TRANSFER FROM PLANNED HOMEBIRTH TO HOSPITAL: VIEWS AND EXPERIENCES OF WOMEN, MIDWIVES AND OBSTETRICIANS

A thesis submitted in accordance with the requirements for admission to the degree of Doctor of Philosophy

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student:

Date: December 1st, 2016

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I would like to acknowledge and pay my respects to the Gadigal people of the Eora nation, as the traditional owners and holders of the knowledge of the place on which the University of Technology Sydney stands. I pay tribute to elders past, present and emerging.

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DISSEMINATION

This thesis was submitted in 2016, as part of the final requirements to fulfil the degree of PhD in Midwifery at the University of Technology Sydney. The meta-synthesis of the literature on women's experiences was published during the candidature (Fox, Sheehan & Homer 2014). Further manuscripts will be submitted for publication in peer reviewed journals after completion of the thesis. Dissemination of the research that occurred during the candidature is listed below:

Publications related to PhD

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Birthplace in Australia: Processes of referral and transfer from planned homebirth to hospital (oral presentation).

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Birthplace in Australia: Supporting woman centred care in homebirth transfer

(oral presentation).

Birthplace in Australia: Midwives provision of homebirth services in the private and public sectors (poster in collaboration with Rebecca Coddington).

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Birthplace in Australia: Midwives experiences of intrapartum homebirth transfer (oral presentation).

Australian College of Midwives National Webinar:

Promoting normal birth for high risk women.

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Child and Early Parenting Educators of Australia Biennial National Conference, Hobart:

Taming the tiger during homebirth transfer: Can we prepare? (oral presentation).

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Birthplace in Australia. Transfer from planned homebirth to hospital: views and experiences of women and caregivers (oral presentation).

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Australian College of Midwives Biennial Conference, Hobart:

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8th International Normal Labour and Birth Research Conference, Grange over Sands, UK:

Birthplace in Australia. Views and experiences of women planning a homebirth who are transferred to hospital: A meta-synthesis (oral presentation).

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ABSTRACT

Background

Recent evidence supports the safety of planned homebirth for low risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place. Much is known about rates of transfer, but little is known about the experiences of the women and caregivers involved.

Aim

The aim was to explore the views and experiences of women, midwives and obstetricians involved in the intrapartum transfer of women from planned homebirth to hospital in the Australian context.

Methods

Thirty-six semi-structured interviews were conducted with women, midwives and obstetricians. A constructivist grounded theory approach was taken to enable exploration of the social interactions and processes that occurred.

Findings

Four categories emerged from the analysis, *'Fostering relationships and reducing uncertainty', 'Transferring out of the comfort zone', 'Us and them'* and *'Celebrating a successful transfer'.* The grounded theory, *'Supporting woman centred care in homebirth transfer'*, was synthesised by integrating findings grounded in the data with theoretical codes gained from intergroup conflict theory.

Effective strategies of collaboration included mutual respect, supporting the midwife-woman partnership and regarding the transfer as a success of the system rather than a 'failed homebirth'. The goal of a 'healthy mother and a healthy baby' was ostensibly shared by women and caregivers, however, arriving at a common definition of a 'healthy mother and a healthy baby' was less straightforward, due to the different paradigms of childbearing that converged on the birthing room of a transferred woman.

Discussion

From the perspectives of Australian law, healthcare policy and human rights, the woman is the only person with the authority to make informed decisions for the health and well-being of herself and her baby. Women's personal definitions of 'healthy' are made in the context of their individual parameters of risk and safety, encompassing psychological, emotional, social, cultural and spiritual domains. These may be used to guide optimal care in the homebirth transfer context.

Conclusion

Synthesis of the social processes and interactions occurring during homebirth transfers enabled the formulation of a theoretical framework which may assist women to prepare for the possibility of transfer, and guide caregivers to understand and communicate complex issues that are unique to the homebirth transfer setting. The grounded theory *'Supporting woman centred care in homebirth transfer'* may also have broader implications for collaboration in the maternity care milieu, especially in circumstances where a woman's labour and birth follows an unexpected trajectory.

CHAPTER ONE: INTRODUCTION

Evidence supports the safety of planned homebirth for low risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place (Catling-Paull et al. 2013; de Jonge et al. 2009; de Jonge et al. 2013; Hutton et al. 2016; Keirse 2014), although there is a higher likelihood of adverse outcomes for the babies of women having their first baby at home (Brocklehurst et al. 2011). Despite the low rates of homebirth in many developed countries, there is increasing demand for homebirth services (Catling-Paull, Foureur and Homer 2012; Cheyney, Everson & Burcher 2014; Vedam et al. 2014). 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).

Aim

The aim of the study was to find out 'What are the views and experiences of women who at the onset of labour, plan to birth at home, and subsequently require intrapartum or early postpartum transfer to hospital, and what are the views and experiences of caregivers involved in such transfers?' As the research developed iteratively, the interactions and processes occurring during and after transfer from planned homebirth became the focus of the study, rather than the experiences of individuals.

The original contribution this PhD aims to make to the field and to the Birthplace in Australia study is to increase the qualitative understanding of homebirth transfer processes and the interactions that occur between the health professionals involved. This may be used to inform optimal collaboration and communication between caregivers and the organisation of homebirth services in Australia and internationally.

Planned homebirth

A planned homebirth is when a woman's chosen place of labour and birth is her home, attended by professionally registered midwives who have processes of medical referral, consultation and transfer in place. The woman's midwives usually provide her all her care during her antenatal, intrapartum and postnatal periods. In this study, 'planned homebirth' is defined specifically to mean when the planned place of birth at the start of labour is the woman's home. It does not mean a birth at home unattended by a professional midwife, a 'free birth', or a birth before a planned arrival to hospital.

