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The phenomenon of intrapartum transfer
from a Western Australian birth centre
to a tertiary maternity hospital:
The experiences of women, partners and midwives

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Doctor of Philosophy

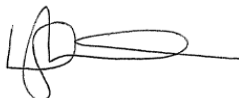
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Statement of Originality

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature 

Date 28.2.17

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Publications, Presentations and Awards

Publications	
2016	Kuliukas, L., Hauck, Y., Lewis, L. & Duggan, R. (2016). The woman, partner and midwife: an integration of three journeys of intrapartum transfer from a birth centre to a tertiary obstetric unit. <i>Women and Birth</i> , 30(2) ppe125-131 ISSN 1871-5192 DOI 10.1016/j.wombi.2016.10.008
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2015	Curtin Mark Liveris Research student seminar Best Presentation: The phenomenon of intrapartum transfer from a Western Australian birth centre to a tertiary maternity hospital: The experiences of midwives.
2012	Department of Health, Western Australia Nursing and Midwifery Office Fellowship for 'Advancing the Midwifery Profession' Department of Health WA 2012.

Authorship Statement


Authorship statement for PhD thesis submitted for examination by Lesley Kuliukas (16520374): *The phenomenon of intrapartum transfer from a Western Australian birth centre to a tertiary maternity hospital: The experiences of women, partners and midwives*

We declare that where there are papers included in the thesis which we are joint authors and our contribution has been identified and acknowledged in the authorship. Lesley Kuliukas initiated the study and collected all the data. All authors were involved in data analysis. Lesley Kuliukas wrote the first draft of each paper for publication and all authors were involved with reviewing and amending each paper for publication. Lesley Kuliukas is the first author of the four publications. The order of authors (second to fourth) was determined by contributions to each publication. Each member of the supervision team was offered the opportunity to be second author on a publication and their involvement to that publication reflected this contribution.

Supervision team



Yvonne Hauck (Professor of Midwifery)



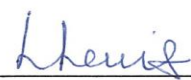
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Ravani Duggan (Deputy Head of School)



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Date

Abstract

This qualitative study explores the experiences of women, partners and midwives when transfer in labour takes place from a low risk birth centre setting to an alongside obstetric unit. An investigation of the literature and comprehensive interviews with women, partners and midwives identify that moving to an unexpected environment and model of care changes the experience of labour. While limited evidence has addressed the intrapartum transfer experience for woman and midwives from home to hospital, the phenomenon of transfer from a birth centre to hospital for all three participants has not been previously described. The primary aim of this Western Australian (WA) study addressed through four specific objectives, was to describe the overall labour and birth experience of firstly the women, secondly their partners and thirdly midwives within the context of an intrapartum transfer occurring from a low risk midwifery-led, woman- centred unit to an obstetric unit. The fourth objective explored the integration of these intrapartum transfer experiences for the three groups of participants; the birth triad.

This study was conducted using a descriptive phenomenological design. This exploratory design included 48 women, partners and midwives who had recently experienced an intrapartum transfer and agreed to participate in the study. Three sets of data were collected. All comprised semi-structured in depth interviews with the participants, women (15), partners (15) and midwives (18).

The interviews were transcribed and thematic analysis employed using Giorgi's method of analysis. Each set of interviews was analysed separately to meet the aim and then together to determine their integration for the final objective.

Analysis of the women's interviews revealed the following main themes: 1) The midwife's voice, 2) In the zone, 3) Best of both worlds, 4) Lost sense of self and 5) Lost birth dream. Women appreciated the benefits of continuity of care and found the midwife's voice guided them through the transfer experience. Disappointment in not achieving the labour and birth they hoped for was acknowledged but women appreciated that the obstetric unit was close and experts were nearby. After transfer women found the central focus of care changed from their needs to the fetus, making them feel diminished. Returning to the familiar birth centre after the birth was helpful,

with women able to talk through and fully understand their labour journey which helped them contextualise the transfer as one part of the whole experience.

The partners' transcriptions were analysed and five main themes emerged: 1) Emotional Roller Coaster, 2) Partner's role in changing circumstances, 3) Adapting to a changing model of care, 4) Adapting to environmental changes and 5) Coming to terms with altered expectations around the labour and birth experience. Benefits of midwifery continuity of care were acknowledged, however partners noted that they also provided essential continuity because their familiarity with the woman surpassed any care provider. Partners found it difficult to witness the woman's labour journey, including the change of environment but appreciated the nearness of medical assistance when necessary. Returning to the birth centre afterwards was acknowledged as beneficial by partners, as was the opportunity to debrief to better understand the process.

The midwives' interviews were transcribed and also analysed using Giorgi's method of data analysis. The overall findings suggested that midwives found transfer in labour challenging, both emotionally and practically. Five main themes emerged: 1) The midwife's internal conversation, 2) Challenged to find a role in changing circumstances, 3) Feeling out of place, 4) A constant support for the parents across the labour and birth process and 5) The midwives' need for debrief.

Midwives acknowledged the difficulty in striking the right balance between fulfilling parents' birth plan wishes, following hospital guidelines and ensuring the health of woman and fetus. Maternal or fetal compromise caused increased anxiety and concern for the midwives. The benefits of continuity of care were acknowledged but midwives perceived a lack of recognition for their knowledge of the woman by the receiving team. Similar to the women and partners, midwives also valued a debrief discussion afterwards in order to review their practice. The midwives acknowledged that effective communication is essential throughout the transfer process to ensure all are fully aware of unfolding events.

Finally the data of all three groups of participants were analysed for integration of the similarities and differences between the women's, partners' and midwives' perceptions of the same journey. Analysis revealed that experiences of intrapartum

transfer were unique to each group and yet there were also shared experiences. Women, partners and midwives had three themes in common: 1) The same journey through three different lenses, 2) In my own world and 3) Talking about the birth. The woman and partner shared two themes: 1) Lost birth dream and 2) Grateful to return to a familiar environment. The woman and midwife also shared: 1) Gratitude for continuity of care model and the partner and midwife both experienced: 1) Struggling to adapt to a changing care model and feeling that their 2) Inside knowledge was not appreciated.

This final analysis offered insight into the integrated experiences of women, partners and midwives when intrapartum transfer from birth centre to an obstetric unit occurred. This knowledge can be used to inform midwives and maternity care providers by empowering them to support parents in a variety of ways. They can offer antenatal education regarding intrapartum transfer to both parents during antenatal appointments and childbirth education classes. Continued communication between midwife and parents through the transfer process may help minimise concern and improve understanding of events. The obstetric unit staff in the referral units can support their colleagues by recognising the accompanying midwife's role and history with the woman. Translation of the findings of this study will also reinforce the importance of birth environment. The negative impact of moving parents from a birth centre setting to an obstetric setting highlights the need to create safe non-medicalised rooms within all obstetric units, which can be an advantage for every labouring woman and reduce the adverse effect for transferring couples.

Our WA findings provide a unique insight into the experiences of women, partners and midwives involved in intrapartum transfer within this context. The work makes an important and original contribution not only to the maternity literature, but to the body of knowledge concerning continuity of care, midwife-led care, intrapartum transfer and birth centre care.

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Chapter One: Introduction

“Empowered, informed, engaged consumers, individually or collectively, can be effective at overcoming ... barriers to safe, effective care.” (Romano, 2010).

Background

In this chapter the rationalisation for this Western Australian (WA) study will be considered. Firstly the science and history leading to emerging realisation of the benefits of birth centre care will be introduced, followed by the background to the author’s interest in this area. Consumer forces leading to changes in childbirth and the demand for provision of an optimal labour and birth environment and midwifery led care will then be presented. The safety of this option of woman-centred care will be discussed, after contextualising the setting of this study. The incidence and risk of intrapartum transfer will follow, leading on to the significance for the study, aims and objectives. Finally the format of the thesis will be described.

Optimal environment for labour and birth

Back in 1966 Newton, Foshee and Newton carried out a series of experiments which confirmed what all farmers, veterinaries and pet owners already knew; that if an animal is able to labour in a safe, comfortable, familiar, dark environment then progress will be efficient. If the animal is disturbed or moved from this comfortable familiar place then stress hormones will cause labour to slow down dramatically and in most cases stop altogether (Lothian, 2004). This phenomenon was also described by Alford, Nash, Fritz and Bowen in 1992 in reference to chimpanzees. Additionally a similar phenomenon has been described by a number of maternity care providers interested in facilitating an optimum environment for women to labour and birth (Buckley, 2004, 2015; Lothian, 2004; Odent, 2002). Despite the evidence that animals, and therefore humans, labour more efficiently in a comfortable, familiar environment, childbirth became more medicalised and choices for women in which this type of labour could be facilitated, reduced. During the 1970s there was an increase in electronic fetal monitoring and decreased mobility of women in labour (Carolan & Hodnett, 2007). The mainstream option of birthing in a brightly lit room with stainless steel surroundings and on a high theatre bed became the only choice for many women

(Cahill, 2001). Increasing medicalisation and reduction in alternatives for childbirth, in the United Kingdom (UK) and Australia, contributed to women looking outside of the mainstream of maternity care options (Carolan & Hodnett, 2007; Hinchliffe et al., 2003).

Author's background and interest

The author's interest in intrapartum transfer began in practice as a community midwife in the south east of England when community midwives were responsible for antenatal and postnatal care of all women within a geographical catchment plus intrapartum care for women choosing to birth at home. Later, as a privately practising midwife, the author provided caseload midwifery care over the continuum for low-risk women wanting a home birth. When caring for women in labour at home, there was always the dilemma of making the right decision to transfer from home birth to hospital at the optimal time, to ensure the safest outcome for the woman and fetus whilst also striving to salvage some parts of the woman's birth plan. It became apparent that anecdotally, women were totally invested in the birth they had planned for with little inclination to consider that their plans may go awry. However, in the author's personal experience, if transfer was necessary women were compliant, accepting the decision made by the midwife, with little upset or obstruction demonstrated. In some cases women were disappointed, some seemed relieved, but most were in 'the zone' of labour, inwardly focused on the task in hand (Dixon, Skinner, & Foureur, 2013; Zambaldi, Cantilino, Farias, Moraes, & Sougey, 2011) and did not always appear to possess clear vision of the events taking place.

At a later point in the author's career, when employed in a birth centre in WA, which was alongside an obstetric unit, the transfer process appeared to be easier because there was no ambulance journey required. The threshold to transfer appeared to be lower, possibly due to the ease of transfer. There was no ambulance to call, no long journey to make and the transfer could be completed within minutes, making the process more straightforward. The experience of the birth centre midwives may also have impacted the transfer rate, with some midwives transferring women due to their requiring procedures outside the midwife's skill set. For example, one midwife interviewed in this study transferred a woman whose birth required an episiotomy. As a consequence of a higher intrapartum transfer rate, more women, partners and midwives were

affected at different levels, with some seeming quite traumatised by events. The author questioned each individual experience; what it meant for the woman, partner and midwife. What was their emotional state before, during and after the transfer? Each woman, partner and midwife were undertaking the same journey but they appeared to experience it differently, with diverse repercussions. The need for a study became apparent as some of the questions raised included recovery concerns and how future choices were impacted for the couple plus the influence of future clinical practice for the midwife.

Consumer push for change

In the 1980s WA women and midwives, who wanted an alternative to the common medicalised model of maternity care, lobbied for a birth centre. A lottery grant was awarded in 1990 and a birth centre was built alongside King Edward Memorial Hospital (KEMH) in 1992 (Lotterywest, 2011), the only tertiary maternity hospital in WA, which provides services for local low risk and state-wide high-risk women. Women petitioning for birth centre care, like many women internationally, wanted to be able to labour and birth in a home-like setting where they could mobilise freely, experience reduced levels of intervention and be offered greater choice around labour and birthing (Deery, Jones, & Phillips, 2007). The philosophy of birth centre midwives was to enable women to birth the way that they chose by promoting informed choice in order to increase their participation in the childbirth experience (King Edward Memorial Hospital, retrieved 2016). The building was designed with active birth in mind, with four large birthing rooms, each with en-suite double showers to facilitate upright positioning in labour. The plans also included a birth tub room which offered women the opportunity to labour and birth in water. As a result of this consumer led initiative, the Family Birth Centre was opened in 1992 and women, who were low risk, were invited to attend for antenatal, intrapartum and postnatal care from anywhere within WA.

Context of the WA Family Birth Centre

Western Australia is the largest state in Australia, covering a geographical area of 2.646 million km² and with a population of 2.6 million, of which 2.194 million live in the capital city of Perth (Anon, 2016). In 2013, 33,928 women gave birth in WA, the majority (98.3 per cent) in hospitals, public and private (Hutchinson & Joyce 2016).

Non-hospital births (1.6 per cent) included women who gave birth at a birth centre (1.0 per cent) and at home (0.6 per cent) (Hutchinson & Joyce 2016). The 1% of women who birthed at the birth centre during the time of this WA study (2013-2014) had to fulfil the inclusion criteria of being low-risk throughout the pregnancy and labour. This protocol was adhered to by reference to an exclusion list which included such conditions as obesity, preeclampsia, antepartum haemorrhage and pre-labour rupture of membranes greater than 24 hours.

When the birth centre was built in 1992 there was a recruitment drive to employ experienced midwives who had a particular interest in supporting women aiming for less medicalised labour and birth, as like many midwives internationally, there was increasing frustration with high levels of intervention (Deery, Hughes, & Kirkham, 2010) and a desire to practice more autonomously (Deery et al., 2007). Over the following 25 years various models of midwifery care were trialled, including rostered shifts, caseload (one-to-one) and team midwifery and at the time of this WA study in 2013-2014, care was provided by two teams of five midwives. Women were allocated to one of the two teams and given the opportunity to meet all of the midwives in that team during antenatal visits and childbirth education classes. Consequently, during labour, the woman was cared for by a familiar midwife who was aware of her history, expectations and birth plan. If intrapartum transfer was necessary, workload within the birth centre would determine whether the team midwife was able to continue as primary carer. In the case of this WA study all women were accompanied by their midwife.

The question of safety with midwifery-led care

Women choosing midwifery-led care often carry out their own research to opt in and out of choices over the continuum of childbirth: they are aware they can make decisions and understand the responsibility, which can increase their feeling of control (Deery et al., 2010; Laws, Lim, Tracy, & Sullivan, 2009). Evidence has confirmed that for most low risk women who choose a midwifery-led model of care, the outcomes are positive, safe and with the majority birthing with reduced intervention (Allen et al., 2015; Biró, Waldeström, & Pannifex, 2000; Brocklehurst et al., 2011; Homer, 2016; McIntyre, 2012; McLachlan et al., 2012; Monk, Tracy, Foureur, Grigg & Tracy, 2014;

Sandall, Soltani, Gates, Shennan, & Devane, 2013; Tracy et al., 2013; Tracy et al., 2014; Turnbull et al., 2009).

Likelihood and logistics of intrapartum transfer from a birth centre to referral centre

The varying incidence of intrapartum transfer for low risk women choosing to labour in a birth centre must be acknowledged. For a variety of reasons, such as meconium stained liquor, or delay in the first or second stages of labour, some women are required to be transferred to an obstetric referral centre (Blix, Kumle, Kjærgaard, Øian, & Lindgren, 2014; Brocklehurst. et al., 2011; da Silva et al., 2012). In the case of the setting and time of this WA study, between July 2013 and June 2014, 609 women were booked to birth in the birth centre. Of these 259 (43%) were transferred during the antenatal period to the obstetric unit, for reasons such as gestational diabetes mellitus, preeclampsia, increased BMI or antepartum haemorrhage. Of the remaining 350 women, 118 (19% of the original number and 34% of women starting labour in the birth centre) were transferred in labour, as shared by the Birth Centre Manager (L. Keyes, personal communication 10th October 2014). Although intrapartum transfer rates from low-risk areas to obstetric units are known to vary from 11.6% to 37.4 % (Alliman & Phillippi 2016), the birth centre in this WA study was at the higher end of this spectrum. The reason for a higher rate of transfer is unknown but has been speculated as being due to the proximity of the alongside obstetric unit, so increasing accessibility and thus making transfer an easy option.

Within the context of this birth centre setting, when intrapartum transfer was required to the nearby obstetric unit, the woman, her partner and midwife were able to undertake the 5 to 10 minute walk, trolley or wheelchair journey along a connecting underground passage from the birth centre to the obstetric unit. Although the physical practicalities of the transfer journey were relatively simple, the emotional impact was more notable. After months of planning and expectation, suddenly the woman's labour plans were undone as the labour journey took an unanticipated turn. Instead of birthing in a familiar, comfortable environment, women and their partners faced a more medicalised obstetric unit with technical equipment on view, no birth aids such as fit balls, floor mattresses and bean bags visible and commencement of continuous electronic fetal monitoring (Rowe, Kurinczuk, Locock, & Fitzpatrick, 2012). The

accompanying midwife also faced a model of care outside of her usual low-risk area of practice and in a less familiar environment.

Significance of the study

Compared to obstetric-led, hospital based models of care, the evidence regarding the benefits of midwife-led care for low-risk women in models of maternity care, such as birth centres and home birth is well established, with women choosing these models experiencing more spontaneous vaginal births than assisted vaginal and caesarean birth (Brocklehurst. et al., 2011, Walsh & Downe, 2004), less intervention, such as episiotomy (Walsh & Downe, 2004) and greater satisfaction with the continuity of care (de Jonge, 2009; Hodnett, Downe, Edwards, & Walsh, 2005; Walsh & Downe, 2004). Improved outcomes are understandable for those women for whom the labour goes according to plan, however transfer to a nearby obstetric unit is necessary in 10% to 45% of cases (Brocklehurst et al., 2011, Evers et al., 2010, Grigg, Tracy, Schmied, Monk, & Tracy, 2015, Mori, Dougherty, & Whittle, 2008), impacting many women, partners and midwives.

International evidence has revealed that women, partners and midwives can be negatively affected when labour plans change (Cheyney, Everson, & Burcher, 2014; Creasy, 1997; Grigg, Tracy, Schmied, Monk, & Tracy, 2015a; Lindgren, Hildingsson, Christensson, & Radestad, 2008; Rowe, Fitzpatrick, Hollowell, & Kurinczuk, 2011; Walker, 2000; Wilyman-Bugter & Lackey, 2013). They experience feelings of disappointment (de Jonge, Stuijt, Eijke, & Westerman, 2014; Geerts et al., 2014; Grigg et al., 2015a; Lindgren, Rådestad, & Hildingsson, 2011), being cheated (Creasy, 1997; Walker, 2000) anger and resentment (Walker, 2000). However, the extant literature findings are mainly from Europe and America, which do not always reflect Australian maternity care models. Furthermore, while the woman's perspective was addressed in many home to hospital transfer studies (Blix et al., 2014; Lindgren et al., 2008; Lindgren et al., 2011), none were found which addressed the experiences of partners and only two studies, from America and England reported the experiences of midwives (Cheyney et al., 2014; Wilyman-Bugter & Lackey, 2013). Neither were there any studies which reported the transfer experience of women, partners and midwives from birth centre to hospital. Gaining insight into the experience of transfer from all parties therefore warranted further investigation. Chapter Two of this thesis will highlight in

detail the findings from the available relevant current literature, pointing out the gaps which justify this WA study. Once the gap in the literature had been established with an in-depth analysis of the extant literature, the aims of the study were decided upon.

Statement of Aim and Objectives

The primary aim of the study was to gain a description of the lived experience of intrapartum transfer from the birth centre to the tertiary hospital of the woman, her partner and her midwife. The specific objectives to meet this study aim were:

1. To describe the overall labour and birth experience of women who are transferred during the first or second stage of labour from a low risk woman-centred, midwifery-led birth centre to a co-located tertiary maternity referral hospital.
2. To describe the overall experiences of partners when the woman they are supporting are transferred in the first or second stage of labour from a low risk midwifery-led, woman-centred unit to an co-located tertiary obstetric referral hospital.
3. To describe the experiences of midwives when caring for women in labour in a birth centre, who they accompany on transfer in the first or second stage of labour, to a co-located tertiary obstetric referral hospital.
4. To explore the integration of the 'lived' experiences of an intrapartum transfer within the labour journey for the women, their partners and accompanying midwives.

Once the specific objectives were established to address the gap in knowledge, the methods to be employed required careful consideration. Therefore Chapter Three, Methodology, is dedicated to outlining how the methodology for this WA study was selected.

Chapter Three begins with an overview of the different methodological approaches and determines why a prospective qualitative exploratory design was chosen. In order to fulfil the aim and objectives of the study the data was analysed according to Giorgi's descriptive phenomenological method of analysis (Giorgi, 1997) to discover and describe the experiences of women, partners and midwives and to explore the integration of all three.

Chapters, Four, Five, Six and Seven include the final accepted manuscripts in three peer reviewed journals, after reviewers' comments had been addressed and the papers accepted for publication. Presentation of the final manuscripts in this format is a requirement of copyright policy of the peer reviewed journals.

Chapter Four details the experiences of women during the complete pathway of labour from the first contraction through to their midwife leaving them after the birth. For many of this group their memories were not as clear and distinct due to being in 'the zone' of physiological labour, which led to a different perspective. The manuscript relating to the women's experiences is presented in Chapter Four in its final version, as accepted for publication, after addressing reviewers' comments.

Chapter Five considers the transfer journey from the perspective of the partners. This chapter considers how transfer in labour impacts the support person who is there throughout the whole labour, often without leaving the side of the woman. The heightened emotions of the witness, the life partner, are described in detail in the first manuscript of this thesis to be published. The manuscript relating to the partners' experiences is presented in Chapter Five in its final version, as accepted for publication, after addressing reviewers' comments.

Midwives' experiences are described in Chapter Six with consideration given to the role from the professional perspective; wanting to ensure the safety of the woman and fetus while trying to accommodate the wishes of the parents. The manuscript relating to the midwives' experiences is presented in this chapter in its final version, as accepted for publication, after addressing reviewers' comments.

The final publication is presented in Chapter Seven where the journeys of all three groups of participants, the women, partners and midwives, are integrated in order to highlight the differences and similarities of each perspective whilst acknowledging some overlapping or exchange of experiences. The manuscript relating to the experiences of all three groups of participants is presented in this chapter in its final version, as accepted for publication, after addressing reviewers' comments.

The final chapter, Implications, Recommendations and Conclusion, Chapter Eight, summarises the WA study on intrapartum transfer and details future recommendations arising from the findings. The implications of the findings from this study for clinical

practice, for education and for future research are proposed to address the issues raised and improve the intrapartum transfer journey for each of these domains.

Summary

This first chapter has outlined the background to the study, including the science and history of birthing trends. The author's background and interest in the topic was explained. The influence of consumer demand was detailed followed by discussion regarding the safety of birth centre care. The setting of this WA study was then put into context together with the incidence of transfer from birth centre to obstetric unit. Finally the aim and specific objectives of the study were listed followed, by a description of the format of the thesis.

Chapter Two: Literature Review

This chapter provides a review of the literature related to the intrapartum transfer experience for women, partners and midwives from a Western Australian (WA) birth centre to a tertiary obstetric referral centre. The findings of prior research were reviewed and conclusions drawn from these studies, contributing to awareness of the gap in evidence warranting further investigation.

Over the period of 2012, 2013 2014 and then again in January to March 2016, extensive searches of the 'PubMed', 'OVID', Web of Science, Scopus and 'CINAHL' databases, as well as 'Google scholar' were conducted using the key words 'labour', 'transfer', 'woman', 'partner', 'midwife', 'perceptions', 'midwifery units', 'birth centres', 'intrapartum care', 'experience' and 'birth' in various combinations. Initially only studies relating to women's experiences were discovered but in 2013 and 2014 two studies relating to midwives' experiences were published, although they related to transfer from home to hospital rather than birth centre to hospital. No known studies focusing on only reporting partner's experiences of transfer have been conducted although many papers were found relating to their general experiences in labour. In order to be able to discuss partners' experiences when labour outcomes change, which could evoke similar emotions to those when transfer occurs, a separate search was carried out as above including the words 'labour', 'caesarean', 'neonatal unit' 'partner', 'father', 'perceptions', 'intrapartum care', 'experience' and 'birth' in various combinations.

The findings in the literature about the experiences of women, partners and midwives will be presented under separate headings with a conclusion statement around the evidence for each topic. A final summary will conclude the chapter to highlight the gap in knowledge which informed this proposed study.

Women's experiences

The ten research studies identified relating to women's experiences during transfer in labour, were predominantly conducted in Europe, (Christiaens, Gouwy, & Bracke, 2007; Creasy, 1997; Ank de Jonge et al., 2014; Geerts et al., 2014; Lindgren et al., 2011; Rowe et al., 2012; Walker, 2000; Wiegers, van der Zee, & Keirse, 1998; Van Stenus et al., 2017) with one recent study from New Zealand (Grigg et al., 2015a) One of the identified studies utilised a quantitative methodology, two a mixed methodology, while the remainder used qualitative/exploratory approaches. The findings from the majority of these studies were not confined to intrapartum transfer from birth centre to tertiary referral centre but also included home to hospital transfer. An international metasynthesis of qualitative literature regarding homebirth to hospital was also included (Fox, Sheehan, & Homer, 2014). Of the relevant papers many important themes were revealed in the data including dissatisfaction, continuity, control, communication, disappointment, timing of transfer, preparation, change of model/environment, and talking through events after the birth. The themes from these studies will now be used as subheadings to consider the evidence around women's experiences regarding transfer in labour.

Measuring satisfaction

The level of women's satisfaction regarding their birthing experience is multifactorial. Ford and Ayers (2009) found that the level of support given to women impacted how they reacted to stressful events during labour. Similarly other authors have reported reasons for dissatisfaction such as high levels of pain and medical intervention in labour and birth (Bayes, Fenwick, & Hauck, 2012; Soet, Brack, & Diiorio, 2003). An additional factor found to contribute to dissatisfaction was when a woman commenced labour in a low risk midwife-led centre and intrapartum transfer occurred. Lindgren et al. (2011) conducted a mixed methods study in Sweden exploring the effects on the experience of birth when transfer takes place from a planned home birth to hospital. Women who had planned a home birth between 1992 and 2005 (n=674) were contacted, making the time from the birth to participation in the study up to 7 years. The transfer rate for this cohort of women was 12% and they were transferred either during labour or soon afterwards. Subsequently 671 women agreed to answer the postal questionnaire, which gave a range of options from 'very satisfied' to

'dissatisfied' for the following aspects: support from midwife, support from partner, participation in decision making, being in control, medical aspects of the birth, emotional aspects of the birth and overall birth experience. The findings demonstrated a high level of dissatisfaction from the transferred woman; 80% compared with 20% of women who laboured and birthed at home ($p < 0.001$). Women were also invited to elaborate on their dissatisfaction which was categorised into three areas; treatment, organisational factors and personal ability. Although this study demonstrated an overall impression of dissatisfaction from women there was no detail to their perceptions; it is also probable that the distance of time between the birth and the questionnaire, up to seven years, may have impacted the women's replies due to recall bias.

In comparison, another Northern European study by Christiaens et al. (2007), using quantitative methodology, was a comparative study which contrasted Belgian women choosing to birth in hospital or at home with Dutch women, choosing to birth at hospital or at home. Like Lindgren et al. (2011), the aim was to analyse the levels of satisfaction of the woman's chosen care; this included satisfaction in the transfer process if it took place. The purpose of the study was to directly compare the outcomes of two different types of maternity health care in these neighbouring countries.

In Belgium very few women choose a home birth option as it is a choice outside standard accepted care (which is usually under the direction of an obstetrician) and is selected by a minority of women. From both countries questionnaires were returned by 827 women at 30 weeks gestation and 605 women at two weeks into the postnatal period; of these 563 were suitable for analysis. No response rate was available as not all women who declined to participate were registered as being invited. The questionnaire was based on the Mackey Childbirth Satisfaction Rating Scale, which consists of six sub-dimensions; general satisfaction (3 items), satisfaction with self (9 items), baby (3 items), nurse/midwife (9 items), physician (8 items), and partner (2 items). This appeared more comprehensive than the questionnaire used by Lindgren et al. (2011) but in the same way omitted to question women regarding the actual transfer experience. The authors acknowledged that they were surprised by the overall findings which concluded that Belgian women who transferred were actually more satisfied than the Dutch women. However there was some disparity with the numbers within

the groups of women. Because home birth is so rare in Belgium, women were recruited from a wider geographical area and from many midwifery practices and so the overall percentage of women choosing home birth within the study did not represent the true national proportion of women choosing home birth. In the Belgian sample 87 (34.3%) women wanted a home birth, whereas in the Dutch sample 176 (63.5%) women intended to birth at home. Of these, 18 (7.1%) Belgian women were transferred compared with 82 (29.6%) Dutch women. It is also of note that Belgian women may be more satisfied because their midwife accompanies them, provides continuity of support and advocates for them, unlike their Dutch counterparts who hand over care.

In this European study there is no reason given for the reason for difference in transfer rates but it may be due to a lower threshold for transfer in the Netherlands where more women birth at home and consequently maternity care providers ensure the transfer process is seamless. Another possibility is due to the differences between the inclusion criteria for home birth in the different countries. In Belgium women wanting a home birth have to employ an independent midwife who works outside of the health system and so transfer to tertiary care may be seen more negatively, as found in a similar system in America (Cheyney et al., 2014). Consideration of the possible negative reception on arrival at the referral centre may raise the threshold of decision making for transfer reducing the number of borderline or 'soft' reasons for transfer.

The findings reported above by Christiaens et al. (2007) contradict the Swedish mixed methods study conducted by Lindgren et al. (2011), also conducted by postal questionnaires in the antenatal (at 36 weeks) and postnatal (3 weeks after the birth) periods. Of the 1836 Swedish women who were sent questionnaires 1720 (93.7%) returned the pre-birth questionnaire and 1640 (89.3%) returned both questionnaires. Although a Likert scale was used to rate their experiences of various aspects of the whole labour and birth experience, again there were no specific questions about the actual experience of transfer. Questions were asked about the first and second stages of labour, overall birth experiences, the first 10 days after birth and the midwifery care. The results revealed that an unplanned transfer to hospital did not influence the overall birth experience of women who had planned to give birth at home, their evaluation of the birth, the midwife's care, or the postpartum period. It did however highlight women

questioning whether they had made the right decision when planning their place of birth.

Continuity

The value of continuity of midwifery care is undisputed and has been found to increase maternal satisfaction, reduce intervention rates including caesarean section and pharmacological analgesia as well as being more cost effective (Benjamin, Walsh, & Taub, 2001; Hodnett, 2000; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Homer, Davis, Cooke, & Barclay, 2002; Tracy et al., 2013, Fox et al., 2014, Sandall, Soltani, Gates, Shennan, & Devane., 2013). The authors of studies considering intrapartum transfer have also highlighted continuity of midwifery care as a factor worth investigating. In a qualitative study by de Jonge et al. (2014), conducted in The Netherlands, 27 women were interviewed about their labour up to five months after the birth to explore their experiences of being transferred from home or midwife-led care within a hospital, to obstetric-led care. De Jonge et al. (2014) commented that continuity of care contributed to women's feeling of safety during labour because the midwife was able to explain procedures and also act as advocate for the woman's preferences. In contrast, in another Dutch qualitative study by van Stenus et al. (2015) in which 17 women were interviewed, there was disconnection due to lack of continuity, due to the midwives handing over care on arrival at the secondary unit. The women described feelings of confusion and detachment. In contrast, Grigg et al. (2015) reported in their mixed methods study in New Zealand that women sometimes felt more confident about the need for medical interventions if their primary care midwife stayed and could explain this to them. Grigg et al. (2015) suggested that the model of care in New Zealand where women can choose a primary midwife to follow through their care, regardless of where they finally birth, appeared to diminish the negative aspects of women's experience of transfer and facilitate positive birth experiences. However of the 174 women who responded to the survey by Grigg et al, (2015), only 21 (12%) transferred in labour and the remainder transferred antenatally, prior to labour or postnatally. As the thematic analysis of the open ended questions in the questionnaire were grouped together it was difficult to separate the experiences of women who transferred in labour although it was apparent that when their births did not go to plan there were no resulting negative issues. Continuity was reported as

favourable with women identifying that the relationship they shared with their midwife was an important part of their experience.

In contrast, Rowe et al. (2012) reported on the concept of discontinuity which they describe as almost inevitable when transfer takes place. One obvious break in continuity came at the doors of the hospital obstetric unit when the woman's care was handed over to someone else. Thirty women were interviewed who were transferred from both alongside and distant low risk units to consultant units from many parts of England. Of these, 28 women were transferred in labour and two in the immediate postpartum period and all were interviewed between 1 and 12 months after the birth. Most women had given little thought to the possibility of transfer and even less to the transfer process and it was found that if they were not told in advance that they would have a change of midwife, this was an unpleasant surprise. A difference in model of care from low risk to high risk was found to affect the woman's expectation and sense of disappointment if she did not have continuity of care from her midwife.

In The Netherlands it is accepted that if care is transferred from primary (midwife-led care) to secondary (obstetric led) care the primary midwife hands over to hospital staff and leaves. As de Jonge et al. (2014) reported, many women in their study would have liked their midwife to stay but they understood and accepted that this was not usually possible. However, a few women in the study did state that it is an odd system where you build up a rapport with a primary care midwife over the course of nine months and then have to establish a new relationship after intrapartum referral and de Jonge et al. (2014) concluded that a system that has two disconnected models has many disadvantages, in particular in terms of continuity of care. This was also commented on by Walker (2000) who suggested that a loss of continuity and support was linked to anger and resentment. Walker's grounded theory methodology study (2000) included 18 women from the south of England, who were transferred from a low risk community based, midwife-led care setting to a distant obstetric unit care setting during pregnancy and labour. However, of the 18 women interviewed, 15 were transferred in the antenatal period and only three during labour. Another form of discontinuity was also described by Walker (2000), and highlighted the tension between the referring community midwife and accepting midwife on the obstetric unit which was evident and appeared to strengthen the sense of estrangement amongst

women who were transferred. This sentiment was previously voiced in 1998 by Wiegers et al. regarding good cooperation between referring midwives and accepting obstetricians as being essential to ensure that all women, regardless of the place of birth, receive optimum care.

The value of continuity was expressed by de Jonge et al. (2014) and Rowe et al. (2012) by the minority of women in their studies who did benefit from their midwife staying with them after transfer took place. Although this was uncommon, women commented that the midwife staying with them helped them feel safe as they could rely on their trusted relationship in a rapidly changing situation (Rowe et al. 2012, de Jonge 2014). The importance of continuity by a known midwife was voiced by de Jonge et al.: “management continuity is silver, relational continuity is gold” (2014 p.7). The value of continuity was also one of the major findings in an international metasynthesis of 5 qualitative studies on transfer from homebirth to hospital by Fox et al. (2014), in which it was found that sensitivity and individualism within continuity was highly valued.

Control

It has been demonstrated by the findings of many studies that women’s perception of being in control contributes positively to their birth experience and feeling of well-being (Bryanton, Gagnon, Johnston, & Hatem, 2008; Goodman, Mackey, & Tavakoli, 2004; Green & Baston, 2003; Hauck, Fenwick, Downie, & Butt, 2007; McNelis, 2013; O’Hare & Fallon, 2011). A longitudinal quantitative Dutch study by Geerts et al. (2014) compared levels of control felt by women, determined by place of birth, home and hospital. Of the total number of women included in the study, 757 were transferred during labour from home or midwife-led hospital care. They discovered that the level of control did not vary according to place of birth but that women who were transferred felt a loss of control in comparison with those who birthed in their original choice of birthplace, however there was no description to add depth or meaning to these findings. In contrast, in New Zealand where midwives provide continual support for women after transfer, Grigg et al. (2015) reported that although the transfer was not wanted or planned, because women were able to maintain support and information from their known midwife, they felt a sense of control and the transfer was not a negative experience.

The sense of control felt by women in Walker's study (2012) was linked to choice. Within her findings, Walker (2012) combined the themes of choice and control because it was considered that loss of choice was found to be an important factor regarding the feeling of loss of control. Back in 1998, in their quantitative Dutch study, Wiegers et al. suggested that one way to reduce the fear of unplanned transfer, especially among first time pregnant women, was to advise them to choose a hospital birth in order to avoid such transfer. A total of 403 women completed questionnaires and there was no exploration of experiences but the final recommendation was that only low risk women, not only at the time of booking but throughout pregnancy and up to the onset of labour, should be offered the opportunity to birth at home. This was recently contradicted by Geerts et al. (2014) who suggested that although it is known that feelings of control are known to decline when transfer takes place, it is important for women to know that their choice need not be influenced by this decline. In other words to not be put off booking for a home or birth centre birth on the chance that transfer might take place. De Jonge et al. (2014) also commented on the link between fear and lack of control, suggesting that when complications arise and transfer is necessary, levels of fear during labour may increase, which could then contribute to a decreased sense of control. Rowe et al. (2012) also referred to this as women becoming passive participants when transfer takes place. These women might be fearful about unfolding events, lose their sense of control and become withdrawn and submissive as they inwardly consider the next phase of the journey.

Communication

Keeping communication channels open in labour enables women to make choices, serving to empower and provide them with a positive birthing experience (Grigg et al., 2015a; McNelis, 2013) and has been found to have a greater impact than other influences such as childbirth preparation, the physical birth environment, pain, immobility, medical interventions, and continuity of care (Hodnett, 2002). Effective communication around transfer in labour would include explanations before, during and after transfer to help women accept and feel in control of their experience (Creasy, 1997). In the study carried out by Creasy, 12 women were interviewed between 3 and 8 weeks after the birth about their experiences when being transferred from a low risk to an obstetric unit in Sheffield, either in the antenatal period or in labour. The interviews were semi-structured and were analysed according to grounded theory

methodology. The main finding was that the transferred women had a strong potential for disappointment, but that this could be helped with good communication and appropriate care. Creasy (1997) emphasised the fact that when women were transferred, they had to contend with having to “experience obstetric complications and a transition from one system of care to another, less familiar, one” (p. 33) which meant having to accept and deal with two major occurrences simultaneously at a very vulnerable time. Creasy (1997) suggested that in order to ameliorate this situation adequate explanation is essential which is enhanced by taking into account the individual woman's current social, physical and emotional state.

Almost 15 years later, Grigg et al. (2015) discussed the importance of communication, suggesting that when women experienced effective communication from their midwife, the transfer did not appear to be experienced negatively. However, a different angle of the effects of communication was discussed by Grigg et al. (2015) who revealed negative communication between referring and receiving staff. As a consequence, Grigg et al. (2015) found that even with their own supportive midwife, women were still aware and affected by episodes of poor communication within the multi-disciplinary obstetric hospital setting. Grigg et al. (2015) concluded that despite the best efforts of the referring midwives, they are only one part in a complex system and while they endeavour to reduce the chasm between communication styles amongst the different maternity care providers they recommended a greater effort on all sides to try to eliminate it. The difference between communication styles was also commented on by Walker (2000), who pointed out that women who were transferred from the midwife-led to the consultant unit were aware of tensions between the staff on the two units, which did little to make them feel at ease or promote trust.

The level of information during transfer was considered by De Jonge et al. (2014) who found that generally women said they received sufficient information, although there was a minority who felt they had received more than they wanted to hear. Similarly Rowe et al. (2012) found that adequate information was necessary to reduce the worry about what could be next. Women wanted to be informed and although transfer was not expected by women, sensitive care and explanation could help women adjust to changing circumstances. Rowe et al. (2012) also commented on the fact that poor communication is associated with concern because without adequate explanation

women described being very worried about the baby's or their own health. They worried about what would happen on arrival at the obstetric referral centre, where their partner was and how their partner was managing with the stress. Rowe et al (2012) concluded by saying that without encouragement women did not voice these concerns and they were rarely anticipated or answered. The importance of communication was also one of three main findings in the metasynthesis of 5 qualitative studies by Fox et al. (2014) in which it was specified that women wanted high quality communication that was timely and clear.

