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Exploring midwives' interactions with mothers when labour begins: A study using participatory action research

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ABSTRACT

Objective: to explore the interactions between mothers and midwives when labour begins with a focus on midwives and unexpected birth out of hospital.
Design: participatory action research (PAR) that sought to understand and improve interactions between mothers and midwives through interviews, focus groups and a joint workshop.
Setting: maternity services in the north of England, in a district general hospital with one obstetric unit and two birth centres, across two sites and where there was a birth rate of 6000.
Participants: a total of 72 participants took part in the study. Thirteen mothers and five midwives were interviewed. Seven mothers were interviewed who had contacted a midwife in labour and subsequently given birth unexpectedly out of hospital. Thirty-one mothers and twenty-three midwives took part in a series of ten focus groups.
Key Findings: three major themes were identified from the midwives' data: 'Formulaic discourse as self-protection', 'One to one or one to everyone' and 'Interactions and time'. The latter theme is discussed in this paper showing that when midwifery activity was high and they did not have enough time, midwives experienced a high degree of conflicting emotions such as fear, helplessness and frustration, which stretched their personal and professional integrity and triggered changes in their thinking and behaviour.
Conclusions and implications for practice: current maternity services appear constrained by a reduced midwifery workforce that is expected to meet excessive organisational demands whilst coping with reduced bed capacity. These pressures can promote changes in midwives' behaviour and thinking which disconnects them from mothers rather than focussing on their needs. Safety depends on a high degree of midwife to mother continuity. However, a business model approach, prioritising throughput and process promotes fragmented care and can potentially threaten the safety of mothers and babies. In this study, there appears to be a link between disconnected interactions when labour begins and mothers giving birth unexpectedly out of hospital.

Introduction

The purpose of this paper is to report some of the findings from a participatory action research (PAR) study, which explored the interactions between mothers and midwives when labour begins. These interactions have significant consequences for women (Carlsson et al., 2009; Eri et al., 2010; Green et al., 2011; Nyman et al., 2011; Spiby et al., 2014) not least because active listening and effective communication are central to promoting safe, high quality maternity care nationally and internationally (Scottish Government 2017; Department of Health 2010). This paper addresses midwives' experiences of interacting with mothers around the onset of labour. Such findings from midwives are under-reported in the research literature. This paper highlights the need for more effective communication with all mothers when labour begins and especially with mothers who then experience unexpected birth out of hospital.

Background

During clinical practice, one of the researchers (XXHS) had met mothers, who described unsatisfactory interactions with midwives around the onset and status of their labour. Some of the key issues mothers raised during consultations were:

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- 'They didn't believe me'
- 'They didn't listen to me'
- 'They said I wasn't in labour - when I knew I was'
- 'They sent me home, again'

Deciding when labour has started is one of the most difficult decisions to be made in pregnancy and there is robust evidence to show that maternity services often fail to meet the needs of the mother at this important time (Hodnett et al., 2012; Janssen et al., 2009; Janssen and Demarais, 2013). Most pregnant women will start their labour at home and then go into a maternity unit for the birth. Remaining at home until labour is established (NICE, 2014) is a recommendation in pathways for maternity care in the UK. As will be seen later in the paper, delaying admissions was based on the assumption that this would improve outcomes for mothers and babies but this was not borne out by the evidence. As a result, some mothers may not have given birth in the place of their choosing because of advice to stay at home longer. These women often go on to give birth unexpectedly out of hospital with no midwife in attendance. Therefore, gatekeeping admission has implications for mothers who seek support from a midwife because when that support is denied safety can be jeopardised (Jones et al., 2011; Loughney et al., 2006; Moscovitz et al., 2000; Rodie et al., 2002; Unterscheider et al., 2011).