Planned homebirth services are available in many Western countries. Literature exploring homebirth in the past decade has originated from Australia (Catling-Paull et al. 2013; Catling-Paull, Foureur & Homer 2012; Dahlen 2012b; Dahlen, Barclay & Homer 2010a; Dahlen, Barclay & Homer 2010b; Dahlen, Barclay & Homer 2010c; Homer 2010; Homer et al. 2014; Keirse 2014; Kennare et al. 2010; McLachlan et al. 2016), New Zealand (Dixon et al. 2014; Grigg et al. 2015; Miller & Skinner 2012), the United Kingdom (UK) (Brintworth & Sandall 2013; Brocklehurst et al. 2011; McCourt et al. 2012), The Netherlands (Amelink-Verburg et al. 2008; de Jonge et al. 2009; Wiegers 2009; Wiegers & de Borst 2013), Scandinavia (Blix et al. 2016; Lindgren, Radestad & Hildingsson 2011), Canada (Hutton et al. 2016; Vedam et al. 2012) and the United States of America (USA) (Cheng et al. 2013; Chervenak et al. 2013; Cheyney et al. 2014a; Vedam et al. 2014; Wax et al. 2010).

The burgeoning awareness of the evidence of the safety of planned homebirth for low risk women, and the expanding evidence that they are less likely to receive intervention if they plan a homebirth than if they plan a hospital birth, will inevitably influence women's decisions around their planned place of birth. Hence it is likely that the number of women planning to give birth at home will increase.

In most countries where homebirth is a legal option, midwives work within a framework that guides their decision making, in partnership with women, about what

indications may require referral, consultation and/or transfer to hospital. In Australia, these guidelines include documents from the Australian College of Midwives (ACM), such as the *'National midwifery guidelines for consultation and referral'* (ACM 2014) which were endorsed by the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) in 2015; the *'Transfer from planned birth at home guidelines*' (ACM 2016); and the *'Birth at home midwifery practice standards'* (ACM 2015). In addition, individual jurisdictions, such as states and territories and/or individual health services, may add their own guidelines and policies. One example is the *'Policy for planned birth at home in South Australia'* (South Australian Department of Health 2013).

For planned homebirth to support women's safety and well-being, preparation for transfer to hospital must be integral to the planning of a homebirth and seen as part of the necessary infrastructure of homebirth services. The next section will discuss why the polarisation of attitudes towards homebirth may create barriers to the smooth transfer of women to hospital during the intrapartum phase.

The homebirth debate

Polarisation of attitudes to the safety of homebirth is a key concept in the literature (Burcher & Gabriel 2016; Catling-Paull, Foureur & Homer 2012; Chervenak et al. 2013; Cheyney & Everson 2009; Coxon, Sandall & Fulop 2014; Dahlen 2012a; de Jonge et al. 2013; Ellwood 2008; Homer 2010; Homer et al. 2014; Leone et al. in press; McNutt et al. 2014; Vedam et al. 2014). There is wide recognition that opposing paradigms exist around perceptions of risk and safety in relation to maternity care (Anderson & Murphy 1995; Ashley & Weaver 2012; Bick 2012; Blix, Øian and Kumle 2008; Chadwick & Foster 2014; Cheyney & Everson 2009; Cheyney, Burcher & Vedam 2014; Coxon, Sandall & Fulop 2014; Foley & Faircloth 2003; Homer 2010; Hunter & Segrott 2014; McLachlan et al. 2016; McMurtrie et al. 2011; Vedam et al. 2012; Vedam et al. 2014; Walsh 2000). Views about risk and safety tend to be broadly influenced by either biomedical perspectives or a social model of health. Many issues involved in the processes of homebirth transfer are implicitly buried in this paradigmatic problem.

The biomedical view of homebirth is characterised by discourse based upon the potential for pathology to occur, seeing normality only in retrospect (Burcher & Gabriel 2016; Chervenak et al. 2013; Coxon, Sandall & Fulop 2014; Dahlen 2012a; Grünebaum et al. 2013; Olsen & Clausen 2012). From this perspective, hospital is regarded as the safest place for birth, where the process may be controlled and emergency care is available quickly in the event of complications. The reason for this view is the concern that something can go wrong with little warning (Hunter & Segrott 2014), and that the time it may take to transfer to hospital may result in poorer outcomes (Cheng et al. 2013; Chervenak et al. 2013; Cheyney & Everson 2009; de Jonge et al. 2013; Olsen & Clausen 2012; Slutsky & Kenny 2012).

A large body of literature, however, including a systematic review by Blix et al. (2014), demonstrated that most homebirth transfers in the presence of professional midwives are for non-urgent indications. Small numbers of women and/or babies are transferred due to potential emergencies. For example, in a prospective cohort study conducted in four countries of Scandinavia, the urgent transfer rate was 3.8% of all planned homebirths. Notably, 71.6% of the women who were transferred required no medical assistance whatsoever upon arrival at the hospital (Blix et al. 2016).

The likelihood of an adverse outcome for a low risk woman or her baby is extremely low, regardless of her choice to birth in hospital, at a birth centre or at home (Brocklehurst et al. 2011). The authors of the most recent Cochrane Review comparing planned homebirth and planned hospital birth, pointed in their commentary to two salient issues in relation to obstetric emergencies (Olsen and Clausen 2012). Firstly, they estimated that the likelihood of a woman with a low risk pregnancy having a complication requiring immediate medical attention is lower than the risk of a person being killed in a traffic accident during a one year period. This estimation was drawn from cited epidemiological statistics on motor vehicle collisions during 2012. The indications for requiring immediate medical attention that carry the highest risk, such as placental abruption and cord prolapse, occur in approximately 1 in 10,000 births.