Disappointment

Women's disappointment has been found to be determined by many factors including having had an assisted vaginal delivery, unplanned caesarean delivery, not having had a choice in pain relief or a negative experience with caregivers (Guittier, Cedraschi, Jamei, Boulvain, & Guillemin, 2014; Rijnders et al., 2008). Transfer in labour is another potential source of disappointment for women (Creasy, 1997; Lindgren et al., 2011; Rowe et al., 2012, Walker, 2000) . The English study conducted by Rowe et al. (2012) demonstrated that women felt disappointment which came from a sense of failure and of letting oneself down. In contrast, the mixed methods study by Grigg et al. (2015a), held in New Zealand, found most of the women were not bothered by the decision to transfer. Grigg et al. (2015) suggested that this could be due to the continuity of care model with an assigned midwife, a common choice for women in New Zealand. Creasy (1997) found in her study that English women felt disappointment but that the disappointment arose not because of the events themselves, but from the woman's attitudes towards them. Creasy (1997) felt that much of this was determined by personality, individual circumstances, and the woman's response to societal norms and peer pressure, because as Geerts et al. (2014) mention, women hope for or expect a natural birth and do not expect to be transferred. Creasy (1997) goes on to suggest that disappointment could be dramatically reduced if maternity care providers operated within a single seamless system.

Disappointment was also linked to loss, as described by Rowe et al. (2012). They reported women commonly voiced the loss felt due to the disruption of their vision of birth. Another factor linked to disappointment indicated by Rowe et al. (2012), was, as Creasy (1997) and Geerts et al. (2014) described, women feeling upset with

themselves for not doing as well as they had hoped, a sense of personal loss or even failure. This view was reflected by Walker (2000) who suggested that failure to meet birth expectations can generate intense disappointment and distress.

Timing of transfer, getting it right

There was discussion with women in several of the studies regarding the timing of transfer and whether they felt the midwife had timed the transfer optimally. Rowe et al. (2012) described some women's accounts as remembering that the decision was made too late which increased the worry and trauma. One woman felt the transfer should have taken place earlier, while there was still an element of control. Eventually, by the time the transfer took place it felt to her as if everything had fallen apart, which may contribute to greater concern due to high levels of tiredness and pain which can be challenging to deal with. In contrast, some English women felt the timing was right but this was generally due to the continuity of care in those cases; the women felt they trusted the midwife to make the right decision because of the one to one relationship they had built up.

In comparison, Walker (2000) found elements of maternal anger in her study, although this was with women who were transferred in late pregnancy rather than in labour. Several women in this English study blamed strict protocols and guidelines on the requirement for their transfer and this anger and upset was reflected onto the midwives who had to break the bad news to them. She found that these women described the transfer negatively, especially those women who were being transferred for induction of labour, who were disillusioned that a perfectly healthy pregnancy was to end in this unplanned way. Rowe et al. (2012) also made similar comments but also suggested that the shock and disillusion could be eased with sensitive care and preparation which may help women adjust to changing circumstances.

The timing of the transfer was another issue raised by women who also voiced concerns about the length of time the actual transfer took, especially if it was by ambulance. Women in the English study by Rowe et al. (2012) described their choice of birthing in an alongside midwifery unit because of their concerns regarding possible delays by ambulance and the possible consequences to their own or their baby's health. Worries about traffic or length of journey were raised. Similarly de Jonge et al. (2014)

found the thought of the journey instilled fear in Dutch women and made them reconsider their choice of birth place.

Preparation

The impact of preparation was raised in some of the transfer studies and included discussion regarding the effects of preparation on women for transfer and whether it was appropriate to give women all the facts beforehand or whether this caused the women unnecessary concern. Creasy et al. (1997) found that women were helped when factual information was given, such as transfer statistics, reasons, the physical ways transfer occurs and what happens on arrival. This was confirmed by de Jonge et al. (2014) who found that women in the Dutch maternity care system thought it was important that they had been sufficiently prepared about the options and logistics in order to involve them in decision making during labour. Walker's study (2000) had similar recommendations, that antenatal preparation, including a tour of the referral centre would help women prepare for all eventualities. In the study by Rowe et al. (2012) an all-round view was reported with a variety of standpoints. Many of these English women chose to deny the possibility and hoped that they would be the lucky ones while others felt that it was important to remain positive and that this sense of determination would reduce the likelihood of transfer. Rowe et al. (2012) also discussed the importance of the relationship with the midwife and how the trust and familiarity helped mitigate the trauma of transfer. This was particularly true in cases where the relationship contributed to good communication which enabled the midwives to prepare them for the idea that transfer might be needed. The importance of this special relationship was confirmed by Grigg et al. (2015) who concluded that the relationship of continuity with the midwife was the most important factor when it came to reducing the trauma of transfer.

Change of environment

When transfer took place women had to undergo a journey, whether it was a short walk, a wheelchair or trolley ride or an ambulance drive. Rowe et al. (2012) found English women felt the ambulance journey put them into an uncomfortable space which many felt to be a huge contrast from the familiar comfortable environment they were moving from. Similarly Dutch women in the study by de Jonge et al. (2014) were perturbed by the discomfort of the transfer journey, described by one woman as 'hell'

(p.9). Anticipation of the journey was associated with fear for some of these women relating to worrying about the practicalities of being moved from the house to the ambulance (de Jonge 2014). This practical aspect was also discussed by women in the study by Rowe et al. (2012) who talked about the discomfort, the cold and the exposure or lost dignity. In contrast, although there was little description in the study by Grigg et al. (2015), there was a comment on the length of time the ambulance took and the cost but overall the responses were not negative. The journey itself could be viewed as the bridge, as Rowe et al. (2012) describe, between the lost hope of a natural birth and the future vision of a more medicalised approach. During this time women can be separated from their partner which adds to the worry and are simultaneously anxious about the uncertainty of what outcomes lie ahead (Rowe et al., 2012).

Change in model of care

On arrival at the referral centre women were faced with a change from a natural to medicalised model of care (Rowe et al. 2012, Creasy et al. 1997). The ease of this transition was marked by how the transferring midwife managed the situation. De Jonge et al. (2014) reported that women remembered that important details, including that their personal preferences and choices, were sometimes not handed over between professionals. The confidence and competence of the transferring midwives was also seen to make a difference by Creasy et al. (1997) who reported that women related that in the worst cases the midwife seemed unable to function in the new medicalised setting. The women found it upsetting and confronting to see a deterioration in confidence in the midwife they had come to trust and rely on. At best, at the opposite end of the spectrum of coping skills by the midwife, the women reported that practical and emotional support was provided, together with advocacy which they felt helped ensure some of their choices were known to the new care providers (Creasy et al. 1997). The Dutch women in the study by de Jonge et al. (2014) commented on the importance of the referring midwife staying with them until they felt safe with the hospital team.

The need for consistent and coherent approaches to labour management was also voiced by the women who in some cases stated that it was actually more important to them that their maternity care providers were competent and that they felt safe rather having their primary midwife stay with them (de Jonge 2014), who did not always

have an influence anyway (Creasy et al. 1997). The influence of the transferring midwife was also questioned by Grigg et al. (2015) who suggested that despite the best efforts of the transferring midwife, they become one small part of a complex system and found it very difficult to protect women from poor communication with hospital staff or a sense of loss of control and isolation (Rowe et al. 2012). Similarly Walker (2000) also found that women noticed that tension between midwives on the two units was evident and impacted on women's transition to the medical model, causing a feeling of estrangement. Tension and division amongst staff was also reported by Wiegers et al. (1997) who suggested that the problem of the divide had to be addressed because good cooperation between midwives and obstetricians was essential to ensure that women received best care.

Talking through events after the birth

Offering women the opportunity to talk through their birth journey has been demonstrated by Gamble, Creedy and Moyle (2004) to help them come to terms with events and move forward. This also extends to women who have experienced transfer in labour. The two English qualitative studies reported the importance of women being given the opportunity to talk through the birth events at some stage in the postnatal period (Creasy et al. 1997, Rowe et al. 2012). This was described by Creasy et al. (1997) as a debrief, which she explained as the opportunity to develop and share a personal narrative of the events which had occurred, in order to start the process of adjustment to and acceptance of experiences. In the same way Rowe et al. (2012) suggested it was beneficial for women to talk about their experiences in order to help make sense of what had happened and then move forward to help them plan for future pregnancies. Rowe et al. (2012) commented that although not all women felt it was necessary, most appreciated the opportunity to talk through the labour and birth journey. They described the need for women to understand their experience and suggested that the most appropriate person to carry out the session was a midwife or obstetrician; Creasy et al. (1997) were more specific and stated that the women's preference was for the talk to be with their own midwife or General Practitioner (GP). The women in the study by Creasy et al. (1997) commented on how women felt the need to talk through events many times, often with their partner, to establish what had happened and to capture the chronological order of events. Women from both studies felt that an important part of the debrief was to understand the reason for transfer and

be satisfied that it was truly justified. The setting and timing of the talk was considered important with women in the study by Rowe et al. (2012) who suggested that debrief on the postnatal ward was too soon after the birth when tiredness and interruptions reduced the value of the process. Rowe et al. (2012) recommended that women needed time to assimilate events in their own mind and needed a quiet room to ensure the most positive experience.

Summary of literature on women's experiences

In summary, findings from the limited available studies have provided some insight into women's experiences within international contexts such as The Netherlands, Sweden and England and with different focuses on timing, method of transfer and geographical location of unit transferred to, which all impacted women's responses. The key findings in these studies included dissatisfaction, continuity, control, communication, disappointment, timing of transfer, preparation, change of model/environment, and talking through events after the birth. The evidence focused upon contexts such as homebirth transfer or midwifery led care units rather than birth centres leading to the conclusion that there was no evidence available from an Australian context indicating a gap in the knowledge of this area.

Partners' experiences

The labour experience has been described as being stressful for the woman's partner (Dahlen, Barclay, & Homer, 2010; Johansson, Fenwick, & Premberg, 2015; Kaye et al., 2014; Mbalinda et al., 2015; Nichols, 1993; Somers-Smith, 1999). As stated previously, an initial literature search took place in late 2012 for the purpose of developing a research proposal and identifying a gap in knowledge around partners' experiences of transfer in labour. Due to the limited number of studies found when carrying out the initial literature search around transfer in labour, a further search was carried out looking specifically at partners' overall experiences in labour, with a view to understanding the general emotions experienced in a variety of settings during normal labour and birth processes. These findings would provide a foundation of usual feelings from partners during the birth journey which could then be used as a backdrop to the discoveries of the experiences when transfer takes place and expectations and outcomes change. It was also considered that although there were no studies found specifically addressing the intrapartum transfer experience, it could also be valuable

to search for any studies where the outcome of labour changed. This would offer insight into how partners felt when the birth journey did not eventuate as expected. This separate search and findings will be discussed after the general experiences have been reported.

In late 2013 and early 2014, once PhD candidacy and ethics was approved and the data collection completed, and then again in 2015 and 2016, further extensive searches of the 'PubMed', 'OVID' and 'CINAHL' databases, as well as 'Google scholar' were conducted using the key words 'labour', 'transfer', 'partner', 'father', 'perceptions', 'midwifery units', 'birth centres', 'intrapartum care', 'experience' and 'birth' in various combinations. A variety of papers relating to partners' experiences during labour were discovered, both qualitative and quantitative and in many settings all around the world. Of the 42 relevant papers many important themes were revealed in the data including being sidelined or kept in the dark, anguish and anxiety from a range of causes, feeling useless or helpless, the need to be supported and involved, having trust in the professionals and the ecstasy of birth. These themes from previous research findings will now be used as headings to critique partners' experiences around childbirth.

Being sidelined

Being sidelined or kept in the dark was the theme that was most prevalent and was reported in studies from Sweden, the United States of America England, South Africa and Malawi (Backstrom & Wahn, 2011; Chandler & Field, 1997; Dellmann, 2004; Draper & Ives, 2013; Eriksson, Salander, & Hamberg, 2007; Hallgreen, Kihlgren, Forslin, & Norberg, 1999; Hildingsson, Cederlöf, & Widén, 2011; Johansson, Rubertsson, Rådestad, & Hildingsson, 2012; Kululanga, Malata, Chirwa, & Sundby, 2012; Longworth & Kingdon, 2011; Poh, Koh, & He, 2014; Premberg, Carlsson, Hellström, & Berg, 2011; Sengane & Nolte, 2012; Steen, Downe, Bamford, & Edozien, 2011). Not receiving enough information or not being kept in the loop, caused partners to feel left out and experience a lack of involvement in the birthing process (Poh et al. 2014, Backstrom & Wahn, 2011, Sengane & Nolte, 2012, and Steen et al., 2011).

In their Swedish study, Backstrom and Wahn (2011) suggested when partners were not included in decision making, the feeling of exclusion led to feelings of helplessness

which could in turn contribute to panic. This lack of involvement made some partners feel that it was not worth asking questions because when they did they were not given straight answers. In another Swedish study, Hildingsson et al. (2011) also found that if the information was insufficient or if the fathers did not get adequate answers to their questions, they felt excluded from the care. The perception of receiving support was found by Hildingsson et al. (2011) to be closely linked to the amount of information given. This link between education or information and perception of support was also found by Chandler (1997) who explained that some American partners felt procedures were not adequately explained. She then went on to say that some partners felt their presence was tolerated rather than embraced; they sometimes felt like they were being taken over rather than being encouraged to help their wife/partner. Even as far back as 1987, also in America, Shapiro noted that although men were encouraged to participate in the pregnancy and birth of their children, they were simultaneously given to understand, in many subtle and not so subtle ways, that they were outsiders. These feelings of disconnection were described more recently about partners in England by Longworth and Kingdon (2011), who stated partners felt they were on the periphery of events rather than being totally involved.

Another reoccurring sentiment experienced by partners and confirmed by Dellman (2004), Backstrom and Wahn (2011) and Johansson (2012) was that being excluded from making decisions about labour and not being included in discussions by health professionals was the source of immense anger, irritation and distress in men. Johansson et al. (2012) found that when Swedish fathers experienced feelings of not knowing what was going on and not knowing what to do, it made them feel worried, helpless, unsafe, lacking control and less satisfied with the birth. These partners felt they were not being listened to, that the healthcare professionals did not involve them and this led to them feeling forgotten and unneeded. Backstrom and Wahn, in their Swedish study (2011), reported that partners wanted continuous information about what was happening across different situations and throughout all stages of labour. These Swedish authors found that when the midwife told the partner what to do, their feeling of involvement increased. One partner in their study stated: “The support I got was that they answered my questions, unimportant questions in reality, but I thought they were important then, and when they gave good answers it calmed me, and when I was calm my girlfriend was too” (Backstrom & Wahn, 2011, p. 69).

Anguish and anxiety

In quantitative and qualitative studies from Sweden, Finland, England, Australia, South Africa, Germany and Malawi, anguish and anxiety have been described as emotions that surface for men at different stages of labour due to a variety of events (Chandler & Field, 1997; Dellmann, 2004; Eriksson et al., 2007; Gawlik, Müller, Hoffmann, Dienes, & Reck, 2015; Hallgreen et al., 1999; Hildingsson et al., 2011; Johansson, Hildingsson, & Fenwick, 2013; Kululanga et al., 2012; Longworth & Kingdon, 2011; Premberg et al., 2011; Sengane & Nolte, 2012; Somers-Smith, 1999; Steen et al., 2011; Vehviläinen-Julkunen & Liukkonen, 1998).

Before labour begins the partner may feel he will be able to comfort and support his wife/partner even through the most difficult times but in reality, as Chandler and Field reported (1997), when the day arrived, they perceived their care as being not effective. The anguish came from seeing their wife/partner in pain and not being able to do anything about it. This was voiced by a prospective father in the study by Eriksson et al. (2007) who admitted that “I had to watch the person I love suffer without being able to do anything about it” (p. 412). Chandler and Field (1997) revealed that all the men in their study reached a point where they had to work hard to control their emotions because they were so overwhelmed with concern and upset. A partner in another Swedish study revealed “There were a lot of feelings when she was in pain, it really hurt to see her in such pain. It hurt in my soul, so much so that I started to cry and I don’t cry very often.” (Premberg et al., 2011, p. 851). Similarly, a southern Malawian study also found that observing the woman in severe pain was an experience that most men could not easily tolerate and resulted in feelings of fear, anger and frustration (Kululanga et al., 2012).

Another source of anguish for partners was the fear that their wife/partner or baby might suffer damage or lose their lives (Eriksson et al., 2007; Hallgreen et al., 1999; Kululanga et al., 2012; Longworth & Kingdon, 2011; Mbalinda et al., 2015; Premberg et al., 2011; Somers-Smith, 1999; Vehviläinen-Julkunen & Liukkonen, 1998). The intensity of this fear was described by Eriksson et al. (2007) who related that the presence of fear in partners during labour was often described by them as a “mental occupation” (p. 412). Kululanga (2012) described the escalation of fear and dread when the men in his study saw the amount of blood that the women had lost during

birth. Most of the men stated that the sight of the blood terrified them and made them fear for their wife/partner losing her life. A study in Japan reflected this feeling of horror with one man stating “It seemed to me that I witnessed hell during that labour.” (Yokote, 2007, p. 106).

Anguish and anxiety are difficult emotions to deal with but these were compounded by the belief that masculine stoicism dictated that these feelings had to be suppressed (Draper & Ives, 2013; Eriksson et al., 2007; Hallgreen et al., 1999; Kululanga et al., 2012; Premberg et al., 2011; Somers-Smith, 1999; Steen et al., 2011). Hallgreen et al. (1999) found that the expected role of Swedish partners during the birth process was that of a protective guide; this meant that it was viewed as important to hide their feelings. The findings of Kululanga et al. (2012) in Malawi, were that most partners put on the act of being strong for their wives/partner but were in fact very much afraid. Partners in another Swedish study by Erikson et al. (2007) referred to societal expectations and the fact they did not want to look weak or afraid and also that the focus should be on the woman, it was her moment: “In that situation it doesn’t really seem appropriate to start talking about your own fears” (p. 414). Premberg et al. (2011) found some Swedish partners reached a point where they were no longer able to maintain a brave stoic exterior, with one man describing how he “broke down, crying like a 3 year old in the corner” (p. 850) and another saying “The midwives saw me crying and said I’d better go out for a while.” (p. 851).

Feeling useless or helpless

When men looked back on their labour experience they frequently voiced feelings of uselessness or helplessness (Capogna, Camorcia, & Stirparo, 2007; Chandler & Field, 1997; Chapman, 1991; Dellmann, 2004; Draper & Ives, 2013; Eriksson et al., 2007; Hallgreen et al., 1999; Johansson et al., 2012; Kululanga et al., 2012; Poh et al., 2014; Somers-Smith, 1999; Vehviliinen-Julkunen & Liukkonen, 1998). The feelings of helplessness could be due to being overwhelmed by the whole labour process but for many men it was the sense of not being able to help and make a difference while watching their wife/partner in pain (Eriksson et al., 2007; Kululanga et al., 2012). Chandler and Field (1997) stated that often men in their American study were dissatisfied with their own performance in labour; this contrasted with their views of how they felt they would have behaved beforehand. In the antenatal period they felt

they would be able to comfort and support their wife/partner through the difficult times and that their presence would make the difference but when the moment came their actions did not provide the support and help they thought it would. They wanted, hoped and prepared to be the other half of a true partnership in labour only to find that on the day their efforts seemed fruitless.

A feeling of exclusion was another reason leading to a perception of uselessness (Chandler & Field, 1997). American men very often felt their presence was tolerated rather than being an essential element of the birth journey, which caused perceived exclusion. In this American study one man stated “They took over from me instead of helping me to help Laura. I began to feel like an appendage rather than being really involved” (Chandler & Field, 1997, p. 21) and from a Swedish study: “I was not part of the process. I felt ignored in the room the whole time.... I felt confused. It was a bit like I was walking around in a fog not knowing where to go. I didn’t understand a thing. Not knowing was horrible” (Johansson et al., 2013, p. 1045).

Having trust in the professionals

Having trust in the professionals was a difficult concept for some partners when they are used to being the person who is in control. In a situation of being in a strange environment and following a process they do not understand, men were often out of their comfort zone. These partners were disadvantaged by not having an understanding of the labour process and everything involved, such as the terminology and equipment used and procedures undertaken (Eriksson et al., 2007; Johansson & Hildingsson, 2013). Being in the hands of someone else; not being in the driving seat led some partners in Sweden to a feeling of being unsafe and lacking control (Johansson et al., 2012). In another Swedish study one partner stated: “Being left so totally to other people’s judgments was what really scared me the most.” (Eriksson et al., 2007, p. 412). Similarly a man from Johansson’s Swedish study said “The assistant who was handling the vacuum seemed to not have done it before; she did not even know how to turn it on.” (Johansson et al., 2012, p. 14). At the same time some men felt completely in the dark and were anxious because they did not know what was about to happen, as expressed by a partner in the Swedish study by Hallgreen et al. (1999): “You’re pretty helpless, you sit there as a fool and can’t do a thing. I was scared the kid would come any minute when the midwife wasn’t around.” (p. 12). This concern about

having to rely on the judgement of others was reiterated in another Swedish study by Backstrom and Wahn (2011) where one man expressed concern around the cardiotocograph recording of the fetal heart rate in labour: “Something with the CTG... they never really gave the answer what... the anxiety was always there, and it was disturbing” (p. 70). This feeling of being completely in the dark, of not understanding processes also caused feelings of worry, not knowing what to do (Johansson et al., 2012), rising panic (Vehviliinen-Julkunen & Liukkonen, 1998) and immense anger (Dellmann, 2004).

The need to be supported

Needing support was noted as one of the three most important aspects associated with a positive birth experience in Swedish studies by Hildingsson et al. (2011) and Backstrom and Wahn (2011) who found that feeling supported was reliant on whether fathers felt involved and not left out. They went on to suggest that to improve feelings of being supported professionals could reassure the partner of the importance of their role and also give guidance on how to help their woman. It appeared that men were very willing to be helped to aid and encourage their wife/partner, as one man in an American study back in 1991, when asked if he needed assistance in his role, answered: “Absolutely! I was unsure of what to do, I just followed the lead” (Chapman, 1991, p. 27).

The midwife’s presence in the room was found to have a positive influence on men’s perception of support (Backstrom & Wahn, 2011; Chapman, 1992; Hallgreen et al., 1999; Hildingsson et al., 2011). With first-time Swedish fathers, Hildingsson et al. (2011) found that it was the support from the midwife that was the only factor explaining their positive childbirth experience. They went on to say that partners relied immensely on the midwife and her ability to help them through the labour and birth journey. These findings were confirmed in a recent meta-synthesis of eight studies conducted in England, Malawi, Nepal and Sweden (Johansson et al., 2015) in which the authors concluded that irrelevant of a partners ethno cultural status receiving support was one of the important elements to improve the experience of partners through the labour and birth journey.

The ecstasy of birth

Continuing with the findings of extant literature of how a labour affects partners, even when an intrapartum transfer experience does not occur, men described the moment of birth as a moment of true ecstasy (Dellmann, 2004; Erlandsson & Lindgren, 2009; Hallgreen et al., 1999; Johansson et al., 2013; Longworth & Kingdon, 2011; Poh et al., 2014; Premberg et al., 2011; Vehviläinen-Julkunen & Liukkonen, 1998). A partner in the Swedish study by Hallgreen et al. (1999) stated:

“It was like, well, an explosive atmosphere. Tense as ever! I think it was the greatest experience in my life. Well, and there he was! When he came everything felt fine. Everything came together!” (p. 11).

Similarly, in another Swedish study, Erlandsson and Lindgren (2009) described how the men found that at the moment of birth they were incredibly happy, had to keep back tears, and were unable to speak. The intense exhilaration lasted for the first few minutes and then there was the significance of the new life before them and the happiness of a living, healthy baby. This joy was intensified because of the simultaneous relief from worry, tension, anxiety and nightmares of the labour being over and with it the possibility that something could go wrong. In the same way, an English partner enthused: “It was like everything! It was just relief, joy, everything!” (Longworth & Kingdon, 2011, p. 591)

When the outcome changes

Generally the woman’s partner aims to offer support in order to help her achieve the labour she planned for, which is known to be a challenging task (Laslett, Brown, & Lumley, 1997). Partners of women choosing to birth in a birth centre have been found to feel more involved in the care (Waldenstrom, 1999) and this involvement can lead to increased satisfaction with the experience (Hildingsson et al., 2011; Johansson et al., 2012). However, during the antenatal period the prospective parents may have developed a birth plan, made decisions about labour choices and planned what action to take in the event of certain incidents taking place. If events do then ensue as anticipated and the outcome changes, the partner may experience a wide range of emotions (Chan & Paterson-Brown, 2002; Fenwick, Bayes, & Johansson, 2012; Johansson & Hildingsson, 2013; Johansson et al., 2013; Kaye et al., 2014; Koppel & Kaiser, 2001; Mbalinda et al., 2015; Rosich-Medina & Shetty, 2007; Steen et al., 2011;

Vehviliinen-Julkunen & Liukkonen, 1998; Yokote, 2007). Although Walker's qualitative English study (2000), exploring the transfer experience of women, included 10 contributions from partners, no research has been undertaken which specifically addresses the individual experience of intrapartum transfer for the partner; there is currently a lack of data to inform understanding of this experience from their perspective.

Due to this complete lack of data addressing the experiences of transfer in labour, another search was undertaken looking for any experience where the labour took an unexpected route and the outcomes were not as expected. Extensive searches of the 'PubMed', 'OVID' and 'CINAHL' databases, as well as 'Google scholar' were conducted using the key words 'labour', 'caesarean', 'neonatal unit', 'partner', 'father', 'perceptions', 'intrapartum care', 'experience' and 'birth' in various combinations. Several papers were discovered addressing assisted vaginal birth, caesarean section and admission of baby to neonatal unit. Although these do not discuss the partner's intrapartum transfer experience they do address the experiences of an unexpected change of circumstance at some point during labour. These studies were both qualitative and quantitative and in many settings all around the world. Of the 12 relevant papers many important themes came out of the data including: worries and anxiety; the need to be informed, feeling cared for, trust, feeling useless, helpless and left out, going to an unfamiliar environment and the trauma of the birth. In the same format as above, these themes from previous research findings will now be used as headings to critique partners' experiences when labour outcomes change.

Worries and anxiety

Worry and anxiety were the reoccurring themes highlighted in the literature (Chan & Paterson-Brown, 2002; Johansson et al., 2013; Johansson et al., 2012; Koppel & Kaiser, 2001; Lee, 1986; Mbalinda et al., 2015; Steen et al., 2011; Vehviliinen-Julkunen & Liukkonen, 1998; Yokote, 2007).

In a maternity unit in London, in a quantitative study of 121 couples, Chan and Paterson-Brown (2002) compared the experiences of partners with different birth outcomes and found that partners were more anxious when the labour pathway resulted in emergency caesarean section. Chan and Paterson-Brown (2002) suggested that this may be the result of various factors, including factors leading up to the caesarean and

then the type of setting and atmosphere actually in the operating theatre. The actual operation itself, as expected, was also found to be more traumatic. Similarly in a mixed methods study of 827 partners in Sweden, Johansson et al. (2012) found that the overall unfamiliar environment of the operating theatre, including theatre scrubs, the different temperature and also that bodily fluids are in evidence was discovered to cause anxiety. In the same way, the qualitative descriptive study by Johansson et al. (2013) involving 22 Swedish partners, found that the level of anxiety was raised when the reality of the caesarean section approached and then remained high throughout the procedure. The fears were caused due to the potential risk for complications such as bleeding. One man said “it’s an operation, they have to cut the belly, so there is always risk, pain, problems with the belly” and another: “I was worried over my partner’s health. Worried about what is going to happen. I kept going over it in my head – hoping nothing would go wrong with the operation; if they cut wrongly for example” (Johansson et al., 2013, p. 1044). Similar findings also emerged from a Ugandan qualitative phenomenological study in which the authors interviewed the partners of 25 women who had complications during childbirth (Mbalinda et al., 2015). These men revealed anxieties about the complications around operative birth, the possibility of losing their wife/partner and child and the concerns about the longer term repercussions following obstructed labours and surgical procedures. It was also discovered that anxiety was heightened by the men feeling excluded due to poor communication with maternity care perceiving providers were arrogant, aloof and hostile.

Local policies and procedures can also have an impact on partners’ emotions as Koppel and Kaiser (2001) discovered. In their German qualitative exploratory study in which 18 partners were interviewed, Koppel and Kaiser found that in some situations the partner was left alone, standing or sitting in front of the operating or delivery room and had no idea whether his wife/partner and baby were alive or dead. The partners in this study went on to say that being left alone caused the most stressful and anxiety-ridden moments of their lives, made worse by being cut off from any information about the women and babies; information that would relieve their huge anguish. A recommendation was made by the authors that there is a need for systematic research into the needs of partners when the birth of their child becomes complicated which further supported the need for this present study.

The meta-analysis of 23 studies of partners' birth experiences in nine high resource countries, (7 UK, 5 Australia, 4 , Sweden, 2 USA, 1 Japan, 1 Taiwan, 1 South Africa, 1 Finland, 1 New Zealand) by Steen et al. (2011) demonstrated that although partners understood the need for surgery, when the decision was announced they felt huge anxiety and had no doubt that the lives of both the woman and baby were at risk. Added to this was the frustration that they could do nothing about the situation, it was out of their hands. In a Finnish mixed methods study in which 107 partners completed a questionnaire after the birth of their babies, Vehviliinen-Julkunen and Liukkonen (1998) also found that concerns around the baby's welfare were a source of anxiety when the labour pathway they were prepared for, altered. They also discovered that individual factors around childbirth, such as having to wait, seeing an episiotomy, witnessing blood loss, as well as operative birth all increased anxiety levels.

The need to be informed

Wanting to be kept up to date with information was described as a factor that impacted the whole experience in situations where the path of normal labour and birth changed (Grobman, Kavanaugh, Moro, DeRegnier, & Savage, 2010; Johansson et al., 2013; Koppel & Kaiser, 2001). A qualitative study which took place at three maternity units in America considered the experiences of parents where the outcome of the baby was precarious, and found that one of the main themes identified was the fundamental importance of providing information (Grobman et al., 2010). The partners wished for clear information so that they could fully understand the situation and so be better prepared to be involved in decision making. Similarly the Swedish qualitative descriptive study of 22 partners by Johansson et al. (2013), also discussed how the sharing of information from the health-care team in leading up to the caesarean section made a difference to how the partners perceived the whole experience. When partners were constantly worried about what was happening, but staff shared information, they went on to report that they had a good birth experience. Staff who explained what was happening and kept the partners up to date were highly valued. Johansson et al. (2013) also commented that personalised attention from staff was important too, for example, being asked how they were feeling. One partner's comment was reflective of many participants:

“The staff explained everything they were doing from the start. It felt good when the staff explained, for example - Now we are giving her the anaesthesia; -Now we are going to do this; -Soon the physician will come. I got to know what was going to happen. I felt good about this” (Johansson et al., 2013, p. 1045).

The partners also described emotions such as feeling calm and being supported, involved, included, being satisfied and safe to define the consequence of being kept well informed. One partner described the impact of information sharing:

“They talked the whole time and explained and said what they were doing. That was very good. I knew what was going to happen and everything. I could visualise what was going on. It stopped me from worrying about a disaster. I felt it was safe and I became more involved.” (Johansson et al., 2013, p. 1045)

On the other hand in Germany, Koppel and Kaiser (2001) described the impact of when partners were not kept informed. In their study where there was a risk of neonatal mortality, partners reported the need for open, honest and frank communication with staff, including clearly presented information. They complained about staff who were reluctant to offer explanations and information. Similarly negative comments arose from partners, who were not kept in the loop, in Sweden Johansson et al. (2013). These men struggled to cope with the experience, their anguish escalated and they felt excluded. In this study there were some examples where men asked direct questions of staff and were not answered. One man suggested that it would have made him feel more secure if staff had given him ongoing communication as the events unfolded. He said: “I would have liked them to talk. I would have liked to have heard that it was all going fine” (Johansson et al., 2013, p. 1045). A variation to the theme was described by men in the African qualitative study (Mbalinda et al., 2015) where it appeared that communication channels were blocked with the use of jargon, medicalised language and an air of superiority, leaving the men feeling marginalised and uninformed.

Feeling cared for and supported

Feeling cared for and supported by staff had a big impact on partners’ experience (Grobman et al., 2010; Johansson et al., 2013; Yokote, 2007). It was found in America that partners, of which 79% were black or Hispanic used words such as: kind, soft, gentle, caring, and attentive, demonstrating compassion and empathy, when describing

the behaviour from staff that helped alleviate their anxiety (Grobman et al., 2010). One person said: “treat people as people and not numbers” (p. 907). Similarly in Sweden, Johansson et al. (2013) also found that when information was worded in an informative manner with appropriate language it helped partners to cope with the challenging situation of an emergency caesarean section. However, in a Japanese study it was pointed out that from the staff member’s perspective it was more difficult to ensure this in an urgent situation, when staff were busy dealing with the emergency in hand (Yokote, 2007). When the midwife is occupied with the safety of the woman and the baby she might have very little opportunity to address the partner’s concerns, feelings and thoughts during this critical and busy time; it is not always top of her list of priorities (Yokote, 2007).

Trust

Trust was described as a necessary emotion in times of crisis; Yokoto (2007) described how the partners in her Japanese study felt that they had no choice but to trust the obstetrician because they were the only route to an outcome which would save the mother and the baby. In a similar way, Johansson et al. (2013) found that Swedish partners felt able to trust the health care team when their perception of the staffs’ level of competency gave a feeling of safety, support and control. They described the team as skilled, expert, knowledgeable and capable and this made a positive difference to their caesarean section experience. One man said: “The childbirth was very good, bloody good, because of skilled professionals. They conducted themselves in a very expert manner and I felt awfully safe” (p. 1046). On the other hand two partners in this study expressed doubt in the teams’ ability with one partner second guessing when the team would take the appropriate action: “I was afraid. In my head I’m thinking this will not do. I did wonder if they really had control of the situation. I was just about to tell them to do something when they started to angle the table” (p. 1045) and another about the lack of eye contact which reduced his feeling of trust: “He was telling me something. It’s about trust in a way, when you make eye contact. He stared down or looked on my side, and maybe he was stressed or something or perhaps it was his personality. However it made me question whether he should be trusted with the task” (p. 1046). These findings demonstrate the importance of both verbal and non-verbal communication in such circumstances.

Feeling useless, helpless and left out

A hollow emptiness as a consequence of feelings of exclusion was described by Johansson et al. (2012), Johansson et al. (2013) and Vehviläinen-Julkenen and Liukkonen (1998). They reported that partners felt excluded if they had not been told what they were supposed to do and also that they sometimes felt forgotten. In their Finnish study Vehviläinen-Julkenen and Liukkonen (1998) stated that the sense of helplessness was widely experienced and in a Scottish study by Rosich-Medina and Shetty (2007), comparing different birth outcomes, they found that men whose partners birthed by an emergency delivery felt significantly more helpless than the vaginal birth group. Similarly Johansson (2013) described partners who talked about being excluded and had to “just sit there watching and waiting” (p. 1044). Others verbalised how they did not have a ‘role’ or ‘task’ in the birth which made them feel like a spare part. For example, one man stated, “I could see she was panicking. I felt completely overwhelmed and helpless. I felt useless during the operation” (p. 1045).

Going to an unfamiliar environment

Couples in labour are unlikely to be very familiar with the birth suite having probably only visited it once on an orientation tour at the beginning of the pregnancy. However, to then be transferred to the operating theatre increases their depth of strangeness and discomfort. In her literature review of the psychosocial impact of caesarean section on the family, Mutryn (1993) described the fact that there are virtually no other situations in modern medicine where a member of the family is allowed into an operating theatre to watch major surgery being performed on the person closest to them. She goes on to comment on the fact that partners participate in this extraordinary event with very little information, due to the fact that many couples ‘tune-out’ during the part of the parent education classes that discuss caesarean birth. Even earlier in America, Lee (1986) found that being in theatre was the source of very high levels of anxiety. For some partners it made them feel so uncomfortable and frightened that they said they would prefer not to be present if it ever happened again. This discomfort was also described by some partners in the Swedish study considering their emotions when caesarean section occurred, by Johansson et al. (2013). The theatre was perceived as an unfamiliar and a somewhat ‘scary’ environment with one partner saying “I was a little nervous about the things happening around me. I was in an unfamiliar environment and as the time got close for the birth I became more nervous” (Johansson

et al., 2013, p. 1044) and others used words such as panic and shock to describe how they felt on entering the unfamiliar theatre.

The trauma of the birth

The trauma of the birth itself was another factor confronting some of the partners when it was not the kind of birth they were expecting. Agonising descriptions were defined by partners in the Swedish study by Johansson et al. (2013) when they were faced with the harsh reality of an operative birth. One of the men described “a knife and lots of blood” and for many men witnessing the manipulation, described as “pulling” and “tugging”, associated with operative birth was something they were not prepared for (p. 1045). The men in the Finnish study by Vehviläinen-Julkunen and Liukkonen (1998) also discussed the shock of the reality of operative birth, including seeing an episiotomy. When, in a large maternity unit in London, Chan and Paterson-Brown (2002) compared the reflections of men at all types of birth, they found that 100% of partners who attended normal vaginal deliveries and caesarean sections would choose to stay next time whereas 97% of those who attended instrumental deliveries would stay.

Summary of literature on partners’ experiences

International evidence has confirmed that partners face an emotional journey when supporting their wife/partner along the birth journey, particularly when the path takes an unexpected turn. This literature review has revealed that no data has been identified that specifically demonstrates the experiences of partners when intrapartum transfer takes place from a low-risk to a high-risk unit internationally. Furthermore none of the studies outlined above took place in Australia indicating that the proposed study on intrapartum transfer in labour will help add understanding to the perspective of Australian partners. As Koppel and Kaiser (2001) pointed out, “it is probably again time to re-think and systematically research fathers’ needs and how they are treated when the birth of their child becomes complicated” (p.249.)

Midwives’ experiences

As stated earlier, over the period of late 2012, early 2013 and then again in early 2014, extensive searches of the ‘PubMed’, ‘OVID’ and ‘CINAHL’ “Web of Science databases, as well as ‘Google scholar’ were conducted using the key words ‘midwife,

'labour', 'transfer', 'midwifery units', 'birth centres', 'intrapartum care', 'experience' and 'birth' in various combinations. One study identifying midwives general experiences in labour was found but as it was based in Africa, most issues discussed were not transferable to an Australian context (Sonto & Hiss, 2010). Several other studies were discovered including discussing midwives' decision making, collegiality and clinical responsibilities in labour (Deery et al., 2010; Page & Mander, 2014), managing women's pain in labour (Lundgren & Dahlberg, 2002) and aiming to facilitate a normal birth in an obstetric unit (Keating & Fleming, 2009). Initially no studies relating to midwives' experiences on intrapartum transfer were discovered. Later in the search two studies relating to midwives experiences of transfer were discovered. The first was a qualitative English study (Wilyman-Bugter & Lackey, 2013) which specifically looked at the transfer experience of the midwife from a planned home birth to the nearest obstetric unit, not from an adjacent birth centre as this author's Australian thesis study reports on. The second study was an American qualitative study (Cheyney et al., 2014) which again looked at the transfer experience from home to a referral centre from the midwife's perspective. Hence while these two studies added to the existing body of knowledge around the transfer experience there was still a need to understand the transfer experience from an adjacent birth centre to a referral obstetric unit and to uncover what this might mean in the Australian context.

