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Fox, D., Sheehan, A., Homer, C. 2018 'Birthplace in Australia: Processes and interactions during the intrapartum transfer of women from planned homebirth to hospital'

Structured abstract

Objective

The aim of the study was to explore the views and experiences of women, midwives and obstetricians on the intrapartum transfer of women from planned homebirth to hospital in Australia.

Design

A Constructivist Grounded Theory approach was taken, so as to conceptualise the social interactions and processes grounded in the data.

Setting

Urban and regional areas in four states of south-eastern Australia.

Participants

Semi-structured qualitative interviews were conducted with 36 women, midwives and obstetricians who had experienced an intrapartum homebirth transfer within three years prior to the interview. Interviews were audio recorded and transcribed verbatim.

Findings

Women who were transferred to hospital from a planned homebirth made physical and psychological journeys out of their comfort zone, as they faced the uncertainty of changing expectations for their birth. The trusting relationship between a woman and her homebirth midwife was crucial to women's sense of safety and well-being in hospital.

Midwives and obstetricians, when congregating in the hospital birthing rooms of transferred women, also felt out of their comfort zones. This was due to the challenges of converging with others who possessed conflicting paradigms of safety and risk in birth that were at odds with their own, and adapting to different routines, roles and responsibilities. These differences were derived from diverse professional, social and personal influences and often manifested in stereotyping behaviours and 'us and them' dynamics. When midwife-woman

partnerships were respected as an inclusive part of women's care, collaboration ensued, conflict was ameliorated and smooth transfers could be celebrated as successes of the maternity care system.

Key conclusions

Supporting woman centred care in homebirth transfers means acknowledging the social challenges of collaborating in the unique context of a transferred woman's hospital birthing room. Understanding the power of the midwife-woman partnership, and its value to the health and well-being of each woman and her baby, is key to facilitating a successful transfer.

Implications for practice

The midwife-woman partnership played a central role in providing the necessary support and advocacy for women transferred out of their comfort zone. When midwives worked together in an integrated system to provide the necessary care and support for women who were transferred, greater levels of collaboration emerged and women's perceptions of their quality of care was high. In practice, this meant health professionals respecting each other's roles, responsibilities and expertise, and ameliorating 'us and them' dynamics.

Keywords

- Birth Place
- Home childbirth
- Hospitals, maternity
- Intrapartum Care
- Midwifery
- Obstetrics

Highlights

- During homebirth transfer, women and caregivers transferred out of their comfort zones.
- Understanding the value of the midwife-woman partnership was key to woman centred care.

- Collaborative care meant midwives respecting each other's expertise, roles and responsibilities.
- Smooth transfers should be celebrated as a success of the system, rather than as failed homebirths.

Manuscript

Introduction

Evidence supports the safety of planned homebirth for women with low risk pregnancies, in the presence of professional midwives who have established collaborative arrangements for medical consultation, referral and transfer (Catling-Paull et al. 2013; de Jonge et al. 2009; de Jonge et al. 2013; Hutton et al. 2016; Keirse 2014). Although one study reported a small increase in the absolute risk of outcomes for the babies of women having their first baby at home (Brocklehurst et al. 2011), a larger study by de Jonge et al. (2015) did not find any differences by parity in serious adverse neonatal outcomes. When transfer to hospital from a planned homebirth (if required) is not handled smoothly, safety and well-being may be compromised for the women and babies involved (Davis-Floyd 2003; Vedam et al. 2014).

Relatively few women in Australia choose, or have access to, planned homebirth. In 2013, only 0.3% of all births in Australia occurred at home (Australian Institute of Health and Welfare 2015). The identification of the optimal setting for birth with access to medical backup is important, so women can make informed choices around place of birth.

Regardless of biomedical opposition to homebirth on the grounds of safety, some women will always choose to birth at home (Catling-Paull, Dahlen & Homer 2011).

Most intrapartum transfers from planned homebirths to hospital are non-urgent. The most common indication is delayed progress in labour (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Cheyney et al. 2014a; Davies et al. 1996; Lindgren et al. 2008; Murphy & Fullerton 1998; Rowe et al. 2013; Tyson 1991). Other less common indications include a request by the woman for pharmacological pain management (Amelink-Verburg et al. 2008; Cheyney et al. 2014a) or the unavailability of her homebirth midwife (Lindgren et al. 2008).