Secondly, Olsen and Clausen (2012) emphasised that many emergencies can usually be managed at home by skilled midwives, as well as they could be managed in hospital. In fact, due to the lack of epidural anaesthesia in a homebirth, shoulder dystocia may be managed more easily because the woman's change of position may be promptly facilitated (Olsen & Clausen 2012).

The philosophy of midwifery care is based upon the social model of health and regards childbearing as a normal physiological process, until proven otherwise (Page 2000). Midwifery perspectives value the importance of women making an informed choice about the place in which they might feel physically and emotionally safe in childbirth, and where they may feel supported by their loved ones and carefully chosen caregivers. If and when complications occur, timely and competent action is taken to address them through emergency intervention and/or medical referral processes (Dahlen 2012b; Olsen & Clausen 2012). In Australia, this process is guided by the Australian College of Midwives (ACM) *'National midwifery guidelines for consultation and referral'* (ACM 2014), which were endorsed by the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) in 2015; *'Birth at home midwifery practice standards'* (ACM 2015) and *'Transfer from planned birth at home guidelines'* (ACM 2016).

Safety and risk discourse in midwifery encompasses not only assessment of perinatal mortality rates, but also a broader view of the psychosocial, emotional, cultural, spiritual and familial aspects of the birth experience (Nursing and Midwifery Board of Australia (NMBA) 2006). Midwifery perspectives embrace human rights and feminist principles, seeing the woman's body as not merely a vessel for carrying the baby (Dixon 2013) but someone with whom the midwife negotiates an individualised and holistic assessment of risk (Cheyney & Everson 2009). The tendency for obstetric paradigms to privilege the safety of the baby over considerations for the woman is contrary to principles of human rights (Cheyney, Burcher & Vedam 2014; Dixon 2013; Kruske et al. 2013; Olsen & Clausen 2012). The argument for and against homebirth is

often gendered (Dixon 2013), highly political and professionally hierarchical (Nove, Berrington & Matthews 2012).

Numerous quantitative studies demonstrate lower rates of intervention for low risk women who plan to give birth at home, compared to low risk women planning to give birth in hospital (Brocklehurst et al. 2011; Cheng et al. 2013; Cheyney et al. 2014a; de Jonge et al. 2013; Homer et al. 2014; Hutton, Reitsma & Kaufman 2009; Hutton et al. 2016; McIntyre 2012; Olsen & Clausen 2012; Wiegers 1998). This evidence suggests that there may be iatrogenic risks for women planning to birth in a hospital. More than 15 years ago, it was acknowledged that medical systems have limitations in facilitating normal birth, due to an overuse of technology and depersonalization of care (Bailes & Jackson 2000). Obstetric safety and risk assessments often tend to focus upon the fetus; whilst consideration for the safety, well-being and autonomy of the woman is seen to threaten medical professional responsibility and the safety of her unborn child (Chervenak et al. 2013; Cheyney, Burcher & Vedam 2014; de Crespigny, Walker & Savulescu 2012; Dixon 2013; Grünebaum et al. 2013).

Fundamental to evidence based midwifery practice is finding out what is important to the woman (Page 2000). Families choosing place of birth co-construct their paradigms of risk and safety in multi-faceted and complex ways (Chadwick & Foster 2014; Cheyney 2008; Coxon, Sandall & Fulop 2014), which acknowledges that *'the meaning of safety varies according to the perception of birth'* (Burcher & Gabriel 2016, p. 158). Women who choose homebirth commonly face challenges in advocating for their decision. The process of choosing and planning a homebirth may involve working outside accepted norms and navigating obstacles in an established maternity care system (Cheyney 2008). Communicating with relatives, friends and/or health professionals about their choice of birthplace is often arduous, as the decision to have a homebirth challenges hegemonic biomedical beliefs (Chadwick & Foster 2014; Cheyney 2008; Jordan 1997). Individuals who subscribe to alternative, nonhegemonic belief systems are sometimes seen as uninformed, naïve or pestilent (Jordan 1997).

Cheyney describes choosing homebirth is an act of resistance, demonstrating rejection of a *'doctor-up, mother-down hierarchy'* (Cheyney 2011, p.531).

Cheyney (2008) applies the notion of a 'systems-challenging praxis', a term derived from the critical medical anthropology work of Singer (1995). Cultivation of this praxis involves three stages. The first stage involves questioning accepted public narratives around childbirth, the second constructing counter-narratives, so to become empowered and, finally, belonging to and becoming supportive of an alternative collective belief (Cheyney 2008).

For some health professionals working in obstetric led environments, planning a homebirth is seen as an alternative collective belief, both for the women and families who choose it and the midwives whose practice is dedicated to it. Cheyney, Everson & Burcher (2014) identified three themes in interviews with hospital staff in the USA: 1) the perception that homebirth is dangerous, indeed more so than current evidence suggests, 2) that physicians experience fear and frustration when taking over the complex or emergency care of a client of another provider and 3) that documentation and communication problems are challenging. In the event of transfer, this results in the birthing room becoming what Cheyney, Everson & Burcher (2014) refer to as a *'contested space'* (Cheyney, Everson & Burcher 2014, p.451).

Context of midwifery education in Australia

Midwifery education in Australia occurs in university settings and must meet national accreditation standards. The current pathways to registration as a midwife 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 registered midwives can practise across the full continuum of childbearing, in hospitals birth centres or at home. Currently there is no professional indemnity insurance available to midwives caring for women at home during the intrapartum period.