The midwives' role

Exploring the concept of the intrapartum transfer experience it is worthwhile considering what difficulties the midwife might face. In the antenatal period the midwife informs and educates the woman supporting her to plan her birth. When intrapartum transfer takes place, the midwife is often in a position of being aware of the importance of the woman's birth plan but now having to take action that he or she is aware was not within the woman's preferences. This conflict can sometimes lead the midwife into suggestive or manipulative dialogue where she strategically phrases her information in order to effect a certain outcome (Hyde & Roche-Reid, 2004). The need of the midwife to deviate the woman away from her original plans either by persuasive means or by having to use very direct communication in a more urgent situation may have an impact on the birth experience for the woman, her partner and midwife. Equally, prioritising care and affording time to offer explanation and choice in an emergency situation can prove to be very difficult (Yokote, 2007). The process

of transfer can therefore affect the emotional and physical wellbeing of the midwife due to the need to make the decision in a timely fashion, advise the parents appropriately without raising alarm but also being realistic, inform the receiving personnel and arrange transportation. As well as dealing with the practicalities of facilitating the transfer the midwife may also be aware of the effects of disrupting her therapeutic presence with the woman.

The decision to transfer

The English (Wilyman-Bugter & Lackey, 2013) and American (Cheyney et al., 2014) qualitative studies both discussed experiences of midwives when transfer took place from a planned home birth to an obstetric unit. The methodology chosen in both cases was phenomenology as it describes the lived experience (Mapp, 2008; Vivilaki, 2008) and so was considered to be most suitable. In the English study (Wilyman-Bugter and Lackey, 2013) ten midwives involved in a transfer from home to hospital were interviewed, however the timing of how soon after the transfer event took place was not disclosed. In Cheyney's (2014) American study, 24 midwives and 16 physicians were interviewed and the authors also observed and made notes of 50 transfer episodes to gain different perspectives.

The main themes that emerged from the English study were around the midwives' decision to transfer, supporting the parents, collaborative working, organisational challenges and ambulance services (Wilyman-Bugter & Lackey, 2013). One of the themes, the midwives' decision to transfer was based on their expertise, experience and available hospital guidelines which together made the midwives feel confident in their decision making. However, an obstacle to making the decision to transfer was being challenged by the parents. The midwives discussed incidents where the validity of their decision to transfer was questioned which added another dimension to the responsibility of trying to ensure a good outcome but also taking into account the parents' wishes. The importance of collegial support was emphasised by the midwives, who said they relied on the labour ward coordinator for advice by telephone when difficult decisions had to be made. The midwives stated that they often felt unsupported due to lack of staffing in some instances and described the feeling of isolation when being the lone professional in a difficult situation during a home birth. The need for provision of a second midwife for the birth was reiterated by the

midwives and the hope for a protocol to ensure this was strongly voiced. The lack of support and feeling solely responsible was also discussed when it came to the organisation of the actual transfer. There was a feeling of stress for the midwives by having to organise transport, let the receiving staff know, prepare the parents and complete documentation, usually all within a short space of time. The weight of this responsibility was felt deeply by the interviewed midwives.

Holistic care

In comparison, the midwives' themes in the American study were focused on the perceived lack of holistic care (physical and emotional) by receiving staff, the bias of physicians and wishing for greater insight from obstetricians to acknowledge their poor national obstetric outcomes, rather than focusing on the small number of home birth transfers (Cheyney, 2014). The lack of holistic care was described by the home birth midwives as a lack of concern by the physicians of the woman's psychological wellbeing, with their focus being solely on the physical safety. The midwives felt that the lack of holistic care from physicians was one of the reasons women chose home birth and therefore there was a need to recognise this in order to improve choices. Similarly the perception of bias from physicians made the midwives feel unwelcome and scrutinised, feeling that they had been judged before being able to justify their decision making. In the same way, the midwives viewed that the physicians' blinkered vision biased them against the reality of poor national obstetric outcomes. The midwives wanted physicians to develop an awareness that the small number of homebirth transfers pale into insignificance when compared with the physical and psychological damage experienced by American childbearing women having a hospital birth.

Mutual respect, support and understanding

It was interesting and valuable to gain insight into perceptions of the receiving staff at the referral hospital. Three themes emerged from the physicians which related to the perceived danger of home birth, the concern of having to 'pick up the pieces' and the poor documentation and communication which they felt led to costly delays. Cheyney (2014) commented on the chasm between the receiving maternity care providers' perception of the danger of home birth and the truth of the statistical evidence. There was however a real fear described by the receiving staff of being responsible to rescue

a situation that they felt had got out of hand and now made very difficult to manage. They also felt there was inconsistency in documentation and midwifery practice leading up to the transfer.

The conclusions from the English study were focused on the logistics of home birth, with an emphasis on support and the midwives voicing their need for a second midwife to always be present at the birth. The findings of the American study highlighted the need for mutual respect and communication between the home birth midwives and the receiving hospital staff.

It was suggested that a limitation of the English study was the fact that the women's views were not sought and it was proposed that their views around the transfer would have strengthened the findings (Wilyman-Bugter & Lackey, 2013). Seeking the views of all three parties involved; the woman, the partner and the midwife may add strength and depth to the findings surrounding each transfer.

Summary of literature of midwives' experiences

The findings from these two international studies provide insight into the challenges midwives face during transfer from home to hospital and how they vary between healthcare contexts, however the results are not directly transferable to experiences of midwives transferring from a birth centre to an adjacent tertiary referral centre in Western Australia. The midwife is the key support person during this phenomenon of transfer and is able to help facilitate a positive birth experience (Cohen, 2003). This literature review revealed evidence of a gap in knowledge around the midwifery experience when intrapartum transfer takes place. This knowledge is required to provide information to enable the midwife to gain insight into the experience in order to help address the needs of the parents and also provide awareness of her/his personal behaviours during this event which will help to develop strategies to assist the process. The difference between contexts reinforces the gap in knowledge and the need for a study to explore the experiences of Australian midwives when transfer from a birth centre to a tertiary hospital occurs. Insight into midwives experiences will inform midwifery learning and help promote the development of collaboration between health professions.

Summary

In this chapter the literature regarding intrapartum transfer has been chronicled. Overall, no literature was identified which provided a comparative analysis of the triad of experiences into the perceptions surrounding the experience of intrapartum transfer and its impact on women, partners and midwives. This lack of both Australian and international knowledge provided the evidence that further research was required to address the gap in knowledge and provide unique insight into the phenomenon of intrapartum transfer from a birth centre to an obstetric unit for the key participants. This insight into the transfer experience for women and their partners would offer midwives the opportunity to reflect on their care and decision making in order to better facilitate a positive labour and birth experience for all parties.

In the following chapter, the specific methodology employed for an investigation into the intrapartum experience for women, partners and midwives is presented.

Chapter Three: Methodology

This chapter offers the background to the choice of methodology for a study of women, their partners and midwives experiences of intrapartum transfer and why it was conducted using a descriptive phenomenological design. All aspects of the study will be described, including the research approach, paradigm, sampling strategy, data collection and data analysis and the justification for selecting descriptive phenomenology as the most appropriate research method to address the primary aim and specific objectives.

Methodology has been defined as a general approach to studying research topics (Silverman, 2013) or, how a researcher approaches a research problem and seeks answers (Taylor, Bogdan, & DeVault, 2015). To demonstrate the comprehensive journey taken in making the decision, an overview of the two main research paradigms, quantitative and qualitative will be outlined and compared, demonstrating analysis of their suitability for this study. The differences will be presented together with the rationale as to why a qualitative design was ultimately chosen. The various qualitative methods, such as grounded theory, ethnography, case study and phenomenology will then be reviewed demonstrating understanding and critical appraisal of why phenomenology was deemed the most suitable. Additionally, comparisons will be made between constructivist/interpretive and descriptive phenomenology, Heidegger vs Husserl, (Endacott, 2005) describing why the choice of descriptive phenomenology, and specifically Giorgi's method of data analysis (Giorgi, 1997) was selected.

After a comprehensive overview of the design methodology the remaining aspects of the thesis methods will be described in detail, including processes to obtain ethics approval, decisions around sample type and size. Methods of recruitment, how the data was collected and then analysed will form the final part of the chapter.

Methodology paradigms

The methods chosen to undertake research depend upon the relationship between the ontological and epistemological perspectives. Ontology is the study, or the nature and relationship, of being, in other words what things actually are (Guba & Lincoln 1994). Denzin and Lincoln (2000) describe it with the question of “ What is the nature of reality?” (p.24). Palys and Atchison (2007) suggest that quantitative researchers

believe in the idea of reality, which can be defined and measured using objective data. Epistemology is the theory of knowledge and studies the method and grounding of knowledge (O'Brien 2017). In particular epistemology gives reference to the limits and closeness to the truth and the validation of knowledge, in other words the way we know things. Denzin and Lincoln pose the question "What is the relationship between the inquirer and the known?" (p.24) to define epistemology. Ontology is the nature of reality or the nature of being, the subject of existence, whereas epistemology is the theory of the knowledge of reality, knowledge and knowing (Guba & Lincoln 1994). The two concepts of ontology and epistemology link beliefs that are held about life and help direct the way that the research will be conducted; the chosen methodology (Gray 2014). Koch (1999) describes methodology as the process or method by which the knowledge is gained and states it as "the process by which we generate data" (p.21). The elements of epistemology and ontology, together with the methodological approach, determine how the researcher formulates the steps to be taken in order to meet the objectives of a research study.

The types of methodology or research activities can be divided into two broad classifications or 'paradigms'; quantitative and qualitative research (Polit & Beck, 2014) . As described above, the philosophical core of a researcher begins with a specific paradigm, or view of understanding the world. The paradigm guides the direction of research and traditionally the quantitative approach was the dominant method, broken down further into 'realist' or 'positivist' views (Bickman & Rog, 2009). A realist uncovers an existing reality and it is the role of the researcher to use objective methods to discover the truth (Maggs-Rapport, 2001). Consequently researchers have to detach themselves in order to maximise objectivity. A positivist is a believer of fixed laws of cause and effect and believes that science can test theories in order to reject or accept them to understand the truth (Maggs-Rapport, 2001). Quantitative researchers therefore follow a positivist's epistemology in the belief that they are able to remain independent from the research participants and their responses and that data collected this way is valid and reliable (Silverman, 2013).

However the view that there is a true reality that is strictly measurable, is problematic and criticisms of the narrowness of this approach led to the emergence of qualitative research which has been divided into critical and constructivist/interpretive

approaches (Whitehead & Whitehead 2014). These approaches developed as a result of the need to move away from the positivist tradition and gain insight into social phenomena. Williamson and Prosser (2002) describe the critical approach as an action research approach which aims to explore and interpret social phenomenon whereas, Whitehead and Whitehead (2014) suggest it gives voice to the participants in order to help bring about change. Similarly, back in 1970 Schutz felt the quantitative approach did not tell the whole story and suggested that it was inadequate when trying to obtain a full understanding of human behaviour. The constructivist/interpretive approach, which includes research designs such as phenomenology, grounded theory and ethnography, explore and generate meaning from many different connotations and possibilities because it is accepted that there are many interpretations of similar experiences (Burns & Grove, 2011).

More recently a mixed methods approach has also been described which is a combination of both qualitative and quantitative and can be used in situations where both statistical significance and detail to information gained provides a more comprehensive set of data (Leech, Onwuegbuzie, & Combs, 2011). Creswell (2010) explains that mixed methods is useful when either quantitative or qualitative data alone does not give full meaning to interpretation of the data. Using mixed methods allows a more complete understanding of the research problem and can give both the broader trends and specific variables but also the more detailed views of the participants so that bringing them together allows a better understanding (Cresswell 2010). Woolley (2009) suggests that this integration of qualitative and quantitative data within one study can be “mutually illuminating, thereby producing findings that are greater than the sum of parts” (p. 7).

The decision around which of the research approaches to take is influenced by the research question or objectives of the study (Bragge, 2010). Another suggestion by Endacott (2007) is that it is useful to clarify the research method by questioning whether a cause and effect relationship is being sought, or whether the question is about seeking perspectives of experiences. Research is usually undertaken to test a theory, known as deductive research, or to develop theory, known as inductive research (Cooper & Endacott, 2007). As this study was inductive, there were no hypotheses (Cooper & Endacott, 2007) but the aim of this study was to gain a rich

description of the lived experience of intrapartum transfer from the birth centre to the tertiary hospital of the woman, her partner and her midwife. Once the aim and objectives had been identified each methodology was examined to determine the most suitable way to collect data to be able to address them (Endacott 2007). An overview of quantitative and qualitative research will now be presented to clarify the information reviewed in making a decision around the appropriate research design for this study.

Quantitative

Quantitative studies aim to measure the relationship between two variables, or more, by experiment or survey. There are fundamentally two approaches to answering research questions: descriptive, which is the observation of phenomena without interference; and experimental, which is the manipulation of phenomena in order to determine an effect (Botti & Endacott, 2005).

Descriptive studies describe the concepts being considered and commonly look at the prevalence, magnitude and/or characteristics, sometime classifying various factors (Borbasi, Hengstberger-Sims & Jackson, 2015). In a descriptive study a questionnaire may be used to survey a population to collect information about phenomena of interest, such as attitudes and beliefs. Descriptive studies are a valuable way to gather information from a large number of people (Botti & Endacott, 2008). In comparison, the primary aim of this WA intrapartum research study was to discover the experiences of participants and to hear their voices, not give a numerical value to the level of satisfaction. For this reason descriptive quantitative methodology was not chosen.

Experimental studies involve manipulation of a phenomenon in order to observe an effect (Botti & Endacott, 2008) and require randomised allocation, a control group and a strictly controlled intervention (Bickman & Rog, 2009; Borbasi et al., 2015). The situation involves asking whether the independent variable can be demonstrated to cause a change in the dependent variable (Dane, 2010) which can be difficult to achieve outside of laboratory conditions, hence the term ‘quasi-experimental’ reflects studies where control over all the study conditions is not possible. A quasi-experimental study is one in which one of the three characteristics of experimental designs is missing – control, randomisation or manipulation. In some studies with human subjects, pure randomisation cannot be carried out as subjects volunteer for the

study. An example might be the process of recruiting women into a control group within a study investigating health behaviour of women following diagnosis of diabetes in pregnancy. The diagnosis is very likely to influence behaviour, therefore a true 'control' group is not possible. Thyer (2012) suggests that in many cases within health care settings, ethical and pragmatic considerations preclude the use of randomly assigning participants to experimental and comparative treatments. Because the aim of this study was to discover and describe participants' experiences, this type of methodology was not deemed to be appropriate.

Qualitative

Qualitative research can be delineated into the theoretical perspectives: poststructural/postmodern approaches, post-positivism, constructivist/interpretive approaches and critical approaches (Hesse-Biber, 2011; Willis, 2007). Interpretive approaches aim to describe and understand; critical approaches take this a stage further by emphasising change, or emancipation, through the research process (Hesse-Biber, 2011) or gaining knowledge to effect positive and empowering change (Borbasi et al., 2015).

Back in 1996 Porter described qualitative research as being founded on four levels of understanding, the first being Ontology; the question of what reality is. The second level was Epistemology which asks 'what counts as knowledge?' Porter (1996) defined the third level as Methodology which questions our understanding of reality and how understanding of the nature of reality might be realised. Finally he stated that the last level, Methods asks how evidence can be collected to reflect reality and enables the researcher to collect 'evidence' about the world (Porter 1996). More recently Speziale and Carpenter (2011) suggest that qualitative research is characterised by certain fundamental values. These values consist of beliefs in many perspectives to a given situation and that the researcher is committed to selecting the most appropriate approach to address the research questions or aims. The commitment of the researcher is also considered to be an essential part, specifically acknowledging how they are an integral part of the research process. However Speziale and Carpenter (2011) emphasise that the participant's viewpoint must be central to the process as well as the requirement to report their experience truthfully. Finally they reinforce the need to present the findings in a literary style which offers depth and richness in describing

participant's experiences. These values were deemed to align well with this Western Australian (WA) study which aimed at capturing a vivid and full description of intrapartum transfer from a birth centre to a tertiary hospital for the key participants; women, their partners and their midwives.

Within the paradigm of qualitative research there are varieties of methodological designs, which includes the specific process of how the study will be conducted. The most common, but not all examples of these research designs include ethnography, grounded theory, phenomenology, historical method and case study (Borbasi et al., 2015) . Each of these designs will now be considered in order to demonstrate the thought process behind the choice of research design for this study.

Ethnography was developed as a method of studying cultures and was developed by the discipline of anthropology for investigating cultures through in-depth studies of members of the culture (Borbasi et al., 2015). This design has been used in nursing and midwifery when studying foreign or remote cultures and enables the researcher to look outside of their own ethnocentric perspective. Data collected for ethnographic studies often involves in-depth interviewing and participant observation. More recently the emphasis in ethnography has moved towards obtaining cultural knowledge about minority populations within the society in which the researcher belongs. As such this has led towards the promotion of culturally specific care (Braddy & Files, 2007; Thackrah, Thompson, & Durey, 2014). It has also been used to investigate groups of professionals practising in new, innovative but different ways to their fellow workers (Dove & Muir-Cochrane, 2014), often including reporting on the experiences of participants situated within this cultural context.

Examples of ethnographic midwifery studies include Thackrah et al. (2014) who described perspectives of student midwives who had a clinical placement on a remote aboriginal community and how their observations could affect their future care of aboriginal women. Another American study, by Braddy and Files (2007) considered the impact of female genital cutting on childbearing women in order to increase awareness for health care professionals to inform the care they offer to these women. In contrast Dove and Muir-Cochrane (2014) used an ethnography design to observe the effects of midwives working in a continuity of care model. For the study described in this thesis, ethnography was not deemed to be suitable as the aim was to discover

the experience of transfer from women, partners and midwives, as participants in the phenomenon of intrapartum transfer from a birth centre to a tertiary hospital. Participant observation is concerned with the researcher spending time observing and focusing on aspects of a situation that are relevant to the phenomena being studied (Polit & Beck, 2014). The method of participant observation was not considered suitable for this WA study because the aim was to determine participants' perceptions around their experience of intrapartum transfer which cannot be elicited through observation. In addition, intrapartum transfer is not planned and the feasibility of having a researcher who was not known to the participants impose on their space during labour and birth posed ethical concerns particularly when there is no indication at the start of labour that an intrapartum transfer may occur.

Grounded theory is used to develop theories grounded in real world observations and is an inductive research technique used to formulate, test, and refine a theory about a particular phenomenon (Polit & Beck, 2014). Grounded theory research initially was developed by Glaser and Strauss in the 1960's and was used to formulate a theory about the grieving process (Glaser & Strauss 1967), which has since been re-defined and re-modelled (Glaser & Holton, 2004, Glaser, 2003). Grounded Theory methodology offers researchers a systematic approach to collect, organise and analyse data for the purpose of generating theory. Cooper and Endacott (2007) suggest that Grounded Theory should be used in areas where very little is known about the topic and the theory is allowed to grow and develop inductively through the data. Over the course of the study, hypotheses are generated and then tested through further data collection, thereby relying on an iterative process of data collection and analysis. Glaser and Holten (2004) describe the method as being a comprehensive structured process in which the researcher starts with an idea, follows a process and emerges with data that has grown with the process. Grounded theory was considered for this current WA study on intrapartum transfer but was not considered appropriate because the aim was to discover the lived experiences of participants rather than trying to explain behaviours (Glaser 2003).

Historical research is described as a description or analysis of events that took place in the past (Munhall, 2012). The events being examined need not be ancient history but can also be based on events in the recent past and can be used to examine previous

practice and move forward by reflecting on any positive and negative actions taken. An example of historical research being used in midwifery was undertaken by Leap and Hunter in 1993 when they interviewed retired midwives who were born from 1900-1950 in the United Kingdom. They were able to gather historical data about the midwives' experiences and the way midwifery was practiced before modern screening techniques and interventions became the norm. This project added great depth to our knowledge of midwifery during the 1900's. However, a historical research design was not deemed appropriate to meet the aim of this WA study on intrapartum transfer as exploration and description of participant experiences was to reflect a recent labour and birth.

Case study design consists of thorough and in-depth analysis of an individual or small group of people (Schneider, Whitehead, Elliot, Lobiondo-Wood, & Haber, 2013). The subject(s) are generally followed closely over a period of time which is long enough to gather data which gives clear understanding to the issue being studied. In health care settings case studies help promote understanding of interventions (Burns & Grove, 2011) and generally use both qualitative and quantitative data (Borbasi et al., 2015). An example of a case study project is a Western Australian study considering the value of a Graduate Midwifery Research Intern Programme (Hauck, Lewis, Bayes, & Keyes, 2015). The aim of the project was to evaluate a programme in which newly graduated midwives were offered an internship in a research department of a tertiary maternity hospital. The participants provided feedback in a survey with open ended questions to determine whether the program had increased their understanding and knowledge around midwifery research. Polit and Beck (Polit & Beck, 2014) explain that with case study design the phenomenon is not the central aspect of the study; the case is. In other words the research questions are focused on why the participant(s) behaves or thinks in a certain way rather than what their feelings or actions are. For this reason case study methodology was not considered suitable for this current WA study on intrapartum transfer.

Following review of the research paradigms and specific research designs, it was decided that for this WA study on intrapartum transfer study, qualitative enquiry was considered to be most appropriate to meet the overall aim of gaining insight into the lived experience of a specific phenomenon. After carefully considering the research

traditions within qualitative methodological designs outlined previously, a phenomenological approach was selected as most suitable. Phenomenological research is an approach used to capture an experience as it is lived by an individual (Patton, 2002), and can be described as a method to develop new knowledge around a particular phenomenon. Phenomenology has its roots in the human sciences and was explained by philosophers such as Husserl, Merleau-Ponty, Heidegger, and Gadamer (Moustakas, 1994; Wilson, 2014). Husserl viewed phenomenology as a method to look or inquire into the world of appearances, to see beyond the initial glimpse of first impressions and appearances and identify the lived experience from perspectives other than one's own (Husserl, 2006; Patton, 2002). Husserl believed phenomenology involved a systematic method of uncovering and describing the internal structure of the meaning of the lived experience (Husserl, 2006).

Within the paradigm of phenomenology there are a variety of methodologic interpretations which reflect two main ideologies: descriptive phenomenology and interpretive phenomenology (Endacott 2005) . Each of these was considered in order to determine the most suitable method for this WA study of the experience of intrapartum transfer.

Interpretive phenomenology

Although Husserl is generally accepted as being the founder of phenomenology (Moran, 2006), many interpretations of his initial ideology can be found in the literature (Merleau-Ponty, 2013; Sartre, 2003). These include the writings of one of his students, Heidegger, who moved away from Husserl's descriptive phenomenology to interpretive phenomenology or hermeneutics, the philosophy of interpretation (Polit & Beck, 2014). As Lopez and Willis (2004) explain, the word hermeneutic is derived from the name Hermes, a Greek god whose responsibilities included clarifying and interpreting messages between the gods. They go on to identify that interpretive phenomenology aims to bring out what is normally hidden and goes beyond mere description to look for meanings within human life experiences. Heidegger believed that in order to understand the human experience it was important to interpret and understand, rather than just describe it (Heidegger, 1962) and that in order to do so it was necessary to be aware of one's own perception as it is impossible to put one's own thoughts, feelings and biases to one side. Heidegger emphasized that it is impossible

to rid the mind and to deny our experiences related to the phenomenon, because personal awareness is intrinsic to the phenomenon being studied (Reiners, 2012) and in fact, personal knowledge could be useful and necessary (Lopez & Willis, 2004).

Descriptive phenomenology

The epistemology of phenomenology focuses on allowing true meaning to be revealed, rather than on arguing a point or developing a theory (Flood 2010) and is both a methodology and a philosophy (Wilkes 1991, Yuksel & Yildirim 2015). Epistemology is essentially the study of knowledge and true belief (Lundin 1998), and is interpreted within phenomenology as being able to justify beliefs which stem from individual experiences. Ontology is the traditional study of what constitutes 'being' and the nature of reality (Lundin 1998). The ontology of phenomenology is multiple and subjective, mentally constructed by individuals (Polit & Beck 2012) and is valid as the truth to that individual.

The 20th century mathematician, Edmund Husserl founded the philosophical movement of phenomenology which he believed was based on the meaning of the individual's experience (Lewis, 2015). Husserl aimed to study phenomena in a rigorous and unbiased way in order to arrive at an essential understanding of human consciousness and experience (Dowling, 2007) and was interested in the individual's experience of what they perceived, thought, remembered, imagined and felt, which led him to ask: What is the truthfulness of being? (Husserl, 2006). Husserl believed in the value of subjective information which, by using a scientific approach enabled essential components of the human lived experience to emerge, which were specific to a group of people (Lopez & Willis, 2004). Husserl's phenomenological approach was described by Tufford and Newman (2012) as being able to understand the lived experience in a way which allows the researcher to look beyond preconceptions and assumptions in order to see the phenomenon as it truly is. Husserl felt he was able to retain elements of objectivity to this phenomenological perspective through the process of bracketing. It was considered necessary to put preconceptions aside and in order to bracket presuppositions there was a need to make them open and clear, a process known as reduction (Dowling, 2007). In this way the researcher's world is reduced to a natural attitude of pure phenomenon and so more likely to prevent subconscious influencing of the data (Reiners, 2012). As a result the researcher

attempts to meet the phenomenon in as free and unprejudiced a way as possible in order to allow full unbiased understanding leading to true description (Dowling, 2007). This process is described in a classical reference by Hycner (1985) as ensuring that the research data are approached with complete openness to allow the true meanings or essences to emerge. Hycner (1985) goes on to explain that there must be a conscious, effortful, opening of the researcher to the phenomenon in its own right, with its own meaning and structure and for the researcher to have 'bracketed' their own perceptions in order to let the event emerge as a meaningful whole. In other words bracketing could be seen as a way of reducing the effects of preconceptions related to the research in order to increase the rigor of the project (Tufford & Newman, 2012). Bracketing or reduction enables the descriptive phenomenologist to consider their preconceived ideas and set these aside in order to allow analysis of the data as the participants see it.

Reflexivity

One formal way of bracketing is by reflexivity. The interviewer is the research instrument and must not influence the findings and so it is important that the researcher puts their own context and frame of reference to one side in order to allow unbiased interpretation of the data (Cooper & Endacott, 2007). It has been argued that researchers have been known to shape the collection of data based on prior assumptions and experience and it is therefore essential that the researcher describes their affiliation to the subject, their theoretical position and any assumptions they have on their chosen topic (Caelli, Ray, & Mill, 2003). At the time of the study the researcher had been a midwife for 31 years with experience within many models of care, including woman-centred, midwifery-led continuity of care models in the UK and Australia. She was employed in the birth centre at the same level as all clinical midwives practising there, who were managed by a higher level midwife manager.

It is important to differentiate between reflection and reflexion when considering the process of bracketing in qualitative research (Sorsa, Kiikkala, & Åstedt-Kurki, 2015). As Engward and Davis (2015) discuss, reflection is a method of looking back to gain insight into actions taken and building on the experience to move forward, whereas reflexivity is a process of awareness and self-consciousness that allows the researcher to consider the decisions made during the research process and its potential impact on the study being conducted.

Reflexivity can only occur where there is transparency of the research process at all levels including personal, professional and ethical. According to McDermott and Varenne (2010) it should also encourage the researcher to question concepts, theories and assumptions around the research topic which could influence interpretation. This also means questioning any preconceived ideas of what is being researched, the people being researched and the research methods. As the researcher in this WA intrapartum study was a midwife working in the setting of the study at the time, it was important to commence a reflexive journal in order to openly and honestly consider biases, prejudices and suppositions about the prospective expected findings. This exercise was enlightening and confronting as it was necessary to truthfully acknowledge one's own expectations regarding which direction the interviews and narratives might take and what the participants would reveal. The resulting openness and honesty led to greater objectivity when conducting interviews with the participants and then later when analysing the data.

Choice of research design and data analysis technique

When deciding which of the phenomenological philosophical schools to choose, interpretive or descriptive, it was important to consider the aim and objectives of the study and how the findings would be generated and used. Interpretive phenomenology is the best methodological design when the research question asks for the meaning of the phenomenon and the researcher does not bracket their biases but instead utilises any knowledge around the subject (Whitehead & Whitehead 2016). Descriptive phenomenology is used when the researcher wants to describe the phenomenon under study in its truest form and brackets their biases in order to put aside any ideas, preconceptions, and personal knowledge, when listening to and reflecting on the lived experiences of participants. If the researcher is able to manage this, features or essences which represent the true meaning of the phenomenon will emerge (Giorgi 1997).

Husserlian phenomenology was decided upon as the research design for this study as the aim was to describe the experiences of the participants, not to interpret the meaning of them (Mapp, 2008). Descriptive phenomenology also allows the researcher more flexibility, as Mapp (2008) goes on to explain, because there is no requirement for the researcher to have in-depth knowledge of the data being studied. Instead the researcher

is able to provide a descriptive account of the lived experience from the perspectives of those who have experienced them. The descriptive phenomenologist is interested in gaining true understanding and knowledge from the participant's own personal frame of reference (Taylor et al., 2015), attempting to obtain a non-influenced perspective. Descriptive phenomenology is a philosophy in which the phenomenon is at the centre and understanding it can only come from allowing it to emerge from a clean slate in order for the new knowledge to reveal itself.

There are several approaches to data analysis within the different schools of phenomenology including Colaizzi, Giorgi, and Van Kaam which are all based on Husserl's descriptive phenomenology (Dowling, 2007). These three methods involve the researcher searching for common patterns which then emerge as themes. As described above, it is necessary for the researcher to bracket preconceived ideas and biases about their own view of the phenomenon in order to be able to focus on interpretation by the participants. In order to validate the true findings within the data, Colaizzi's method instructs the researcher to return to the study participants using a process of member checking to ensure the data is a true representation of the reported findings (Edward & Welch, 2011). Van Kaam's method requires similar validation by involving expert judges to confirm the findings (Anderson & Eppard, 1998). In contrast Giorgi's classic work outlines how it is inappropriate to ask participants or experts for validation (Giorgi 1975) as he believes that the participant provides the rich data necessary and there is no requirement to confirm any interpretation of their experiences.

Giorgi's phenomenological method of data analysis is based on the work of Husserl and Merleau-Ponty (Giorgi, 2007). The method Giorgi devised is also recognised as originating from the Dusquesne School as it was during his time there, at Pittsburgh University that he and Van Kaam began to formalise their phenomenological methods of psychology and founded the Dusquesne School of Psychology. Giorgi and Van Kaam proposed a method of analysis involving description, reduction and search for essential structures. It was their dissatisfaction with the available methods that led to them establishing a reliable convention in order to be able to conduct phenomenological research (Giorgi 2000). The method of analysis, which developed from this collaboration, and which Colaizzi, Van Kaam and Giorgi all use, consists of

firstly dividing the original descriptions into units, secondly transforming the units into meanings that are expressed in concepts by the researcher and thirdly the transformations are combined to create a general description of the experience (Finlay, 2014; Polkinghorne, 1989).

Over time Giorgi's method of data analysis has been described in various formats but more recently three stages have been described, consisting of firstly bracketing or reduction by the researcher, followed by rich description by the participants and finally the search for essences (Finlay, 2014; Giorgi, 1997). The analysis, or search for essences then follows four steps; firstly reading and re-reading the data, secondly dividing the data into parts and re-reading again to look for 'meaning units' (in other words identifying meanings relevant to the study). Next these are reduced so that the meaning of the essential features is distinguished and finally the participants' experiences are synthesised into a rich story which describes the phenomenon (Giorgi, 1975, 1985, 1997; Polit & Beck, 2014). The method of data analysis described by Giorgi was chosen for this WA intrapartum transfer study because the study focuses on descriptions of individual experiences and suggests consideration should be given to the same phenomena as it manifests itself to different individuals. The importance of considering the same phenomenon from different perspectives offered the ideal method of analysis for this intrapartum transfer study as the phenomenon being considered included three participant groups; the women, their partners and the midwives.

Setting

The Family Birth centre in Perth, Western Australia (WA) was built in 1992 on the grounds of the tertiary referral centre, King Edward Memorial Hospital. It is an alongside birth centre, built as a separate building to the main hospital but connected by a walkway which enables transfer from the birth centre to the labour and birth suite in the main hospital to take place within a timeframe of 5-10 minutes. Initial funding for the birth centre was by a lottery grant and the project was conceived by women, who wanted to move away from the increasing medicalised model of care. The women who wanted to be able to choose a model of care in which there were fewer interventions, were supported by midwives, who also felt maternity care was being

increasingly medicalised and wanted to provide a continuum of midwifery care for low risk women; healthy women with uncomplicated pregnancies.

The philosophy of the birth centre at the time of the study, today currently, and in ongoing future plans, includes involving couples in planning their pregnancy and childbirth care by providing evidence based information and enabling informed choice. The environment provides a safe, non-threatening setting in order to enable the women to labour and birth their babies in home-like, familiar surroundings so that stress hormones are reduced and labour is more likely to progress well (Brocklehurst et al., 2011; Hodnett et al., 2005; Hodnett, Downe, Walsh, & Weston, 2010). In the birth centre, during antenatal clinic appointments and in childbirth education classes throughout the pregnancy, women and their partners are educated about the choices they can make around various management options, for example screening procedures, care options and birthing choices. They are also encouraged and helped to do their own research to support information already provided in order to help them to make informed decisions around the choices offered to them.

During the time of the study, in 2013-2014, women who booked to have their maternity care at the birth centre were allocated to a group of five midwives who they met during the antenatal period through clinic and childbirth education classes. In this model of care there was not one primary midwife within the group, all were an equal part of the team. Because the women were offered the opportunity to meet all midwives in the group during the antenatal period, women were very likely to see one of those midwives, a familiar face, on arrival in labour. The women had a high chance of being cared for by a midwife with whom they had built up a trusting relationship and who knew their preferences for labour and birth. If intrapartum transfer was necessary, workload within the birth centre would determine whether the team midwife was able to continue as primary carer. In the case of this WA study all women were accompanied by their midwife.

The outcomes in the birth centre in 2013-2014, as confirmed by the Birth centre manager (L. Keyes, personal communication, 10th October 2014), reflect previous findings in the literature; that women who labour and birth in a low-risk familiar setting have lower rates of intervention, operative birth and pharmacological analgesia

(Brocklehurst. et al., 2011; Hatem, Sandall, Devane, Soltani, & Gates, 2008; Rooks, Weatherby, & Ernst, 1992b).

The WA Mothers and Babies 2013 report (Hutchinson & Joyce, 2016) revealed that for the majority of women (65%) booked to have their babies in the birth centre the labour journey went according to plan and they were able to labour with low levels of intervention and pharmacological analgesia and birth within the birth centre setting. However, it was necessary to transfer 35% of birth centre women to the obstetric unit at some stage during labour. The reasons for transfer included delayed progress in the first or second stage, meconium stained liquor, undiagnosed breech presentation, prolonged rupture of membranes, fetal distress and request for epidural anaesthesia. For the couple, the need for transfer was unexpected and unplanned, which led the researcher to question what the experience was for the woman, her partner and midwife. Therefore, the primary aim of the study was to gain a description of the lived experience of intrapartum transfer from the birth centre to the tertiary hospital of the woman, her partner and her midwife. The specific objectives to meet this study aim were to:

1. Describe the overall labour and birth experience of women who are transferred during the first or second stage of labour from a low risk woman-centred, midwifery-led birth centre to a co-located tertiary maternity referral hospital.
2. Describe the overall experiences of partners when the woman they are supporting are transferred in the first or second stage of labour from a low risk midwifery-led, woman-centred unit to an co-located tertiary maternity referral hospital.
3. Describe the experiences of midwives when caring for women in labour in a birth centre, who they accompany on transfer in the first or second stage of labour, to a co-located tertiary maternity referral hospital.
4. Explore the integration of the 'lived' experiences of an intrapartum transfer within the labour journey for the women, their partners and accompanying midwives.

Ethics

In Australia there are statutory organisations that provide advice on ethical issues in health related research and the guidelines within these state that all research that directly involves human beings must be assessed by a recognised research committee (Woods & Lakeman, 2016). The purpose of the Ethics committee is to ensure that informed and voluntary consent to participate has occurred and that there is a favourable risk: benefit ratio (Chater, 2011). It is also necessary that the committee has ensured that the researcher has fulfilled their obligation to minimise the risk for the participants (Chater, 2011) and considered how to manage any negative repercussions (Polit & Beck, 2012).

In the case of this WA study it was necessary to obtain ethical approval from both the Health Service in which the study was taking place and the university under which the study was registered. Ethical approval was firstly obtained from the birth centre and tertiary referral centre's Hospital Human Ethics committee (2013031EW). Following this reciprocal ethics approval was requested from the University's Human Research Ethics Committee (HR91/2013). Copies of the approval letters are included in Appendix A and B. The concern regarding negative repercussions was raised due to the possibility that re-living a traumatic experience may cause upset and the need for further exploration and possible counselling (Woods & Lakeman, 2016). This was addressed with a statement from the researcher regarding the nature of her clinical experience and ability to provide support to distressed parents during the interview process. It was also pointed out that all women would also have access to the Clinical Psychology services of the tertiary referral hospital. A pathway referral to counselling services was considered for all participants if the need arose, however despite some distress expressed by women and their partners during interviews, no participant required an offer of further referral.

During the process to obtain permission to undertake the study from the Ethics committees, information and consent forms for each of the groups of participants were constructed to fulfil the criteria of voluntary participation and the right to withdraw at any stage without repercussions. During application and also throughout the process of gathering data and storage of information the rules regarding confidentiality and security were also adhered to. This comprised of the digital audio recordings of the

interviews being kept on a USB drive in a secure locked filing cabinet in the researcher's office at Curtin University until it was erased following transcription. Transcribed data was solely used for this research project being stored in a locked room in a locked filing cabinet in the researcher's office. All information was held in the strictest confidence and analysed as de-identified data. Access to data was restricted to study personnel assisting the researcher with analysis. Now that the study has been completed, the data will be archived in the university for seven years before being destroyed.

Sampling and Selection

Sampling in qualitative research is known as non-probability sampling (Whitehead & Whitehead, 2014), as compared with probability sampling which is used in quantitative research. There is no randomisation and participants are often approached purposefully by the researcher because they fulfil the requirement of the study. There are a variety of sampling approaches suitable for qualitative research such as convenience, snowball, opportunistic, theoretical and purposive sampling, amongst others (Kuzel, 1992). Purposive sampling is used when the participants need to meet a specific criterion or purpose that is consistent with the study aims (Johnson & Chang, 2011) which was the case for this WA study.

The inclusion criteria for the study included women booked for birth centre care, who read and spoke English and who initially received intrapartum care in the birth centre but were transferred to the tertiary hospital during the first or second stages of labour. The woman must also have had the support of her life partner (referred to as partner in this thesis) during labour. It was also a requirement of the study that the couple were accompanied during the intrapartum transfer by the birth centre midwife.

Recruitment took place from mid-July to mid-October 2013, with the researcher approaching couples who met the inclusion criteria while they were receiving postnatal care in the birth centre or the hospital postnatal ward, prior to discharge to home. Alternatively if the woman was discharged to home prior to recruitment taking place, the woman and partner were contacted by telephone within four weeks of the birth. As the researcher was employed as a birth centre midwife at the time of the study, no couples under her care were included in this study. An information letter (Appendix

C) was provided individually to the woman and partner and consent forms (Appendix D) were signed by both parents to confirm interest in participating. Following informed consent, demographic information such as name, contact details, date of birth, educational level, parity and gravidity were collected. The length of labour, reason for transfer and type of birth was also collected verbally from the couple and further details and verification was obtained from the woman's medical record (see Table 1.).