Small numbers of women are transferred due to emergencies (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Davies et al. 1996; Durand 1992; Lindgren et al. 2008; Murphy & Fullerton 1998; Rowe et al. 2014; Tyson 1991).

International studies demonstrate a trend for larger proportions of primiparous women to be transferred than multiparous women (Blix et al. 2012; Blix et al. 2014; Blix et al. 2016; Brocklehurst et al. 2011; Tyson 1991; Wiegers, Zee & Keirse 1998). Much is known about rates of transfer but literature on the experiences of the women and caregivers involved is limited.

Maternity Services in Australia

Most women in Australia give birth in private or public hospital settings. In the public system, women experiencing healthy pregnancies are primarily cared for by midwives and women experiencing complications are primarily cared for by obstetricians. In the private system, women are primarily cared for by private obstetricians. Midwifery education in Australia occurs in university settings and must meet national accreditation standards. The current pathways to midwifery registration include a three-year Bachelor of Midwifery degree, four-year dual degree (Bachelor of Nursing/Bachelor of Midwifery), or a twelve to eighteen-month post-graduate diploma, for which nursing registration is a pre-requisite (Gray, Taylor & Newton 2016). All midwives are registered to practise across the full continuum of childbearing in hospitals, birth centres or at home. The majority work in hospitals only (Australian Government 2017), and therefore would work in the homebirth context only when receiving a woman transferred in to hospital. There are only a few hospitals offering practising rights to privately practising midwives.

Women can access homebirth in Australia in two ways. Publicly funded homebirths have emerged as a model of maternity care in Australia with most of the 15 services in place at the time of writing being established in the past decade (Catling-Paull, Dahlen & Homer 2011; Catling-Paull, Foureur & Homer 2012; Catling-Paull et al. 2013; McMurtrie et al. 2009; University of Technology Sydney (UTS) 2015). Publicly funded homebirth services in

Australia are available to women living within a 30-minute drive from the public hospital to which they are attached. An evaluation of the publicly funded homebirth programs in Australia showed a high normal vaginal birth rate (90.3%), a high intact perineum rate (56%), a low caesarean section rate (5.4%) and a transfer rate of 17.4% (Catling-Paull et al. 2013).

Women can also access homebirth in Australia by engaging the services of a self-employed privately practising midwife. Privately practising midwives provide antenatal and postnatal care in the community and may also offer homebirth care and/or birth support in hospital. Many are Medicare-eligible, which means that women they care for can receive government rebates for the cost of their antenatal and postpartum care. However, due to the lack of indemnity insurance available to privately practising midwives for intrapartum care in the home, women cannot obtain rebates for intrapartum services at home, making the cost of engaging a privately practising midwife financially prohibitive for some women.

Our metasynthesis of the literature on women's experiences of transfer from planned homebirth is published elsewhere (Fox, Sheehan & Homer 2014). The literature on caregivers' experiences of homebirth transfer demonstrates that interactions between different caregivers may involve conflicting paradigms of childbearing. This may function as an opportunity to develop and strengthen connections between them, or it may serve to consolidate discord, potentially threatening women's safety and well-being (Cheyney & Everson 2009; McLachlan et al. 2016; Vedam et al. 2012; Vedam et al. 2014). The presence of conflict between homebirth midwives and hospital staff may impact upon the ability of a homebirth midwife to provide continuity of carer during a transfer. Her access to the hospital may depend upon both her credentials (Vedam, Goff & Marnin 2007) and her relationships with hospital staff (Dahlen 2012; Foley & Faircloth 2003; McCourt et al. 2012; Vedam et al. 2014). The significance of this is that the ability of the homebirth midwife to provide continuity of care throughout the transfer and into the hospital setting is important, both to women (Fox, Sheehan & Homer 2014) and to homebirth midwives (Ball et al. 2016; Wilyman-Bugter & Lackey 2013).

The aim of this study was to explore the processes and interactions that occur during transfer from the perspectives of women, midwives and obstetricians involved in the intrapartum transfer of a woman from a planned homebirth to hospital.