Context of homebirth in Australia

Relatively few women in Australia choose, or have access to the opportunity, to birth at home. In 2013, 0.3% of all births in Australia occurred at home (Australian Institute of Health and Welfare 2015). In Australia, homebirth has been associated, by many, with poor outcomes (Pesce 2010). The data currently available is problematic, due to the 'underground' homebirth system that has developed. Women who would traditionally be deemed as having a high-risk pregnancy have given birth at home (Jackson, Dahlen & Schmied 2012), sometimes with very poor outcomes for the mother and/or baby (Kennare et al. 2010). Both high risk and low risk women are known to have been 'free birthing', that is, planning a homebirth without a professional midwife in attendance (Dahlen, Jackson & Stevens 2011). The identification of low risk women who have the optimum chance of a safe homebirth, attended by skilled caregivers with adequate medical back up in place is important, so women may 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). The establishment of publicly funded homebirth services for low risk women and the expansion of visiting rights for privately practising midwives may address some of this demand.

Publicly funded homebirths in Australia

Publicly funded homebirths have emerged as a model of maternity care in Australia; most of the services have been established in the past decade (Catling-Paull, Dahlen & Homer 2011; Catling-Paull, Foureur & Homer 2012; Catling-Paull et al. 2013; Chapman & Matha 2011; McMurtrie et al. 2009; University of Technology Sydney (UTS) 2015). Fifteen such services belong to the 'National publicly-funded homebirth consortium', a network supporting the implementation and development of the services, and research and evaluation being undertaken (UTS 2015). Publicly funded homebirth services are available to women living within a 30-minute drive from the health services to which they are attached. The available literature demonstrates positive outcomes for women cared for in publicly funded homebirth programmes in Australia (Catling-Paull et al. 2013). Although not statistically significant due to a small sample

size, the results were promising, with a 90.3% normal vaginal birth rate, 56% intact perineum rate and 5.4% caesarean section rate, and a transfer rate of 17.4% (Catling-Paull et al. 2013). Further results will be released by the Birthplace in Australia study in the near future.

Privately practising midwives offering homebirth services in Australia

Women may also access homebirth in Australia by engaging the services of a privately practising midwife, who is self-employed and working either in a group practice or independently. Privately practising midwives provide antenatal and postnatal care in the community and may also offer homebirth care and/or birth support in a hospital. Many are Medicare-eligible, which means that they are registered midwives who have been notated by the Nursing and Midwifery Board of Australia. To qualify, they need to meet several specific requirements, including working to their full scope of practice, having at least 3 years of full time experience and successful completion of a prescribing course.

Privately practising midwives provide a valuable service to women who are unable to access publicly funded homebirth services for geographical or other reasons. Anecdotally, some women are known to prefer to engage a privately practising midwife. This preference may be due to the strict low risk criteria and long waiting lists that women face to be accepted into a public program, restraints on continuity of carer that exist in some publicly funded homebirth programs, and/or having engaged privately practising midwives for previous births.

The cost of engaging a privately practising midwife may be prohibitive for many women. There are other barriers for privately practising midwives wanting to offer homebirth services. Currently there is no indemnity insurance available to privately practising midwives, for intrapartum care in the home; nor can women obtain Medicare rebates for intrapartum services at home.

Intrapartum homebirth transfers

An intrapartum homebirth transfer is the transport of a woman from a planned homebirth to an obstetric hospital, occurring after the onset of labour or within 24 hours after birth. The transfer may have occurred due to developing complications or risk factors and/or the woman may have requested to transfer due to social reasons or a desire for pharmacological pain management. Women who plan a homebirth are sometimes transferred to obstetric care in a hospital during their pregnancy. Antenatal transfers such as these were not included in this study, however, because the clinical circumstances and processes of transfer are quite different from those that occur during the intrapartum period.

There are a number of quantitative studies examining reasons for intrapartum transfer from planned homebirth. Reported transfer rates vary, ranging from 9.8% (Anderson & Murphy 1995) to 29.3% (Amelink-Verburg et al. 2008) of all planned homebirths. Many studies demonstrate a trend for larger proportions of primiparous women to be transferred than multiparous women. Rates of transfer for women having their first baby range from 22.9% (Cheyney, Everson & Burcher 2014) to 45% (Brocklehurst et al. 2011) of all planned homebirths. Rates of transfer for women having their second or subsequent baby are considerably lower, with a range of 5.7% (Murphy & Fullerton 1998) to 12% (Brocklehurst et al. 2011). A more detailed range of descriptive statistics on homebirth transfers from around the world are displayed in the published metasynthesis on women's experiences of transfer (Fox, Sheehan & Homer 2014) (Chapter 3, Table 1).

As explained earlier, most transfers are for non-urgent indications. Most transfers occur for delayed progress in labour (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Blix et al. 2016; Cheyney, Everson & Burcher 2014; Davies et al. 1996; Johnson & Daviss 2005; Lindgren et al. 2008; Lundeen 2016; Murphy & Fullerton 1998; Tyson 1991), the woman's request for pharmacological pain management (Amelink-Verburg et al. 2008; Johnson & Daviss 2005; Lundeen 2016) or the unavailability of her midwife

(Lindgren et al. 2008). Small numbers of women and/or babies are transferred due to potential emergencies.

The exact rates of urgent transfers are difficult to determine because the term 'urgent transfer' is often poorly defined in the literature (Blix et al. 2016). Examples of indications for urgent transfer included postpartum haemorrhage (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Davies et al. 1996; Durand 1992; Johnson & Daviss 2005; Lindgren et al. 2008; Murphy & Fullerton 1998; Tyson 1991), neonatal respiratory distress (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Durand 1992; Johnson & Daviss 2005), or neonatal asphyxia (Amelink-Verburg et al. 2008; Anderson & Murphy 1995; Durand 1992). Blix et al. (2016) recommended that government bodies standardise the definition of urgent transfer, and make it mandatory for caregivers to report indications for all transfers of women who were eligible for planned homebirth at the onset of labour.