Table 1. Demographic information of participants

Age Woman/Partner	Education level Woman/Partner	Ethnicity	Gravidity:Parity	Length of labour#	Primary reason for transfer	Type of birth	Return to FBC
31/34	Tertiary/Tertiary	W/P	1:1	3:35	Fetal distress	Vacuum	Yes
29/31	Tertiary/Tertiary	Cauc/Cauc	2:1	9:40	Delay 1 st stage	SVB	Yes
32/31	Tertiary/Tertiary	Cauc/Cauc	2:1	10:15	Epidural	Vacuum	Yes
25/26	Tertiary/Tertiary	Cauc/Cauc	1:1	16:57	Epidural 8cm	SVB	Yes
32/36	Tertiary/Tertiary	Cauc/Cauc	2:1	13:40	Delay 2 nd stage	Vacuum	Yes
22/24	Year 12/TAFE	Cauc/Cauc	2:2	4:18	Fetal distress 2 nd stage	SVB	Yes
28/34	Tertiary/Tertiary	Cauc/Cauc	1:1	4:54	Intrauterine Growth Restriction picked up on admission in labour	SVB	Yes
28/36	Tertiary/Tertiary	Cauc/Cauc	3:2	7:47	Epidural 8cm	SVB	No
32/35	Tertiary/Tertiary	Cauc/Cauc	1:1	23:37	Delay 2 nd stage	Non-Elective Caesarean Birth	No
34/34	TAFE/TAFE	Cauc/Cauc	2:1	6:28	GBS pos, in early labour, for augmentation	Forceps	No
29/32	Tertiary/Tertiary	Cauc/Cauc	1:1	14:38	Delay 2 nd stage	Vacuum	Yes
32/35	Tertiary/Tertiary	Cauc/Cauc	2:2	3:46	Fetal tachycardia	SVB	Yes
32/34	Tertiary/Tertiary	Indian/Indian	2:2	2:14	Undiagnosed Breech	Breech	Yes
35/39	Tertiary/Tertiary	Cauc/Cauc	1:1	13:46	Delay 1 st stage	SVB	Yes
38/36	Tertiary/Tertiary	Cauc/Cauc	1:1	5:40	Delay 2 nd stage	Vacuum	No

Abbreviations:

Expressed as hours and minutes. SVB = Spontaneous vaginal birth; GBS = Group B Streptococcus; TAFE =Technical and Further Education; Tertiary = University or College; Cauc = Caucasian

For the third group of participants, the midwives, the inclusion criteria was that they had cared for the recruited women who had been transferred to the tertiary referral centre in labour. It was also a requirement that the midwife had then stayed with the woman and her partner for the remainder of her labour and birth or handed over to another birth centre midwife.

Because the author of this thesis was a peer of the midwives recruited to the study it was necessary to consider the ethical impact and question of bias. A reflexive journal was used to bracket presuppositions in order to increase awareness of potential bias. This was a useful exercise when it came to considering the type of questions to be used for the interviews and the influence of verbal and non-verbal prompts. The other issue of the researcher being employed in the same area as the participants was the consideration that revealing their thoughts and actions during a stressful experience might influence their interview narrative due to the thought of being judged. Following discussion with supervisors, it was concluded that because the researcher was a peer of the midwives and not their manager, it was unlikely that there would be any impact on the participants or researcher, including the consideration of future relationships and roles.

As with the women and partners, an information letter (Appendix E) was provided and a consent form (Appendix F) was signed to confirm interest in participating. Following informed consent, information regarding length of midwifery experience was gathered. Although a total of 15 interviews with midwives took place, there were only 10 participants as some were interviewed more than once if involved with more than one transfer. All midwives were female and their midwifery experience ranged from 1 to 30 years (mean 18 years) with a mean 6.7 years (range of 0.5 to 20 years) in a birth centre. The midwives had qualified and previously practiced in Australia (n=5 midwives), Britain (n=3) and New Zealand (n=2). One of the midwives was also a lactation consultant and one was undertaking a post graduate education certificate.

Data collection

Recruitment took place from mid-July to mid-October 2013 as detailed above. Although altogether 48 (18 midwives, 15 women and 15 partners) interviews took place, not all were complete triads of woman, partner and midwife. Forty-five made up completed triads and three extra midwives were interviewed with the aim to

interview the other members of the triad. However due to lack of availability within the timeframe, those interviews were not included in the triad comparison addressing objective four, but were included in the analysis of individual group experiences (objectives one to three).

The women were all interviewed in their own homes, away from their partners in order to ensure that each did not influence the other's recollections. The interviews of couples all took place within 8 weeks of the birth, with most taking place within 4 to 8 weeks in order to aid recall of labour and birth events. The women's ages ranged from 22 to 34 (see Table 1) and all apart from two were educated to tertiary level. All couples were Caucasian apart from one couple of Indian origin. Out of the 15 couples, 11 were first time parents with the other 4 having had their second babies. Altogether 15 partners were interviewed, 13 face to face in their own homes, again, separately to the women, and two by telephone. The partners' age ranges were from 24 to 39 and all apart from two were educated to tertiary level.

As the primary aim of this study was to gain a description of the experience of intrapartum transfer from the birth centre to the tertiary hospital on the woman, her partner and her midwife, it was decided that an individual open-ended, face-to-face interview was the most suitable method to understand their experience (Polit & Beck, 2014) in order "to capture as closely as possible the way in which the phenomenon is experienced" (Giorgi, 2003, p. 27). For the couples the interview began with a broad opening question, namely 'Please could you tell me your whole story from when labour started, right through until the birth of your baby?' This question was followed by open ended prompts and queries as necessary, in order to encourage the interviewees to describe their emotions during each phase of the experience. Interview guides for the women and partner are provided in Appendix G and H. The experience being examined was not just the actual transfer from the birth centre to the tertiary referral centre but the whole labour experience so the interviewees were firstly asked to talk about how labour started and their arrival at the birth centre. Parents were then encouraged to describe their feelings during the events leading up to the transfer and to describe why the transfer took place, the actual transfer experience and then their feelings on arrival at the tertiary referral hospital. They were finally prompted to recall events leading up to the birth, the actual birth and then what happened afterwards. The

question of whether they returned to the birth centre was also raised and what that meant to them.

The midwives were interviewed in a quiet room in the birth centre. Some midwives were interviewed more than once due to being involved in the transfer of more than one woman; a total of ten midwives participated in 15 interviews. To help the midwives with their recollection of events all interviews took place within one week of the birth, apart from one where the midwife went on annual leave soon after the birth; this interview occurred four weeks after the birth. Another aid for the midwives was in the form of the woman's medical record, which was made available for them prior to and during the interview to serve as a reminder. Individual face-to-face interviews started with this open ended question, "Tell me your story of this woman's birth from the moment of first contact with her in labour until she returned to the birth centre after the birth or you left her in someone else's care." The midwives were encouraged to examine their feelings at every stage of the labour and prompts were used and further questions asked to elicit as much information as possible to determine their experiences in depth at every stage of the labour and birth journey. The interview guide for the midwives is provided in Appendix I.

All interviews were audio taped and transcribed verbatim on the day or close to the day the interview took place. The length of the interviews ranged from 15 minutes to 70 minutes, with most lasting for more than 30 minutes. After every interview field notes were made by the researcher describing any notable observations, including the general demeanour and facial expressions of the interviewees and also any comments made by them about their experiences at the end of the interview, after the digital recorder was switched off.

Although consideration was given to an external person conducting the interviews, the author felt that complete immersion in the data would be enhanced by knowing the participants more fully through interview. When the interviews were carried out the women had been discharged from care, thus eliminating any fear by couples that their honesty of accounts may jeopardise care.

Consent from prospective participants was obtained at times when the author was "off duty" and therefore not providing midwifery care, thus reducing any perception of coercion.

Transcription was carried out by the researcher in order to maximise immersion in the data. The transcription software Dragon Naturally Speaking© was used for transcribing which first necessitated ‘training’ the software to understand medical terminology and recognise the researcher’s voice. Because the software is not adaptable to different accents the researcher listened to the interviews while simultaneously talking into the microphone repeating the interviewee’s words. Due to the fact that the transcription were not always accurate after the first attempt, further corrections were made whilst reading and simultaneously listening to the original digital recordings at least three further times and to ensure accuracy. This assisted with deep immersion to “get a sense of the whole” of the data, as described by Giorgi (2008, p. 38) to the extent that the researcher felt she knew all participants and their experiences extremely well .

Data saturation and analysis

Data collection and analysis occurred concurrently (Harding & Whitehead, 2014) and recruitment ceased once no new findings were being generated from the data, with data saturation being achieved after approximately 36 interviews. A further three interviews were carried out in each group to ensure confirmation of data saturation (Whitehead & Whitehead 2014). As Polit and Beck (2014) suggest, there is no minimum or maximum number of participants required in qualitative research, as sample size is based on the information gathered and whether it has fulfilled the criteria to meet the aims of the project. As Fusch and Ness (2015) state, the numbers required for data saturation depend on when “there is enough data to replicate the study, when the ability to obtain additional new information has been attained, and when further coding is no longer feasible” (p.1408). In quantitative research the frequency of occurrences is often what the findings are based on, however in qualitative studies only one occurrence of the data is necessary because qualitative research is concerned with meaning and not making generalised hypothesis statements (Mason, 2010).

It is usual in qualitative research to gather an abundance of rich data which according to Giorgi (1985) is a method of depth rather than breadth. While Giorgi has suggested that three participants can provide enough data, Morse (2000) argues a minimum of six and Cresswell (1998) states that there should be between five and 25. However it is very difficult to determine actual numbers required before the data is gathered

because it is dependent on the point of the study when most of the pertinent perceptions around the research subject are uncovered. When no new information emerging and it is becoming repetitious then data saturation is said to have occurred (Glaser & Strauss, 1967) and there is no further need to gather more data (Polit & Beck, 2012).

Analysis took place with the aid of NVivo 10©, employing Giorgi's descriptive phenomenological methods of analysis (Giorgi, 1975, 1985). Giorgi's method of data analysis was chosen because it focuses on descriptions of individual experiences and suggests that consideration should be given to the same phenomenon as it manifests itself to different individuals (Giorgi, 1970).

The stages of Giorgi's analysis (1985) are: firstly assuming the phenomenological attitude, secondly reading the entire written accounts to understand the meaning of the whole, thirdly delineating meaning units, fourthly transforming the meaning units into statements of lived meaning of experiences and finally synthesizing a general structure of the experience based on the constituents of the experience, in this case 'experience of intrapartum transfer' (Broomé, 2011).

The first stage of analysis, assuming the phenomenological attitude, is different to the everyday way of understanding the world. In the phenomenological attitude, the researcher "brackets" his or her everyday knowledge to take a fresh look at the data, putting aside previous assumptions, as described above.

The second phase of full immersion in the data was achieved by firstly listening to each interview and transcribing each one. Following transcription each interview was re-listened to whilst reading the transcript several times in order to understand the meaning of each individual experience to give a view of the overall whole picture (Giorgi, 1997). During this stage the interviewer attempted to put herself into the shoes of the participants, to truly empathise and attempt to understand the narrative and comprehend the meaning as described by participants (Koivisto, Janhonen, & Väisänen, 2002).

The third step, after grasping the essence of the whole, was to start the process all over again by reading through the texts once more with the specific aim of discriminating different concepts from the experiences of the participants with a focus on the phenomenon of intrapartum transfer (Broomé, 2011; Koivisto et al., 2002). This

allowed separation of the data and identification of “meaning units” (Giorgi, 1997, p. 12). These meaning units are statements made by the interviewees which define a single, recognisable aspect of their experience. Once the meaning units had been identified they were each considered and re-grouped based on their intertwining meanings and placed in a way that accurately reflected the original event (Giorgi, 1985; Koivisto et al., 2002).

Next data reduction took place which is where essential features are identified. These essential features formed the labelled codes which were then grouped, “like with like” (Harding & Whitehead, 2014, p. 133), into tentative themes. From this the data was integrated into overarching themes and subthemes.

Fourthly the meaning units were transformed into statements of lived meaning of experiences. The central themes and subthemes were considered and the question ‘what does this tell me about the experience of transfer?’ asked. Giorgi (1975) describes this as the question being put to the data in a systematic manner in order to ensure the themes relate directly to the phenomenon. This clarified the final themes which could subsequently be synthesised into definitions regarding the experience, all of which could be linked to direct quotes from the participants illuminating the rich story of their experience (Giorgi, 1975). However, although this process has been described as a linear or step-by step process, Whitehead suggests that thematic analysis is an “iterative and reflexive process” (2011, p. 266) and as Polit and Beck (2014) point out, it is necessary throughout the process to go back to the original transcripts to see if the themes really do fit and then refine or re-define them as necessary, a similar concept to Giorgi’s idea of putting a question to the data.

Finally a general structure of the experience was synthesised, based on the constituents of the experience (Broomé, 2011; Koivisto et al., 2002). Definitions for each theme and subtheme were composed which together gave the overall story of each group of participants’ experiences giving insight into being transferred in labour from a birth centre to an obstetric unit.

After this process was applied to the three groups of interviewees, the women, partners and midwives, further analysis took place to integrate the findings of all groups together. The transcripts were revisited and analysed afresh, with the original findings

and themes being set aside. Meaning units were identified and formed into labelled codes, grouping like with like, thus leading to the formation of integrated themes.

Demonstrated rigour of the study

Rigour of the study was considered against Guba's four constructs: credibility, transferability, dependability and confirmability (Guba, 1981). It has been suggested that research findings are more credible when the data analysis methodology is derived from those that have demonstrated success in previous comparable projects (Shenton, 2004). In the case of this WA study, this was achieved by using Giorgi's method (Koivisto et al., 2002). Specific strategies included having prolonged engagement with data collection and transcription, which resulted in achievement of data saturation (Broomé, 2011). The duration of interviews allowed the participants to be fully immersed in telling the story, enabling full descriptions, which also increased credibility (Boyce & Neale, 2006). Similarly, the use of person triangulation, by giving full appreciation to three interpretations of the same event, supported a 360 degree perspective, also adding credibility to the findings (Adami & Kiger, 2005). Although Giorgi's method of data analysis suggests no member checking, in order to increase rigour, individual discussions took place with all midwives (not partners or women) to confirm that they felt the findings reflected their experiences to confirm there was no bias. Through this process agreement was confirmed for the findings.

Guba's second construct, transferability refers to whether the findings can be transferred to other similar groups (Shenton, 2004). In this WA study, rich data was obtained around the whole labour experience, from a low-risk experience to a labour requiring collaborative care and interventions. There is also the added value of the experience of intrapartum transfer being seen from three different perspectives which make the findings transferable on many levels (Adami & Kiger, 2005). These again include the use of multiple perspectives, allowing a broad description of the phenomenon. Similarly the detailed and rich descriptions of the participant group, together with the methods and findings allow readers to determine transferability (Polit & Beck, 2014).

The third concept described by Guba, dependability, is considered to be achieved when findings are consistent and could be repeated with similar results being obtained (Polit & Beck, 2014). Dependability is also confirmed when stability of data can be

demonstrated over time and conditions, as demonstrated by a very recent WA study of midwives' perceptions during home to hospital intrapartum transfer, in which similarities of midwives' concerns around intrapartum transfer were found (Ball, Hauck, Kuliukas, Lewis, & Doherty, 2016). Another way to demonstrate dependability is with consistency of findings (Polit & Beck, 2014), which is confirmed in the final publication from this WA study where there was consistency of findings from all three groups of participants. It would be beneficial to undertake similar studies in the future to confirm future consistency, however previous studies around partner's experiences of labour and women's and midwives' experiences of transfer in labour demonstrate some consistency of findings (Cheyney et al., 2014; Creasy, 1997; Draper & Ives, 2013; Hildingsson et al., 2011; Johansson et al., 2012; Steen et al., 2011; Wilyman-Bugter & Lackey, 2013).

The fourth construct, confirmability, refers to whether the findings are well grounded in the gathered data (Shenton, 2004). In this WA study, in order to ensure confirmability and reduce bias, after coding had been completed by the researcher, the interviews were then divided and coded independently by the three other members of the research team. The process of independent coding helped corroborate the themes to ensure validation, with all coders referring back to the data for any discrepancies (Liamputtong, 2010). Confirmability is also demonstrated with the use of participants' quotes which support the interpretations of findings within each published paper. The coding system assigned to participant quotes is clarified in each individual paper as pseudonyms were used for one publication and a letter/number code were used in the other publications.

Summary

The chapter has described the methods of research, comparing each with its appropriateness to this WA study of intrapartum transfer. The rationale for using a descriptive phenomenological approach was provided and specifically the reason for choosing Giorgi's process for data analysis was explained. Clarification around the steps taken through the research process and details of the methods used have been described in detail up to the point of how the data was analysed.

The next four chapters comprise of the four manuscripts which were submitted for publication. These peer reviewed papers describe the findings of the intrapartum

transfer experience for women, partners and midwives. The final paper integrates the three distinct experiences.

Chapter Four: Women's Experiences

Yeah it just, I can't remember a lot you know Mikey kind of had to remind me a bit of what was happening and who was in there because I had no concept of time or really of anything that was going on around me... I was on another planet really, It did feel like I wasn't really there. (Ellen)

This chapter provides the final manuscript, after addressing reviewers' comments, of the published paper on women's experiences. The overall findings demonstrated that the women in WA felt that when intrapartum transfer from their chosen birth centre was necessary, they lost the birth dream they had been visualising and planning for. Women's appreciation of birth centre care was confirmed, especially one which is co-located to a referral centre. It was reassuring for women to know that extra help was there if necessary and they were pleased to be able to labour as far as possible in the birth centre and then return to its familiarity afterwards.

The midwife's voice is a point of reference for women during labour and can be used to help focus the woman, impart important information and maintain a sense of calm and normality even when problems occur. After the birth women were aware that they had unclear memories that midwives could help clarify by offering time to talk through events to help complete the picture for them.

Reference: Kuliukas, L., Duggan, R., Lewis, L., Hauck, Y. (2016). Women's experience of intrapartum transfer from a Western Australian birth centre co-located to a tertiary maternity hospital. *BMC Pregnancy and Childbirth*, DOI: 10.1186/s12884-016-0817-z.

Women's experience of intrapartum transfer from a Western Australian birth centre co-located to a tertiary maternity hospital.

Lesley Kuliukas, Ravani Duggan, Lucy Lewis, Yvonne Hauck.

Abstract

Background

The aim of this Western Australian study was to describe the overall labour and birth experience of women who were transferred during the first and second stages of labour from a low risk woman-centred, midwifery-led birth centre to a co-located tertiary maternity referral hospital.

Methods

Using a descriptive phenomenological design, fifteen women were interviewed up to 8 weeks post birth (July to October, 2013) to explore their experience of the intrapartum transfer. Giorgi's method of analysis was used.

Results

The following themes and subthemes emerged: 1) The midwife's voice with subthemes, a) The calming effect and b) Speaking up on my behalf; 2) In the zone with subthemes, a) Hanging in there and b) Post birth rationalising; 3) Best of both worlds with subthemes a) The feeling of relief on transfer to tertiary birth suite and b) Returning back to the comfort and familiarity of the birth centre. 4) Lost sense of self; and 5) Lost birth dream with subthemes a) Narrowing of options and b) Feeling of panic. Women found the midwife's voice guided them through the transfer experience and were appreciative of continuity of care. There was a sense of disruption to expectations and disappointment in not achieving the labour and birth they had anticipated. There was however appreciation that the referral facility was nearby and experts were close at hand. The focus of care altered from woman to fetus, making women feel diminished. Women were glad to return to the familiar birth centre after the birth with the opportunity to talk through and fully understand their labour journey which helped them contextualise the transfer as one part of the whole experience.

Conclusions

Findings can inform midwives of the value of a continuity of care model within a birth centre, allowing women both familiarity and peace of mind. Maternity care providers should ensure that the woman remains the focus of care after transfer and understand the significance of effective communication to ensure women are included in all care discussions.

Keywords

Woman-centred, intrapartum, transfer, continuity, midwife, birth centre, labour, communication.

Background

In Western Australia (WA) 98% of women birth in hospital (Hutchinson & Joyce, 2014). In the 1990s women looking for an alternative option lobbied the government to provide access to a birth centre (BC). Birth centres are small maternity units, staffed by midwives, offering a homely, rather than clinical, environment in order to support women to make informed choices across the childbirth continuum with an aim to birth without medical intervention (Hodnett et al., 2010). The familiarity afforded women with known midwives in a home-like environment prepares them for a labour in which stress hormones are more likely to be reduced so increasing the probability of normal progress of labour (Brocklehurst. et al., 2011; Walsh, 2009). Childbearing women seek out maternity care that is woman-centred and offers informed choice and involvement in decision making (Jenkins, Ford, Morris, & Roberts, 2014), indeed women from all walks of life want to have confidence and trust in the staff and simply be treated with kindness (Henderson, Gao, & Redshaw, 2013). In addition, women opting to birth in a BC are often highly educated and take responsibility for their health, which also includes making informed choices in childbirth planning (Cunningham, 1993) and they know it is their right to make decisions and take responsibility for them (Laws et al., 2009). In 1994 in WA, women looking for such options successfully petitioned for funding which was obtained from the Lotteries Commission, to build a BC alongside the state's only tertiary referral obstetric unit (OU).

For the majority of women birthing in the BC is straightforward and goes as planned (L.Keyes, personal communication 10th October 2014), but for some complications occur and it becomes necessary to transfer to the adjacent OU. When this occurs

women who are used to making choices and taking responsibility may now be reduced to a more passive role, which may affect the woman's sense of self accountability and control. Alternatively the woman herself may make the decision to transfer, for instance in order to obtain epidural analgesia; this choice may impact on a woman who has prepared herself for natural birth, with no drugs or interventions (Waldenstrom & Lawson, 1998).

Women are affected in a variety of generally negative ways when transfer takes place from a low risk setting to a maternity referral centre (Creasy, 1997; Lindgren et al., 2008; Rowe et al., 2012, Walker, 2000). In an English qualitative study, 12 women were interviewed who were booked for home or BC birth but were transferred to the local OU in pregnancy or labour (Creasy, 1997). The findings indicated that these women felt a sense of disappointment and failure. Similarly an earlier qualitative English BC study demonstrated a perceived loss of choice, continuity and control which led to feelings of anger and resentment, however as only three of the 18 were transferred during labour, the experiences of intrapartum transfer were not fully explored (Walker, 2000). In a more recent English qualitative study, 30 women were interviewed who had been booked to BCs either alongside or distant to referral hospitals. In these cases the transfer did take place either intrapartum or immediately after the birth and these women also described a sense of disappointment and a feeling of not belonging during the transfer process (Rowe et al., 2012). However the timing of interviews was up to one year after the birth which is significant because the length of time between the birth experience and collection of data may impact a woman's recollections of the labour details so impeding the veracity of the findings.

Findings from this limited number of studies have provided some insight into women's experiences internationally but in WA the culture of birth represents a different context as a large proportion of women choose to birth with a private obstetrician (41.4% in 2011 (Hutchinson & Joyce, 2014)). Recent data indicate that the proportion of births at private hospitals in WA over the past 30 years has increased and now equals the proportion that occurred at public hospitals (42.3%), excluding the tertiary referral teaching hospital (16.3%) (Hutchinson & Joyce, 2014). Non-hospital births (2.0%) included mothers who gave birth at a BC (1.2%) and home (0.8%). An important influence to this choice is the Australian government's promotion of private health insurance by imposing a medicare levy surcharge on high income families who do not

take out private health insurance (Australian Government Private Health Insurance Ombudsman, 2013) which may influence these women to take up the option of private obstetric care. As a consequence of the medicare levy, the rate of people taking out private health insurance has risen and it has been demonstrated that if women have insurance cover they will choose to use it in preference to the public system (Shorten & Shorten, 2007; Stevens, Thompson, Kruske, Watson, & Miller, 2014), possibly due to a perception that private health care is the better option. As a result women choosing BC care, which is publically funded, may find themselves swimming against the tide of the opinion of friends and family and so may have more to lose when their plans are undone.

A lack of published literature describing women's emotions during intrapartum transfer indicated a gap in knowledge, especially because the published literature is from England, where most women birth in the publically funded NHS, compared to WA where 41.4% of women choose to birth with a private obstetrician. Furthermore the women in the English studies were not only subject to a change in birth environment but also a change in lead professional as the midwife handed over care, which could impact the sense of loss and disappointment the women felt. This study aimed to address the lack of information and awareness in order to help promote a positive labour and birth experience for women when unexpected transfer takes place during this significant life event.

Methods

The aim of this Western Australian study was to describe the overall labour and birth experience of women who were transferred during the first and second stages of labour from a low risk woman-centred, midwifery-led birth centre to the nearby tertiary maternity referral hospital.

Design

A descriptive phenomenological study design was chosen in order to capture the lived experience of intrapartum transfer (Polit & Beck, 2010) as it facilitates exploring, explaining and describing phenomena in order to interpret their meanings . This method focuses on subjective description in order to gain rich data which provides insight into an understanding of the described experiences (Liamputtong, 2010; Polit

& Beck, 2010; Schneider et al., 2013). The phenomenon in this study was *the overall intrapartum transfer experience* as described by the woman.

Setting and participants

The study, part of a larger project which also considered the emotions of the partners (Kuliukas, Hauck, Duggan, & Lewis, 2015) and midwives (Kuliukas, Lewis, Hauck, & Duggan, 2016c), was carried out at a BC set in a separate building, alongside the tertiary OU referral centre in WA, with a transfer time from the BC to the OU of 5-7 minutes. The BC provided woman-centred, midwifery-led care for low risk women in a homelike environment, encouraging family support, partners to stay and use of water during labour and birth. Women were allocated to a group of five midwives during the antenatal period with the expectation that they would meet all midwives in the group during appointments and childbirth education sessions. Women were advised at their first visit that while it was not always certain that they would be familiar with all the midwives in the group, they were reassured that all midwives shared the same philosophy in order to ensure continuity of *care*, if not continuity of *carer*. The shared BC philosophy is based on being woman-centred, facilitating informed choice and helping empower women to help them achieve a vaginal birth with minimal intervention.

In WA 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 intrauterine growth restriction or malpresentation. Of the remaining 350 women, 118 (34%) were transferred in labour leaving 232 (66%) birthing in the birth centre (Manager, 2014).

During labour women were encouraged to use non-pharmacological comfort measures, such as double shower and bath but nitrous oxide and oxygen and opiates were available if requested. If an epidural was required or any other intervention for complicated labours, transfer to the co-located OU occurred.

The inclusion criteria for the study consisted of women booked for BC care, who read and spoke English and who were transferred to the tertiary hospital during the first or second stages of labour, accompanied by their partner and the BC midwife. Although the aim of BC care was for all women to be accompanied by a BC midwife when intrapartum transfer took place, this did not always happen. In order to ensure consistency when comparing experiences, only women who were accompanied by a

BC midwife were included in the study. 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

Sampling was purposeful (Patton, 2005) and because each transfer experience is so individual, and therefore impossible to compare like with like, there was no intention to sample women transferred in different situations. Recruitment took place from mid-July to mid-October 2013, with the first author identifying women who met the inclusion criteria from birth records as women who had been transferred during labour, were accompanied by a BC midwife and their partner and who spoke English. The first author was able to gain access to the BC by her employment as midwife there at the beginning of the study. The BC midwives caring for the women acted as gatekeepers, by asking them first whether they were prepared to be included in the study. If they agreed the first author approached women prior to discharge from the BC, OU postnatal ward or by telephone within four weeks of the birth. An information letter outlining the aim of the study and consent form were provided at least one week prior to the interview and then signed prior to the interview, if there was agreement to participate. At the beginning of each interview, demographic information such as name, age and educational level was collected from each participant and can be seen in Table 1. Data related to ethnicity, gravidity, parity, length of labour, reason for transfer and type of birth were collected from the woman's medical record. Women's ages ranged from 22 to 34, all were Caucasian apart from one woman of Indian origin. Out of the 15 women, 11 were first time mothers with the other 4 having had their second babies. All women apart from two were educated to tertiary level.

Table 1. Demographic information of women participants

Age Woman/Partner	Education level Woman/Partner	Ethnicity	Gravidity:Parity	Length of labour#	Primary reason for transfer	Type of birth	Return to FBC
31/34	Tertiary/Tertiary	W/P	1:1	3:35	Fetal distress	Vacuum	Yes
29/31	Tertiary/Tertiary	Cauc/Cauc	2:1	9:40	Delay 1 st stage	SVB	Yes
32/31	Tertiary/Tertiary	Cauc/Cauc	2:1	10:15	Epidural	Vacuum	Yes
25/26	Tertiary/Tertiary	Cauc/Cauc	1:1	16:57	Epidural 8cm	SVB	Yes
32/36	Tertiary/Tertiary	Cauc/Cauc	2:1	13:40	Delay 2 nd stage	Vacuum	Yes
22/24	Year 12/TAFE	Cauc/Cauc	2:2	4:18	Fetal distress 2 nd stage	SVB	Yes
28/34	Tertiary/Tertiary	Cauc/Cauc	1:1	4:54	Intrauterine Growth Restriction picked up on admission in labour	SVB	Yes
28/36	Tertiary/Tertiary	Cauc/Cauc	3:2	7:47	Epidural 8cm	SVB	No
32/35	Tertiary/Tertiary	Cauc/Cauc	1:1	23:37	Delay 2 nd stage	Non-Elective Caesarean Birth	No
34/34	TAFE/TAFE	Cauc/Cauc	2:1	6:28	GBS pos, in early labour, for augmentation	Forceps	No
29/32	Tertiary/Tertiary	Cauc/Cauc	1:1	14:38	Delay 2 nd stage	Vacuum	Yes
32/35	Tertiary/Tertiary	Cauc/Cauc	2:2	3:46	Fetal tachycardia	SVB	Yes
32/34	Tertiary/Tertiary	Indian/Indian	2:2	2:14	Undiagnosed Breech	Breech	Yes
35/39	Tertiary/Tertiary	Cauc/Cauc	1:1	13:46	Delay 1 st stage	SVB	Yes
38/36	Tertiary/Tertiary	Cauc/Cauc	1:1	5:40	Delay 2 nd stage	Vacuum	No

Abbreviations:

Spontaneous vaginal birth = SVB; Emergency Lower Segment Caesarean Section = Em LSCS;

Technical and Further Education = TAFE; University or College = Tertiary

In order to elicit individual perceptions and meanings, individual in-depth interviews were conducted (Polit & Beck, 2010) which began with the broad opening question, “I’d like you to tell me about your birth journey from when the contractions started, to the events leading up to the transfer, your arrival on labour ward up until the birth.”, allowing women the opportunity to give a narrative of their experiences (Polit & Beck, 2010). As the birth story unfolded prompts were used as necessary, to encourage women to describe any part of the experience they felt was relevant, including emotions in the postnatal period based upon reflections of their labour and birth experiences.

The interviews were carried out with 15 women in the naturalistic setting of their homes. They were conducted by the first author, in private in order to minimise any outside influence and all took place within 4 to 8 weeks of the birth, to enhance recall. The interviews were digitally recorded, transcribed verbatim and were read and listened to several more times to ensure accuracy and to maximise immersion in the data. Interviews ranged from 20 minutes to 70 minutes and a reflexive diary was also completed following each interview to describe overall perceptions and any other relevant information. Data collection and analysis occurred concurrently and recruitment ceased once data saturation occurred, in other words when no new data was being discovered (Schneider et al., 2013).

The transcripts were coded and analysed with the assistance of NVivo. The initial 19 codes (Giorgi, 1997), were reduced and grouped into themes and subthemes using Giorgi’s descriptive phenomenological method of analysis (Giorgi, 1975, Kuliukas et al., 2015) . Giorgi’s method focuses on descriptions of individual experiences and consists of four steps, starting with immersion in the data by listening and re-listening to the interviews. This is followed by identifying meaning units, which are reduced further by the grouping of similar meaning units leading to an “organic formation of meaningful themes and subthemes” (Giorgi, 1997, p. 12). Giorgi then suggests putting the focal question to the final themes and subthemes to ensure again that they relate directly to the phenomenon, which in this case was ‘What does this tell me about the woman’s overall experience of *intrapartum transfer*?’ (1975). This process confirmed the validity of the themes and subthemes. To ensure confirmability, once the initial

coding had been carried out by the first author, it was also performed independently by the three other members of the research team. Similar themes evolved and all were discussed and corroborated to ensure trustworthiness with the original transcripts. The themes were then synthesised into definitions and linked to direct quotes to illustrate the richness and depth of the participant’s lived experiences.

Findings

Overall the women felt the midwife’s presence was important to them but while appreciating the fact that help was close at hand, were disappointed to not have achieved the birth they planned for. Five themes with eight corresponding subthemes reflected the variety of experiences and emotions the women felt. These were 1) Listening for the midwife’s voice with subthemes, a) The calming effect and b) Shared philosophy; 2) In the zone with subthemes, a) Hanging in there and b) Post birth rationalizing; 3) Best of both worlds with subthemes, a) The feeling of relief on transfer to tertiary birth suite and b) Returning to the comfort and familiarity of the birth centre; 4) Lost sense of self and 5) Lost birth dream with subthemes, a) Narrowing of options and b) Feeling of panic (See Table 2.).

Table 2 - Themes and subthemes

Themes	Subthemes
The midwife’s voice	The calming effect Speaking up on my behalf
In the zone	Hanging in there Post birth rationalising
Best of both worlds	The feeling of relief on transfer to tertiary birth suite Returning back to the comfort and familiarity of the birth centre
Lost sense of self	
Lost birth dream	Narrowing of options Feeling of panic

A coding system for each woman was implemented and pseudonyms were assigned and are linked to quotes (noted in italics) to demonstrate confirmability of the findings. Pseudonyms were also assigned to the women’s partners and midwives to ensure confidentiality.

The midwife's voice

Women relied on the midwife for advice and were aware that through the labour fog they often focused on the midwife's voice reminding, advising, informing and generally helping them through. The reassuring guidance was appreciated by Rosie after transfer: *Josie (midwife) was really reassuring and said the birth plan wasn't completely out the window, we could still have a natural birth.* Reminders of how to breathe through the contractions during the transfer journey were appreciated, for example by Alison: *She kept whispering things in my ear about focusing on breathing and to keep my eyes closed... that really helped,* and Rosie: *She helped me to remember to breathe because there was a time during the labour that I was hyperventilating so she just reminded me to slow my breathing down.* Mandy described the midwife's voice as a guide which helped her navigate through the events just prior to and during transfer and said her advice to pregnant friends would be to: *Listen to the midwife's voice, that's what I remember most when I was in the nightmare of pain and worry; her voice was like a beacon... it gave me a focus.*

The calming effect

When navigating the transfer journey and arriving in a new environment women were calmed by the tones of the midwife's voice, as pointed out by Peta: *She was very good, calming influence; I remember her calm voice explaining everything.* This was corroborated by Deb: *Like talking me through it, I didn't know anything that was going on around me but I was hearing nothing but her voice.* This calmness helped many women including Janine who commented that: *Her voice was gentle and encouraging.*

Speaking up on my behalf

Many of the women were reassured that all BC midwives shared the same beliefs and philosophy that birth is a normal physiological event. The women felt they knew that the midwives would speak up for them and put forward their views and preferences when necessary, as voiced by Peta: *The midwife had the birth plan with her so I trusted her to have read that and she did..., she knew what we wanted. I felt all the birth centre midwives would know what we wanted.* In the same way Maria stated: *Having that support from a midwife I knew was on the same page in a time of crisis; I knew that her philosophy would be the same as mine.* The value of advocacy was pointed out by Ruth: *Massive. A massive difference because you feel like you've got... an advocate there for your well-being and your choices.*

In the zone

There was haziness and blurring of women's memories of labour. The women talked of not being aware of time or surroundings and that normal clarity and perception did not exist, as illustrated by Deb: *But it's just all such a daze... I spent most of the time with my eyes closed, zoned in ... time meant nothing, it lasted like forever and it lasted like for no time at all.* The fogginess of trying to recollect the labour was summed up by Irena: *It's such a blur in my mind* and the lack of clarity was defined by Diana: *There are parts that I don't remember ... because I was zoned out.*

Their labour world was one of being inside themselves, totally withdrawn, almost as if the body was getting on with the job in hand, as remembered by Ruth: *You know I was sort of in that zone of... focus on the labour, like your body's doing it for you.* Being the woman inside the experience was acknowledged as being different from the observers' experience, again by Ruth: *Talking to mum and Mike (partner) about it, hearing what they had to go through was, it's way more scary than actually being the person that it's happening too; I was in another place in my own head.*

Hanging in there

At the point of transfer women knew that they had to try to keep themselves together as Judy described: *I do remember the journey ...I was saying can I bring the gas with me? I don't remember if I was able to bring with me or not now. I just remember was a pretty nasty... it was horrible getting up and getting into the chair.* Trudy acknowledged her readiness to transfer over: *I was getting really really tired and exhausted and just ready to stop the pain,* and Julia: *I didn't have my eyes open most of the time, I was basically trying to deal with the pain.* Susie knew that transfer was the best option due to her long labour but she couldn't imagine having to make the journey over:

I just remember I was in agony, I was trying to get through the contractions when they said they were going to transfer me. I just thought oh can't they come here? I just felt I couldn't move, I was in that much pain. I thought I could only be in an upright position and I just thought oh God...I just need to get this baby out, but how on earth am I going to get to the hospital?