Methods

Constructivist grounded theory was the approach used for this study, because it emphasises the conceptualisation of social interactions and processes involved in human experiences and formulates theory grounded in the data (Charmaz 2014; Dey 2004; Hall, Griffiths & McKenna 2013; Skeat 2010). The constructivist approach to grounded theory enabled the exploration of views and experiences of women and their caregivers, as well as the processes of interaction and the contexts and environments in which they occur. The analysis spans across individual people and single events to reveal an analysis of the interactions that occur between individuals and the processes that brought about and resulted from events, and the relationships between those interactions and those processes (Charmaz 2011).

Thirty-six semi-structured interviews were conducted face-to-face or by phone with women, midwives and obstetricians in 2014 and 2015. The interviews were conducted with the first author, herself a midwife, in participants' homes or workplaces. The interviews varied in length from 30 minutes to 2 hours. Data were audio recorded and transcribed verbatim. Field notes were taken, to describe the setting and context of the interview and to make note of significant non-verbal actions and interactions.

Grounded theory methodology involves two phases of sampling, namely initial sampling and theoretical sampling. The initial sample was 10 women and 20 caregivers. Due to the sample including different groups of midwives (midwives from private, public and hospital settings), who offered rich and complex data, theoretical saturation was not reached until 21 midwife

interviews were completed. The sample therefore increased to a total of 36. Most participants were not known to the interviewer prior to study commencement.

Initial sampling was purposive. Participants were recruited from private midwifery practices, two publicly funded homebirth programmes and personal networks, across four states of south eastern Australia. No participants withdrew from the study.

The woman's births had occurred in the three years prior to the interview taking place. This period was chosen in order to recruit adequate numbers of women and because in the past three years the expansion of publicly funded homebirth models has occurred. Participating health professionals were not necessarily caregivers of the individual childbearing women interviewed, although this occurred coincidentally in a few instances.

Interviews were conducted with:

1. Ten women who, in the past three years, had planned a homebirth and were subsequently transferred to hospital during labour or with their baby soon after birth. Each is described in the Findings as a 'homebirth woman'.
2. Thirteen midwives who, in the past three years, cared for women as described above (1) at home. Each is described in the Findings as a 'homebirth midwife' (HBM)
3. Eight midwives working in a hospital who, in the past three years, experienced receiving women as described above (1). Each is described in the Findings as a 'hospital midwife' (HospM)
4. Five medical staff working in a hospital who, in the past three years, experienced receiving women as described above (1). Each is described in the Findings as an 'obstetrician'.

NVivo 10 software was used to sort and store data. Initial and focussed coding, categorising, constant comparison and theory development was undertaken simultaneously, whilst further interviews took place, as per the methods of grounded theory analysis outlined by Charmaz (2014). Pseudonyms have been used, to protect the confidentiality of the

participants. Ethics approval was granted by the Human Research Ethics Committees of the University of Technology and two health services.

Findings

The findings comprise three categories that explain the interactions and processes involved in the intrapartum transfer of a woman from a planned homebirth, namely: *'Transferring out of the comfort zone'*, *'Encountering us and them'* and *'Celebrating a successful transfer'*.

Transferring out of the comfort zone

Women undertook psychological journeys, as they found themselves *'Transferring out of the comfort zone'* of their homes into hospital. Women said that being in their own familiar environment was, *'one of the biggest reasons I had wanted a homebirth'* (Tess, homebirth woman). Being transferred out of the comfort zone of their homes was challenging for women:

It's being removed from your little comfortable place into a place that's not your place...you'd had your little nest where you were going to give birth in and then suddenly it changed (Mary, homebirth woman).

I was immediately struck by how clinical and white it was. It just didn't have any warmth to it at all. The lights were bright and the room felt bare and unhomey (Tess, homebirth woman).