Results of the Birthplace in England study that pertained specifically to intrapartum transfers from planned homebirth were published recently (Hollowell et al. 2015). Details included that the risk of transfer rose with gestational age, and that the risk of transfer rose when women had one or more complicating conditions at the start of labour. Transfer rates tended to be lower in health services where homebirth rates were higher. The authors suggested that this might be attributed to midwives with more frequent homebirth experiences being more comfortable managing women labouring in their homes, and perhaps not as quick to transfer them to hospital.

Median transfer times from decision to transfer until the woman's first assessment in hospital were shorter for women transferring from home (49 minutes) than women transferring from freestanding birth centres (60 minutes), and this was statistically significant ($p<0.0001$). For potentially urgent indications, these median transfer times were shorter in both cases, that is, 42 minutes for transfer from planned homebirth and 50 minutes from freestanding birth centres.

A qualitative exploration of the issues involved in transferring women from midwifery units/birth centres to hospital was undertaken as part of the Birthplace in England study (Rowe et al. 2012), however, homebirth transfers were not addressed. The first author of the afore-mentioned paper identified three gaps in the qualitative literature; women's experiences of transfer from planned homebirth, midwives' experiences of transfer (Rowe 2012, pers. email comm., 16 April) and the experiences of ambulance personnel involved (Rowe 2013, pers. comm., 5 June). This PhD addresses the former two gaps. The aim was also to interview paramedics, however, ethics approval from the ambulance service was not granted.

Definitions

For the purposes of this study, the terms 'woman' and 'women' refer to a childbearing woman or women, and may include the needs and wishes of her baby, her partner, family and significant others. This recognises that women's decisions and needs occur within their individual social milieu, and is aligned with the Australian Nursing and Midwifery Board (NMBA) definition of woman centred care, which states that, 'Woman centred care is a concept that…encompasses the needs of the baby, the woman's family, significant others and community, as identified and negotiated by the woman herself' (NMBA 2006, p.3).

'Planned homebirth' is defined as when the planned place of birth at the start of labour is in the woman's home, with care from a private or publicly funded registered midwife, as per the Birthplace in Australia (BPA) study proposal (Homer 2011). That is, it does not mean a birth at home unattended by a professional midwife, a 'free birth', or a birth before a planned arrival to hospital.

'Publicly funded homebirth' services are those that provide maternity care within a public hospital system, offering low risk women the option to birth at home. Professional care is provided by midwives who are employed and insured by the providing hospital. There are currently 15 such services around Australia.

A ‘privately practising midwife’ is a self-employed midwife, working independently or in a group practice. Privately practising midwives provide antenatal and postnatal care in the community and may also offer homebirth care and/or birth support in a hospital. Some such midwives may have rights to practice as a primary carer in a hospital setting. Currently there is no indemnity insurance available to privately practising midwives who provide homebirth services in Australia. Eligible midwives may provide their clients with access to Medicare rebates for antenatal and postnatal care if practising collaboratively with a medical practitioner.

‘Transfer’ is defined in this study as the transport of a woman from a planned homebirth to an obstetric hospital during the intrapartum period, after the onset of labour or within 24 hours after birth. The transfer may occur due to complications or risk factors emerging during the labour or immediate postpartum period, and/or the woman requesting to transfer due to social reasons or a desire for pharmacological pain management. This study does not include women for whom consultation with a medical practitioner was sought on the telephone, if she subsequently remained at home for birth and the early postpartum period.

The term ‘homebirth midwife’ is used to describe a registered midwife who has cared for a labouring woman at home prior to transfer from planned homebirth. He/she may be either in private practice, or employed as part of a publicly funded homebirth programme; and may or may not have accompanied the woman into hospital. The role may be further defined as ‘privately practising midwife’ or ‘MGP midwife’, in order to delineate between the two types of homebirth midwives.

The term ‘hospital midwife’ is used to describe a midwife who works as a core or rotating staff member in a hospital, such as in an antenatal assessment centre, labour ward or postnatal ward; that is, not in a continuity of care programme, homebirth practice or Midwifery Group Practice.

This PhD study was attached to the Birthplace in Australia project, led by my primary supervisor, Professor Caroline Homer. The Birthplace in Australia project is retrospectively examining, from routinely collected data, neonatal mortality and morbidity associated with births planned at home, in birth centres/stand-alone midwifery units and standard labour wards. Intervention rates, maternal morbidity and mortality, and intrapartum transfers will also be examined. The sample is expected to include approximately one million women. The study is the first of its kind in Australia and is funded by an Australian National Health and Medical Research Council (NHMRC) Project Grant (2012-2015). This is an important project for providing evidence on the safety of childbearing in different settings in Australia.

Conclusion

Chapter 1 has introduced the aims of the study and the research question and provided background information about transfers from planned homebirth, including a depiction of the significance of the study and definitions of the terms used in this document. The contexts of the international debates around homebirth and the homebirth milieu in Australia were also described.

Outline of the structure of the remainder of the thesis

Chapter 2 examines the literature on the views and experiences of caregivers (midwives and obstetricians) who have cared for or received women transferred from a planned homebirth.

Chapter 3 is a published literature review on women's experiences of transfer from planned homebirth, written in the first and second year of candidature:

Fox, D., Sheehan, A. & Homer, C.S.E. 2014, 'Experiences of women planning a homebirth who require intrapartum transfer to hospital: A meta-synthesis of the qualitative literature', *International Journal of Childbirth,* vol. 4, no. 2, pp.103-119.

