] and fear.[21] The English study which used phenomenological methodology, analysed interviews of 10 midwives who were involved in a home to hospital transfer situation and discovered five main themes; the decision to transfer; the importance of supporting the parents; the significance of collaborative working; the ongoing organisational challenges; and the need for a reliable ambulance service.[20] The American qualitative study, which also focused on the home to hospital experience, found the transferring midwives described three themes; a perceived lack of holistic care by the receiving staff, the bias of physicians and in the third theme the midwives wanted physicians to have insight into the poor national obstetric outcomes rather than being focused on the small number of homebirth transfers.[21] An Australian qualitative study recently demonstrated that when the midwife arrives with the transferring couple at the tertiary referral centre there are feelings of role confusion and unfamiliarity.[7] Findings from these studies suggest that the midwife relies on confidence and expertise when making the decision to transfer and that this decision may result in fear and anxiety. The need for openness and honesty with parents and collaboration with other health care professionals was discussed, with a focus on communication, teamwork and support.[7,20,21]

Although three separate pathways have been considered independently, there is currently no literature describing the integration of the interwoven journey of the three main participants when transfer in labour takes place from a birth centre to a tertiary obstetric hospital.

3. Participants and methods

The study was conducted at a birth centre in Western Australia, on the grounds of a tertiary obstetric hospital, which provided woman-centred, midwifery-led care for low risk women. The outcomes in the birth centre reflected existing evidence whereby women have lower rates of intervention, operative birth and pharmacological analgesia.[22–25] The purpose of this paper is to describe the integration of the 'lived' experiences of an intrapartum transfer within the labour journey for the women, their partners and accompanying midwives and Giorgi's descriptive phenomenological philosophy was the chosen method used.[26]

Study inclusion criteria comprised women booked for birth centre care and their partners, who read and spoke English, who laboured in the birth centre but were transferred to the tertiary obstetric unit during the first or second stages of labour, accompanied by a known midwife. The midwife was included if she remained with the woman to provide care in the tertiary obstetric unit following transfer. Ethical approval was obtained from the University's Human Research Ethics Committee (HR91/2013) and the Hospital Human Ethics committee (2013031EW).

As the first author was a birth centre midwife, experienced in intrapartum transfer, it was decided follow Giorgi's philosophy[26] and use reflexive bracketing to identify preconceived ideas and assumptions prior to collecting data to reduce bias. Reflexive bracketing facilitates reflection to reveal personal values and background.[27] In addition, the first author was an employed peer of the midwives recruited to the study.

Recruitment occurred from mid-July to mid-October 2013 using purposive sampling,[26] with participants recruited in the birth centre or hospital postnatal ward. If the woman was discharged prior to recruitment, the woman and partner were contacted by telephone within four weeks post birth. The midwife was

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