The trusting relationship between a woman and her homebirth midwife (HBM), herein referred to as the *'midwife-woman partnership'*, was crucial to women's well-being, as Mary expressed, *'I still felt very safe because I had [my homebirth midwife] there'* (Mary, homebirth woman). Having support and advocacy from their midwife in hospital was often described as having someone *'on their side'*, as Tess said:

If you have to go to a hospital, having someone there who you know is on your side, who shares your values, who you've chosen to be on your team, that you've spent time with leading up to the birth and then who would continue to be with you afterwards, is just so, so worth [it]...having familiar faces there, people you trust,

whose opinion you trust, I think that is the key to having a positive birth experience at a hospital (Tess, homebirth woman).

The presence of the HBM was crucial for women at the time of transfer, when they were feeling most vulnerable. Midwives said that they *'need to be able to follow women through when those...scary scenarios happen to women. The women need the person they know and trust'* (Jill, HBM).

The psychological journey women took when being transferred to hospital involved managing their changing expectations for how their labour and birth might unfold. This required a sense of *'being aware, sensitive [to]...managing changing expectations...when plans change, that's a psychological journey for people to travel'* (Thalia, obstetrician).

Women valued having time to think about their options and to manage the psychological impact of their decisions in this journey. Even in urgent situations, it was usually still possible to enable women to have a few minutes to process what was occurring:

'Sometimes in obstetrics there is no time, but usually there is. And even if it's five minutes, that five minutes can make a big difference [to women]' (Thalia, obstetrician).

Communicating effectively with women about the clinical changes that were occurring was also key:

So much of what we do is about communication with the women we work with about how things have changed. 'This has now developed, this is now the pathway that we recommend that you go down, [we understand] that's not what you were planning and that's not what you're envisaging'. And that's a skill set that we, obstetricians, midwives, all of us need to have; it's critical in what we do (Thalia, obstetrician).

Midwives and obstetricians also found themselves transferring out of their comfort zone when they congregated in the hospital birthing rooms of transferred women, as they strived to collaborate in the social context of homebirth transfer. Other health professionals may have paradigms of safety and risk in birth that were at odds with their own: *'How well [a transfer] goes all depends on the attitudes that we all bring...and they're formed by what our*

personal opinions are about women's birthing choices' (Thalia, obstetrician). Adapting to different professional roles and responsibilities was complex and challenging. The second category, *'Encountering us and them'*, deals more specifically with interactions in the birthing room between HBMs and hospital staff.

Encountering 'us and them'

Homebirth midwives and hospital midwives (HospMs) often encountered *'us and them'* dynamics emerging in the transfer setting, saying, for example, *'It seems there is this you and us thing'* (Daisy, HBM) and, *'You do get that animosity sometimes between them and us. It's not nice'* (Laura, HospM). The behaviours that which engendered *'us and them'* dynamics included stereotyping, resisting, blaming and taking over.

HospMs reported that they were *'very aware of the stereotypes surrounding women who had [planned] homebirths'* (Kay, HospM). Women transferred from a planned homebirth were often stereotyped as *'people that were difficult'* (Charles, obstetrician), and *'patients that are quite hard work...[who] won't take direction'* (Keith, obstetrician). There was an expectation that women who had planned homebirths were more burdensome to care for than women who chose hospital birth. HospMs felt that transferred women *'don't want to listen to any advice'* (Ellen, HospM) and are *'very hard to look after, sometimes, because they are not prepared to bend or compromise'* (Laura, HospM).

Most hospital staff recalled experiences in which they had struggled to deal with resistant behaviour from transferred women and their HBMs. Midwives tried to support and advocate for women but sometimes hospital staff felt unable to communicate directly with the women. This led to a delay in assessment or treatment, as expressed here: *'Sometimes you're not allowed to speak to the woman and it has to go through the [homebirth] midwife and...that can lead you down the pathway of the Swiss cheese and the baby is even further compromised'* (Lily, HospM). HospMs felt disrespected if they sensed resistance, as this quote demonstrates:

I find that the respect isn't two way, which really annoys me...you'll say, 'Do you mind if I do a blood pressure?' Well the eyes roll, and that could be the midwife, that could be the support team, that could be the woman (Ellen, HospM).