Chapter 4 details the methodology, including the ontological, epistemological, theoretical frameworks and methods underpinning the work. Ethics committee approval processes are also described.

Collectively, chapters 5 to 8 inclusive describe the findings and analyses from this study. The findings comprise four categories, in four chapters, *'Fostering relationships and reducing uncertainty', 'Transferring out of the comfort zone', 'Us and them',* and *'Celebrating a successful transfer'*, respectively.

Chapter 9 is the Discussion, which includes the grounded theory emerging from the study.

Chapter 10 concludes the thesis, encompassing implications for practice and further research.

CHAPTER TWO: LITERATURE REVIEW OF CAREGIVERS' EXPERIENCES

Introduction

As outlined previously, the quantitative literature demonstrates a wide range of overall intrapartum transfer rates of women from a planned homebirth to hospital, varying from around 10% (Murphy & Fullerton 1998; Cheyney et al. 2014) to almost one-third (Amelink-Verburg et al. 2008) of all planned homebirths. There is a greater likelihood of transfer to hospital during the intrapartum period for women having their first baby (primiparous women) than for women having their second or subsequent babies (multiparous women). For example, in a Scandinavian study (Blix et al. 2016), the rate of transfer for primiparous women was 32.6%, whilst the rate for multiparous women was 8%, of all planned homebirths. In the USA, Cheyney et al. (2014) showed rates of 22.9% for primiparous women and 7.5% for multiparous women. The Birthplace in England study from the UK (Brocklehurst et al. 2011) showed a similar disparity, with 45% of primiparous women and 12% of primiparous women transferred.

Notably, most transfers from planned homebirths were for non-urgent indications. Although the exact numbers of potentially urgent transfers were difficult to determine because of the differing definition and usage of the term of 'urgent' (Blix et al. 2016); the proportions were small, ranging from 0.1% of all planned homebirths (Anderson & Murphy 1995) to 3.8% of all planned homebirths (Blix et al. 2016). The issue of defining 'urgent' transfers was also raised by Hollowell et al. (2015), who noted that in their study the degree of urgency of transfer was not explicitly recorded in the data. Hence, during analysis the authors made clinical judgements about 'potential urgency' based upon the clinical indications for the transfers that were stated in the data. The authors also clearly stated that their classification of 'potentially urgent' did not mean that an emergency occurred (Hollowell et al. 2015).

This chapter will review the literature on the views and experiences of caregivers involved in homebirth transfers, including homebirth midwives who have transferred

women into hospital, midwives and medical staff working in obstetric units who have received women transferred from home, and ambulance paramedics and telephone operational staff involved in transporting such women and/or babies. The question posed for this part of the review was 'What does the literature tell us about the views and experiences of the caregivers of women who at the onset of labour, plan to birth at home, and subsequently require intrapartum or early postpartum transfer to hospital?'

Methods

Search strategy

Constructivist grounded theory methodology was used for this study, to enable a focus upon the processes and interactions occurring during homebirth transfers (Charmaz 2014). The methodology and methods of the study will be explored in detail in Chapter 4, however, it is relevant here because different versions of grounded theory take different approaches to the literature review process.

Early versions of grounded theory (Glaser & Strauss 1967; Strauss & Corbin 1990) adopted the view a literature review was to be avoided prior to undergoing the processes of data collection and analysis. This avoidance was thought to enable researchers to approach the study without 'contaminating' the data under investigation (Birks & Mills 2015). This version of grounded theory is still widely used and known as 'classic' grounded theory.

The approach to the literature review that was taken for this study was aligned with constructivist approaches to grounded theory, that it is untenable to approach a topic with a blank perspective, no matter how hard one might try (Charmaz 2014). Furthermore, Birks and Mills (2015) assert that an understanding of the literature from the outset is an important way in which to enhance theoretical sensitivity. Hence, a literature review was undertaken as an important precursor to the empirical stage of the work. During data collection and analysis, the literature was set aside as I became

immersed in the concepts emerging from the data. Literature was collected throughout the four years of my candidature so that later, I could update my review and weave it through the analysis. In this way, it became a valuable aspect of the body of knowledge being generated (Charmaz 2014). The initial literature review was conducted in the first year of my candidature (2012-2013). An update of the literature review on the views and experiences of caregivers occurred in 2016, after data generation was completed. In the latter, a narrative synthesis was conducted, in which the studies were analysed, according to theme and content. These will be referred to as the initial and ongoing literature reviews, respectively.

During the initial literature review, a systematic search of the following databases was undertaken: Academic Search Complete, CINAHL (Ebsco), Informit, Cochrane Library (Wiley), Intermid, Maternity and Infant Care, Medline (Ovid), Pubmed, Scopus, ScienceDirect (Elsevier), ANL Trove (theses), ProQuest Dissertations and Theses. Seeking articles published since 1990 and in English, and using the search terms, *homebirth* OR *home birth* AND *transfer,* there were 1520 hits, from which 333 titles were chosen for abstract review. From the abstract review, 196 relevant full texts were identified, from which 23 studies were identified as being relevant to the initial literature review pertaining to caregivers. These papers were assessed as being relevant if they explored the views and experiences of the caregivers of women planning a homebirth, who were subsequently transferred to hospital during the intrapartum period. Further papers that explored women's experiences of transfer were identified. These will be reviewed in Chapter 3.

Ongoing literature collection occurred progressively from 2013-2016. Numerous email alerts from databases were set up, to automatically alert me to any newly published papers related to homebirth. The papers emailed to me were sorted manually as they were received, and assessed for relevant content. Those deemed relevant were stored in my Refworks library. In March and April 2016, this chapter was rewritten, encompassing the extra literature on caregivers' experiences that had been collected. A systematic review was not repeated as this had been done initially.