Post birth rationalizing

Talking through the birth with the midwife and partner afterwards helped women fill the gaps and revisit what had happened and why. Some women weighed up the decisions made at the time and how they affected the outcome, like Julia: *At the time I was... questioning what would've happened if they hadn't broken my waters and what would've been the events after that?* The disappointment Mandy felt following a manual removal of placenta made her question whether it was because she had asked for an epidural which had reduced her mobility: *I don't know whether if I'd just done it naturally without the epidural whether things would have followed through and I wouldn't have had a retained placenta.*

Women sometimes spoke of the outcome being the most important result; the fact they ended up with a healthy baby and that the transfer was a very small part of the whole journey, as Ruth explained: *It was just this tiny little bit at the hospital ... and then we got to go back... When I look back on the whole experience the hospital bit was the tiniest part of the whole thing.* Some women, like Rosie said they would do the whole thing again and had no regrets: *It was good, I would do it all again.*

Best of both worlds

Women appreciated the fact that the OU was very close by to the BC. They articulated that they considered themselves to be in the best place if all went well with the familiar home-like environment of the BC but that expert professional help was easily available when necessary, as described by Maria: *I had my 'homebirth' but ... it was two minutes away from upstairs if anything went wrong.* Janine was thankful that the distance between the BC and OU was relatively short: *I was pleased it was so nearby, no ambulance journey to make.* Similarly Susie felt the same way about help being close at hand: *I was so worried when her heart rate started dropping we needed to get her out, it was great that help was so close by.* In comparison Judy, described how her view shifted, because of requiring an emergency caesarean section, to appreciating the help at hand: *Before I probably had an attitude that ... childbirth is totally natural and it's been medicalised much too much but I ended up falling into the category where I was really glad that there was all of that stuff available to me.*

The feeling of relief on transfer to the tertiary birth suite

Women described how the transfer often afforded them a sense of there being light at the end of the tunnel, as Trudy stated: *I was relieved, I felt that at least the end was in sight now* and reiterated by Alison: *It just felt that finally it was going to come to an end and that was a big relief; I just felt like a weight had been lifted off my shoulders.* Added to this was the knowledge that extra support was now at hand, as Janine acknowledged: *I was quite open to some kind of assistance at that point, I was really tired.*

Returning to the comfort and familiarity of the birth centre

Women's experiences in the immediate postnatal period were improved by returning to known midwives in a familiar comfortable environment, as described by Ruth: *I really didn't want to stay up in the hospital and then Callie (midwife)... said we'll transfer you in about half an hour and I was so relieved that I didn't have to stay up there.* Another woman, Carmel was grateful to go back so that her 18 month old first child would be able to join them and spend the night there: *The great benefit of the birthing centre is that whole family can stay overnight.* This was corroborated by Maria who reiterated the value of early family togetherness: *I could have her, Kerry (first child) stay with us, I wanted it to be as normal for her as possible. I didn't want her to be away from us... the bonding with a new family, that meant so much.*

Similarly Janine talked about the importance of the first night as a new family: *It meant everything... having Harry (partner) stay for that first night together; people who don't have that really miss out.* The familiarity of the midwives increased satisfaction for Irena: *Knowing the midwives... I mean Poppy (midwife) came in the next day on shift and she came in and saw us... it's nice to have familiar faces around especially when they're on your wavelength.*

The experience of returning was particularly beneficial for Susie as it allowed her to emerge from a state of absolute physical and mental exhaustion to a feeling of normality: *Just getting out of there must have helped because as soon as I got to the birthing centre I just felt so much better, like arriving at home, a feeling of peace, comfort, familiarity.* A different perspective was offered by Rosie who interpreted the return to the birth centre as a sign that all must be well: *Coming back was the message to me that everything was good, healthy, normal.*

The women who were unable to return felt saddened by not being able to end the experience in a familiar environment, as expressed by Mandy: *Disappointed. Yeah, because you know down there you can have your family... up there I was by myself the whole time.*

Lost sense of self

Some of the women found they lost their sense of being included in the events encircling them and instead felt they were being 'done to' rather than being 'part of'. By choosing to birth in the BC women had already made the statement that they wanted to be involved in decision making and make their own choices. However in the transfer process they sometimes felt they were reduced to a non-person because of a different, less woman-centred philosophy, as described by Ruth: *It changed from being caring and focused around what I wanted, to be focused around procedure, without explanation or care or compassion... I felt like I was being treated like a bit of meat rather than a person.* Similarly, a concept referred to frequently by women was the feeling of being left wide-open and vulnerable, as voiced by Alison: *Just not feeling like you have any dignity left ... it's just being naked and exposed* and Mandy: *You felt really undignified...they strap your legs upon stirrups, you don't really get told that's what's going to happen.*

In a similar way women discovered that in this new position they were diminished and became a teaching tool for junior doctors and students and in some cases found they were being observed by many maternity care professionals because they were an 'interesting case'. An example of this is Maria, who arrived in the BC with a breech presentation and described how, after transfer to the OU, she had to close her eyes for the birth in order to try to recapture a sense of being a woman birthing a baby: *There were too many... lots of people and that freaked me out so I just didn't want to have to look at them.*

Lost birth dream

Women voiced disappointment that their planned birth was never achieved. Throughout the pregnancy and up until the point of transfer they had visualised a calm and peaceful birth with personal choices such as water birth, the cord to be left pulsating, the baby to be skin to skin, but the eventual reality was that for many the opposite happened. The sadness of not achieving the anticipated plan was considered

by Diana: *Because I'd always wanted a water birth that's why we went with the birthing centre... so I didn't get to have what I wanted... I was disappointed.* In comparison some of the women were saddened but accepted the transfer as necessary, for example Trudy: *I was disappointed but at the same time knew that we had to do what we had to do so* and Rosie: *A bit upset because I really wanted the water birth but at the same time it was okay, we were doing what we needed to do.*

Interestingly some women felt the disappointment happened because they perceived that they had set themselves up for failure by preparing for the perfect birth and presuming that everything would go according to plan, as Ruth vocalised: *But it's so true because the higher you set your goals the more disappointed you will be if you don't get there... I set myself up; I set my goals too high.*

Narrowing of options

After transfer took place the realisation dawned that care was managed with a different focus. There was a sense of urgency and also an expectation that the women would conform; they would lie on the bed, they would be continuously monitored with a cardiotocograph (CTG) machine, they would follow directions and accept the decisions made about their care, as Trudy remembered: *Pretty much all my birth preferences went out of the window. Things like waiting for the cord to stop pulsating and that sort of stuff.* In a similar way Ruth found it hard to have to relinquish the bath: *I just wanted to get back in the bath and she was like no... I'm sorry but you can't get back into that bath.* The discomfort of continual fetal monitoring and the immobility it caused was voiced by Maria:

In a hospital, you can't do any of the things that make you comfortable; I couldn't move around like in the birth centre, and I had this heart rate monitor which is a big plastic thing and every time I bent over I pushed it off and they had to keep putting it back on... that really affected my experience because I had to worry about how I was standing to make sure the monitor kept working.

Feeling of panic

The transfer brought with it a sense of urgency which many women likened to being in an episode of a hospital emergency drama program. The feeling of being rushed and losing her partner's hand was described by Peta: *I was holding on to Robbie's (partner) hand and I wasn't allowed to do that while I was on the trolley because there*

wasn't enough room and so I was gripping onto the side and they kept saying stop gripping onto the side. Being raced up to the OU was outlined by Julia: I could tell that they were racing up with the bed bumping into things. Similarly the dramatic change from calm to drama was summed up by Alison: It was like lights, camera, action.

Discussion

The main findings from this qualitative study demonstrate that when women were transferred in labour, they were affected by disruption to their prior expectations and they felt that various factors helped or hindered the process. The alteration to their labour journey was eased by the BC midwife's presence, providing continuity of midwifery care and a calming influence. When the time came to transfer many felt relieved that help was close at hand but despite this they often felt vulnerable and exposed after arrival in the tertiary birth suite and were aware of a change in attitude and behaviours towards them. There was a sense of disappointment at leaving the familiarity of the BC and losing their planned birth and women were appreciative when they were able to return to the BC again afterwards. The labour phenomenon of women 'being in the zone' was confirmed in this study with women wanting to talk about the journey afterwards to be able to fill in the gaps and rationalize what had happened.

The value of the phenomenological approach of the study was used to give a window of insight to allow maternity providers to appreciate the woman's lived experience (Polit & Beck, 2010). This method allowed depth and richness of description from the women during a time that was close enough to the birth to enable recollection of their experiences. The interviews were not time-limited which gave women the freedom to carefully explore their labour memories. These methods provided a wealth of information which is not normally shared and can give an enhanced understanding of women's experiences of intrapartum transfer. Interviews from the women in this study demonstrated that they valued being accompanied by a BC midwife when transferred to the OU and appreciated knowing that they shared the same beliefs and philosophy. Women also commented on hearing the midwife's voice through the labour haze and the fact it was calming and reassuring when they needed it most. Midwives' sensitivity to women's cues in labour regarding the nuances of communication and remaining calm and connected, to enhance the labour experience (Kuliukas et al., 2015; Leap, 2010; Powell Kennedy, Anderson, & Leap, 2010), was also confirmed in this study.

The woman-midwife relationship is multi-faceted and trust and mutuality are enhanced with insight and awareness from and the presence of the midwife (Lundgren & Berg, 2007).

Findings from previous studies (Creasy, 1997; Rowe et al., 2012), suggesting that transfer in labour causes disappointment to women, were endorsed in this study which clarified that these feelings were due to prior expectations being disrupted and choices reduced. Constraints such as such as being confined to bed, unable to use the bath or shower and needing to conform to such practices as continual fetal monitoring made women feel restricted and uncomfortable, which is also described in previous studies (Green & Baston, 2003; Macfarlane, Rocca-Ihenacho, & Turner, 2014b). For some women the transfer brought a feeling of relief (Rowe et al., 2012), often underlined by the knowledge that the OU was close by. Women were reassured that the BC setting offered the best of both worlds with the advantage of a home-like environment and woman-focused care but the back-up of medical expertise just minutes away if necessary (Rowe et al., 2012). The facility to return to the BC afterwards closed the circle for many women and gave a feeling of relief and returning home.

On arrival at the OU many women were concerned about the change in attitude and behaviours towards them. Women in labour are very vulnerable (Van der Gucht & Lewis, 2014) and need close attention and care but often the focus of maternity care staff is on the fetus rather than the woman herself (Nilsson, 2014). This study revealed that women felt the anguish and humility of being a vessel of the fetus rather than an individual person. Similarly women spoke of feeling exposed and vulnerable and experienced a loss of dignity from being used as a teaching tool for the benefit of staff. Although many maternity facilities are also teaching hospitals to benefit future generations of obstetricians and midwives, the privilege of being able to learn a skill on another human being should never be taken for granted and the vulnerability of the woman must be carefully considered. Feelings of having been violated and the subsequent threat of dealing with post-traumatic stress disorder are well recognised in women who suffer trauma during labour and birth (Mozingo, Davis, Thomas, & Droppleman, 2002; Reynolds, 1997). These known anxieties, confirmed by the tearful episodes demonstrated by several women during interviews in this study provides maternity care providers with the evidence that the woman's birth space is where her wishes should be supported, birth attendants limited and dignity preserved.

The instinctive behaviour of women in labour was highlighted in this study and how it impacts on their experiences during labour and also their memories of labour in the few weeks afterwards. Getting into the zone is a well-known phenomenon (Dixon et al., 2013; Zambaldi et al., 2011) but this study also demonstrated how after the birth women became aware of the need to fit missing pieces of the jigsaw and fill gaps in their memory. This WA study confirms the value of revisiting the birth through a conversation afterwards (Gamble et al., 2004) but also that it should always take place with reference to the woman's medical record in order to enlighten the woman accurately and ideally with the midwife who looked after her in labour.

The limitations of this study include the fact that women were only eligible to take part in this study if they were accompanied during transfer by their partner and a midwife. This excluded valid experiences of women who were transferred without the benefit of an accompanying BC midwife and the difference this might have made. Similarly there was no maximum variation sampling used, so the circumstances of transfer, for example, whether the transfer was for a 'non-urgent' reason or an emergency was not taken into account and this could also be an important factor in the transfer experience. Another limitation is that it is a small study that only reflects the experiences of women in one Australian birthing centre however a rich description has been provided to allow the reader to determine the transferability of the findings to other contexts.

Conclusions

Women in WA felt that on intrapartum transfer from their chosen birth centre to a tertiary obstetric unit, they lost the birth dream they had been visualising and planning for. It has been established that ongoing conversations between the woman and midwife during the antenatal period increases preparedness and facilitates a more satisfying labour experience (Kemp & Sandall, 2010) and could also prepare women for an altered labour journey. Continuity from the midwife plays an important role in preparation and also in helping the woman transition to a new environment if intrapartum transfer becomes necessary. The current emergence of midwifery group practices in Australia following the recommendation of the National Maternity Services Plan (Hames, 2010) will allow more Australian women in the future access to this preference.

The Western Australian Reid report (Reid, Daube, Langoulant, Saffioti, & Cloghan, 2004) recommends that more women should have access to birth centres as they are known to improve maternal satisfaction across the childbirth continuum (Brocklehurst, et al., 2011; Hatem et al., 2008). Women's appreciation of BC care was corroborated with this WA study in which they voiced that choosing to birth in a BC co-located to an OU offered the best of both worlds. They felt reassured that extra help was there if necessary and often relieved when the transfer took place, but were very pleased to be able to labour as far as possible in the BC and then return to its familiarity afterwards. This recommendation should be considered by policy makers in the health sector when the value of birth centres is being questioned; current birth centres should not be threatened with closure and new birth centres considered for any new or existing maternity facility.

Information that has emerged from this study, that women are committed to try to achieve aspects of their birth plan even after transfer to the OU takes place. Midwives may now be encouraged to consider simple measures such as mobilisation and use of water in OUs, despite the woman being subject to intervention, which will also reduce length of labour, reported pain and increase satisfaction (Priddis, Dahlen, & Schmied).

To increase inclusion for women in decision making, health care professionals should ensure that sensitive communication channels are kept open at all times so that women can continue to make choices and feel involved in their care. The need for true informed consent has been well documented in the literature (Chase, 2003; Mahmud & Ahmad, 2009), but is still not universally offered. These corroborated findings direct maternity care providers to ensure this is obtained in all cases. The experience of being excluded was described by women as having left their sense of 'self' back in the birth centre and their dignity and modesty were compromised as they were treated as a vessel for the baby rather than as a person in their own right. Maternity care providers should ensure that women are treated with dignity and respect and remain central to care, rather than focussing solely on the wellbeing of the fetus. These findings direct maternity care providers to widen their focus from fetal wellbeing to considering the woman as her own person.

The midwife's voice is a point of reference for women during labour and can be used to help focus the woman, impart important information and maintain a sense of calm

and normality even when problems occur. It is well documented that there is always room for improvement with communication throughout labour (Alderson, Hawthorne, & Killen, 2006; Halldorsdottir & Karlsdottir, 2011) but this new knowledge will give midwives impetus to inform, advise and reassure women when required. After the birth women were aware that they had unclear memories that midwives could help clarify by offering time to talk through events to fill in the missing pieces of the jigsaw.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

LK conceived of the study, carried out the interviews, transcribed the interviews and performed initial coding. LK and YH obtained ethics approval. LK, YH, RD & LL participated in the design of the study and performed analysis. LK, YH, RD and LL participated in drafting the manuscript, reading and approving the final manuscript.

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Summary

This chapter presented the final version, after addressing reviewers' comments, of the manuscript regarding women's experiences when intrapartum transfer takes place.

The next chapter presents the final version of the publication regarding the partner's experiences when transfer in labour occurs from a birth centre to the neighbouring referral centre.

Chapter Five: Partners' Experiences

And then ...we were wheeled into the same room that you ladies took us around when we visited on those parent evenings which is the kind of 'where things go wrong room' was how we portrayed it. And unfortunately just by chance it was exactly the same room we'd been in during the tour so obviously Amy was like 'Oh no'. She just, I think she just saw forceps in her head because they'd shown us forceps on that night and so I think she was then already on the back foot. (Joe)

This chapter provides the manuscript of the published paper on partners' experiences. The findings demonstrated that partners were affected by the transfer experience, causing an emotional upheaval for many requiring a need to address the negative impact of this. There is therefore a need to better prepare couples for the transfer situation with an emphasis on equipment, atmosphere, involvement, numbers of staff and management of emergencies with further research being necessary to confirm the effectiveness of such preparation. Although partners are not patients under the care of maternity service providers, they are often the key support person for the woman and this involvement must be respected and promoted in order to improve the overall care she receives. The following paper is in its final version, after addressing reviewers' comments, prior to publication in the peer reviewed journal Midwifery.

Reference: Kuliukas, L., Hauck, Y. L., Duggan R. and Lewis L. (2015) The phenomenon of intrapartum transfer from a western Australian birth centre to a tertiary maternity hospital: The overall experiences of partners. *Midwifery*, 31 (5): e87-e93 doi:10.1016/j.midw.2015.01.010.

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

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. Fifteen male partners were interviewed in the first 8 weeks postpartum 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.

Keywords

Partner, father, intrapartum, transfer, midwife, birth centre.

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 birth care provided by a midwife (either through a government funded program 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 & 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 to be stressful, even when progress is still normal (Dahlen et al., 2010; Nichols, 1993; Somers-Smith, 1999).

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 (Draper & Ives, 2013; Johansson et al., 2012; Kululanga et al., 2012) , 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 & 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 & 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., 2007) and enables description of the human experience, providing

detailed accounts of various aspects of the event through seeing, feeling, remembering and evaluating (Polit & 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 (Brocklehurst. et al., 2011; Walsh, 2009). 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 women 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 (L.Keyes, personal communication 10th October 2014).

Women who book at the BC are allocated to a group of five midwives who 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 (Brocklehurst et al., 2011; Hatem et al., 2008; Rooks et al., 1992) .

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 & Beck, 2010). Interviews began with a broad opening question, such as 'Please could you tell me your whole story from when labour started, right through until the birth of your baby?' This question was followed by open ended prompts as necessary, aimed at encouraging the partners to describe their emotions during each phase of the experience leading up to how and why the transfer took place, the actual transfer journey including their feelings on arrival at the tertiary hospital and events leading up to the birth.

The interviews were carried out by the first author with 13 partners in their homes and two by telephone. Interviews were not conducted in the presence of the woman to minimise the influence from her own labour recollection. All interviews took place within 8 weeks of the birth, thirteen within 4 weeks. The interviews were audio taped and transcribed verbatim on the day the interview took place and transcription was carried out by the first author in order to maximise immersion in the data. The transcriptions were listened to three further times to ensure accuracy. Interviews ranged from 15 minutes to 65 minutes, with fourteen lasting for more than 20 minutes.

A reflexive diary was completed following each interview describing any notable observations, including the general demeanour of the partner and also any comments made after the recorder was switched off. To reduce bias and enhance confirmability, coding was independently performed by three other members of the research team and similar themes were found, discussed and corroborated to ensure validation, referring back to the data for any discrepancies.

Analysis took place with the aid of NVivo 10, employing Giorgi's descriptive phenomenological methods of analysis (Giorgi, 1975). Giorgi's method of data analysis focuses on descriptions of individual experiences and suggests that consideration should be given to the same phenomena as it manifests itself to different individuals. The method consists of four steps. Firstly each interview was listened to and the transcript read several times in order to understand the overall whole picture and secondly the data were separated and "meaning units" (Giorgi, 1997, p. 12) were identified. These meaning units are statements made by individuals which are self-defining in the expression of a single, recognisable aspect of the individual's experience. Thirdly data reduction took place; in other words only what was essential to the meaning of the experience to distinguish essential features remained. This formed the labelled codes which were then grouped into tentative themes (like with like) and finally integrated through conceptualisation of grouped data into (still tentative) overarching themes and subthemes. The final phase consisted of looking at the central themes and subthemes and asking 'what does this tell me about the experience of *transfer*?' Giorgi (1975) describes this as the question being put to the data in a systematic manner to ensure themes relate directly to the phenomenon. This helped generate the final themes which were synthesised into statements or definitions regarding the experience and linked to direct quotes giving the rich story of their experience (Giorgi, 1975). This process is similar to the "fracturing, grouping and gluing" style commonly referred to in qualitative data analysis (Schneider et al., 2007).

Findings

Data collection and analysis occurred concurrently and recruitment ceased once no new data was being heard, in other words data saturation was achieved. This occurred after 12 interview, however, a further 3 interviews were carried out to confirm data saturation (Schneider et al., 2007). A total of 15 partners were interviewed and their

ages ranged from 24 to 39 (mean 33 years). All 15 couples were Caucasian except from one couple with Indian ethnicity. Eleven of the women were primiparas and 14 achieved a vaginal birth with one having a caesarean birth. Thirteen of the partners were first time fathers, two were expecting their second child. Further demographic and labour information is provided in Table 1. Eleven couples were able to return to the BC following the birth.

Asking about the whole labour and birth journey allowed each partner to describe their own individual pathway. It must be remembered that these findings do not necessarily represent the absolute reality of the situation, but the partners' perception of their reality. Data analysis revealed five overarching themes incorporating seven subthemes (Table 2). A coding system for each partner was implemented (P1 to P18) and will be used with quotes noted in italics to demonstrate confirmability of the findings. Due to the failure of some partners to respond after the women had been interviewed, the numbered codes are not consecutive. Pseudonyms for women's names have been used to ensure confidentiality.

The Emotional Roller Coaster

The first theme highlights how the transfer journey took the partner on a ride of emotional highs and lows, like an emotional roller coaster. General concerns, such as the safety of the baby or feelings caused by specific events compounded the experience. These different events resulted in men sharing feelings of excitement, concern, uselessness, disappointment, frustration, anger, relief and pride which triggered an internal roller coaster of extreme turmoil that the partner had to acknowledge inwardly while outwardly being the calm supporter.

The roller coaster ride at the start of the labour reflected feelings of anticipation and excitement that the day had actually arrived. This excitement often gave way to the reality of witnessing a woman in normal labour. Interestingly, although not related to the transfer experience, an issue voiced by several partners was about how unprepared they were to witness the visceral behaviours of their women and also the reality that labour can be a long process. In fact a forerunner to transfer taking place was that the partners perceived labour to be long and slow. It was common for partners to voice concerns over the length of time labour was taking. Watching the clock was described with great emotion by P18 who was willing progress to be made: *hopefully 6 o'clock*

won't come around. I'd been praying for three not to come around, four, five ... maybe six won't come around I hoped we wouldn't still be doing this ... I mean the whole thing was agony really. Anxiety that the woman may be losing the ability to cope due to her internal dwindling resources due to a longer than anticipated labour was also voiced by P9: *I was concerned about how much energy Elle had left, given that we'd nearly been going a day and we weren't getting anywhere.* Anxiety rolled into fear for some partners when the need to transfer eventuated, with many being worried for the lives of their woman and baby, as P11 revealed:

All I was just thinking of was.. my wife.. and just as long as my wife's okay... even if this went wrong and the baby died like.. as long as my wife's all right ...as a husband you want to help your wife but .. you're helpless and it's out of your control.

On the other hand, for some partners it was more about disappointment, due to the loss of the birth dream, as P15 summed up: *We didn't really have a choice in the matter, we just had to go. Yeah it was disappointing because I knew .. that was the waterbirth out the window.*

After the decision was made, the actual transfer, which took place by foot, wheelchair or trolley, was described by most partners as being straightforward, with P18 commending the fact that the hospital was just a short journey away: *I mean, the idea of having to...wait for an ambulance.. at least I knew the wheelchair was there and were going to be there in five minutes and that was great you know, to know that.* Once the transfer had taken place, for some partners there was a sense of frustration and anger as proceedings did not eventuate as they felt they should have. One partner expressed frustration with the apparent inability of the accompanying BC midwife to use unfamiliar equipment in the hospital labour and birth suite:

At that point she tries to call, a paed I think but .. she didn't know how to work the computer... and I stood there and Ayla was screaming and ...the baby is in jeopardy and they're trying to fix the frigging computer. I was like... What? Can we just deal with the problem in hand? It was just frustrating (P12)

Another common frustration after transfer was having to wait; in the case of P15 it was for pain relief for his distraught woman: *That was the hardest part I think through the whole thing was waiting for the anaesthetist ... we're in like a world of pain.*

On reflection during the postpartum interviews, the roller coaster ride often ended on a high as partners remembered with pride their woman's choices and achievements. For example P1 clearly felt humbled by what his woman had achieved: *No gas you know, nothing. Incredible.*

Partner's role in changing circumstances

As the birth journey evolved the partner found himself in a situation of knowing her so well that he, above others, knew her best and was able to read her coping abilities. This second theme around the partner's role in changing circumstances included two subthemes; recognising his inside knowledge of his labouring woman and at the same time dealing with the challenge of being witness to the traumatic events she was enduring.

Acknowledgement of his inside knowledge of her

The partner had expert knowledge and understanding of his woman; he was the only person with personal history to judge when she was coping and when she had reached her limit. He was able to read her signs and understand what her sphere of 'normality' was. This insight was captured best by P3's comment confirming he knew his woman's limitations. He could make the comparison with what she was normally like and what he now saw before him, he felt he needed to take charge as he could see she was not coping:

She was getting really tired, and I'll never forget, this is probably the clearest memory for me.. she sort of looked at me ... her eyes were wandering and I thought oh my God.... Kay was clearly in distress. That's why I had to pull the plug and said 'Babe, look you're struggling now... we're going to bring you upstairs'. So ...in the end it was me that made the decision like I want this to happen ... straightaway.

Challenges of being a witness

The partner had to stand by and watch the physical and mental challenge his woman was experiencing. He was witness to her disappointment, distress and extreme tiredness which led him to feelings of concern, anger and frustration. This anguish was illustrated by P7's statement: *I don't know how you would prepare mentally for seeing that but... I wish someone had said to me listen, you're going to see your partner or wife or loved one in more pain than you've ever seen them before.*

Adapting to a changing model of care

The third theme acknowledges the movement between models of care from the birth centre to the hospital demonstrating an appreciation for continuity of care and an awareness of the differences between the midwifery and medical models. Two subthemes reflected the partner's perceptions of the transfer from a nurturing, continuity model to a medicalised model.

Moving from an inclusive nurturing and continuity model

While being immersed in the midwifery model of care at the birth centre there was an acknowledgement of the benefit of knowing the midwife, a feeling of being kept informed, being involved in decision making and allowing the labour to unfold under its own steam. P18 acknowledged his involvement: *At the birth centre everything was discussed ... you're fully aware of everything that was going on.* Partners' stories also reflected an appreciation of continuity of care, feeling comfortable with the known midwife when they were moving to an unfamiliar place. This is illustrated by P4's comment: *So we got up there It was good to have the midwife come up with us ...and have a little bit more peace of mind to have that familiarity.*

Transferring to a medicalised model

When transfer took place from the birth centre to the tertiary hospital, the model of care changed to one of bustling efficiency with larger numbers of staff. What emerged was a range of emotions from relief that 'things will get sorted' to frustration and anger with the feeling of not being kept informed and being coerced into accepting certain treatments or procedures, and the resulting physical distress by these measures. The lack of information and involvement in decision making was voiced by P8 who quoted the obstetric registrar as saying: *This is how it's going to be, we don't have any time to talk about anything.* One change that challenged many partners was the sudden emergence of people and equipment, as described by P12:

Then all the doctors suddenly, then there were like 10 people in the room which I think what was scary ... they were bringing in all of the machines which was to be expected but... we were still like.. all right... Jesus, trays of knives and stuff all around you, .. we were like.. holy shit.

The other perspective to the transfer, described by some partners, was the sense of reassurance and rescue. The relief was summed up by P5: *I felt we were in safe hands,*

I felt a sense of relief that we were there now and that we were going to have a senior consultant there and all the options were on the table. This assurance was corroborated by P4: Yeah, .. being able to trust the medical professionals. And just knowing they would have the expertise and the skills and the facilities to deal with whatever emergency was going to happen.

Adapting to environmental changes

The fourth theme captured the movement from a comfortable well-known environment to a clinical hospital setting which evoked feelings of fear, worry and powerlessness. In addition, any hopes of achieving the birth dream were over. However, a subsequent movement back to the birth centre post birth contributed to feelings of contentment and relaxation and there was appreciation as the new family had time together. Three subthemes outlined below describe this adaption process.

Feeling comfortable in the familiar birth centre

The familiar environment of the birth centre was the expected place of labour and birth. Being immersed in this known place evoked feelings of being able to relax, feel safe and comfortable. This was voiced by P1 when discussing reasons for choosing birth centre care: *Vee liked the idea of going in the pool ... so that was a big driver for us. We were pretty relaxed, the environment was... perfect.* Similarly P3 commented on the fact that when they arrived in labour: *It was quite warm in there, we brought the music ... the lights were down low so it was a good comfortable place for us.*

Going to the place where things go wrong

Labour and birth suite in the tertiary hospital was viewed as the opposite of the low technological, quiet birth centre. It was seen as the place associated with complicated labours and births, bright lights and scary equipment. One partner, P11 described how during the childbirth education class they had visited the labour room and then coincidentally were transferred to that very same room when the labour went awry:

And then ..we were wheeled into the same room that you ladies took us around when we visited on those parent evenings which is the kind of ‘where things go wrong room’ was how we portrayed it... So I think she was then already on the back foot.

A similar view was reiterated by P3: because [we] were in a good place not long ago ... the Birthing Centre, beautiful environment, nurturing, candles, music, to the bloody

horror show that we experienced a few hours later.... seeing it face-to-face, the sheer violence of it.

Back to comfortable familiarity afterwards

Returning to the birth centre after the birth evoked a feeling of 'going home' where the pace slowed back down. There was a sense of relief to be back in the familiar environment which felt safe, as P12 described: *After that we were taken back down.. we were back in our sort of homely environment of the birthing centre, although tired, exhausted, emotionally retarded.* This feeling was substantiated by P5 who commented: *The birth centre was really comfortable.. it's really homely and things and all very comfortable, it's not that sterile hospital feel. I was very glad to get back down to the birth centre after the birth.*

Coming to terms with altered expectations around the labour and birth experience

The final theme addressed participants' descriptions of coming to terms with their experience. Despite preparation classes and an awareness of the transfer statistics, being transferred in labour fuelled feelings of disappointment and confusion. There was sadness and anger around reduced participation in this life event, as P6 comments: *The doctor wanted to cut the cord so I said mate, look, what's the rush? Just wait a little bit to let the cord blood do its thing.*

However notwithstanding some partners' negativity, a sense of gratefulness emerged. The overwhelming relief of ending up with a live mother and baby was paramount as stated by several partners including P11: *Well obviously it went the way we didn't want it to go but at the end of the day we had a healthy baby and Kylie was fine so was all good in the end.* Finally the need to debrief was discussed by many partners, for example P18 stated: *I definitely found it a bit traumatic ... I was so surprised with how intense the whole saga is and even though friends had told me it just doesn't register I guess, It's good to talk about it.*

Discussion and Recommendations

The findings from this qualitative study provide some understanding into the emotional turmoil experienced by partners when intrapartum transfer takes place. This insight offers midwives the opportunity to reflect on their care and decision making to better facilitate a positive labour and birth experience for both the woman and her partner. According to Premberg et al., (2011) many men feel anxious and afraid at

different points in labour; this WA study demonstrated that when transfer occurs in labour it is a further source of anguish. In addition, transferring partners also portrayed feelings of disappointment, fear and frustration at different stages of the transfer process, which in most cases they kept completely to themselves as these were private feelings. They remained stoic, a trait also found in Kululanga's Malawian study (2012) of men supporting women in uncomplicated labour. When complications occurred and transfer became necessary in this WA study, the feeling of needing to be strong whilst internally suppressing feelings of despair and worry led to inner turmoil. These anxious feelings were similar in Yokoto's Japanese study (2007), which looked at the impact on the partner when the labour ended in caesarean section. As in this WA study, men often feared for the very lives of their women and babies.

Knowledge of this roller coaster of emotions will give midwives an awareness of how to respond and better support the partner in their need to stay informed and involved. The importance of updating couples, involving them in decision making and obtaining informed consent is well documented (Alderson et al., 2006, Johansson et al., 2014, Meyer 2003). Poor communication is one of the most common causes of complaint from parents and of those, obstetricians have been found to receive the most (Cornthwaite, Edwards, & Siassakos, 2013). This WA study demonstrated that in a busy labour ward environment being actively involved in decisions does not always occur. At best this non-inclusion leads to a feeling of not being involved (Blix-Lindstrom et al., 2004, Miller & Shriver 2012) and at worst means that procedures, such as episiotomy have taken place without consent, or even knowledge until afterwards (Hayes-Klein, 2013). In other words the fundamental ethical principles have not been adhered to (Foster & Jon, 2010). Clearly then the findings of this WA study confirm that all members of the maternity care team should be cognisant of the fundamental right of women and partners to be kept informed and consent sought for all procedures.

In unexpected situations such an intrapartum transfer, the value of continuity of care was demonstrated to have been appreciated by partners who found the accompanying BC midwife helped improve the transfer experience. Similarly Lindren et al., (2011) found women experienced a sense of abandonment when their midwife was unable to stay with them when transfer occurred, albeit from home to hospital rather than BC to hospital. Interestingly, in another study by Lindgren et al., (2008) the recommendation

was that continuity of care by the midwife actually reduces the risk of transfer. Consequently where transfer may be necessary, a continuity model is the preferred model both to reduce the risk of transfer and to improve parents' satisfaction if it does occur. Conversely one disadvantage of continuity of care revealed in this WA BC study was the fact that often the BC midwives were not familiar with labour ward equipment which led to some frustration by partners. Scheduled upskilling sessions for BC midwives are therefore indicated, as well as mindfulness that extra support may be required from core labour ward midwives.

The main source of true continuity was demonstrated by the comments from partners about their own role in labour and the fact that they know the woman best. This information is of benefit to midwives who need to recognise that partners are a useful resource when assessing women's capabilities in labour. Having insight will allow midwives to utilise this inside knowledge which could make a difference with decision making.

Partners prepare themselves for labour in a variety of ways including childbirth education classes, which have been demonstrated to improve partners' involvement (Ferguson et al., 2013) and reduce anxiety (Sapkota et al., 2012) . Such classes would provide the ideal forum to inform partners around the various issues which arose in this study. Points of confusion and potential concern, which surfaced in the study, could be discussed in this setting, such as length of normal labour, nutritional needs in labour, the impact of transferring to a changed environment and challenges of being a witness.

Finally the wish to talk about the birth afterwards was voiced by several partners suggesting that opportunity for men to debrief after the birth would be beneficial in order for them to fully understand the reasons and timing of why the transfer took place. It also gives them the opportunity to consider and reflect on the lost dream. Although debrief for women is accepted as a beneficial tool (Gamble et al., 2004) , there is no evidence in the literature suggesting that this opportunity should also be offered to partners. This opportunity could be arranged before discharge or during one of the home visits in the postnatal period.

A limitation of these findings is the nature of qualitative research not professing to be generalizable beyond the specific context of this study, a WA birth centre. However

rich description has been provided to assist the reader determine the transferability of these findings to other birthing contexts. Also the participants were predominantly Caucasian and findings might not reflect the experience and needs of other ethnic groups within the WA birth centre.

In conclusion, findings suggest there is a need to better prepare couples for the transfer situation with an emphasis on equipment, atmosphere, involvement, numbers of staff and management of emergencies. Further research is necessary to confirm the effectiveness of such preparation. Study findings offer insight into the intrapartum transfer experience for partners and can therefore inspire discussion between maternity health professionals as to how this experience can be enhanced. Although partners are not patients under our care, they are often the key support person for the woman and this involvement must be respected and promoted for the welling being of the woman and her entire family. Finally the new information found could lead to improvement in professional support and communication when partners face the experience of intrapartum transfer from a low risk to a high risk unit.

Chapter Five. Table 1. Demographic and labour information.

T	Age:Woman/Partner	G:P	Education level	Length of labour	Reason for transfer	Birth Outcome	Return to FBC	Ethnicity:W/P
1	31/34	1:1	Tertiary	3:35	Fetal distress	Vacuum	Yes	Cauc/Cauc
2	29/31	2:1	Tertiary	9:40	Delay 1st	SVB	Yes	Cauc/Cauc
3	32/31	2:1	Tertiary	10:15	Epidural	Vacuum	Yes	Cauc/Cauc
4	25/26	1:1	Tertiary	16:57	Epidural 8cm	SVB	Yes	Cauc/Cauc
5	32/36	2:1	Tertiary	13:40	Delay 2 nd stage	Vacuum	Yes	Cauc/Cauc
6	22/24	2:2	TAFE	4:18	Fetal distress 2 nd stage	SVB	Yes	Cauc/Cauc
7	28/34	1:1	Tertiary	4:54	IUGR	SVB	Yes	Cauc/Cauc
8	28/36	3:2	Tertiary	7:47	Epidural 8cm	SVB	No	Cauc/Cauc
9	32/35	1:1	Tertiary	23:37	DTA	N El LUSC	No	Cauc/Cauc
11	34/34	2:1	Trade	6:28	GBS pos NIEL	Forceps	No	Cauc/Cauc
12	29/32	1:1	Tertiary	14:38	Delay 2nd	Vacuum	Yes	Cauc/Cauc
13	32/35	2:2	Tertiary	3:46	Fetal tachycardia	SVB	Yes	Indian/Indian
14	32/34	2:2	Tertiary	2:14	Breech	Breech	Yes	Cauc/Cauc
15	35/39	1:1	Tertiary	13:46	Delay 1st	SVB	Yes	Cauc/Cauc
18	38/36	1:1	Tertiary	5:40	Delay 2nd	Vacuum 3 rd degree tear	No	Cauc/Caus

Abbreviations:

SVB = Spontaneous vaginal birth; GBS = Group B Streptococcus; TAFE = Technical and Further Education; Tertiary = University or College; Cauc = Caucasian; G:P = Gravidity: Parity; DTA = Deep Transverse Arrest; NIEL = not in established labour; N El LUSC = Non Elective Lower Uterine Segment Caesarean Section

Chapter Five. Table 2. Overarching themes and subthemes.

Overarching themes	Subthemes
The Emotional Roller Coaster	
Partner's role in changing circumstances	<i>Acknowledgement for his inside knowledge of her</i>
	<i>Challenges of being a witness</i>
Adapting to a changing model of care	<i>Moving from an inclusive nurturing and continuity model</i>
	<i>Transferring to a proficient medicalised model</i>
Adapting to environmental changes	<i>Feeling comfortable in the familiar birth centre</i>
	<i>Going to the place where things go wrong</i>
	<i>Back to comfortable familiarity afterwards</i>
Coming to terms with altered expectations around the labour and birth experience	

Summary

This chapter presented the final version, after addressing reviewers' comments, of the manuscript regarding partner' experiences when intrapartum transfer takes place.

The next chapter presents the final version of the publication regarding the midwives' experiences when transfer in labour occurs from a birth centre to the neighbouring referral centre.

Chapter Six: Midwives' Experiences

Oh, how does that make me feel? On one way I guess I'd like to say relieved and I know that sounds really silly but it's like, okay, I've done those things, they haven't resolved it so we need to do something else. Then action feels better than inaction. So at least you feel like you're making a decisive step forward even though you're going to a place where you know she is possibly going to be compromising not having an experience that she doesn't want. So you feel guilty straightaway. You just think... can we give her another five minutes? You know, can we stretch it out? You know, do we really have to go? And so all of those questions are going through your mind. (Abby)

This chapter provides the final manuscript, after addressing reviewers' feedback of the published paper on midwives' experiences of intrapartum transfer from a midwifery-led, low risk continuity of care model to a tertiary hospital, which was found to cause a variety of emotions. These included the anxiety regarding the timing and management of transfer, the requirement to work in an unfamiliar environment under a medicalised model of care and the awareness of not being able to facilitate the birth the woman hoped for.

Reference: Kuliukas, L., Lewis L., Hauck, Y. L., Duggan R. (2016). Midwives' experiences of transfer in labour from a western Australian birth centre to a tertiary maternity hospital. *Women and Birth*, 29, 18-23 DOI:10.1016/j.wombi.2015.07.007

Midwives' experiences of transfer in labour from a Western Australian birth centre to a tertiary maternity hospital

Abstract

Background: When transfer in labour takes place from a woman-centred, midwifery led centre to a tertiary maternity hospital it is accepted that women are negatively affected, however the midwife's role is unevaluated, there is no published literature exploring their experience. This study aimed to describe these experiences.

Methods: Giorgi's descriptive phenomenological method of analysis was used to explore the 'lived' experiences of the midwives. Seventeen interviews of transferring midwives took place and data saturation was achieved.

Findings: The overall findings suggest that midwives find transfer in labour challenging, both emotionally and practically. Five main themes emerged: 1) 'The midwife's internal conversation' with subtheme: 'Feeling under pressure', 2) 'Challenged to find a role in changing circumstances' with subtheme: 'Varying degrees of support', 3) 'Feeling out of place' with subtheme: 'Caught in the middle of different models of care, 4) 'A constant support for the parents across the labour and birth process' with subthemes: 'Acknowledging the parents' loss of their desired birth' and 5) 'The midwives' need for debrief'.

Conclusion: Midwives acknowledged the challenge of finding the balance between fulfilling parents' birth plan wishes with hospital protocol and maintaining safety. Transfer for fetal or maternal compromise caused anxiety and concern. The benefits of providing continuity of care were acknowledged by the midwife's knowledge of the woman and her history but these were not always recognised by the receiving team. Discussing the transfer story afterwards helped midwives review their practice. Effective communication between all stakeholders is essential throughout the transfer process.

Keywords: Midwife, intrapartum, transfer, continuity, birth centre, communication.

Introduction

Maternity care options have been under review over the last decade in Australia. The Reid Report (Reid et al., 2004) and The Report of the Maternity Services Review (Bryant, 2009) identified the need for improved choice and information about maternity care for pregnant women as a priority with a recommendation to increase access to birth centres (BC) and models offering continuity of care. The benefits of woman-centred care for low-risk women who birth at home or in BC are well established internationally, with women opting for these models experiencing more spontaneous vaginal births, fewer medical interventions and greater satisfaction (Brocklehurst et al., 2011; Hodnett, Downe, Walsh, & Weston, 2010; Walsh, 2008). Equally beneficial, the value of continuity of care models have been demonstrated to increase the feeling of being in control for women and to also provide greater overall satisfaction (Homer et al., 2002) as well as reduced levels of regional analgesia, episiotomy and instrumental birth (Sandall et al., 2013). Furthermore, these models have been found to increase satisfaction for midwives (Sandall, 1995, 1997) in addition to reducing health care costs (Tracy et al., 2013).

Midwives choosing to offer continuity of care in Western Australia (WA) have the option of working independently or in a group practice or team, either privately or under the umbrella of the Department of Health. One such model is a birth centre (BC), in WA, where low-risk women can labour and birth in a home-like environment. In WA in 2011, of the 31,734 women that gave birth, 1.2% were booked for midwife-led BC care (Hutchinson & Joyce, 2014).