Lack of respect from another midwife was difficult to accept for HospMs, as one said, *'...to be quite honest it would get my back up if she wasn't backing and supporting what I was saying, as a midwife'* (Laura, HospM). HospMs felt much less willing to cooperate if they felt disrespected: *'You would sort of get your back up, and go, "Do you know what? Stuff you, I'm not doing this...Can you just get that baby out quick smart so I don't have to be involved in this anymore?"'* (Ellen, HospM).

The blame for complications experienced by women was often apportioned to perceived misdemeanours of HBMs, accentuating the 'us and them' dynamic, as expressed here:

They blame the midwife...something's gone wrong and the midwife should have figured it out 5 hours ago, and not now. There is a feeling and a judgement by the midwives at the hospital that this decision could have been made sooner and therefore the outcome could have been less harrowing for the woman (Cassie, HospM).

HBMs often sensed that blame was being directed toward them, for example, *'I felt like I was being intentionally intimidated and bullied...I think that they [hospital staff] were looking to see if I had done something wrong so they could pin it on me'* (Tracy, HBM). Iris described the treatment she received from a doctor who suggested that she was of unsound mind for having assisted the woman to plan a homebirth: *'[The woman] was assessed and then I hear...the obstetrician calling me...he starts abusing me in the passage...[saying] "Are you mad? You've lost your...head!"'* (Iris, HBM). Bullying behaviours had the potential to develop when 'us and them' dynamics were allowed to flourish.

'Us and them' dynamics were heightened by hospital policies that stated that the clinical rights and responsibilities of HBMs ceased in the hospital setting. Midwifery managers in hospitals directed their staff to take over the care of transferred women: *'I was given the*

talk that we were responsible for her care once she came, and so the care with her midwife at home dissolved, disappeared' (Kay, HospM). Adhering to the requirement to take over, HospMs sometimes received women's care similarly to the way they might take over at a routine change of shift, for example: *'Assuming that someone has come in from a homebirth and it is not working out too well then certainly the expectation is that you would definitely take over from that [homebirth] midwife'* (Thea, HospM). In a routine hospital shift change, when one midwife finishes a shift and hands over to another midwife, the former midwife then goes home. At that point hospital staff are adept at quickly developing rapport: *'We have to meet the woman when she presents for labour. And most people are so used to that that they can establish a rapport very quickly'* (Lily, HospM).

Other HospMs perceived the social and professional dynamics of a homebirth transfer as a more complex situation, as this quote demonstrates:

The difficulty initially, was that knowing the intensity of that relationship between...the woman and her midwife...being the person to take over care once this woman walked in the place and sort of just move on...I couldn't work out my role (Kay, HospM).

HBMs accepted the loss of their clinical rights in hospital but strived to maintain their partnerships with women. This sometimes contributed to the development of 'us and them' dynamics because negotiating their role was difficult when HospMs expected to take over women's care in every sense, clinically and emotionally. One HBM said:

Occasionally you get [hospital] midwives who just don't get it at all, and who just try desperately to...be the support person for the woman and that's just not appropriate...Who owns this woman that's in the room? Well no one does. But who will she look for, for emotional support? It will be me, not you! (Trish, HBM).

The midwife-woman partnership was, therefore, a powerful entity that impacted upon the dynamics between caregivers. Uncertainty around ways of enacting interprofessional roles and responsibilities had the potential to cause at best, discomfort, and at worst, conflict and animosity. When the strengths and nuances of the midwife-woman partnership were poorly understood, uncertainty prevailed, as this quote illustrates:

They've had the relationship together for...months. I don't know who or where the pressure starts with a relationship like that. Are you influencing her or is she influencing you? Are you advocating for her or is she advocating for herself, only by what you've told her?...You can't break down all of that in that short space of time (Blair, obstetrician).

Although policies stating that HospMs must take over clinical responsibility for the care of transferred women were clear; there was little guidance as to how to approach their interactions with the midwife-woman partnership. HospMs noticed that *'taking over was awkward, because they [homebirth midwives] don't want to let go'* (Thea, HospM). HBMs observed that hospital staff would *'very easily be riled by it [the midwife-woman partnership], irritated by... [what they saw as] that power, ego thing happening in the room'* (Jill, HBM). Ultimately, the most unfortunate consequence of this conflict was for women, as Barbara noticed:

If you start getting someone who comes in and dictates...the woman [feels] that she's a failure because she hasn't had her birth at home...In some instances, the medicalised model needs to be involved. But they don't have to take over, they could work alongside (Barbara, HospM).