There is a growing body of evidence that supports continuity of care models where safety and efficacy are enhanced through mothers and midwives working and being in relationship (Fahy et al., 2011; Hodnett et al., 2012, 2011; Sandall, 2015). In the context of rapidly changing UK NHS maternity services, mothers' expectations around choice, continuity of care and staying in control of decision-making may not be being met despite these factors being important to women (Cumberlege, 2016; Renfrew et al., 2014; Scottish Government, 2017). The decision to delay admission to hospital is made either on the basis of behavioural cues, as assessed by a midwife via telephone conversations, or by assessment of cervical dilatation when mothers self-refer to the hospital (Burvill, 2002; Cheyne et al., 2006). If the cervix has not dilated more than 4 cm (NICE, 2014) the mother is informed she is not yet in labour and advised to go home to await events. This was best summed up by one mother in this study who reported:

> "You're looked after throughout your pregnancy, you're made to feel really special, you know you get a headache "you must phone up in case it's pre-eclampsia", anything when you're pregnant, you know it's so precious, the baby's so precious. Why when you are in labour does no one give a shit? No one cares about you, you're just an inconvenience until you get to 4 cm and then you're fine but if you're 0 to 4 you're a massive pain in the bum to everybody. Why is it like that? It's atrocious really'.
>
> (Interview with participating mother, 2014)

As a result of delaying admissions until labour is 'established', HS observed that some mothers were repeatedly sent home, and told they were 'not in labour' even when they were experiencing significant pain, distress and fear. Some mothers, deterred from admission, arrived in advanced labour and some gave birth unexpectedly out of hospital, sometimes at home, or on the way to the maternity unit. This paper will consider those mothers who gave birth unexpectedly out of hospital with a focus on the midwives' accounts.

Literature review

Five randomised controlled trials from 1998 (McNiven et al., 1998) to 2008 (Hodnett et al., 2008; Janssen et al., 2003, 2006; Spiby et al., 2007) were identified. Each tested an intervention to support mothers to stay at home in the early stage of labour. Interventions ranged from early assessment or direct admission to labour ward; to telephone or home assessment; to a more formalised intervention targeting mothers' psychological well-being. A sixth study, a cluster randomised controlled trial (Cheyne et al., 2008), tested an algorithm to improve diagnosis of labour. In each of the trials, the main aim was to determine if support interventions, or a more accurate diagnosis of labour, would reduce caesarean sections, instrumental deliveries and oxytocic drugs, by encouraging mothers to remain at home longer. None of the trials showed a reduction in medical interventions, however, what was significant in Spiby et al., (2008), was mothers' increased level of satisfaction related to support and there is a growing body of evidence to support continuity of care models (Fahy et al., 2011; Hodnett et al., 2012, 2011; Homer et al., 2008; Sandall, 2015). The mothers who took part in these studies reported experiencing improved satisfaction through more support which was a significant finding and one of the aims that this PAR study set out to explore in more detail.

Ethical considerations

University and NHS ethics approval was granted in October 2013 (Ref:13/NW/072513352). Careful consideration was given to recruitment and consent and how not to exert pressure on midwives and mothers. Consideration was also given to support for participants should this be required because of taking part in the study.

Methodology

PAR was chosen for its collaborative and participatory potential (Brydon-Miller et al., 2011). This methodology helps to create new approaches to, and understanding of, changes over time and across physical, social and emotional boundaries (Glassman and Erdem, 2014 p.206). True to the PAR process the focus was to explore interactions between mothers and midwives when support is sought after the onset of labour. An ambition for the study was for participants to be actively involved, and to experience each other's worlds, as well as raise awareness around mother and midwife interactions at the onset of labour.

Based on Freirean concepts, PAR takes account of adult learning theory, in that collaboration can lead to empowerment and social change (Kirkwood and Kirkwood, 2011). Therefore, PAR enables participants to be involved in knowledge production more than just as a resource for data collection. It is a group activity where people with different power, status and influence can come together to work on a problem. PAR brings together action, reflection, theory and practice to raise consciousness in participation with others (Glassman and Erdem, 2014), in order to reach practical solutions to issues that concern people. As such, this methodology has the potential to improve the lives of those participating.

Recruitment

The approach to sampling was borne out of a strong desire to undertake a locally based study, working with mothers and midwives who had been caught up in the dilemmas that this study sought to understand. The research setting straddled two towns serving multi-ethnic populations. At all times, the researchers endeavoured to reach mothers who were representative of regional ethnicity and social class. In order not to exert pressure on mothers a letter was sent via a third party from the maternity unit, inviting mothers to take part without obligation. Midwives who were purposefully chosen either for their forthright views of, or their involvement in conversations with mothers about whether they were in labour or not, were initially approached personally to ensure they too would not feel obliged or compromised.

Recruitment to the mothers' focus groups was achieved through social media networks. As the research was undertaken in a culturally diverse area the assistance of a maternity support worker was required to recruit some mothers. Recruitment to the midwives' focus groups

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