In a BC setting it is expected that the majority of women will have a normal vaginal birth. However, a UK based study suggests that approximately 25% of women may be transferred to a referral hospital during labour (Rowe et al., 2011) and a New Zealand study (Patterson, Foureur, & Skinner, 2011) found the rate to be 17%. In this BC in WA between July 2013 and June 2014, the rate was in between. Of the 609 women booked to birth in the BC, 259 (43%) were transferred during the antenatal period to the tertiary obstetric unit (TOU). Of the remaining 350 women, 118 (19%) were transferred in labour leaving 232 (38% of the total bookings) birthing in the birth centre (L.Keyes, personal communication 10th October 2014).

Evidence suggests that intrapartum transfer may cause negative emotions for the woman and her partner who often face anxiety and disappointment amongst other emotions (Kuliukas et al., 2015; Rowe et al., 2012). However, the third party involved, the midwife's role is unevaluated; currently there is no published literature exploring their experience during such a transfer from a BC to a TOU. Although women and partner's experiences of intrapartum transfer have been explored, the midwife's experience in this scenario is missing.

Although generally not all midwives are women, in this BC all midwives are female and so are referred to as she/her.

Continuity of care models vary (Sandall et al., 2013), but in the case of the BC context in this study, the midwife meets the woman at 15-20 weeks of pregnancy, takes her antenatal history and is central to helping her plan for the birth. When transfer takes place in labour, the midwife who transfers with her from the BC to the hospital, is often in the difficult position of being aware of the importance of the woman's birth plan but now has to take action that is outside of the woman's preferences. This conflict and the whole process of transfer has the propensity to be traumatic for the midwife due to the need to make the decision in a timely fashion, advise the parents calmly but realistically, inform the receiving personnel, and arrange transportation. No research has been undertaken to highlight the reality of the BC transfer experience for the midwife.

Literature Review

Although there are no Australian or international studies exploring the BC to hospital transfer from the midwife's perspective, there are two recent international studies exploring midwives' experiences of intrapartum transfer from home to hospital. A qualitative English study, using phenomenological methodology, discovered five main themes (Wilyman-Bugter & Lackey, 2013). The ten midwives who were interviewed revealed difficulties surrounding 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. Their findings suggest that the midwife relies on confidence and expertise when making the decision to transfer and that this decision making may cause her fear and anxiety. The midwives suggested a need for openness and honesty to build relationships with parents in order

to foster trust, respect and confidence. The need for collaboration with health professionals was stressed, with a focus on communication, teamwork and support. The limitations of this study include the small number of midwives interviewed, as acknowledged by the authors. Another omission in the paper is the interval of time between the transfer and interview of the midwife. The length of time could influence the midwife's recollection of events.

A qualitative American study, researching the transfer experience from home to hospital in labour or immediate postpartum period interviewed and observed 24 transferring midwives and 16 receiving obstetricians (Cheyney et al., 2014). The American study authors acknowledged that obstetricians were more difficult to recruit which could have distorted results whereby being discontented was the cause of coming forward. The three main themes that emerged from the receiving staff related to the perceived danger of home birth, the concern of having to 'pick up the pieces' and the poor documentation and communication leading to costly delays. The first of three midwives' themes was the perceived lack of holistic care by receiving staff, the second focused on the bias of physicians and the third theme was midwives wanting physicians to have insight into the poor national obstetric outcomes rather than focusing on the small number of homebirth transfers. The findings from this study highlighted the need for mutual respect and communication between the homebirth midwives and the receiving hospital staff.

The findings from these two international studies provide insight into the challenges midwives face during transfer from home to hospital but neither is wholly related to an Australian setting. They do demonstrate how the challenges vary between international healthcare contexts. The difference between contexts reinforces the gap in knowledge and the need for a study to explore the experiences of Australian midwives when transfer from a BC to a TOU occurs. Insight into midwives experiences will inform midwifery knowledge as well as facilitate collaboration between health professions.

Subjects and Methods

A qualitative design was chosen due to its characteristic flexibility and holistic approach which strives for understanding of the whole experience (Polit & Beck, 2010) and the subjective description from participants' words to gain rich data and

insight into human experiences (Liamputtong, 2010; Schneider et al., 2013). To capture the lived experience of intrapartum transfer from midwives' perspectives, a descriptive phenomenological study design was chosen as it is based on recognition that "participants have lived through an experience from which relevant opinions, values or beliefs have emerged" (Schneider et al., 2013, p. 106). In this study, the phenomenon was *the intrapartum transfer*, as described from the midwife's perspective. In order to elicit personal perceptions and descriptions of the experience, in-depth interviews were conducted (Polit & Beck, 2010) .

The study setting was a midwife-led birth centre in WA, which is in a separate building but adjacent to the TOU. The BC provides a home-like environment in order to enable women to feel more at ease so that stress hormones are reduced and the chance of normal progress of labour is enhanced (Fahy, Foureur, & Hastie, 2008). In this BC women were allocated to a small group of 5 midwives who provided on-call midwifery care across the continuum of antenatal, intrapartum and postnatal care. The aim of this model of team midwifery was that the women would meet all 5 midwives in the group during the antenatal period in order to increase the probability of being cared for by a known midwife in labour. This enabled the development of a relationship between the woman and midwives in order to build trust and respect for birth and the postnatal period. During antenatal appointments and in childbirth education classes, couples were educated about the choices they can make and were encouraged to carry out their own research to support information already provided to facilitate their desired pregnancy and birth experience. The reasons for and rates of transfer were also discussed in the antenatal period and a tour of the tertiary labour ward offered to prospective parents in order to reduce anxiety and increase familiarity in case transfer in labour was to take place.

The inclusion criteria for study participants were midwives who cared for women in the BC who were transferred to the TOU intrapartum and then stayed with the woman and her partner for the remainder of her labour and birth or until her shift ended. Ethical approval was obtained from the University's Human Research Ethics Committee (HR91/2013) and the Hospital Human Ethics committee (2013031EW).

The first author was a peer of the midwives recruited to the study, being employed at the same level of the BC midwives. The potential ethical impact of this was considered

including the question of bias. The conclusion reached was that because the author was not at manager level it was unlikely that there would be any impact on the participants or author, including future relationships and roles. Sampling was purposeful (Patton, 2005) with the first author approaching midwives employed at the BC from July to October 2013, who were involved in the care of a woman who was transferred in labour and agreed to share their experience of that woman's transfer from the midwife's perspective. All midwives who were asked to be interviewed agreed.

An information letter was provided to the midwife and consent gained for participation in the study. Individual face-to-face interviews offered the opportunity for midwives to give a narrative of their experiences (Polit & Beck, 2010) and started with this open ended question, "Tell me your story of this woman's birth from the moment of first contact with her in labour until she returned to the birth centre after the birth or you left her in someone else's care."

The first author carried out 17 interviews with midwives, in a quiet, private room in the BC. To aid recall all interviews took place within one week of the birth, apart from one where the midwife went on annual leave soon after the birth; this interview occurred four weeks after the birth. The woman's medical record was made available for the midwives prior to and during the interview to serve as a reminder. The interviews were digitally recorded and transcribed verbatim on the day the interview took place. Transcription was carried out by the first author in order to maximise immersion in the data. The transcriptions were read whilst simultaneously listening to the digital recordings at least three further times to ensure accuracy. Interviews ranged from 15 minutes to 45 minutes, with 14 lasting for more than 25 minutes. Field notes were made at the end of each interview adding midwives' comments which were made after the digital recorder was turned off. To reduce bias and enhance confirmability, once coding had been completed by the first author the interviews were then divided and coded independently by the three other members of the research team in order to corroborate the themes to ensure validation, referring back to the data for any discrepancies (Polit & Beck, 2010).

Recruitment ceased once data saturation was achieved, which occurred after 14 interviews. However, a further three interviews were conducted to confirm data saturation, resulting in 17 interviews (Schneider et al., 2013). Transcripts were

managed with NVivo 10 and employed Giorgi's descriptive phenomenological methods of analysis (Giorgi, 1975). Giorgi's method focuses on descriptions of individual experiences and consists of four steps including immersion in the data, identifying "meaning units," data reduction and formation of themes and subthemes (Giorgi, 1997, p. 12). Finally Giorgi (1975) suggests putting the focal question to the data to ensure themes relate directly to the phenomenon, which in this case was 'What does this tell me about midwives' experience of *transfer*?' This process assisted with the generation of themes which were synthesised into definitions regarding the experience and linked to direct quotes, illustrating the rich story of the midwives' lived experiences. This process is similar to the "fracturing, grouping and gluing" style commonly referred to in qualitative data analysis (Schneider et al., 2013, p. 145).

Findings

This study was part of a larger project exploring the experiences of all three participants of an intrapartum transfer; the women, her partner and the midwife. Because the triad of experiences of each birth journey was being explored, some midwives were interviewed for more than one triad/transfer so although 17 interviews took place, only ten midwives were involved. The midwives' employment history of clinical midwifery experience varied, with one midwife having less than three years' experience of which 6 months had been spent in the BC. Of the remainder, two had less than 10 years' experience, with at least 2 years BC experience and the rest had been BC midwives from 7 to over 25 years. The midwives had qualified and previously practiced in Australia (5 midwives), Britain (3) and New Zealand (2). One of the midwives was also a lactation consultant and one was undertaking a post graduate education certificate.

Thematic analysis was carried out as the data was collected and coded. The coding tree, made up of the initial 28 meaning units (nodes in NVivo) was reduced and the nodes grouped into five themes and four subthemes by merging similar data. These themes reflected the wide variety of experiences the midwives faced on this journey and revealed that midwives found transfer in labour challenging, both emotionally and practically. These experiences included feeling under pressure, needing support, feeling out of place, providing continuity, and having an awareness of their own need for debrief (Table 1.). A coding system for each interviewee was implemented (Int1 to

Int17) and will be used with quotes noted in italics to demonstrate trustworthiness and credibility of the findings.

Themes

Table 1. Themes and subthemes around midwives' experience of intrapartum transfer

Themes	Subthemes
The midwife's internal conversation	Feeling under pressure
Challenged to find a role in changing circumstances	Varying degrees of support
Feeling out of place	Caught in the middle of different models of care
A constant support for the parents across the labour and birth process	Acknowledging the parents' loss of their desired birth
The midwife's need for debrief	

The midwife's internal conversation

The first theme emerged from the process leading up to the transfer which contributed to the midwife's internal dialogue analysing the path of labour: *Should we stay or should we go?* (Int 10). She played out different scenarios in her head as labour fluctuated from the edge of normality into areas of concern. The dilemma of making the decision was revealed by Int2: *It kept changing... It was sort of okay, shall we transfer, okay, maybe we can stay a bit longer, oh, now she's shaky maybe we should transfer, oh no she's well again...* This concern regarding decision making on the right time to go was described by Int17: *A few things going on in my mind ... it was a matter of time before the baby started showing signs of stress and then we would be in a more urgent scenario as opposed to one where we could do it more gently and relaxed.* A similar picture was illuminated by Int12 who described the inner conflict over making the decision: *You feel guilty; you think ... can we give her another five minutes? Can we stretch it out?* The need to listen to intuition was acknowledged by Int9 who talked about her internal alarm bells: *Those bells, they were ringing... and even though she had only really been doing active pushing for three quarters of an hour, I just said there is something not appropriate here, I think we need help.*

Feeling under pressure

Timing was of the essence and one of the reasons for the subtheme, feeling under pressure, was the ticking clock once the decision to transfer has been made. The need to get to the tertiary referral centre as soon as possible created a feeling of tension and anxiety, as explained by Int1: *The worst thing was waiting for the registrar to call back. You know, once you want to transfer, you want to transfer. You're hopping by the phone waiting when you know the fetal heart isn't good.* Equally there was a feeling of panic in getting the transfer organised and carried out in a timely fashion, whilst also allowing time for explanations to the parents and getting the documentation up to date, as Int12 depicted: *You're waiting for the orderly, you're trying to placate the parents who have lost their birth dream, you're trying to get the documentation together.* As well as the panic there was also a worry around professionalism; Int5 expressed the worry of 'looking bad' for not transferring in a timely fashion: *The clock is ticking now and her second stage is getting longer and longer...it looks bad. You know questions will be asked but ... calls have to be made and pagers have to be answered, we actually can't get over there in five minutes.*

Challenged to find a role in changing circumstances

The second theme became apparent as the transfer eventuated and the midwife found herself in a changing situation where her role was redefined. In the BC she was the primary carer and decision maker but when transfer occurred, the responsibility shifted to the medical team. Her role was uncertain; some midwives considered that they should continue to be the primary midwife whereas others felt they should be more of a support person and focus on being 'with woman'. However they were often unable to because of having to focus on other duties, as Int7 stated: *It changes because here [in the BC] the focus is on the woman and her partner ...but when you transfer ... I really feel my care was compromised because of the extra duties that I needed to do instead of concentrating on the couple's experience.* The need to be 'with woman' was corroborated by Int2 who pondered: *If I was her what would I want? I would want someone that I know standing by my side explaining what's happening, why it's happening, keeping me calm ...and I think I can do that role incredibly well.* There also appeared to be confusion about the role the transferring midwife was expected to undertake from the perception of the different receiving staff members, as described by Int2: *It was an interesting dynamic because the coordinator was pushing me to*

remain as the main care provider but the doctor was pushing for... 'lay her on her back, get her in the stirrups'... I can never work out where I'm supposed to be. An increasing feeling of invisibility was also raised by Int16 who felt her inside knowledge of the woman was not acknowledged by the receiving team: I see my role... I should just leave them at the door, they don't seem to listen to me anyway and there are no questions asked of me it's just... it's like you're invisible. The value of knowledge of the woman's history was reiterated by Int17 who suggested: I think I would like to be... seen as someone who has a lot to offer in terms of advice and background to the case.

Varying degrees of support

When the BC midwife arrived at the TOU her reception led to the subtheme, varying degrees of support. The BC midwife found herself feeling sometimes very well supported, sometimes unsupported, other times feeling judged or useless. These perceptions were often dependent on how she felt she had been received by the labour ward team which, in turn, was often influenced by how busy the ward was. When TOU was busy the role of advisor or 'with woman' support was considered extravagant, as recognised by Int7: *If it's busy it's even worse because there's no one to help you... I think the stress of not being helped is huge.* However the acuity of TOU could not be blamed for some BC midwives who felt that their professional judgement was questioned; Int9 felt she had no role to play: *At that point I wanted to leave, I really really really wanted to leave because I was just... I just wanted to be not here. I was feeling like they were saying that I was completely incompetent.*

In contrast to experiences of feeling unsupported, there was appreciation by some midwives for great collegiality, as voiced by Int14: *The [TOU] midwives were fantastic ...amazing, we had three or four midwives waiting for us upstairs, helping us get everything set up.* A similar experience was described by Int15: *And then the midwife did come in ... and she was lovely, she said if you need anything give me a shout.*

Feeling out of place

The midwife has had to leave her area of familiarity, where she was in her home environment and go to an area to which she is less well acquainted which highlighted the third theme of feeling out of place. The setting was less well-known and procedures

and the location of equipment could be challenging. The atmosphere had changed from one of tranquillity to one with an air of urgency and she was out of her comfort zone which could lead to feelings of inadequacy, outlined by Int12 as she tried to find essential equipment in an unfamiliar place: *You just feel like you can't find anything that you need, so you feel, inadequate and ... I'm looking like a headless chicken ... not great.* The escalation of stress caused by inability to find equipment was described by Int7: *So I ran from room to room looking ... I was cognisant of the fact that the woman was in there by herself, the monitor was not even on properly, with the Reg [registrar] waiting there.*

Caught in the middle of different models of care

The BC midwife had to deal with the impact of differences in practice between the BC and TOU models of care and be able to offer explanations to the parents as to how and why their plans had to change. The subtheme, caught in the middle of different models of care, reflects how the midwife became aware of the different pressures the woman was under and the different practices she had to face. One midwife (Int17) described bearing the brunt of the fallout from couples who now faced a different pathway: *And of course I was left picking up the pieces of that; I had to deal with the questions.* Several midwives felt parents were swayed into making decisions against their wishes, including Int 7: *They were being quite forceful about her needing antibiotics, telling her about the fact the baby could die... not what you want to hear when you're in labour, particularly when you'd already made an informed choice not to.* As this situation continued Int7 attempted to advocate for the couple: *I said that they weren't keen for the antibiotics and she [registrar] said well do you know, babies die of GBS [group B streptococcus]? The difference in practice caused many midwives to struggle, particularly when they perceived the parents' wishes weren't taken into account, as Int3 noticed: *The cord was clamped and cut straight away and he [partner] was offered to, but shrugged his shoulders and declined, as if to say what's the point? Everything else has been taken out of our hands, why offer me this token?**

A constant support for the parents across the labour and birth process

The fourth theme captured the constant support the midwife felt that her presence offered during and after the transfer process to reassure the parents and contribute to a more positive experience. She acknowledged the benefit of continuity of philosophy of care, certainly from the woman's perspective before and during labour. The

importance of continuity to women was pointed out by Int1: *I'd met her before a couple of times in the clinic. I know it makes a difference for them. Women think it's important to know the person that's going to be looking after them.* Similarly Int5 voiced her satisfaction when she was able to hand over care to another BC midwife at the end of her shift on labour ward: *That was another birth centre midwife, so great for continuity, exactly what she needed, someone on the same page, who knew what she wanted and how to help her best to try to achieve it.*

Maintaining continuity by returning couples to the birth centre following the birth was seen to be advantageous due to returning to the known environment and known midwives providing postnatal care, as acknowledged by Int2: *They were delighted to get back down and for me it was kind of lovely to be able to bring them back to where we came from,* and reiterated by Int3 : *and that was a really big positive for them, I think that made a big difference that they could have their postnatal care here [BC].*

Acknowledging their loss of their desired birth

Disappointment from the parents in losing their planned birth was recognised by the midwife in the fifth theme acknowledging this loss and the role she played in this reality. The upset caused by making the decision to transfer was illustrated by Int12: *A little bit shocked, a little bit worried, little bit anxious, she really didn't want to go. 'I just want to get back into the bath' and I had to explain that that really wasn't an option. And that's hard delivering that.* Some midwives described a feeling of standing on a 'knife edge', caught between what the parents wanted and the need to stay safe: *On the edge you know because you're kind of, you're aware that she doesn't want to transfer* (Int2). The reality of a complete change of birth plan was voiced by Int17: *She had the hypnobirthing tape going and she thought she was going to breathe her baby out ... so there are few things going on in my mind but I had to speak about my concerns and had to say it was time we consider transferring.*

The midwives' need for debrief

The final theme reflected the need to debrief although working practices in the BC meant that the opportunity to debrief did not exist in a formal capacity. Many of the midwives acknowledged that often an informal debrief occurs during handover or in the tearoom, but that it's not always a reflective exercise. *You do it informally as in when the next midwife comes on, but you're not doing it necessarily to reflect on it or*

to learn from it, you're kind of almost doing it just to share a story (Int12). The process of being interviewed for this study was commended by several midwives It's useful. Sometimes it all goes on in your head but we don't actually verbalise it and until we verbalise it sometimes it doesn't make sense. No it's really positive (Int17).

The need to rationalise and learn from the experience was acknowledged as a way to move forward and help enhance practice. *It's useful to know what you could have done differently and ask opinions of other people (Int13) and To talk through different strategies and what would you have done at that point? (Int3).* Another important realisation was the need for honesty when debriefing or discussing cases with colleagues; having a true awareness of being analytical of practice, as clearly demonstrated by Int2: *To articulate that you are analysing your own practice and to be honest and open to some judgement.* The reality of needing to make time to debrief was highlighted by Int 4: *We don't do enough debriefing and analysis of cases, we should really do it as a matter of course for all our transfers...it's time I suppose, like everything else.*

Discussion and Recommendations

The main findings were that intrapartum transfer for fetal or maternal compromise contributed to anxiety and concern for midwives. Midwives acknowledged the challenge of balancing parents' wishes with hospital protocol and providing safe care. The benefits of the relationship of trust by providing continuity of care were acknowledged, however the midwife's previous knowledge of the women was not always taken advantage of. The change of environment from the familiar BC to the TOU brought with it a change in the midwife's role which caused confusion. Midwives demonstrated a wish to be provided with opportunity to debrief in order to review their practice.

The need for clear communication was demonstrated throughout the intrapartum transfer. Initially as the need for transfer became obvious the midwife was required to inform the parents while bearing in mind that the birth they had planned for had ended. This can be a difficult dialogue to manage and in this situation midwives carefully consider how they phrase their language in order to effect the outcome they wanted. Midwives commented on spending time reassuring parents and managing their disappointment whilst internally feeling angst because of the need for timely

management of clinical matters. This leads to the question of how best to prepare the couple. For women planning to birth in a BC environment preparation for a potential transfer could take place during antenatal appointment time, when sharing and support can be offered and parents can voice their own concerns. This strategy may prompt parents to consider the prospect of their planned birth not being realised and help them determine what could assist them to come to terms with this different birth journey (Creasy, 1997).

The next point of the transfer journey involves the midwife's need to communicate her intention to the receiving team on LBS, which is enhanced when there is mutual respect and supportive leadership (Cornthwaite et al., 2013; Wilyman-Bugter & Lackey, 2013). There is often a sense of urgency and in this WA study this part of the transfer had the propensity to cause frustration due to time-wasting whilst waiting for pages to be answered and phone calls to be returned. We recommended a simplification of the process whereby one phone call informs all appropriate personnel that a transfer is imminent, which would allow the BC midwife time to update documentation, inform and reassure parents.

A need for excellent communication continues on arrival at TOU where the midwife's knowledge of the woman is a valuable resource for the receiving team (Cheyney et al., 2014). In this WA study midwives often felt their history with and knowledge of the woman was not utilised. Cheyney, Everson and Burcher (2014) recommended that this knowledge should be recognised to facilitate ongoing care.

The role of the transferring midwife varied with some midwives feeling better placed in a supporting and advocating role rather than as the primary midwife due to a lack of confidence in an unfamiliar environment. Others felt devalued by hospital personnel. A culture of fear of being devalued or belittled was also revealed in an American qualitative study (Cheyney et al., 2014) which described every clinical encounter as a "cross-cultural interaction" (p 453) and suggested that "smooth interprofessional collaboration" (p 452) could be enhanced in several ways resulting in "mutual accommodation and smooth articulations" (p 454). Communication and respect were considered to be the key with acknowledgement from both groups of staff of each other's expertise and the combined desire to facilitate the best outcome for the woman and baby. They also sought appreciation of the woman's possible viewpoint

that any perceived devaluing of the midwife by hospital personnel may be seen by the woman as a criticism of her birthing choices. Respectful communication on all fronts is therefore recommended to enhance information sharing and prevent women from feeling alienated (Cheyney et al., 2014). The extension of professional respect to include acknowledgement and respect for the woman's birth choices would also lead to the reduction of the use of scare tactics by the receiving team in order to facilitate true informed consent (Chase, 2003; Cheyney et al., 2014). This type of coercion was voiced by the WA midwives' who sometimes felt that the parents' wishes were not respected. Although major birth plan variations such as such as requirement for caesarean birth were unavoidable, midwives perceived that the decisions or choices made by women antenatally, such as delayed cord clamping or declining antibiotics for ruptured membranes, were not respected. We recommend that the receiving team respect and accept the parents' wishes as written on the birth plan rather than try to alter or dismiss their view during a vulnerable time.

Continuity of care is known to increase satisfaction for women (Tracy et al., 2013) and in cases of intrapartum transfer women are known to experience a sense of abandonment in cases where their midwife is unable to stay with them (Lindgren et al., 2011). These WA midwives were able to continue care when the women were transferred which they voiced as being of benefit to the women. The transferring midwives felt their knowledge of the woman and her wishes meant that they were being advocated for and facilitated as far as possible. However conversely one disadvantage of continuity of care is that the transferring midwife is not always familiar with labour ward equipment (Kuliukas et al., 2015). We recommend that scheduled re-orientation sessions for transferring midwives are therefore indicated, as well as mindfulness that extra support may be required from core labour ward midwives (Kuliukas et al., 2015).

The value of debrief after birth is well documented for women (Gamble et al., 2004) however, a need for midwives to reflect on specific cases was revealed in this study. The effect of debrief on staff perceptions of women's safety is considered by Ackenbon et al., (Ackenbom, Myers, Schwartz, Beshara, & Srinivas, 2014) who state that when practiced in a group setting it improves staff openness which in turn directly correlates to improved safety culture and outcomes.

Limitations

The experiences of these WA midwives may not reflect those of other midwives, working in woman-centred, midwife-led low-risk models of care, in different contexts and must be considered a limitation. However rich description has been provided to assist the reader determine the potential transferability of these findings to other birthing contexts.

Conclusion

Intrapartum transfer from a midwifery-led, low risk continuity of care model to a tertiary hospital causes a variety of emotions for the transferring midwife. These include the anxiety regarding the timeliness and facilitation of transfer, the requirement to work in an unfamiliar environment under a different model of care and the awareness of being unable to help the woman achieve the birth she hoped for. Recommendations have been offered to improve professional communication and support both at time of transfer and the use of reflective debrief as a learning exercise after the event.

Acknowledgement

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Summary

This chapter presented the final version, after addressing reviewers’ comments, of the manuscript regarding midwives’ experiences when intrapartum transfer takes place.

The next chapter presents the final version of the publication regarding the triad of all three perspectives, the woman, partner and midwife, when transfer in labour occurs from a birth centre to the neighbouring referral centre.

Chapter Seven: A Triad of Experiences

I was quite open to some kind of assistance at that point. I was really tired and didn't know what was going on and I was like, if I'm pushing but nothing is happening, what does that mean? (Woman, Triad 2)

I was reluctant (to transfer) really, maybe we should think about another strategy, I was thinking we should keep going. (Partner, Triad 2)

I feel like a pressure cooker. I feel like I'm going to explode with all the conflicting worries. Worried about making the right decision, worried about getting over there without too much delay, worried about not being efficient enough when you get there. (Midwife, Triad 2)

This chapter provides the final manuscript of the published paper on the comparative journeys that the triad of participants experienced. The findings demonstrated that while each had their own distinct journey there were areas where they felt similar emotions. The manuscript presented here is the final publication for this thesis and has been subject to addressing the reviewers' comments for the peer reviewed journal it was published in.

Reference: Kuliukas, L., Hauck, Y., Lewis, L. & Duggan, R. (2016). The woman, partner and midwife: an integration of three journeys of intrapartum transfer from a birth centre to a tertiary obstetric unit. *Women and Birth*, 30(2) ppe125-131 ISSN 1871-5192 DOI 10.1016/j.wombi.2016.10.008

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

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.

Introduction

Summary of relevance

Problem

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.

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 (Callister, 2004). The overall experience changes if her birth plan is not realised due to problems occurring during labour (Kuliukas, Ritchie, Lewis, & Hauck, 2013; Walker, 2000). 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 (Creasy, 1997; Lindgren et al., 2011). 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 (Johansson et al., 2012; Kuliukas et al., 2015; Kuliukas et al., 2016c; Steen et al., 2011). 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 (Kuliukas, Duggan, Lewis, & Hauck, 2016a; Kuliukas et al., 2015; Kuliukas et al., 2016c). 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).

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 (Hutchinson, 2015). 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 (Cunningham, 1993). However labour does not always progress according to plan and women and partners can be confronted by the unexpected when intrapartum transfer becomes necessary (Creasy, 1997; Kuliukas et al., 2016a; Kuliukas et al., 2015; Kuliukas, Hauck, Lewis, & Duggan, 2016b; Lindgren et al., 2008; Rowe et al., 2012; Walker, 2000).

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 (Creasy, 1997), confirmed that these overwhelming emotions were experienced by 12 women. Another mixed methods Swedish study (Lindgren et al., 2008) 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 (Rowe et al., 2012; Walker, 2000). 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 (Dahlen et al., 2010; Nichols, 1993;

Somers-Smith, 1999). Partners of women choosing to birth in a birth centre have been acknowledged as feeling more involved in the care (Waldenstrom, 1999) however, this increased involvement may contribute to the range of emotions that have been described when the anticipated path of labour changes (Kuliukas et al., 2015). 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 (Kuliukas et al., 2015).

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 (Patterson, Skinner, & Foureur, 2015) whilst reassuring the parents and facilitating the transfer which can, according to recent American and English qualitative studies, cause stress (Wilyman-Bugter & Lackey, 2013) and fear (Cheyney et al., 2014). 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 (Wilyman-Bugter & Lackey, 2013). 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 (Cheyney et al., 2014). 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 (Kuliukas et al., 2016). 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 (Cheyney et al., 2014; Kuliukas et al., 2016; Wilyman-Bugter & Lackey, 2013).

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.

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 (Brocklehurst. et al., 2011; Hatem et al., 2008; Rooks et al., 1989). 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 (Giorgi, 1997).

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 (Giorgi, 1997) 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 (Ahern, 1999). 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 (Polit & Beck, 2012), with participants recruited in the birth centre or hospital postnatal ward. If the woman was discharged prior to recruitment, the woman and partner was contacted by telephone within four weeks post birth. The midwife was contacted and interviewed as soon after the birth as possible and clinical records were made available to prompt reflection of the journey with that particular couple. An information letter was provided and consent forms signed prior to conducting

interviews. Demographic information such as name, contact details, age, educational level, reason for transfer and type of birth was collected from the partner and woman's medical record and midwife details such as length of midwifery experience were gathered.

All interviews apart from two (partners) were face-to-face interviews in order to truly understand the narrative of their experiences. The interviews were conducted privately, in the participants' home or, for the midwives, in the birth centre. Triad members were interviewed individually, in order to minimise the influence of the other two members and to enable capturing of each participants' authentic journey. All interviews took place within 8 weeks of the birth, forty-one within 4 weeks, in order to aid recall but at the same time also allowing participants time to reflect on the experience.

The interviews followed a story-telling style beginning with a broad opening question asking for a description of the whole journey, followed by open ended prompts to encourage the participants to describe their feelings during each phase of the overall experience. The interviews were audio taped and transcribed verbatim. Each interview was listened to three further times and checked against the transcription to ensure accuracy. One interview lasted 15 minutes but all others were 25 to 65 minutes. A reflexive diary was completed after each interview to describe any notable observations, including comments made after the recorder was switched off (Polit & Beck, 2012).

Analysis involved the use of NVivo 10 to manage the data and employed Giorgi's descriptive phenomenological method of analysis. (Giorgi, 1975) Giorgi's method was chosen because it focuses on descriptions of experiences and suggests consideration be given to the same phenomenon as it manifests to each individual (Giorgi, 1970). Each group of transcriptions were separated into NVivo nodes which formed a recognisable aspect of the individual's experience. Comparison was then made between the three node groups and it became obvious that there was an integration of themes of the three parties demonstrating some similarities of experiences. Some themes were shared by two of the parties and there were individual themes indicating singular experiences. The themes were then mapped out in a triad triangle (Figure 1.) representing similarities and differences and linked to direct quotes in order to demonstrate the richness of stories (Giorgi, 1975).

To reduce bias and enhance confirmability (Polit & Beck, 2012), comparisons of the three node groups was also independently performed by the three other members of the research team. Similarities were found by all team members although negotiation and refinement occurred to confirm findings accurately reflected the integration of experiences. The team were female, clinical or academic midwives.

Findings

Data collection was in the form of interviews with a total of 45 individual interviews took place, making a total of 15 triads (women, partners and midwives) which, according to Giorgi forms sufficiency of data (Giorgi, 2008). It was considered that sufficiency was reached when the narratives appeared to have revealed full and comprehensive interpretations of events with as much variation as possible and also beginnings of repetition were being heard. Eleven primiparous and four multiparous women participated. Maternal ages ranged from 22 to 38 years (mean 31 years), and partners were 24 to 39 years (mean 33), with 13 couples having a tertiary level education. Eleven midwives were interviewed for the 15 birth experiences: four were interviewed twice for their experience with two couples. Midwifery experience ranged from 1 to 30 years (mean 18 years) with an average of 6.7 years (0.5 to 20 years) in a birth centre. The coding system for quotes from triads 1-15 (T1-15) are separated for women (W1-15), partners (P1-15) and midwives (M1-15).

Integration of the journeys of the woman, partner and midwife

Asking about the whole labour and birth journey allowed each participant to describe their own individual pathway giving rise to different views or perceptions of the same experience. Analysis took place as described above by comparing the 3 node groups from 3 sets of qualitative data against each other, revealing integration of similar experiences. Figure 1. illustrates how the experiences of triad members are pulled together whilst they simultaneously have a singular unique view. The three subthemes within the integration of the triad experiences were: 'In my own world', 'Talking about the birth' and 'The same journey through three different lenses'.

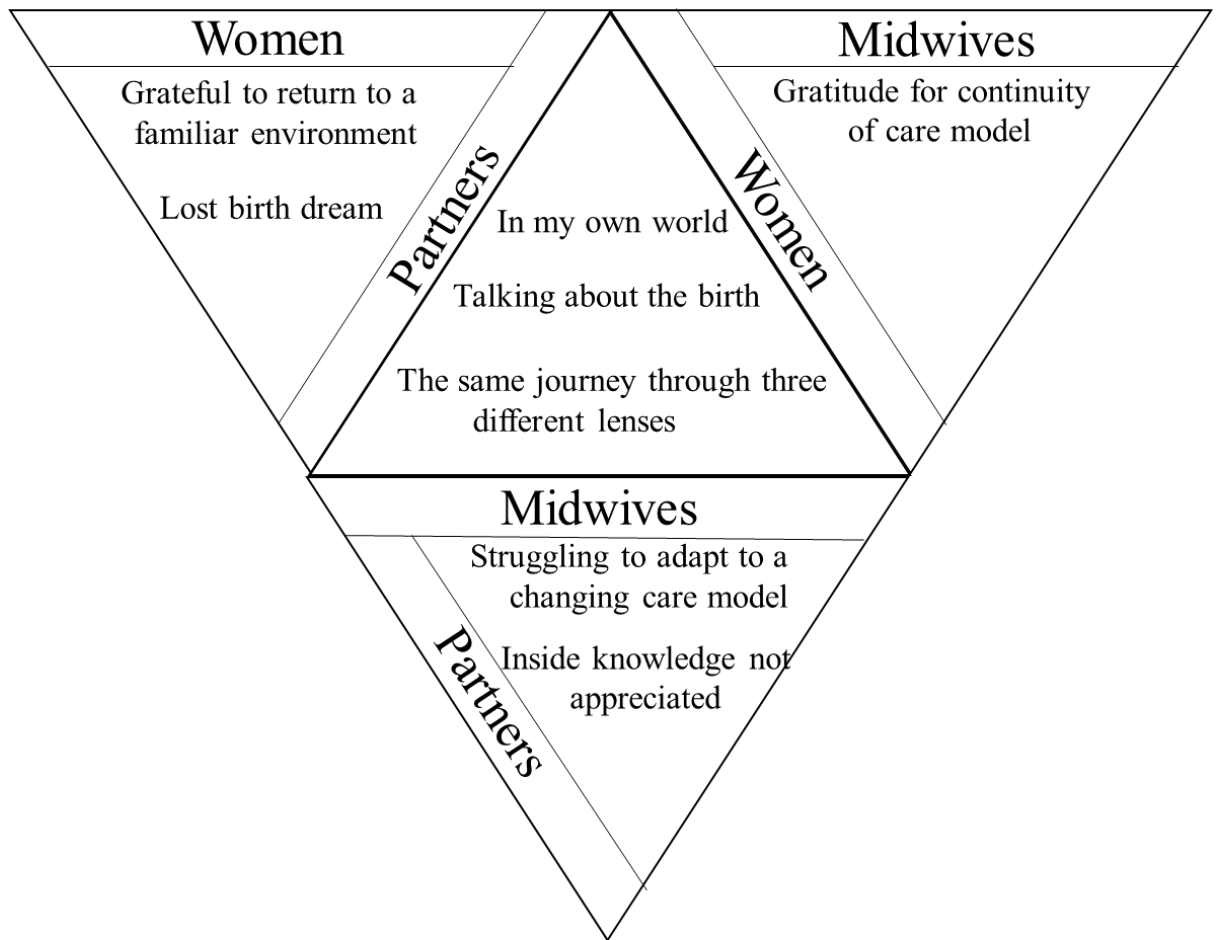


Figure 1. The triad of integrated experiences with subthemes shared by all participants with corners of the triangle representing experiences shared by two parties

In my own world

‘In my own world’, emerged from each triad member being immersed in their own emotions. The woman’s body, full of endorphins and oxytocin, took over the business of birthing whilst she was inwardly focused. The partner’s perspective was influenced by his high levels of anxiety and stress causing the ‘fright/fight/flight’ mode which resulted in a level of high alertness and sensitivity to what was happening. The midwife’s perspective resulted from a sense of responsibility to ensure the parents were provided with what they desired while simultaneously feeling incumbent to ensure a healthy outcome.

The reality of each experiencing an inner world was demonstrated by Triad 10 as each gave a typical report of these three perspectives. The woman described how she had little recollection of certain events because of being ‘in the labour zone’: *I can’t remember a lot you know... I had no concept of time or of anything that was going on*

around me... I was just on another planet really. It did feel like I wasn't really there (W10). In contrast her partner remembered with great clarity his emotions watching his wife during her prolonged labour: *I had a feeling all the way along ... it's not going to plan. I was just really concerned about B being so exhausted It just felt I mean the whole thing was agony really* (P10). While these thoughts were going on for the woman and her partner, the midwife was having her own internal conversation, completely immersed, wondering why there was no progress in the second stage. She carried out a vaginal examination and said to herself: *There was a heap of caput, heap of moulding, and I thought, blow, anterior fontanelle sitting at sort of 2:30 and it's like, hang on, where's my posterior fontanelle gone? My lovely little tiny triangular posterior fontanelle where are you* (M10)?

Talking about the birth

The second overlapping subtheme between all three parties was an appreciation that talking about the birth afterwards was worthwhile. Women felt that because they were often 'in the zone' for their labour and birth they needed the space afterwards to clarify what had actually happened, as W8 commented: *I mean no one came and told me what happened with the operation (manual removal of placenta) afterwards so it would have been nice ... for them to come and say why that happened. It would have been good to get some clarity* (W8). This was reiterated by W11: *It is good to talk about the experience, it helps clear things in your head* (W11). Partners felt the need to de-stress by talking through what was clearly, for some, a harrowing day, as P10 stated: *I definitely found it a bit traumatic ... I was so surprised with how intense the whole saga is... It's good to talk about it.*

Midwives talked about informal debrief that takes place on a daily basis, as described by M12: *You do it informally as in when the next midwife comes on.* However, other midwives, like M13 felt it should be a learning exercise, for midwives to be able to discuss which and when actions were taken: *It's useful to know what you could have done differently or ask opinions of other people. After this case I wasn't sure whether I did do the right thing or not* (M13). Helping to clarify the labour pathway by talking afterwards about it was reiterated by M9: *It's useful, until we verbalise it sometimes it doesn't make sense.*

The same journey through three different lenses

For each triad member, intrapartum transfer within the labour experience was an eventful and emotional journey, with each seeing it from their unique perspective. The women's perception was influenced by feeling exhausted and in pain whereas the partners' view came out of a sense of protectiveness, being out of their comfort zone but sometimes unable to be realistic in their expectations. The midwives' view was influenced by their satisfaction in providing care based on experience and intuition but involving periods of stress when considering whether they were making the right decision at the right time. For example, contrasting emotions and perceptions were felt by each member of Triad 2, each focused in on their own inner turmoil. The midwife felt stressed at the responsibility of everything that needed to be organised for the transfer:

I feel like a pressure cooker. I feel like I'm going to explode with all the conflicting worries. Worried about making the right decision, worried about getting over there without too much delay, worried about not being efficient enough when you get over there (M2).

The partner's inner emotion was frustration at not being given more time to try to allow for further progress: *I was reluctant (to transfer) really, maybe we should think about another strategy, I was thinking we should keep going* (P2). In contrast the woman had reached her limit and felt relieved at the thought of transfer: *I was quite open to some kind of assistance at that point. I was really tired and didn't know what was going on and I was like, if I'm pushing but nothing is happening, what does that mean* (W2)?