Midwives being able to work alongside each other meant that 'us and them' dynamics were ameliorated, as Kay described:

I wanted to quickly establish that actually, I am an okay person and there are some nice people in here and...we want everything to go well now...you have just got to bide your time and build the relationship slowly...you think, 'Oh, okay, alright, let's just see how things go because I actually want to be a part of this and I am not going to treat you badly because of it' (Kay, HospM).

The third category, *'Celebrating a successful transfer'* draws further upon the positive experiences of HBMs and hospital staff, exploring the ways in which they collaborated to provide successful transfers that optimised the health and well-being of each individual woman and her baby.

Celebrating a successful transfer

The value of regarding transfer as a success of the system, rather than a 'failed homebirth' meant '*Celebrating a successful transfer*'. Providing smooth processes for timely, safe and woman centred care in the setting of a transfer from planned homebirth to hospital enabled positive outcomes for women and babies, as these quotes demonstrate:

They [women] should be celebrating the fact that they've been smoothly and efficiently and appropriately moved to the venue where they can have their baby...The transfer to a hospital should be celebrated. It's a positive thing (Keith, obstetrician).

Wow! How well did that work?...[There] was no sense of it being a failed homebirth...What I saw was how well the homebirth midwives...the ambulance, the hospital...they all worked so professionally amongst each other to give me and my baby the best care (Mary, homebirth woman).

Labelling a woman's transfer to hospital as a 'failed homebirth' was not a helpful approach, as illustrated here:

When people come in and you hear about this is a 'homebirth failure', I always pull people up and go, 'Well actually, let's look at what's happened. Somebody has had a care plan, things have gone different to expectations, well that's been recognised and appropriate transfer has been arranged, that's the system working. That's a success, that's not a failure'. The only time I would think of it as a failure would be if the problem isn't recognized or the decision to transfer when the problem is recognised isn't made, those sorts of things, that's a failure in the system (Thalia, obstetrician).

Women rated their birth experience positively when they experienced homebirth transfers in which the partnership with their HBM was respected, as these women enthusiastically declared:

To have [HospMs] respect her and respect our relationship with her was amazing, it was unexpected, it was so wonderful, it just provided a seamless passage...I still felt loved and supported in a really hard time and that was great (Naomi, homebirth woman).

When HospMs became accustomed to caring for transferred women and their HBMs as a partnership, they found that their work became easier. *'[Transferred women] have such a relationship with that [homebirth] midwife...you can't separate [them]...it's all one unit...The midwife and the woman...have belief in themselves [as a partnership]'* (Cassie, HospM). Supporting the midwife-woman partnership involved stepping back and observing, thereby learning what each individual woman needed. An experienced HospM who was often allocated transferred women illustrated this when she said:

The way I dealt with that most of the time in the early days was just to be silent and to just be there...I actually ended up learning so much about the power of that relationship between a woman and her midwife...Hospital midwives should be functioning as a support for the midwife and the woman, and there should be a team approach.... we should be involving independent midwives [HBMs] when women are transferred into hospital because we need the relationship that they have. That sustains women and that that helps them through the experience (Kay, HospM).

Respectful interactions between midwives, from their initial greetings, enabled them to negotiate how they might optimise the quality of care for the woman. One HBM was sure to proffer respectful interactions from the moment she entered the hospital, saying that:

It's in the woman's best interest that I behave in a certain way when I'm involved in a transfer...The energy around the transfer is...I'm asking for their help. That's why we've come... we can't facilitate the birth at home and we know that this is the best place for her to be (Trish, HBM).

Mutual respect was an important part of the process of identifying roles and responsibilities, for example: *'I see what you're doing and accept you for that and glean what I can from you because that's your expertise'''* (Daisy, HBM). Acknowledging that different caregivers had different roles, specific to their main area of work, was fundamental, *'It is about respecting each other as clinicians and respecting that we need each other'* (Kim, HBM). Feeling respected engendered a willingness to collaborate and cooperate, as one midwife stated: *'If there's mutual respect I think then you would certainly help out where you can, more'* (Ellen, HospM).