Inclusion and exclusion criteria

Qualitative studies or only the qualitative section of mixed method studies that explored the views and experiences of caregivers involved in the transfer of a woman from a planned homebirth to hospital, were included. Literature on free birthing and homebirths in low income countries without skilled birth attendants was excluded, as these bring unique and complex issues that are beyond the primary aim and scope of the study. Also excluded was literature about women who, at the onset of labour, planned to give birth in a hospital but unexpectedly gave birth before reaching the hospital. In addition, search terms embryo, IVF and blastocyst were specific key word exclusions. This was decided after an initial search drew hundreds of hits related to assisted reproduction, due to the use of the word 'transfer' identifying papers on embryo transfer.

Synthesis results

Interactions that occur between different caregivers during a homebirth transfer bring conflicting paradigms of childbearing into direct contact. 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 2012a; 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).

Professional collaboration

Hospital staff and homebirth midwives report effective collaboration and communication as paramount to the success or failure of transfer processes, hence

they value collegial efforts to cultivate rapport (Ball et al. 2016; Brintworth & Sandall 2013; Cheyney, Everson & Burcher 2014; Dahlen 2012a; Foley & Faircloth 2003; Frank & Pelloso 2013; McCourt et al. 2012; McLachlan et al. 2016; Vedam et al. 2014; Wilyman-Bugter & Lackey 2013). The views and attitudes of hospital staff towards their involvement in homebirth transfers are often influenced by the quality of their previous experiences of receiving transferred women (Davis-Floyd 2003; Vedam et al. 2014), or even by rumours they had heard of the experiences of their hospital colleagues involved in transfers (Cheyney, Everson & Burcher 2014; Davis-Floyd 2003).

The contrast between midwifery and medical paradigms around childbearing extend to the interpretation and reporting of evidence (Dahlen 2012a; Downe, Walsh & Gyte 2008; Downe 2016; Licqurish & Evans 2016; de Melo-Martin & Intemann 2012; Roome et al. 2016; Vedam et al. 2012; Vedam et al. 2014). The same piece of evidence may be interpreted positively or negatively, depending upon the professional perspectives and value system of the reader. This phenomenon is known as confirmatory bias (Roome et al. 2016). An example is the contrasting responses to the Birthplace in England findings, ranging from claims that it demonstrated high absolute safety of all birth settings for the majority of healthy women, to recommendations that doctors should recommend all births occur in hospital, especially for first time mothers (Vedam et al. 2012). That the very same study may be interpreted to mean by some that homebirth is safe and to others that homebirth is risky demonstrates the conviction with which polarised views are held.

Lack of integration in maternity care systems is problematic (Cheng et al. 2013; McLachlan et al. 2016), as is the lack of homogeneity in the training and background of caregivers attending homebirth in some countries (Cheng et al. 2013). This was most striking in a recent report from the United States, which compared outcomes for neonates born at home with those born in hospital. One quarter of the homebirths included were attended by certified nurse midwives (CNMs), the other three quarters of the births were attended by other types of caregivers (certified professional midwives or lay midwives) or were unattended free-births. The study demonstrated

similar outcomes for neonates born at home with certified nurse midwives and those born in hospital (Cheng et al. 2013), showing that homebirth was as safe as hospital birth for newborns, if they and their mothers were cared for by certified nurse midwives. However, the article emphasised the outcomes based on composite data for all neonates born at home, regardless of caregiver. Overall, therefore, outcomes were shown to be poorer than those born in hospital, although neonates born at home with CNMs had outcomes similar to those born in hospital (Cheng et al. 2013).

Recognition of the need for professional collaboration and integration of maternity care spurned the establishment of the United States Home Birth Consensus Summits, held in 2011, 2013 and 2014. The summits resulted in the establishment of the Home Birth Summit Collaboration Task Force, a multidisciplinary group of stakeholders who compiled a document entitled *'The Best Practice Guidelines: Transfer from planned homebirth to hospital'* (Vedam et al. 2014). The guidelines are an evidence based document outlining practices and policies that support effective inter-professional collaboration in the context of homebirth transfer. The guidelines are accompanied by template documents to guide care providers in their communication in the context of transfer, and are displayed on a comprehensive website (www.homebirthsummit.org) that is devoted to the promotion of collaboration between care providers in the United States who may be involved in the care of families planning to give birth at home. Nine 'Common Ground Principles' are also outlined on the website, encompassing issues such as autonomy and choice for women, collaboration and communication between care providers, equity and access, regulation and governance for homebirth midwives, advocacy, education, insurance, research and normal birth. It is an excellent example of collaboration and could be replicated in Australia and elsewhere.

Collaboration, respect and sensitivity have been shown to be strengthened by multidisciplinary training (Foley & Faircloth 2003; Harris et al. 2011; McCormick et al. 2013; Vedam et al. 2012; Wiegers & de Borst 2013) and homebirth transfer review meetings (Cheyney & Everson 2009; Vedam, Goff & Marnin 2007). Caregivers from The Netherlands reported attending regular meetings which involved homebirth midwives,

obstetricians, paediatricians, hospital nurses and midwives, general practitioners and maternity care assistants. Unfortunately, such meetings rarely involved ambulance personnel (Wiegers & de Borst 2013). The absence of ambulance personnel is problematic because they play an important role in the care of women during the vulnerable transition phase from home to hospital.