Integrated themes between two parties

As well as the integrated themes between all members of the triad there were overarching themes made up of shared experiences between the other member pairs: the woman and partner, the woman and midwife and the partner and midwife.

Integration of woman and midwife

The emerging subtheme from both the women and midwives' perspective was an appreciation of the continuity of care model.

Gratitude for continuity of care model

Midwives appreciated knowing the women and having the opportunity to see them through the birth journey. Equally women were grateful to be cared for by someone who followed the philosophy of woman-centred care, as W1 stated: *I hoped that if it happened the midwife would be able to come with us because we knew she would be on our side and speak up for us, I felt all the birth centre midwives would know what we wanted.* The midwife caring for W1 clearly felt the same way as she independently commented: *I'd met her before a couple of times in the clinic... I know it will make a difference for them. I think women think it's important to know the person that's going to be looking after them* (M1). Even in situations where the same midwife was unable to stay for the birth, midwives were able to reassure women that another birth centre midwife, with the same philosophy of care would be able to take over, for example M8: *I said to her look, my shift ends at seven so ...the lovely C (midwife) will be up, and she'll support all of the choices that you've put in place* (M8). The appreciation of having care followed through by someone with the same philosophy was commented on by W7 who was cared for by a team member she hadn't met before: *I met all of the midwives in my team apart from M (midwife), I didn't mind though because I knew she would have the same philosophy around birth centre care, natural birth and all that* (W7).

Integration of partner and midwife

The subthemes shared by the partner and midwife were 'Struggling to adapt to a changing model of care' and feelings of 'Inside knowledge not appreciated'.

Struggling to adapt to a changing care model

The two 'onlooking' triad members, the partner and midwife, shared how they found it difficult to adapt from one model of care and environment to another. The feeling of having to conform in the tertiary obstetric unit was noticed by M12: *Can we... take off the CTG because she's back to normal... but we're up here now, so that's a bit tricky.* Conforming with tertiary obstetric unit practice also meant loss of choice as noted by P3 who became disgruntled as preferences were taken away. Finally when the baby was born he was denied cutting the cord: *I would like to have cut the cord but that offer was never extended to me either so ... I was angry at the junior doctor* (P3).

Inside knowledge not appreciated

The second subtheme shared between midwives and partners was: Inside knowledge not appreciated. Some partners had a sense of being able to read their women better than anyone else and this extended to knowing when the woman had reached her limit of endurance, as P3 pointed out: *I noticed a real struggle for her... her eyes were kind of wandering and she looked just like she was on drugs...you're struggling, we're going to bring you upstairs ... in the end it was me that made the decision.* The midwife's perspective of 'inside knowledge' was about the woman's history and events leading up to the transfer; vital knowledge that some midwives did not think was taken advantage of, for example, M15: *They don't seem to listen to me... no questions asked of me.* Similarly M9 felt that the transferring midwife's role should be clarified as the advisor, the one with the history and knowledge: *An adviser, being seen as someone who has a lot to offer in terms of advice and background to the case.*

Integration of woman and partner

The subthemes shared by women and their partners were that they were 'Grateful to return to the familiar environment' of the birth centre after the birth and secondly the importance of reflecting on their 'Lost birth dream'.

Grateful to return to the familiar environment

After the birth most couples were able to return to the birth centre which enabled them to close the loop. Returning felt like going home to familiar territory where they were at ease; an aspect of care that was really appreciated, as P1 voiced: *We were able to go back to the birth centre and that was fantastic because I got to stay,* also appreciated by P7: *Less intrusions as far as doctors coming in and bright lights and things like that.* The fact that family members were able to stay at the birth centre was appreciated by P13 who had no family in Australia so was delighted his toddler was able to stay: *The best thing ... all family can stay overnight.* This was corroborated by his wife (W13): *Birthing centre is good in that way that we can stay together after the birth.* The opportunity for family members to stay was also valued by W14: *The bonding with a new family; that meant so much.* The psychological impact of returning to a familiar environment was expressed by P3: *I think the most beautiful thing about the whole experience was that as soon as K got back to the room she was okay,* and supported by his wife (W3): *As soon as I got to the birthing centre I just felt so much better, like arriving at home, a feeling of peace, comfort, familiarity.*

Lost birth dream

The birth dream of couples anticipating a birth centre birth is often one with soft lights, familiar environment and known carers. (Stark, Remyne, & Zwelling, 2016; Symon, 2011) The investment into preparation for this birth meant that for many transfer was an eventuality they had not prepared for which caused anguish, as P12 described: *I was, yeah concerned because now we're heading to the hospital which was not like the birth centre, all natural, suddenly you're getting wheeled into the hospital where it all very clinical.* The decision to choose a birth centre birth was based on using water for labour and birth so when this was denied, there was disappointment : *Because I'd always wanted a waterbirth, that's why I went with the birthing centre and so... was disappointed about missing out on the birth I wanted* (W15). This was also independently confirmed by her partner (P15) who remembered the moment the decision was made: *It was disappointing because I knew at that point that was the waterbirth out the window.*

Discussion

Our findings suggest that when intrapartum transfer occurred from a birth centre to a tertiary obstetric unit there were commonalities and differences in the labour and birth journey for the woman, her partner and accompanying midwife. The normal path of labour was disturbed which impacted them all, but in different ways. It has been suggested that disturbances during labour and birth can change birth moods and cause tension (Crowther, Smythe, & Spence, 2014) and in this WA study the disturbance was in the form of moving from a familiar to an unfamiliar medicalised environment which a concealed constitutive mood at birth can be seen. The view of events was seen through three distinct lenses, with the women's view being through the haze of labour hormones, immersed in a timeless zone, focused on reaching the ultimate end to her journey. In contrast the partners were in a state of raised anxiety, on high alert and felt sometimes excluded and sidelined. The midwives were juggling responsibility, timely decision making and the safety of the woman and baby with trying to ensure communication channels stayed open and choices were offered. Although this was one birth journey it was perceived in three ways demonstrating how different perspectives impact every experience. Each angle and perception was distinct from the other two but there were also areas where similar experiences allowed insight across the three parties. Similar to the work of Crowther et al., which explored the mood of

joy at birth through stories from women, partners, midwives and obstetricians, perceptions from all parties offered a deeper understanding of the phenomenon and contributed to greater insight on how the joy of birth may be protected.

‘The subtheme, In my own world, emphasised that all members of the birth triad have their own feelings, priorities and perceptions. Each member was consumed in their own world and what that meant to them at each particular point, ‘The same journey through three different lenses’ demonstrated how interpretation of events is dependent on the individual viewer’s perspective.

Maternity care providers need to be aware of the perspectives of the woman and the partner, in order to customise care that reflects and addresses their needs across the labour journey. Intrapartum transfer is known to be a stressful and busy time for midwives (Kuliukas et al., 2016) and necessitate a “mind shift” (Patterson et al., 2015) but there is a need to streamline the procedures in order to be able to focus on the couple’s needs. The partner is very anxious at this time (Kuliukas et al., 2015) and the woman usually exhausted and in pain (Baker, Ferguson, Roach, & Dawson, 2001; Niven & Gijbers, 1984) therefore it is essential that both are given explanations and reassurance to acknowledge the emotions of the transfer process (Kuliukas et al., 2015).

The other subtheme which shared commonalities between all members of the triad demonstrated that an opportunity to debrief or talk after the birth about what happened was considered important. Because of increasing time demands, finding quality time to talk about what unfolded is not always factored into postnatal care (Fullerton, Humphrey, & Forrest, 2015) but it is universally accepted that women benefit from the opportunity to talk through the events of their labour (Fullerton et al., 2015; Gamble et al., 2004). Increasing evidence also suggests that partners value the opportunity to revisit events as well, to clarify them in their mind and be given the opportunity to discuss the journey (Kuliukas et al., 2015). This Western Australian study also revealed that midwives welcome the chance to be able to learn from their labour management and enhance reflective practice by talking through experiences with colleagues shortly after the birth (Kuliukas et al., 2016).

The subtheme for women and midwives, ‘Gratitude for continuity of care model’ is confirmation of the published literature that continuity is beneficial for both the woman

and midwife (Page, 2013). Our findings confirm how a group of midwives with the same philosophy were able to provide a high quality service from the woman's perspective, even if she had not met the particular midwife before her labour started.

The partner and midwife gave different perspectives within two subthemes, 'Struggling to adapt to a changing care model' and 'Inside knowledge not taken advantage of'. The first subtheme reveals an anxiety associated with moving to a model of care at odds with the philosophy of the birth centre. The main issue was reduced choices for the couples which was also concerning for the midwives. There was despondency from some partners when they felt more excluded from the labour they had planned and prepared for. Although in emergency situations options such as cutting the cord may not be accommodated, in many cases in this study reasons for reducing choices were not always explained, leaving the partner feeling excluded with diminished control and participation. It is recognised that women report higher levels of satisfaction when they are involved in their care, (McKinnon, Prosser, & Miller, 2014) presumably the same may be true for partners. Having choices removed and not being as involved as intended had a negative impact on these Western Australian partners.

Both the partner and midwife felt the information, history and knowledge they had of the woman was not acknowledged during the transfer experience. The partner felt his ability to interpret the behaviours of the woman he knew best could be useful in helping maternity carers gain better understanding of her needs at different points in labour, which could be used to make timely decisions. It is recommended that receiving staff respect and acknowledge the partner's role in the birth journey. In an American study it was demonstrated that transferring midwives are frequently dismissed by receiving staff rather than being asked questions about the woman's history (Cheyney et al., 2014). Our Western Australian findings confirmed that the transferring midwife often feels she is a valuable resource in terms of knowledge but this is not appreciated by the tertiary obstetric unit staff. A clinical handover tool, ISOBAR (Porteous, Stewart-Wynne, Connolly, & Crommelin, 2009) gives guidance to ensure that pertinent information is relayed as comprehensively, yet concisely as possible by following the acronym: Identify, Situation, Observations, Background, Agreed Plan, Read back. The Background section could be expanded upon to capture this information and provide a full picture of the transferring woman.

The shared experiences of the woman and partner included 'Grateful to return to familiar environment' and 'Lost birth dream'. The lost birth dream was expressed by disappointment at not achieving the non-intervention labour and birth in a birth centre setting that they had hoped for. A continuity of care model could help in this situation, as demonstrated previously, particularly in adverse situations, such as intrapartum transfer (de Jonge et al., 2014; Grigg et al., 2015a). The second subtheme, 'Grateful to return to familiar environment' reflected the benefit to couples of being able to return to the birth centre again after the birth. Being able to return to this comfortable familiar place could be another way to mitigate the negative impact of the lost birth dream. The offer of going straight home from the tertiary obstetric unit labour ward (if all is within normal limits) is another way to achieve the positive benefit of new parents' appreciation of being able to spend time as a new family (Nilsson et al., 2015) with the opportunity to debrief being offered by the midwife during a postpartum home visit.

The perceptions of this sample of birth centre consumers and midwives may not reflect those in different cultural and geographic locations and must be considered as a limitation. However rich descriptions of participants, methods and findings have been provided to assist the reader to determine the transferability of findings to other contexts.

Conclusion

When intrapartum transfer takes place from a low risk birth centre to a tertiary obstetric unit the experience is shared by three parties who see the journey through their own lenses. Each is absorbed in their own world, with the woman 'in the zone', the partner in a heightened sense of awareness and the midwife responsible for ensuring a safe outcome. Shared perceptions must be appreciated including the opportunity to talk about the birth and have their experience acknowledged whilst facilitating personal reflection. The midwife and woman confirmed the value of a continuity of care model and the midwife and partner acknowledged that their in-depth knowledge of the woman could be better utilised. Adjusting and accepting the medical model of care after transfer was a challenge and new parents' shared loss for their desired birth must be recognised. Having insight of individual and common experiences across the birth triad will provide maternity carers with knowledge to tailor their care to all participants

and facilitate a positive labour and birth experience when transfer in labour is necessary.

Summary

This chapter presented the final version, after addressing reviewers' comments, of the triad of experiences as described by women, partners and midwives when intrapartum transfer takes place.

The next and final chapter, and Recommendations, Implications and Conclusions, summarises the study and gives detailed recommendations arising from the findings. This chapter discusses the importance of giving space to women and partners following the birth to be able to talk independently about their experiences in order to make sense of them. It also raises the important issue of giving time to midwives to discuss cases, with colleagues, specifically around decision making and management. The value of continuity of care models to women, partners and midwives is also demonstrated in this chapter. Finally there is a reminder of the importance of the birth environment and the need to provide all labouring women with a comfortable, spacious, safe, familiar place to labour and birth their babies.

Chapter Eight: Discussion, Implications and Recommendations and Conclusion

Although recommendations arising from this West Australia (WA) study have been summarised in the previous four chapters, this chapter will combine and expand the recommendations and conclusions from the published papers, by considering the implications of what these findings mean. Further comprehensive overall recommendations will also be presented. Firstly a summary of key findings of the study will be outlined and then the implications and recommendations will be discussed.

Summary of key findings

Gaining insight into the unique perceptions of women, partners and midwives in this WA study offers an understanding of the emotions and experiences that can be experienced when intrapartum transfer occurs from a birth centre to an obstetric unit. The three groups of participants (women, partners and midwives) will now firstly be considered individually before exploring the integration of these intrapartum transfer experiences for the birth triad.

Women

This WA intrapartum transfer study offered women the opportunity to talk in depth about their birth journey. The interviews gave women the occasion to contextualise the transfer as one part of the whole experience and fully understand what had happened. Many women described their time in labour as being in ‘the zone’ which meant parts of the labour were unclear to them; they felt they were in a different world and needed this opportunity to talk through the events to fill in the missing gaps. There was also an added advantage of their narratives being in their own time, with no sense of being rushed which women appreciated.

The themes and subthemes arising from the analysis of interviews from the women, describe a multi-faceted journey made up of many emotions. Women felt the transfer experience contributed to a loss of their sense of identity as a woman, in the central role of a woman in labour, going through a major life event. Sadly women felt some

level of exclusion from their own birth experience once transfer had taken place. There was a sense that the right to make informed choices and decisions no longer formed part of the birth process when they should have been central to all management decisions.

However, despite the feeling of loss of control, many women were very grateful that geographically the referral centre was close by with the shortness of the transfer journey often being a source of relief. Expert practitioners were close at hand which was voiced by women as having the best of both worlds.

Women expressed appreciation for the continuity of care the birth centre midwives were able to provide which helped them feel supported as there was someone who was familiar, knew them well and would speak up for them. The value of continuity of care became apparent during the trauma of the transfer, when women appreciated hearing the midwife's voice, which guided them through, with explanations and reminders about breathing and relaxing. Some women expressed this as hearing the midwife whispering in their ear, which was a source of focus, comfort and calm amongst the surrounding commotion.

However, despite having the support of a known midwife, women were disappointed to not achieve the labour and birth they had anticipated, in the environment they had prepared for. They felt a sense of loss having to birth in a medicalised environment, which was removed from what they had prepared for which was to birth in a home-like, comfortable, familiar, flexible and spacious surroundings.

Being able to return to the familiar birth centre following their birth was very welcomed by women, with many describing it as a feeling of going home. For one woman it had an enormous effect, allowing her to relax and return to normal after experiencing some form of shock or panic attack after what she viewed as a traumatic birth. It was only on arriving back at the birth centre that she emerged from what she and her partner perceived as her almost 'catatonic' state.

Partners

The second group of participants, the partners, also acknowledged the benefits of midwifery continuity of care with great appreciation that the midwife was able to accompany them to the unfamiliar environment. It was noted that the midwife

advocated for the couples' wishes which in some cases had a positive impact on clinical management decisions, which was very much appreciated.

One factor which partners felt was not given its due appreciation and respect was their inside knowledge of the woman. They felt that as partners, they provided essential continuity as they felt they knew their woman better than any care provider and as such were able to give advice and remind carers about choices previously decided on.

Partners found it difficult to witness their woman's difficult labour journey contributing to their heightened sense of awareness, due to stress, with many of them fearing for their woman's and or baby's life. They felt that communication could have been more inclusive and comprehensive which could have helped allay their fears.

The change of environment from birth centre to labour ward was challenging similar to the women, partners appreciated that experienced medical assistance was at hand when necessary. Being able to return to the birth centre environment after the birth was also acknowledged as beneficial as it contributed to feeling together as a family in a familiar environment.

Similar to the women's appreciation of being able to talk through events afterwards, partners valued the time to make sense of what had happened. The interviews for this WA intrapartum study gave partners the opportunity to share experiences and discuss the decisions that were made. Partners wanted explanations for what took place and why, needing an opportunity to talk through events to clarify and better understand the process that had occurred.

Midwives

The themes that emerged when analysing the data from the midwives' interviews reflected the wide variety of experiences they faced on this journey. The findings describe the main experiences of feelings around making the right decision at the right time. This involved the uncertainty of their role once the woman was transferred, facing the new environment of labour ward, being grateful to be able to provide continuity and wanting a space to think through actions and piece together the transfer journey.

Midwives acknowledged the challenge of finding the balance between fulfilling parents' birth plan wishes with hospital protocol and maintaining safety. Transfer for

fetal or maternal compromise contributed to anxiety and concern with the process leading up to the transfer prompting an internal dialogue. The midwives described the difficulty around decision making and the need to get the timing right with an awareness of the responsibility of balancing the parents' wishes with hospital guidelines and their own experience and confidence. There was an awareness by midwives of accountability for their actions, and the importance of timing which could affect the outcome of a healthy mother and baby.

Similar to the findings described for women and partners, the benefits of providing continuity of care were acknowledged by the midwife. There was an appreciation that knowing the couple from antenatal visits, valuing the familiarity with the woman's history and birth plan wishes assist the midwife to provide woman-centred care. However there was also frustration this knowledge was not always recognised or taken advantage of by the receiving team. Midwives acknowledged the importance of effective communication between all stakeholders throughout the transfer process.

Another factor the midwives reflected upon was their change of role on transfer, from primary carer and decision maker to being under the direction of the medical team. They shared the impact of moving from an autonomous care model to a dependent care model. This introduced a feeling of conflict between the different models of care but instilled a sense of responsibility that explanations to the parents were necessary about changing plans and choices.

Midwives found that the fulfilment of the changing role depended on many factors including the acuity and staffing levels, with the result that there were differing levels of support. The uncertainty of role was compounded by being in an unfamiliar environment, out of the comfort zone of the birth centre.

Again, like women and their partners, midwives also valued discussing the transfer story afterwards. They suggested that it helped them to review their decision making and practice. It was proposed during the interviews that regular case discussion with colleagues could be valuable in improving management decisions when the path of labour veers from normality. Midwives voiced their need to talk through actions taken and timings of transfer. They felt it would be valuable to discuss and compare colleagues' opinions and refer to the evidence in order to be able to improve transfer decision making and outcomes.

Discussion

In this phenomenological study the researcher set out to describe the lived experiences of women, their partners and midwives when transfer took place in labour from a low risk birth centre to an obstetric unit. What was evident during analysis of the transcripts was that while the three groups shared some common experiences they also reflected divergent journeys. For each group this was an eventful and emotional journey with all having varied but consistent sets of feelings. The women felt determined, focused and resolute in their single-mindedness in undertaking the momentous journey. Although disappointed when intrapartum transfer took place the women were immersed in the labour journey, focused on the immediate task of giving birth but grateful for continuity of care and the opportunity to talk through events in detail afterwards. In contrast, the partners felt anxious, protective and out of their comfort zone, unable to take charge of and control the situation as they are used to in their usual routine life circumstances. The journey was made more challenging for partners when they felt they were not being included and as involved as they would have wanted. The midwives felt satisfaction in being 'with woman' and providing continuity of midwifery care but also went through periods of stress when considering whether they were making the right decision at the right time and how they were received in the referral centre. As recognised by the literature (Buckley, 2004, 2015), a woman's perspective can be influenced by labour hormones, endorphins and oxytocin, where her body takes over the business of birthing and she is inwardly focused on the task in hand. The partner's perspective can be influenced by his anxiety and stress causing the 'fright/fight/flight' response which contributed to acute alertness and sensitivity to what was happening to his unborn baby and life partner. The midwives' perspective reflected a sense of responsibility to ensure the parents were provided with what they hoped for in their labour and birth, while simultaneously feeling incumbent to ensure a healthy outcome.

Despite all three parties taking the journey together there was at times an unawareness of the other's viewpoint. Each party was engrossed in the role they had to play where their own emotions and responsibilities were uppermost in their consciousness, which could cloud their ability to see into each other's viewpoint along the labour and birth journey. Each group will now be considered individually and the implications of the

findings and subsequent recommendations will be discussed, considering the perspectives from the clinical, educational and research viewpoints.

Implications and recommendations for changes in current clinical practice

This qualitative study offers greater understanding of emotions and experiences of women, partners and midwives when intrapartum transfer occurs from a birth centre to an obstetric unit. The implications of these findings and recommendations for future practice will now be considered, addressing firstly women, secondly partners and lastly midwives.

Women

What this study adds to the existing literature

While there has been much published literature regarding women's experience of transfer in labour, it is mainly from home to hospital (Cheyney et al., 2014; Lindgren et al., 2008; Lindgren et al., 2011; Wieggers et al., 1998) and the studies that do describe transfer, both antenatal and intrapartum, from low risk birth centres, did not take place in Australia (Grigg et al., 2015a; Grigg, Tracy, Tracy, Schmied, & Monk, 2015b; Rowe et al., 2012). These studies shared similar findings around the disappointment, dissatisfaction, continuity, control, communication, disappointment, timing of transfer, preparation, change of model/environment, and talking through events after the birth. These previous findings have some similarities with the findings of this WA study but our use of a descriptive phenomenological design allowed greater expansion and depth to the narratives in which women revealed new and important findings. The importance of the midwife's voice to help keep women focused was highlighted in our findings. Women expressed that they were in a world of the intensity of labour, being 'in the zone' but through that fog hearing the midwife's voice, encouraging them and keeping them calm and grounded. This new knowledge demonstrates the value of midwives truly being 'with woman', fostering and maintaining that special relationship. In the context of this study, most women had already met the midwives looking after them so had been able to foster a relationship during the antenatal period. Although midwifery led models of care are gaining momentum in Australia, the majority of women meet the midwife caring for them in labour for the first time, when admitted to hospital and in labour. It is therefore necessary to use skills to build a

trusting relationship in a very short space of time. The value of good communication must be acknowledged by midwives and all opportunities taken to improve the skill of developing rapport in a timely manner.

Midwife as advocate

An equally important aspect of care women commented on was the shared philosophy around childbirth that sustained them through what was often described as the traumatic and disruptive experience of needing to transfer in labour. Even though they were being taken to an unfamiliar setting with a different set of rules they felt their midwife knew them and would speak up on their behalf. Women felt the midwives had a good understanding of their birthing preferences and would advocate for them in order to achieve some of their original goals. These findings demonstrate the need for midwives to be aware of women's expectations and goals, to examine the birth plan, to discuss their hopes for labour and take time to ensure they have an understanding of what is important for that couple. An awareness of what women want is only the beginning of facilitating the best experience for their labour and birth. There is an increasing need for advocacy for women as clinical maternity care in Australia is increasingly dictated by obstetrician preferences, hospital guidelines and management flow charts. In order to be able to speak up for the woman who does not want to follow standard care, midwives must develop skills to help build their confidence and resilience. It is necessary for midwives to undertake the necessary education which will give them the ability to assertively present the woman's perspective, choice and argument to safely respect her choices. The attainment of these skills in advocacy may help reduce the damage and fall-out of unfulfilled birth dreams that sometimes leads to post traumatic stress disorder (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Creedy, Shochet, & Horsfall, 2000; Reynolds, 1997; Sderquist, Wijma, & Wijma, 2006). There is increasing evidence that women who have an unsatisfying or traumatic birth experience are more likely to choose alternative and sometimes unsafe care in future pregnancies (Dahlen, Jackson, & Stevens, 2011b; Feeley & Thomson, 2016).

Lost choice

The implications of the loss of an expected and desired birth experience emerged from this WA study. The issues that surfaced included the women feeling sidelined and losing their sense of self. They found that once transfer to the tertiary referral centre took place their options narrowed, the choices were no longer available, leading to a

sense of disappointment and sometimes panic. Ultimately the women voiced this as losing their birth dream. The implications of these findings suggest that wherever women labour and birth their babies, it is incumbent on the maternity care professionals to ensure that the experience does not leave them feeling at best disappointed and at worst, traumatised (Dahlen et al., 2011b; Nilsson, 2014). It is recommended that women are involved in their care and their wishes taken into account at every stage as much as safely possible.

The women in this WA study felt they were listened to and their choices were facilitated up until the point of transfer out of the birth centre. There appeared to be a dramatic change in the care provided on arrival at the referral centre which, being offered a medicalised model, involved less inclusion and greater paternalism (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010). Because many of the women in this study had based their choices on careful thought and in-depth research, it was disappointing and enfeebling to then be dictated to. The interviews which took place in this WA study, with women and their partners, the witnesses, revealed that many procedures in the tertiary birth suite were conducted without explanation or consent and sometimes without adequate pain relief. One recommendation to address this issue would be to foster a greater sense of empathy, self-reflection and an intention to actively and respectfully involve women in care decisions (Jenkinson, 2015; Meyer, 2003) and provide holistic maternity care (Davis-Floyd, 2001).

Best of both worlds

When considering professional awareness and clinical practice, it is important for all maternity health professionals to consider the voices of women who in this study, specifically sought birth centre care (Reid et al., 2004). Women appreciated having “the best of both worlds”; the knowledge that they were able to birth in a home-like environment but with the awareness that tertiary level care was close should it be needed. It was evident from our findings that woman appreciated the feeling of security, knowing that if transfer was necessary it was only a matter of a short journey and expert professional help was available. Many women in this WA study revealed that when they arrived at the referral centre, a short distance away, they felt relief that the issues could be addressed quickly and medical expertise was accessible.

Following the birth, another theme in our findings was that women appreciated being able to return to the comfortable and familiar home-like environment they had grown to know over the course of their pregnancy. Evidence has confirmed many women prefer to be in a less medicalised setting that makes them feel at ease, less pressurised, more in control and comfortable (Macfarlane, Rocca-Ihenacho, & Turner, 2014a; McKinnon et al., 2014). Another recommendation to decision makers in the public health system in WA is that there needs to be consideration to building birth centres alongside hospitals with maternity departments. The Reid Report conducted in WA argued that alongside birth centres offer choice for women and also afford a safe path when the childbirth journey veers away from normality (Reid et al., 2004). Women's requirement for this choice was reinforced when the Reid report was published in 2004 and the findings from this WA study confirm that women appreciate the service and security that an alongside Birth centre affords.

Continuity of care

The availability of maternity care options should acknowledge the extensive evidence that suggests that women want continuity of care from a known provider (de Jonge et al., 2014; Hauck, Lewis, Ronchi, Crichton, & Waller, 2015; Hodnett, 2000; Hodnett et al., 2011; Homer et al., 2002; Huber & Sandall, 2009; Lewis et al., 2016; Lindgren et al., 2011). The investigators for the Australian National Maternity Services Plan (Hames, 2010) recognised this and recommended that women should be offered the option of being cared for within a Midwifery Group Practice with a named primary midwife. At the time of this WA study in 2014, the study birth centre offered a midwifery team approach. This model of midwifery care provided women with care from a group of midwives, rather than having a named primary midwife. In order to understand the value of continuity it was decided that women would only be included in this study if they were accompanied by one of the midwives in their team, when intrapartum transfer took place. This was in order to ensure consistency, however it revealed that women truly appreciated being cared for by someone they knew who shared the same philosophy. The benefits of continuity of care and continuity of carer have been presented previously (Davison, Hauck, Bayes, Kuliukas, & Wood, 2015; Homer, 2008; McCourt, Page, Hewison, & Vail, 1998; Walsh, 2008) however, this WA study's findings also revealed that a shared philosophy was paramount.

A shared philosophy

Women who choose birth centre care generally do so in order to be able to reduce intervention and interference (Albers & Katz, 1991; Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011a; Walsh, 2008; Walsh & Downe, 2004). They want to know that their choices are supported and that they are not faced with defending their decisions on every step of birth their journey. These WA women shared how they valued that their midwives shared the same beliefs of putting women at the centre of care, offering choices and facilitating a healthy outcome. The findings and recommendation from this study to increase women's access to midwifery led care models aligns with current trends. The number of Midwifery Group Practices available for women has been increasing on a nationwide scale due to the recommendations of the National Maternity Services Plan and Australian evidence confirming the safety and economic value of this care (McLachlan et al., 2012; Tracy et al., 2013).

Acknowledging the birth space

An important finding from this WA study supports the findings and commentaries of many midwifery authors that women can lose themselves in a mist of hormones when they are in established labour (Buckley, 2015; Fahy et al., 2008; Leap, 2010a; Stables & Rankin, 2010). As Leap (2010) asserts, when women are in a safe environment they are able to become immersed in the hormones of labour and birth and can become impervious to the outside world often seen by midwives as “disappearing into their bodies” (p 452). In this current study women shared how they lost the sense of time and focus on the immediate surroundings as they turned inward. The implications of this finding suggests that women and their partners have privacy so that her focus is not disturbed (Crowther et al., 2014). The environment should limit distractions such as too many people, bright lights and ensure privacy to not disturb and to respect the woman's inward focus to cope with labour. There is still much work to be done in order to provide labour wards in which all rooms are comfortable and more birth-centre-like. The impact of safe, comfortable spacious birthing rooms affects all women, not only those transferred from birth centre care (Oakland, Harte, Sheehan, Stewart, & Foureur, 2016). The recommendation is that women should not labour in a brightly-lit medicalised environment with loud noises and surrounded by strange people as this is known to lead to a reduction in their own natural oxytocin (Leap, 2010a; Sheehy, Foureur, Catling-Paull, & Homer, 2011; Walsh, 2007).

Currently many women in modern labour wards are subject to intervention, in the form of artificial rupture of membranes and oxytocin infusions due to the normal progress of labour not meeting strict timelines and being categorised as delayed (Hutchinson & Joyce, 2014). Once this occurs the rate of epidural anaesthesia is increased leading to increased intervention including electronic fetal monitoring, possible fetal compromise and operative birth (Tracy & Tracy, 2003; Tracy, Wang, Black, Tracy, & Sullivan, 2007). It has been recommended that the labour room set up in all maternity centres is reconsidered to make the focus home-like rather than hospital-like which will allow women to enter the 'labour zone' where they are able to focus inward as described by women in this WA study. The recommendation from this WA study, as well as previous literature, to de-medicalise labour and birth rooms should be considered for all new units where each room can be designed to be warm, comfortable, encourage upright positions with the use of props and have an en-suite bath and shower room (Oakland et al., 2016; Sheehy et al., 2011; Walsh, 2007). In maternity units which have little or no funding there is still the capacity to facilitate change. The simple act of pushing the bed to the side of the room and having other comfort props available such as a floor mattress, bean bag and fit ball can alter the focus of the room and encourage an upright posture for the labouring woman. Any cost in providing these changes will be quickly compensated when fewer women choose pharmacological pain relief options and fewer labours result in operative births (Tracy & Tracy, 2003).

Revisiting the birth experience

The 'labour zone' or internal focus that these WA women described suggests that some aspects of the labour and birth journey were a mystery as they had selective memory of the labour experience. Due to this 'inward focus', loss of time and awareness of the immediate surroundings they welcomed the opportunity to talk through the events afterwards. Although many women are offered the opportunity to debrief about the birth in the few days afterwards (Ackenbom et al., 2014; Meades, Pond, Ayers, & Warren, 2011), there could be increased value in being able to do this with the same midwife who was there for the labour. To ensure accuracy in sharing the labour experience and enhance the woman's understanding of her labour, it would be ideal if the midwife accessed her clinical record and referred to it during the meeting. Based upon the findings of this study, we recommend that all women are afforded the

opportunity to talk through the labour and birth journey with the midwife who provided intrapartum care and together with the clinical record as a resource clarify any unclear issues or memories. It would be ideal that this process is carried out after the first five days of the birth, as suggested by Martell (1996) when discussing Rubin's classic theory of 'taking in' and 'taking hold', because during this time women are still recovering from the birth, establishing breastfeeding and catching up on lost sleep. If the post-birth conversation takes place after a week then any distracting factors, for example managing mastitis or a sore perineum, are less consuming, so allowing a fuller focus. To achieve this recommendation, we need to consider more services that enable women to access their midwife beyond the usual five days of postnatal care in WA, to clarify and discuss their labour and birth journey which means greater access to continuity of care models such as caseload or midwifery group practices, the gold standard of care for low risk women (Fereday, Collins, Turnbull, Pincombe, & Oster, 2009; Tracy et al., 2013; Tracy et al., 2014; Wong, Browne, Ferguson, Taylor, & Davis, 2015).

The maternity care needs of women whose birth plans change during labour can differ from those women who are able to stay in the labour and birth environment they wanted. Therefore to address and mitigate the potential negative experiences of an intrapartum transfer on a woman's perceived birth experience a number of recommendations that could be adopted to better support these women have been suggested.

Partners

What this study adds to the existing literature

There was a paucity of published literature regarding experiences of partners' experiences of intrapartum transfer prior to this WA study. Although there was an awareness that labour can be traumatic for labour partners (Backstrom & Wahn, 2011; Draper & Ives, 2013; Hildingsson, Johansson, Fenwick, Haines, & Rubertsson, 2014; Johansson et al., 2012; Kululanga et al., 2012; Steen et al., 2011), particularly when problems occur (Johansson et al., 2013; Steen et al., 2011), this WA study revealed important new findings. Firstly the level of anxiety partners are expressing has to be acknowledged as having a significant impact on their experience. How women behave in labour, even when progress is normal, is known to be unexpected and confronting,

with the potential to cause anxiety for partners (Draper & Ives, 2013). The level of concern and worry is likely to increase when the course of labour does not go to plan, as confirmed by this research, but with the added hurdle of having to change environment and model of care. It was evident in this WA study that partners' feelings of anxiety escalated as labour events went awry and transfer to the obstetric unit became necessary.

Partner anxiety

Knowledge on the potential impact of intrapartum transfer on partners' anxiety highlights how the support partners are able to provide may be compromised if they are subsumed in their own trauma. Women may therefore not be afforded the support they want from their partner during the transfer process. Based upon these findings we recommend that partners are educated in the antenatal period to the same level of the woman regarding expectations of normal labour. For this to occur and for partners to be fully involved in all aspects of the childbirth continuum it is suggested that as well as attending childbirth education classes, partners are strongly encouraged to attend as many antenatal appointments as possible in order to benefit from the education and information offered at each appointment by the midwife. In addition, together with having the partners attend many antenatal appointments, it is important that the midwife share the intrapartum transfer rates of the birth centre and the intrapartum experiences reported in this study with parents during childbirth education classes so they have a realistic idea of the probability of this occurring.

Being a witness

The challenges of witnessing unexpected events such as vaginal examination to determine position of the fetus, insertion of epidural, cutting of an episiotomy and assisted vaginal birth, was raised by many partners and some commented that their preference for the next birth would be caesarean section due to the perceived personal trauma of their recent labour and birth experience. Some partners found it hard to comprehend that the trauma of witnessing the labour and birth could be more confronting than the woman's actual experience as they wanted to protect her from going through that journey again. This study's findings suggest there may be benefit around improving education in relation to the transfer experience to promote awareness of the reasons, practicalities and expectations to help reduce the shock and worry for partners. If the standard course of childbirth education classes was expanded

to reflect these issues it may alleviate partners trauma. Additionally a tour of the obstetric unit should be included in these classes to reduce the unfamiliarity of a strange environment. It is also suggested that antenatal appointments are offered during evenings and weekends so that partners can easily attend, thereby allowing them exposure to the same level of information as the women, and better preparation for all outcomes.

Listening to the partner

During the course of labour, both before and after transfer, partners felt that their background knowledge and insight of the woman was not always recognised, appreciated and used by maternity health professionals, including their known midwife as well as receiving staff on the obstetric unit. Some partners voiced frustration at not being listened to and felt that their knowledge and concerns were not acknowledged. The patronisation by certain staff members was difficult for some partners to accept when they felt they were the ones who knew and understood the woman's behaviours and preferences around care. It is known that couples opting for birth centre care have a desire to have some control over their pregnancy and birth and the right to make choices should be encouraged and respected (Laws et al., 2009; Waldenstrom, 1999). Couples often carry out their own research and discuss their labour preferences so it follows that in labour, when the woman is withdrawn into herself, the partner is the obvious resource to turn to for clarification. The determination of choices offered, management decided on or procedures performed at relevant points of labour may then be made in accordance with the woman's wishes. Findings in this WA study confirmed that partners felt their opinion should have been asked for or accepted, if offered voluntarily. An implication of this finding is that women's labour care can be improved by ensuring the partner is involved as this may better fulfil the women's wishes. In addition, maternity care providers must engage with the partner of the labouring women and also refer to the detailed birth plan they were encouraged to complete during pregnancy. Choices and preferences are then known and discussed during pregnancy and the birth plan can be used as a tool to increase awareness of the possibility of alternative events if labour does not follow the assumed pathway. It is incumbent on the midwife during antenatal appointments to offer time to talk through various options and actions that may be taken at different points of the journey to better prepare the childbearing couple.

Change of environment and care model

Adequately preparing the couple for possible changes to their desired birth plan is challenging when the reality of having to move model of care and environment was highlighted as a journey of contrasts. Partners revealed that this was a difficult adaptation as they were ‘moving from an inclusive nurturing and continuity model’, to a ‘medicalised model’ which they described as ‘going to the place where things go wrong’. This was a traumatic change of environment and type of care which both partners and women found challenging to come to terms with. Based upon these findings, we recommend that labour ward managers focus on changing the environment to be more conducive to a normal life event rather than a medical emergency which was not the case in most/all intrapartum transfers in this study. Measures relevant to the birthing environment, discussed previously, could be implemented, such as pushing the bed to the side of the room, placing a comfortable chair in the centre of the room with a floor mattress, fit ball and beanbag. Dimmed lighting, aromatherapy burners and access to bath and shower would make the transfer less confronting for birth centre women but would also give all women admitted to the labour ward a more comfortable environment, conducive to facilitating a more mobile and upright labour and birth (Lawrence, Lewis, Hofmeyr, & Styles, 2013; Priddis et al., 2012). Decision makers in health need to use evidence about birthing environments that improve labour and birth outcomes for women.

Midwives

What this study adds to the existing literature

The existing literature surrounding midwives’ experiences of transfer during our study period included two studies based in England and America (Cheyney et al., 2014; Wilyman-Bugter & Lackey, 2013), both of which involved transfer from home to hospital. The English researchers’ findings revealed that midwives questioned their decision to transfer, they understood the importance of supporting the parents and valued collaborative working but faced organisational challenges including the machinations of ambulance services (Wilyman-Bugter & Lackey, 2013). The American researchers’ findings focused upon the perceived lack of holistic care by receiving staff and the bias and lack of insight that physicians and obstetricians demonstrated by not appreciating the overall quality of midwifery led care (Cheyney et al., 2014). Another angle was demonstrated in a British study regarding conflicts

felt by birth centre midwives (Deery et al., 2010). Although the study by Deery et al. (2010) was not about transfer in labour, poor collegiality between Birth centre and hospital staff was an issue of concern. These previous studies have similar findings to our WA study however, new knowledge was also revealed, which included midwives feeling pressurised about making the right decision at the right time. WA midwives revealed how they found it hard adapting when transfer took place, how they felt uncomfortable in an unfamiliar environment, and sometimes unsupported by their hospital Obstetric Unit colleagues. Our findings also disclosed that midwives felt caught between two models of care but that their presence and being able to provide continuity of care made a difference for the women. Finally they appreciated the opportunity to talk through the experience with midwives in their team, as a case study discussion, after the event.