By demonstrating mutual respect for the expertise of others, a willingness to listen and skills in clarifying roles and goals, collaborative homebirth transfers could be successfully facilitated. Positive interactions were key to providing a good experience to women, as Nancy expressed:

It would be nice to have those good relationships between the families that we see unexpectedly and the hospital staff, to then make it as a good birth experience for that mum as possible...without making the mum feel like she's a failure because she had to come to the hospital...They still need to be able to enjoy the experience of having their baby, even with some assistance (Nancy, HospM).

Participants agreed that the *'primary goal is to have a healthy mother, healthy baby'* (Charles, obstetrician). Putting the woman and her unborn child at the centre of the care was the basis of sharing the goal of a healthy mother and a healthy baby, for example, *'at the end of the day it's not about our [midwives'] relationship, it is about the woman and the baby...you have to be respectful of their situation, regardless of what you feel'* (Ellen, HospM). Women's views about safety, risk and well-being stemmed from a complex set of factors, from a purview much broader than that of the labour and birth episode, as expressed here:

People come with their expectations, come with their plans, with their priorities, with their understandings, and then the antenatal care that they're provided by their midwives explores that...But some women will always have strong beliefs...as long as those decisions are informed decisions...at the end of the day, women make their choices (Thalia, obstetrician).

Being woman centred meant respecting a woman's informed decisions, even when they were incongruent with one's own beliefs, for example: *'It's remembering that the woman is in the centre of everything, it's not actually about everyone else - it's about her'* (Trish, HBM), and, *'It's about responding to individual women, caring for individual women but also [remembering] that their journey isn't always your journey'* (Kay, HospM).

Discussion

Most women who choose to give birth at home, in the care of midwives, will labour and give birth safely with no intervention. Smooth referral, consultation and transfer processes ensure that when women experience variations from the normal trajectory, they can access timely and appropriate medical care in a hospital setting.

The findings support the large body of literature exploring the midwife-woman partnership as a unique trusting relationship (Berg 2005; Guilliland & Pairman 1995; Lundgren & Berg 2007; Page 2000). The benefits of continuous support for women in labour and birth are widely recognised (Hodnett et al. 2013). Both the findings and a published literature review (Fox, Sheehan & Homer 2014), demonstrate that women valued the relationship with their midwife not only during pregnancy and whilst labouring at home, but also in the event of transfer to hospital. It is overwhelmingly clear that in the homebirth transfer context, prioritising continuity of midwifery carer is congruent with a woman centred approach (Vedam et al. 2014).

The presence of the midwife-woman partnership made a valuable contribution to women's well-being in the homebirth transfer setting, more so when hospital staff embraced its value. When the midwife-woman partnership was not understood, it simply created perceived barriers for hospital staff trying to engage with the woman. Hence, the quality of the partnership may be of immense value to the woman and her midwife whilst simultaneously a nuisance to hospital staff. The midwife-woman partnership has the potential to catalyse the development of 'us and them' dynamics that already exist due to conflicting paradigms of childbearing and fragmentation of maternity care. In the context of transfers from alongside midwifery units (AMUs) in the United Kingdom, McCourt et al. (2016) identified similar 'us and them' tensions between AMU midwives and other professional groups within the hospital, and noted that this had the potential to threaten the integration of the AMU into the wider maternity service. It is possible that interprofessional tensions in the hospital birthing room of a transferred woman may contribute to poor communication and less than optimal care.

The term '*contested space*' (Cheyney, Everson & Burcher 2014, p.451) has been applied in relation to the hospital birthing room of a woman who has been transferred. Cheyney Everson & Burcher (2014) identified three mechanisms which are impacted by the presence of different paradigms of risk and safety in maternity care. Firstly, homebirth is frequently regarded as more dangerous than research evidence demonstrates. Secondly, health professionals receiving the care of transferred women are often fearful of being made accountable for any poor outcomes that result. Thirdly, they identified the enormous challenges for inter-professional communication (Cheyney, Everson & Burcher 2014). Synthesising these anthropological perspectives with the concept of intergroup conflict, derived from social psychology, has the potential to move the discussion further.

'*Us and them*' interactions are referred to by social psychologists as 'intergroup conflict' (Hogg & Abrams 2001). To increase confidence and self-esteem, humans align themselves with groups of like-minded individuals. There is a tendency to then boost the perceived status of their own group ('in-group favouritism') and discriminate against the other group ('out-group derogation'). Examples include the way in which we may identify ourselves with a particular race, religion or sporting team, and favour our group over another.

We propose that the powerful presence of the midwife-woman partnership also contributes to the notion of a '*contested space*', due to the social interactions between midwives who may possess competing views about their relationships with women. By addressing the way in which social dynamics develop between health professionals, as well as the psychological and cultural influences that may drive their behaviours, a deeper understanding of collaboration during homebirth transfer may be gained.

In settings where high levels of collaboration are required, such as in the context of homebirth transfer, the presence of intergroup conflict can be a barrier. The convergence of different paradigms of childbearing in the birthing space and the strength of the pre-existing

relationships may contribute to the presence of intergroup conflict, hence fertilising the growth of the 'us and them' dynamics such as those that were evident in our findings.

The midwife-woman partnership, the woman's partner and her other support people usually enjoy strong trusting relationships with each other and are likely to identify as an in-group. In-group favouritism leads to enhanced feelings of trust, allegiance, and advocacy towards in-group members. This aligns with the findings showing that when women and their homebirth midwives built their midwife-woman partnership, high levels of reciprocal trust were developed and HBMs adopted an advocacy role for the women they cared for. Conversely, out-group derogation is known to lead to stereotyping, prejudice and poor communication (Tajfel & Turner 2001). The findings showed examples of all these behaviours amongst health professionals. Women, who may view hospital staff as unwilling to share their goal of a normal birth, as an out-group. Hospital staff, who may stereotype homebirth women and their midwives as alternative people making risky choices, may also view them as an out-group.

In the healthcare literature, intergroup conflict has been shown to affect the quality of teamwork in healthcare settings (Bartunek 2011). Intergroup conflict theory has also been addressed in relation to the professional identity of nurses (Willets & Clarke 2014), collaboration between nurses and doctors in the operating theatre (Greer et al. 2012), in processes of care in the prevention and treatment of cancer (Harwood & Sparks 2003) and in the context of communication in maternity care (Watson et al. 2012).

Our argument for applying the framework of intergroup conflict to the transfer context is strengthened by the evidence that the release of the neuropeptide oxytocin in labouring women's bodies may enhance group identification (Van IJzendoorn & Bakermans-Kranenburg 2012), heighten attention to social cues (Bartz et al. 2011) and facilitate empathy and trust in her in-group (Bartz et al. 2011; de Dreu et al. 2010; Van IJzendoorn &

Bakermans-Kranenburg 2012). Oxytocin is also known to elevate defensive behaviour toward an out-group (de Dreu et al. 2010) and decrease out-group cooperation.

When effective collaboration occurred, the midwives involved usually possessed significant experience with homebirth transfers, which brought a sophisticated level of understanding of the dynamics. They demonstrated mutual respect, a woman centred approach and a willingness to work at fostering relationships. Hopefully the illumination in this study of the positive interactions that frequently occurred will assist those with less experience to understand the unique context of homebirth transfer.

This is the first study to look at the processes and interactions involved in transfer from planned homebirth in both private and publicly funded settings in Australia. However, data was collected only from urban and regional areas of four states of south-eastern Australia. A further limitation of this study was the lack of access to data from ambulance service personnel. Ethical approval from the Ambulance Service, to interview paramedics for this study, was not possible.

Conclusion

When all women can access continuity of midwifery carer for their childbearing continuum, and women who choose to plan a birth at home are provided with a smooth transition to back up medical care in hospital when it is needed, home as a planned place of birth will have the opportunity to become accepted by mainstream as a safe option for those who choose it. This study is significant because it adds an analysis of the dynamics involved in the interactions and processes of homebirth transfer from the perspective of intergroup conflict theory, derived from social psychology. Hopefully this may help midwives, medical staff and policy makers to see the complexities of the situation from a new perspective.

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