Recent evidence has been published regarding midwives' experiences of intrapartum transfer (Ball et al., 2016) but again involved the home to hospital experience, rather than from an alongside birth centre. However, the study did take place in WA and similarities were found with this birth centre transfer study. Findings in this recent study reported that midwives felt they were being scrutinised for their decision making regarding timely transfer. Similarly Ball et al (2016) found that midwives' reception at the hospital varied, that they valued the continuity of carer model when they were able to stay with the woman and they appreciated time to reflect and come to terms with the experience.

Timing of transfer

The issue around the timing of transfers and challenges in decision making has implications as gaining understanding and skills in making timely decisions is essential for midwives who practice in low risk settings where transfer may become necessary. Getting the timing right depends on the ability of midwives to be able to be with woman, observe carefully and act appropriately (Skogheim & Hanssen, 2015). Midwives working in low risk settings must be astute and decisive as it can be inappropriate to have blind faith in normality or only see childbirth as normal in retrospect. As such, the use of hi-fidelity simulation in the clinical setting has been recommended to provide a safe environment for health professionals to gain awareness and practice decision making in emergency situations (Kuliukas, King, & Ford, 2009). The implementation of a midwifery peer support system in order to foster discussion

around decision making could also be considered. It can be isolating for midwives caring for women at home or in a birth centre but if a system was introduced which gave midwives, particularly those with less experience, the opportunity to discuss an evolving situation with an experienced midwifery colleague, it would allow for the sharing of responsibility and documentation of the discussion around the transfer decision.

Division between staff

The concern the transferring midwives have around decision making can be viewed from another perspective in how their decision will be interpreted by receiving staff in the obstetric unit. This concern is, in part due to a real or perceived divisive midwifery culture which has a 'them and us' component (Cheyney et al., 2014; Davison et al., 2015; Wilyman-Bugter & Lackey, 2013). Cheyney et al., (2014) found that midwives in their American study felt that receiving staff in the hospital were looking for fault in their practice, only seeing the situation from a narrow and biased view and commented that the receiving staff felt they were 'picking up the pieces' of poor practice from the homebirth midwives. The midwives in this WA birth centre study found the reception by receiving labour and birth suite staff varied but some perceived a feeling of not belonging and of being regarded as outsiders. Non-cohesiveness of staff is known to impact mental wellbeing of workers (Johnstone, 2016) and this issue was shared by some of the midwives who participated in this WA birth centre study. There is an industry dedicated to improving workplace relationships by group counselling, company coaching and motivational days (Brubaker, Noble, Fincher, Park, & Press, 2014) but one recommendation to improve staff cohesiveness based upon our WA findings would be to introduce rotation or secondment of staff across all areas to gain an appreciation of the realities of practising in the birth centre and tertiary Birth Suite. Sincere and non-judgemental case discussions could also be conducted on a regular basis with all maternity care providers, where each hears the other's perspectives and the history behind why decisions were made at certain times. Such discussions could engender greater understanding thereby reducing the division between clinical areas.

Working across clinical areas could also address one of the concerns that WA birth centre midwives raised; that of feeling uncomfortable in the unfamiliar labour and birth environment and being unable to find equipment was embarrassing and humiliating.

Providing the opportunity for birth centre midwives to be seconded into the tertiary Birth Suite to familiarise themselves with the environment might lessen their concerns.

The dilemma of being caught between two models of care was another factor that led to an unsettled feeling for some of the WA birth centre midwives. Midwives choosing to work in a birth centre generally do so because they prefer to help women achieve a non-intervention and non-technological birth (de Labrusse & Kiger, 2013; Maillefer, de Labrusse, Cardia-Vonèche, Hohlfeld, & Stoll, 2015). When intrapartum transfer took place in this WA study, the birth centre midwives had to come to terms with an opposing philosophical model; instead of allowing nature to take its course, the best outcome was now reliant on taking full use of the advantage of medical skills and equipment. The implications for the midwives is the realisation of how they feel challenged to continue caring for women in a model that is not aligned with their own birthing philosophy which reinforces a need for open mindedness, flexibility and adaptiveness in order to maintain woman-centred care.

Continuity of care

Similar to the women's findings the value of continuity of care was recognised by birth centre midwives in this WA study. They shared how they felt the women they were caring for benefitted when accompanied by their birth centre midwife during an intrapartum transfer. As an epilogue to this study, which was conducted in 2014, in order to ensure that all birth centre women were able to accompanied by a birth centre midwife should an intrapartum transfer become necessary, the model of care in the birth centre changed to a midwifery group practice. The National Maternity Services Plan recommendations have ensured that such changes are now taking place on a nationwide scale (Hames, 2010). This WA birth centre now has a model of care which is more woman-focused as all women are now allocated a primary midwife working within a small team, who ideally is able to continue being her primary midwife, regardless of whether transfer takes place at any time over the continuum of midwifery care. In addition to the primary midwife, the woman and her partner are introduced and familiar with all midwives in the team.

When the birth journey was over, midwives in this WA study shared their appreciation for the opportunity to talk through the events leading to transfer and culminating in the birth of the baby. This need to discuss their experiences in order to learn from decisions

that were made and actions that were taken is supported by other research (Ackenbom et al., 2014). Quarantined time is recommended for midwives to meet in facilitated small groups on a regular basis to share birth stories and offer constructive discussion in order to positively analyse the timing of decision making and management with a view to continually improving practice.

The Triad

As well as considering the implications of each of the individual groups it is also important to look at all three groups or the triad as a whole and what recommendations can be made taking into account their integrated experiences. The three groups, women, partners and midwives make up a triad and while some parts of their journey were experienced quite differently from each other, there were some similarities.

Talking about the birth

There is no doubt that the concept of talking through events after the birth from each of the groups was felt to be worthwhile and of benefit for a variety of reasons. For the women it was valuable to be able to fill in the gaps of their labour that was not always remembered in full. The partners on the other hand wanted an opportunity to debrief, to talk through their recollections of what happened to make sense of them. The final group, the midwives felt the benefit would be as a learning exercise and valuable for continued learning and management of future women. It is strongly recommended that time is allowed for all three parties individually in order to offer the appropriate counsel.

Empathy and awareness

When considering the differences in journeys that each triad member experiences when intrapartum takes place, it is important that maternity care providers are able to have insight into the contrasting journeys each takes. An awareness of how the transfer affects each member will help carers adjust their communication and management appropriately in order to ease the transition.

Implications and recommendations for education

Recommendations from this study's findings can only be facilitated by maternity care providers who understand these findings and are willing to consider innovative strategies to improve the services we offer to women and their partners across the childbirth continuum. It is therefore essential that our findings are used to inform the

education of student midwives, medical students and also qualified midwifery or obstetric staff. Greater insight is a priority into how the experiences of intrapartum transfer on women, partners and midwives are multifactorial but can contribute to all parties feeling out of place in the medicalised environment. This WA study demonstrated conclusively that women, partners and midwives found that the change of environment from the homely birth centre to the obstetric unit was confronting and contributed to negative experiences. Consequently students need to be educated regarding the subtle nuances of how physical surroundings can affect the emotional wellbeing of women and their partners.

The rationale of providing women with an environment which best facilitates a physiological labour and birth must be stressed (Buckley, 2004, 2015; Leap & Hunter, 2016). Women choose to birth in birth centres because they provide the environment most conducive to facilitating labour and birth with fewer interventions and less pharmacological analgesia (Dahlen et al., 2011a; Geerts et al., 2014; Leap & Hunter, 2016). If transfer from this environment is necessary then having a referral centre also set up to replicate a home-like environment could alleviate the stress generated by the transfer. One of the partners in this WA study said that on arrival at the obstetric unit, all he saw was 'trays of knives'. A labour and birth suite with more subtle presentation of such equipment and machinery may lessen the impact of seeing unexpected equipment, such as forceps, for prospective parents (Leap, 2010a). This is important information for students, qualified staff and those who have the responsibility for labour and birth suite management.

Preparation of the couples for the possibility of intrapartum transfer could be improved. Students and midwives who facilitate childbirth education classes should introduce this topic to prospective parents. During the study period, couples were prepared for transfer within the childbirth education classes run by the birth centre midwives, however, comments highlighted that the focus of the class was negative, centred on the problems that might occur, and could be presented in a more positive way. This session also consisted of a tour of the labour and birth suite, including one of the rooms they could be transferred to, which in most cases would be considered helpful to transferring couples. However, one partner said that when they were transferred in labour, to the very room they were shown during the transfer talk, they felt they had been taken to the place where 'things go wrong'. As a consequence, the

childbirth education class that focuses on the need for transfer could be more coupled. For example, the emphasis could be on how to keep the labour on the right track, how to maintain an upright and mobile uncomplicated labour and encourage couples to incorporate a potential transfer into their birth plan. This strategy would facilitate their ownership of the labour and birth rather than focus on the problems that might occur. Couples could be made aware and encouraged to consider requesting the telemetric, waterproof electronic fetal monitoring, the mobile oxytocin pump, the use of the shower or bath, fit balls, bean bags and floor mattresses rather than accepting the standard path to the bed and then remaining immobile for the duration of labour. Equally Midwives working in obstetric units also need to be aware of these options so that they become realistic choices for couples and those who find themselves in this position are not having to 'fight' for such initiatives.

Another frustration of both partners and birth centre midwives was not being listened to when they felt they had valuable information to offer. Embedded within syllabus for midwifery students is essential information about clinical handover using the iSoBAR (identify–situation–observations–background–agreed plan–read back) acronym (Porteous et al., 2009). iSoBAR is a useful tool which enables concise yet comprehensive handover of information which is imperative for all clinicians to follow in order to ensure that handover is succinct but informative. Students and midwives may need to improve their skills related to the fine nuances of picking up cues, both verbal and non-verbal and asking pertinent questions at the appropriate time. To illustrate this point, one partner in this WA study commented that he could see his wife's exhaustion before the midwife and wanted to communicate that this was beyond the expectation of albeit, sometimes extreme, labour behaviours. However, he felt he was ignored by the midwife and in the end had to become persistent to be listened to. Tertiary and professional development education must reinforce awareness of the partner's value in sharing thoughts, ideas and confirmation of carefully considered plans when any management questions are raised.

Similarly these WA midwives suggested they had more to offer the receiving team in the Obstetric Unit in terms of valuable information; knowledge that comes from being with the woman over the continuum of her pregnancy and labour journey thus far. Education for all maternity care providers around communication, including reinforcing the importance of listening skills would be beneficial to ensure full

advantage is taken at the point of handover to obtain all the relevant information. Best practice can then be provided, where knowledge of background, history, hopes and choices are understood by all. Once the basic iSoBAR information has been handed over there should be an 'anything else' point at which the midwife can add in salient facts such as, the woman's sister had a stillbirth six months ago, or the woman wants to cut the umbilical cord herself, or for a vacuum birth she would prefer not to have an episiotomy.

An essential component of all medical and midwifery education is the need for an opportunity to talk through events in the clinical setting, especially after a traumatic event (Faron & Hiner, 2015). An appreciation of how to conduct a debrief session can be explored by students in role-play situations in the classroom or through simulation learning activities. This knowledge can facilitate debriefing all women but especially those women and partners who have undergone an unexpected detour from their original labour and birth plans. Students should be taught and supported to adopt techniques that allow couples to feel they have the space to talk through events and be offered explanations for whatever transpired, together with an opportunity to talk about expectations for the next birth. Many couples in this WA study did not understand the decisions that were made during the labour and birth and how this may influence expectations for a subsequent pregnancy and birth. Another advantage of students being trained in skills around debrief is that it will also strengthen their own ability to recognise the need for debrief for themselves and colleagues and their ability to initiate and participate in the process with regards to their own clinical experiences.

The importance of continuity of care surfaced as a theme for all three parties and is another factor that should be addressed in all courses leading to midwifery and medical qualifications. The National Maternity Services Plan (Hames, 2010) states that this is women's preference and the reasons for women's choice should be respected and acknowledged in the education of health professionals. Comparing the different models of care available in Australia and internationally could assist students identify the value of continuity of care and reinforce how continuity of care is the gold standard. There are many opportunities for imparting this knowledge to students and practitioners, including its inclusion in midwifery and medical course syllabi. For qualified staff, education could take place at ad-hoc opportunities in the clinical area

by clinical midwifery consultants and managers, 'in-service' sessions and specifically-themed education days.

Implications and recommendations for future research

As with many studies, this WA birth centre study not only answered our aim and objectives but raised questions to be addressed by further research. The findings indicated that women, partners and midwives found the transfer experience difficult and contributed to disappointment, discomfort and confusion. Recommendations have been offered previously around how intrapartum transfer from a birth centre to a tertiary birth suite could be improved. However, the following key areas for future research should be considered a priority.

Firstly, this study could be expanded by considering the impact of transfer from stand-alone birth centres as well as alongside birth centres in order to determine differences for women, partners and midwives. There were comments from participants of this WA study that they felt grateful that the journey to the tertiary referral centre was close by; it made them feel they had the best of both worlds. It would be valuable to be able to directly compare these experiences with those having to make journey by ambulance to transfer to determine the differences.

When intrapartum transfer occurs, whether from an alongside or stand-alone birth centre, an area of interest would be to investigate decision making by midwives which has been found to be challenging both by this and other studies (Ball et al., 2016; Cheyney et al., 2014; Kuliukas et al., 2016c; Wilyman-Bugter & Lackey, 2013). There are opportunities to use challenging experiences as reflective learning which could be further investigated in the form of qualitative research. The main concerns the midwives raised was around the timing of their decision making and whether the decision to transfer was being made too early or too late, which could be due to being a lone practitioner in the birth centre. It would be valuable to know whether the concern they felt was due to inexperience and/or a concern of appearing to have made the wrong decision by the receiving team in the tertiary referral centre. An example of this is from the narrative of one midwife in this WA study, who spoke of her dilemma around transferring for delay in the second stage. The midwife had a previous experience of transferring a woman for delay and felt she was derided by the receiving staff when the woman birthed five minutes after transfer. When a similar problem

occurred she was understandably reluctant to transfer and waited, hoping that the woman would progress and birth quickly but then got to the stage when it felt too late. The midwife was then fearful of being disparaged for allowing a prolonged second stage of labour. Therefore it would be valuable to explore midwives' decision making and how it may be influenced by previous negative experiences.

Similarly, it could be useful to explore the value of group based case discussions by maternity care professionals. Midwives in this WA study commented that they valued being given the opportunity to discuss the cases they were involved with in detail with the interviewer researcher who was gathering data. Several suggested that it would be a useful learning opportunity to hold such discussions on a regular basis. It would be interesting to assess the value and experiences of such an interdisciplinary group through a qualitative research design.

Another topic worthy of further investigation would be to explore the cortisone levels of women, partners and midwives on the same birth journey to compare degrees of stress, collecting the samples by buccal swabs. The finding of this WA study of women being in 'the zone' of labour and partners being on 'high alert' and the emotions exhibited from this could be reflected in cortisol levels as the roller coaster of emotions, concerns, pain and anxiety unfolded. It would also be interesting to analyse the hormonal levels of midwives as they navigate the decision making process. This information would add to the body of knowledge about the levels of stress during labour and the impact physiologically on women, partners and midwives during the labour journey.

As well as measuring the stress of labour, an additional consideration would be to determine the incidence of post-traumatic stress suffered by women and their partners after an intrapartum transfer event. Although extant evidence demonstrates that women are affected by traumatic births (Gamble et al., 2004; Reed, Fenwick, Hauck, Gamble, & Creedy, 2014; Söderquist, Wijma, Thorbert, & Wijma, 2009), there is a need to also investigate the partners' experiences. Partners provide important support and the effects of doing so require further investigation. Anecdotally, from carrying out the interviews in this study, it seemed apparent that some partners were more stressed from the labour events than the women were. During the interviews the partners gave more detail to the events which were traumatic to them and some said

they would rather choose an elective caesarean for the next birth, rather than risk going through a similar experience. The majority of the women, in comparison, said they would not change any part of their birth journey and would go through the whole process again. It would be valuable to compare the after effects or trauma suffered, of the same journey from both perspectives. Similarly midwives might also feel trauma in such situations and as such another recommendation would be an intervention study that introduces the rotation of midwives (suggested under the section Implications and recommendations for changes in current clinical practice relevant for midwives) and examining the outcome this has for midwives, woman and their partners.

The trauma experienced by partners could be mitigated by improved preparation during the antenatal period. Looking at different methods to educate partners would also add to the body of knowledge. For example, exploration into the impact on partners who attend an increased number of antenatal visits, which might occur if more were offered during evenings and weekends, and whether it improves their level of involvement, information and preparation in order to lessen the impact and negative effects of intrapartum transfer.

In a similar way the value of antenatal classes which are more inclusive for partners could also be assessed by a qualitative study. Childbirth education which includes a partners' only class, possibly led by a man, would be interesting to explore as men may feel more comfortable to share concerns in a safe environment with other men.

Summary of Recommendations

Recommendations for clinical practice

- Support and expansion of midwifery led models of care must be continued allowing midwives to develop and maintain the special relationship with the woman and partner; essential components of being 'with woman' and acting as an advocate.
- Improvement of midwifery communication skills is essential in order to improve the advocacy role and be able to assertively represent the couple's perspective and preferences to the multidisciplinary team.
- To support a positive birth experience, health professionals must be encouraged to demonstrate characteristics of empathy, self-reflection and an intention to actively and respectfully involve women and their partner in care decisions,

ensuring their preferences are considered throughout labour and birth as much as is safely possible.

- The privacy of the ‘birth space’ must be respected and distractions such as brightly lit medicalised environments with people unknown to the women be restricted to facilitate the woman’s ability to focus inward during contractions. Attention should be considered to making the environment of labour rooms more home-like, designed to encourage upright positions and movement rather than a clinical, hospital atmosphere. Change to all obstetric environments should take place to allow women a ‘birth space’ which can be adjusted to present a birthing environment conducive to birth being recognised as a normal life event, such as movable furniture, dimmable lights, access to aromatherapy, baths and showers.
- To promote a positive birth experience for the woman and her partner, a ‘debrief’ opportunity with the midwife who provided intrapartum care should be encouraged in the early days, ideally five days post birth. During this session the midwife should refer to the clinical record as a resource as a memory jogger and for clarification.
- The partner should be encouraged and supported in care decisions as he may understand the woman’s preferences better than any other person.
- Health professionals must become familiar with the couple’s birth plan that they completed during pregnancy. This tool can also be used by the midwife to prepare the couple for potential events that may eventuate in the preferred pathway no longer being followed.
- Midwives working in the birth centre and the obstetric unit need to be involved in a peer support system to hold regular case reviews including intrapartum transfer events to review decisions made and facilitate learning. Open discussion could assist in midwives recognising and acknowledging the challenge of continuing to care for women in a model not aligned with their birthing philosophy to reinforce a need for open mindedness, flexibility and adaptiveness to maintain women-centred care.
- Introduction of a rotational or secondment system for midwives working in a midwifery-led model of care and the obstetric unit would help them gain an appreciation of the realities and skills required to practice in each setting.

- Women requiring an intrapartum transfer should always be accompanied by the midwife from their midwifery-led model of care. The relationship developed with this midwife is precious and must be respected and acknowledged. Although the couples will always be most familiar with their primary midwife, they must be introduced to all midwives who work in the small team with their primary midwife in case she is not be available during the intrapartum period.
- Clinical handover should acknowledge all relevant information including the knowledge the birth centre midwife has due to her close relationship with the couple.

Recommendations for policy

- Decision makers in healthcare systems must consider increasing low risk women's' access and choice to attend birth centres that are built alongside hospitals with maternity services. This arrangement can offer a model of midwifery continuity and holistic maternity care whilst affording a safe path when the childbirth journey veers away from normality.
- Decision makers in health must continue to support the increase in midwifery led care models in support of the National Maternity Services Plan recommendation. Women and partners should have access and choice to select the option of continuity of care from a known provider such as a Midwifery Group Practice model with a named primary midwife embedded in a small team.

Recommendations for education

- Partners must be afforded the same level of antenatal education as woman around the expectations and normal physiological processes of labour. This education can be made available to partners through antenatal education classes and also through attendance at antenatal appointments.
- Information presented through antenatal education to the woman and her partner should also address the possibility and reality of intrapartum transfer rates including transfer process and common reasons for transfer.
- Information presented during antenatal education could focus upon how to maintain and upright and mobile uncomplicated labour and encourage couples to incorporate a potential transfer in their birth plan. This strategy could facilitate their ownership of the labour and birth rather than focusing on problems.

- Couples who desire a midwifery-led model of care within a birth centre should also have the opportunity to tour the obstetric unit. This exposure to the obstetric environment may alleviate some of the initial anxiety couples experience when confronted by this unfamiliar environment should an intrapartum transfer become necessary.
- Findings regarding the intrapartum experiences of women, partners and midwives must be shared with student midwives, medical students and qualified staff during professional development sessions.
- Tertiary and professional development education for maternity health professionals must reinforce awareness of the partner's value in sharing thoughts, ideas and confirmation of carefully considered plans around labour and birth care.
- Midwives and students must be educated in how to conduct and facilitate a 'debrief session' with women, partners and colleagues.

Recommendations for further research

- The differences of an intrapartum transfer for the woman and partner who transfer to hospital whilst labouring at home could be explored, including the method of transfer such as an ambulance.
- The decision making processes that midwives undergo when determining how and when to conduct an intrapartum transfer could be evaluated and how these decisions may be influenced by previous experiences.
- The process and perceived value of group based case discussion by maternity health professionals could be explored.
- The cortisone levels of women, partners and midwives on the same birth journey could be evaluated to compare degrees of stress.
- The incidence and prevalence of post-traumatic stress experienced by women, partners and midwives following a 'perceived' traumatic birth experience could be determined.
- Perceptions of what women, partner and midwives consider a traumatic birth experience could be explored.

- The impact of partner's increased participation in antenatal visits could be evaluated by measuring their involvement in decisions around care and perceived satisfaction with the labour and birth experience.
- Partners' satisfaction of a targeted antenatal class facilitated by another father, could be evaluated, which may encourage men to share concerns and feelings in a safe environment with other potential fathers.

Limitations of the study

Transfer in labour is a concept that many couples who choose to birth in a birth centre hope and anticipate will not happen to them. The researcher's intention in using the phenomenological method was to pursue this enquiry and to disclose feelings, thoughts and perceptions in order to gain insight into their experiences when intrapartum takes place, however there were limitations to the study.

To begin with, an important limitation is that the researcher was a peer of the midwives in the birth centre, which could potentially have affected the dialogue of the midwives' interviews. The concern of midwives being influenced was discussed in depth with both study investigators and the birth centre midwives. However, because the researcher was not a manager, but at the same peer level as the midwife participants, it was considered to be unlikely to cause any major differences in what the midwives revealed. There was some confirmation that midwives were not inhibited when the interviews were commenced; there appeared to be complete openness with the researcher, with many midwives revealing doubts about their practice and decision making that they may not have revealed if there was any reservation on their part.

Secondly the inclusion criteria for this study meant that only couples who could speak English could participate. While the study included one Indian couple with excellent English skills, the data could have been richer if several different ethnic origins and cultural backgrounds had been included, although at this birth centre the majority of attendees were Caucasian.

Another limitation is that the study only included women who were accompanied by their life and birth partner and a birth centre midwife during their intrapartum transfer to the tertiary birthing suite. During the study period, birth centre midwives were not

always able to accompany the woman as they were obliged to hand over care to a labour and birth centre midwife due to other responsibilities, such as providing postnatal care to women in the birth centre. Thus, choosing women who were fortunate to be accompanied by a known midwife was not always usual practice, increased recruitment time, limited the number of couples who could be included in the study and did not give a voice to those who were handed over to birth suite staff. It would be important to give voice to couples who had not been accompanied by a birth centre midwife to the tertiary birth suite and compare their experiences.

Future research is warranted for women and their partners who planned to birth in a stand-alone birth centre and experienced an intrapartum transfer to an obstetric unit, as the scope of this study did not include the capacity to do so. In keeping with this phenomenological study, the focus was upon participants, women, partners and midwives, who experienced a similar experience, the phenomenon of accompanied intrapartum transfer from a birth centre to a tertiary birth suite.

An associated limitation with the researcher being an employed midwife in the birth centre and frequently undergoing the very process that was being investigated, namely intrapartum transfer, it was possible that the analysis of the data was coloured by previous assumptions. As a consequence, careful and detailed bracketing took place in order to consider these beliefs before the interviews and analysis was conducted. Additionally, the analysis was conducted by a research team of four, which comprised of the researcher and her higher degree supervision team, who did not work in the birth centre environment.

Conclusion

The study aim and objectives to discover the experiences of women, partners and midwives when intrapartum transfer occurs from a birth centre to a referral centre were fulfilled. Consequently, new knowledge has been generated adding to the existing body of work around a central phenomenon that is important to all maternity health professionals. In addition, this thesis provides a unique and innovative approach by offering an integration of the three groups of individual experiences. The resulting integrated themes provide comprehensive insight, greater than the sum of the three parts.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendices

Appendix A	HREC approval letter from Curtin University
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Appendix A

Human Research Ethics Committee approval letter from Curtin University



Memorandum

To	Professor Yvonne Hauck, Nursing and Midwifery
From	Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval HR 91/2013
Date	2 July 2013
Copy	Lesley Kuliukas, Nursing and Midwifery Dr Ravani Duggan, Nursing and Midwifery Dr Lucy Lewis, Nursing and Midwifery

Office of Research and Development
Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Committee (HREC) for the project titled "*The phenomenon of intrapartum transfer from a Western Australian birth centre to a tertiary maternity hospital: The experiences of women, partners and midwives*". The Committee notes the prior approval by King Edward Memorial Hospital Ethics Committee (WNHS) (2013031EW) and has reviewed your application consistent with Chapter 5.3 of the *National Statement on Ethical Conduct in Human Research*.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 91/2013**. *Please quote this number in any future correspondence.*
- Approval of this project is for a period of four years **02-07-2013 to 02-07-2017**.
- Annual progress reports on the project must be submitted to the Ethics Office.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Faculty Graduate Studies Committee.
- The following standard statement **must be** included in the information sheet to participants:
This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 91/2013). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **Progress Report** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development annually.

Our website https://research.curtin.edu.au/guides/ethics/non_low_risk_hrec_forms.cfm contains all other relevant forms including:

- Completion Report (to be completed when a project has ceased)
- Amendment Request (to be completed at any time changes/amendments occur)
- Adverse Event Notification Form (If a serious or unexpected adverse event occurs)

Yours sincerely

Professor Stephan Millett
Chair Human Research Ethics Committee

Appendix B

Human Research Ethics Committee approval letter from King Edward Memorial Hospital



Government of **Western Australia**
Department of **Health**

WOMEN AND NEWBORN HEALTH SERVICE

Mrs Lesley Kuliukas
7 Rossmoyne Drive
ROSSMOYNE WA 6148

Dear Mrs Kuliukas

REGISTRATION NUMBER: 2013031EW

TITLE: **The phenomenon of intrapartum transfer from a Western Australian birth centre to a tertiary maternity hospital: The experiences of women, partners and midwives**

MEETING DATE: 07 May 2013

RGO and Ethics requirements satisfied on 07 May 2013

The WNHS Ethics Committee has recommended approval be given for you to undertake the abovenamed research study. This recommendation has been ratified by the Women's and Newborn Health Service.

The Ethics Committee does however wish to be informed immediately of:

- I. any untoward effects experienced by any participant in the trial where those effects in degree or nature were not anticipated by the researchers, and steps taken to deal with these,
- II. substantial changes in the research protocol together with an indication of ethical implications, and
- III. other unforeseen events.

The Ethics Committee has been charged with the responsibility of keeping the progress of all approved research under surveillance. A copy of the final result must be forwarded to the Committee upon completion of the research or if the research is not completed within twelve months you are asked to submit a progress report and annually thereafter. This information should include:



Appendix C

Information Letter for Women and Partners:

Exploring the experiences of women, support partners and midwives when transfer in labour takes place from the Family Birth centre to King Edward Memorial Hospital Labour and Birth Suite.

Why are we doing the study?

Women planning to birth in the Family Birth centre (FBC) may have to transfer in labour. Although there has been limited research looking into women's experiences when this takes place, none has taken place in Western Australia, and none has included the experiences of the woman's partner and midwife.

Who is carrying out the study?

The research is being conducted by Lesley Kuliukas (PhD student) and supervised by Dr. Yvonne Hauck, Dr. Ravani Duggan and Dr. Lucy Lewis.

What will the study tell us?

Although we are aware of the statistical outcomes when transfer takes place we have little knowledge around the experiences of women, partners and midwives. New knowledge will help health care providers' understanding of the emotional impact of transfer and how it might affect future choices. This understanding will aid care of women such as yourself and their partners during this transition of care. The aim of the study will be to examine the experiences of women, their support partners and midwives when intrapartum transfer occurs in order to analyse the different events and incidents that may impact on the birth experience and how these affect the overall impression and reflection of labour and birth in order to determine what measures can be introduced to improve the disruption to labour and the birth experience.

What will you be asked to do if you decide to take part in this study?

If you consent to participate, you will be invited to a face-to-face interview. The interview will be at a time and date convenient to you and will be audio recorded. The interviews will be transcribed but names will be changed and any identifying information will not be identifiable. Participation in this study is completely voluntary.

As a participant you are free to withdraw at any time without it affecting your current or future care in any way.

Is there likely to be a benefit to other people in the future?

Your feedback could assist us to understand the experiences that women such as yourself are faced with and the impact these have on their birthing experience so that strategies can be developed to help improve the experience for these women and their partners when transfer takes place.

What is my involvement in the study?

Your involvement in the study will be to participate in a one-to-one interview to share your perceptions of your transfer from the Family Birth centre to King Edward Memorial Hospital while in labour. The interview will be digitally recorded and carried out in your home or the Family Birth centre according to your preference. The interviewer is an experienced Registered Midwife, employed in the FBC who is currently researching this issue as a PhD student. It is expected that the interviews may take up to 45 minutes.

Where is your information kept?

All information will be stored on a password protected computer at Curtin University. The transcribed interviews and field notes will be kept in a locked filing cabinet in the researcher's locked office for a period of 5 years and then destroyed.

What about my privacy?

Interview transcripts will not have name-identifying data on them and will be coded by a number to ensure confidentiality. The consent forms will be kept in a locked filing cupboard separately from the interview data. All the information we collect will be kept private and confidential. Only the researchers will know your identity. The findings of the research may be published in an academic journal but you will not be identifiable.

Who has approved the study?

The Human Research Ethical Committee at King Edward Memorial Hospital and Curtin University Human Ethics Committee have approved the study.

Who to contact if you have any further questions or concerns about the organisation or running of the study?

The researcher, Lesley Kuliukas on (08) 92664035 or supervisor Dr. Yvonne Hauck on (08) 9266 2076 will be available by phone call or appointment to answer or clarify any questions. If you have any concerns or complaints you can contact the Ethics Committee at KEMH on (08) 9340 7845 or by email at kemhethics@health.wa.gov.au AND/OR Curtin Human Research Ethics Committee on (08) 9266 7863 who are monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANK YOU FOR YOUR TIME

Appendix D

Consent Form (Women and Partners)

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND SUBJECTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT ON CURRENT OR FUTURE CARE.

Ihave read

Given Names

Surname

the information explaining the study entitled Exploring the experiences of women, support partners and midwives when transfer in labour takes place from the Family Birth centre to King Edward Memorial Hospital Labour & Birth Suite

I have read and understood the information given to me and agree to participate in the study. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not interfere with routine care.

I understand that in the event of this work being published, as a participant, I will not be identifiable in any way.

Dated: day of 20

Signature

I, have explained the above to

(Investigator's full name)

the signatory who stated that she understood the same.

Signature

Appendix E

Information Letter for Midwives (Interviews)

Exploring the experiences of women, support partners and midwives when transfer in labour takes place from the Family Birth centre to King Edward Memorial Hospital Labour & Birth Suite

Why are we doing the study?

Women planning to birth in the Family Birth centre (FBC) may have to transfer in labour. Although there has been limited research looking into women's experiences when this takes place, none has taken place in Western Australia, and none of the research includes the experiences of the partner and midwife.

Who is carrying out the study?

The research is being conducted by Lesley Kuliukas (PhD student) and supervised by Dr. Yvonne Hauck, Dr. Ravani Duggan and Dr. Lucy Lewis.

What will the study tell us?

The aim of the study will be to examine the experiences of women, their support partners and midwives when intrapartum transfer occurs in order to analyse the different events and incidents that may impact on the experience of transferring women in labour from 3 different perspectives. The general experience of transfer from a midwife's point of view will also be examined.

What will you be asked to do if you decide to take part in this study?

Your involvement in the study will be to participate in one-to-one interviews specific to the care of women who you transferred in labour and stayed with (for any length of time) from the Family Birth centre to King Edward Memorial Hospital. The interviews will be digitally recorded and carried out in the FBC. The interviewer is a midwife who is currently researching this issue. It is expected that the interviews will vary in time but may take up to 30 minutes. Participation in this study is completely voluntary. As a participant you are free to withdraw at any time without consequence or prejudice.

Where is your information kept?

All information will be stored on a password protected computer at Curtin University. The transcribed interviews and field notes will be kept in a locked filing cabinet in a locked office at Curtin University for a period of 5 years and then destroyed.

What about my privacy?

Interview transcripts will not have name-identifying data on them and will be coded by a number to ensure confidentiality. Each case will be coded separately so that midwives who are interviewed more than once are not linked. The consent forms will be kept in a locked filing cupboard separately from the interview data. All the information we collect will be kept private and confidential.

Who has approved the study?

The Human Research Ethical Committee at King Edward Memorial Hospital and Curtin University Human Ethics Committee have approved the study.

Who to contact if you have any further questions or concerns about the organisation or running of the study?

The researcher, Lesley Kuliukas on (08) 92664035, or Dr. Yvonne Hauck on (08) 9266 2076 will be available by phone call or appointment to answer or clarify any questions.

If you have any concerns or complaints you can contact the Ethics Committee at KEMH on (08) 9340 7845 or by email at kemhethics@health.wa.gov.au AND/OR Curtin Human Research Ethics Committee on (08) 9266 7863 who are monitoring the study.

What to do next if you would like to take part in this research:

If you would like to take part in this research study, please read and sign the consent form provided.

THANK YOU FOR YOUR TIME

Appendix F

Consent Form (Midwives)

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND SUBJECTS CAN WITHDRAW AT ANY TIME WITH NO IMPACT

Ihave read

Given Names

Surname

the information explaining the study entitled Exploring the experiences of women, support partners and midwives when transfer in labour takes place from the Family Birth centre to King Edward Memorial Hospital Labour & Birth Suite.

I have read and understood the information given to and agree to participate in the study. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage with no consequences.

I understand that in the event of this work being published, as a participant, I will not be identifiable in any way.

Dated day of 20

Signature

I, have explained the above to the

(Investigator's full name)

signatory who stated that she understood the same.

Signature

Appendix G

Interview Guide.

Each interview will begin with asking whether there are any questions before the tape recorder is turned on while also noting that it can be stopped at any time. Each interview will be recorded with a digital recorder. To protect each participant's identity a pseudonym will be used when transcribing occurs and the interviews will be conducted whilst alone and if necessary (if a meeting room is used) a 'Do Not Disturb: Interview in Progress' sign will be put on the door (Trier-Bieniek, 2012). The woman will be asked an open question in order for her to tell her story. The list of questions is to be used as a prompt or guide, not to direct the conversation. The questions are to remain fluid and flexible depending on the direction the woman takes while answering.

Interview guide: Woman

Thank you for agreeing to participate in this study. The aim is to try to discover more about the experiences parents have when they planned to have their baby in the Family Birth centre but were transferred in labour to KEMH. **I would like you to tell me about your experience right through from when you started labour until the birth of your baby.**

Potential prompt questions as needed:

- Can you explain what led you to choose the FBC to have your baby?
- Did you have a birth plan? If so what were the most important choices that you made?
- In the antenatal period did you consider that you might be transferred in labour? If so how did that make you feel?
- Were you given any information about possible transfer? Was there any other information you would have liked to have known?
- What do you remember about the events leading up to the transfer?
- What do you understand about the reason for your transfer?
- What do you remember about the actual transfer? What explanation or information did you receive?
- Tell me about the transfer journey from FBC to L&BS?
- What are your recollections about arriving on L&BS? What expectations did you have?
- Did your midwife stay with you? For how long?
- What support do you feel she provided?
- What kind of birth did you have? How did that go? Did you receive enough information? What were your feelings? Did you receive enough information and support?

- How do you feel about the whole experience now? Do you have any ongoing problems or worries?
- If you're planning another baby at some stage in the future where do you think you would choose to go? Why?
- What advice would you give to your friends about the whole experience?
- What do you think could have been done to make whole experience better?

Appendix H

Interview guide: Partner

Thank you for agreeing to participate in this study. The aim is to try to discover more about the experiences parents have when they planned to have their baby in the Family Birth centre but were transferred in labour to KEMH. **I would like you to tell me about your experience right through from when your partner started labour until the birth of your baby.**

Potential prompt questions as needed:

- Can you explain what led you to choose the FBC to have your baby?
- Did you have a birth plan? If so what were the most important choices that you made? Did your partner ask you to ensure that certain parts of it were carried out, e.g. “Make sure you don’t let them give me an epidural?”
- In the antenatal period did you consider that you might be transferred in labour? If so how did that make you feel?
- Were you given any information about possible transfer? Was there any other information you would have liked to have known?
- What do you remember about the events leading up to the transfer? How did you feel?
- Do you understand why you were transferred?
- Were you given any choice? Do you feel you were involved in the decision?
- What do you remember about the actual transfer? Did you receive explanation, information? How was your partner cared for? How did you feel?
- What do you remember about the transfer journey from FBC to L&BS?
- What are your recollections about arriving on L&BS? Did you have any expectations? How did you feel?

- What kind of birth did your partner have? How did that go? Did you receive enough information? What were your feelings? Did you receive enough information and support?
- Did you return to the FBC afterwards? With the same midwife? If not back to FBC where did you go and why?
- How do you feel about the whole experience now? Do you have any ongoing positive/negative feelings?
- If you're planning another baby at some stage in the future where do you think you would choose to go? Why?
- What advice would you give to your friends about the whole experience?
- How do you feel the experience could have been made better?

Appendix I

Interview Guide: Midwife

Each interview will begin with asking whether there are any questions before the tape recorder is turned on while also noting that it can be stopped at any time. Each interview will be recorded with a digital recorder. To protect each participant's identity a pseudonym will be used when transcribing occurs and the interviews will be conducted whilst alone and if necessary (if a meeting room is used) a 'Do Not Disturb: Interview in Progress' sign will be put on the door (Trier-Bieniek, 2012). The midwife will be asked an open question in order for her to describe her experience. The list of questions is to be used as a prompt or guide, not to direct the conversation. The questions are to remain fluid and flexible depending on the direction the midwife takes while answering:

Thank you for agreeing to participate in this study. The aim is to try to discover more about the experiences parents and midwives have when intrapartum transfer takes place from the FBC to L&BS. **I would like you to tell me about your experience from when your involvement started with this couple right through to the birth.**

Potential prompt questions as needed:

- Did you meet the woman prior to labour?
- Did she have a birth plan? What were her main priorities?
- At what point in labour did you first consider that transfer may have to take place? Why?
- Describe the whole transfer process from the moment you made the decision until you arrived on L&BS.
- Were you able to obtain timely manual (PCA or orderly) help for the transfer?
- How did the transfer take place? (Trolley, chair, walk?)
- Was it an emergency transfer? If so how long did it take from the decision being made to arrival on L&BS?
- What do you remember about the actual transfer? How did you feel? Did you feel conflicted in any way?

- Was there a member of staff waiting for you when you arrived on L&BS? Was the room set up for your arrival?
- Did you stay with the woman? For how long?
- What was the outcome?
- Did you feel supported? Did you get help?
- Did the woman return to the FBC afterwards? With you? If not back to FBC where did she go and why?
- How do you feel about the whole experience now? Do you have any ongoing positive/negative feelings?
- How do you think the transfer process could have been improved upon?