Transport to hospital

There is a paucity of qualitative literature on the issues surrounding ambulance transportation during homebirth transfer. The perceptions of ambulance personnel on their professional responsibility and the quality of handover communication during transfers were addressed in a mixed methods study from The Netherlands (Wiegers and de Borst 2013), a country in which homebirth is well integrated into the maternity care system. Most caregivers surveyed felt that transfer information was usually transmitted smoothly between caregivers, communicating by phone and written documentation on paper. However, they noted that the process could be improved by electronic linkage of medical records between primary care settings and hospitals. Less than half the midwives surveyed felt they were usually able to speak directly to the obstetrician on call. More direct referral processes from midwife to obstetrician were called for, to reduce the need for superfluous assessment of the woman by hospital staff (Wiegers & de Borst 2013).

Allocation of appropriate emergency codes by ambulance operational staff enabled efficient despatch of vehicles for transportation. The emergency code was chosen based upon their telephone conversation with the referring homebirth midwife (Wiegers & de Borst 2013). Ambulance paramedics and operators expressed concern that midwives may delay calling for their assistance, unaware of the amount of time it may take to reach them and get the woman to hospital. Two-thirds of midwives interviewed by Wiegers and de Borst (2013) claimed that operators were seldom able to give them an indication of how long the ambulance may take. Traffic conditions, weather and distance from the woman's home to hospital are additional factors that impact upon the safety and ease of transfer from home to hospital (Blix et al. 2014;

Blix et al. 2016; Chardon et al. 1994; Vedam, Goff & Marnin 2007; Wiegers & de Borst 2013). Clearly, an efficient transport system is an essential part of the homebirth transfer process, and is an area that requires further study.

Delay in appropriate care upon arrival at the hospital

Delay in receiving care can occur due to the ambulance taking the woman to the emergency department, without realising the woman needs to be taken to delivery suite (Wiegers & de Borst 2013). Other barriers to timely care in the hospital after transfer include misunderstandings by staff of the urgency of the situation, or needing to summon on-call medical staff from home or elsewhere (Davis-Floyd 2003; Wiegers & de Borst 2013). Eighty-three percent of the Dutch midwives surveyed by Wiegers and de Borst (2013) said they usually follow the ambulance carrying the woman to hospital. They midwife would only travel in the ambulance if the paramedics requested it and/or the birth were imminent. Hospital staff appreciated it when they were given advanced warning of a woman's arrival, however, only one in four midwives and one in three ambulance paramedics reported that they called the hospital ahead of their arrival (Wiegers & de Borst 2013).

Barriers to medical practitioners providing optimal care to transferred women

Negative views about homebirth transfers were commonly expressed by medical staff who had received women transferred to hospital from planned homebirth in the United States (Leone et al. in press; Vedam et al. 2014), however, in integrated systems, such as publicly funded homebirth programmes in Australia, attitudes were less negative. Half the doctors surveyed in two such settings in Australia felt comfortable receiving the care of a woman transferred from a planned homebirth (McLachlan et al. 2016). 93% of midwives and 75% of doctors felt that inter-professional collaboration during transfers was easier when the midwives were staff members in an integrated homebirth system that was attached to a public hospital (McLachlan et al. 2016).

Taking responsibility for another caregiver's 'patient' who may experience complications is seen by some as problematic (Cheyney & Everson 2009). Frustration with the possibility of encountering a non-compliant woman and a hostile midwife, who may make the situation worse by being difficult to work with, was also described. Midwives' behaviour may be interpreted as an attack of the doctor, when the midwives' intentions may simply be to advocate for the woman (Cheyney & Everson 2009). Of the doctors surveyed in the state of Ohio, United States, 80.2% responded that they were unwilling to collaborate with homebirth midwives (Leone et al. in press). The authors postulated that the negative views held by doctors are related to their lack of exposure and experience with homebirth, and concluded that further research is required to determine if these negative views affect safety during transfers (Leone et al. in press).

Positive transfer experiences

Despite the challenges, some midwives have reported positive experiences of transferring women from home to hospital. Dahlen (2012b), whilst acknowledging that transfer processes in Australia are often problematic, describes her transfer experiences as being positive, both for her as a privately practising midwife and for the women she has cared for. Midwifery preparation for a planned homebirth should include a thorough discussion of emergency transport arrangements (Dahlen 2012b; Dancy & Fullerton 1995), the criteria for transfer (Spindel & Suarez 1995), booking into a back-up hospital during pregnancy, and helping the woman to regard the hospital as the best place to be in the event of a complication (Ball et al. 2016; Dahlen 2012b). Preparation of this nature is part of an informed decision making process to which every woman and her family is entitled (Ball et al. 2016; Spindel & Suarez 1995). The process of booking all women into hospital provides a platform for maintaining a continuous relationship with mainstream services. Appreciation of the assistance hospital staff offer, and building confidence in women about the care they will receive in hospital if transferred, aims to reduce or eliminate potential hostilities upon transfer (Dahlen 2012b).

By maintaining woman centred principles of respect for a woman's rights and dignity, better experiences and safer outcomes are achieved (Dahlen 2012b; Foley & Faircloth 2003). Woman centred perspectives can form a bridge between polarised concepts of normal and abnormal and support collaboration which is focussed on the woman's needs rather than conflicting professional discourse (Davis & Walker 2011; Foley & Faircloth 2003). In New Zealand, this is enacted when lead maternity carers (primary care midwives) provide continuity of carer for women with complications by remaining co-ordinator of a woman's care when obstetricians are required to collaborate or take over primary responsibility (Davis & Walker 2011). Similarly, in The Netherlands, midwives transit through homes, birth centres and hospitals in a variety of settings to care for women's individual needs, and obstetricians support the system (Jabaaij & Meijer 1996).

By never witnessing homebirth, but only experiencing caring for transferred women, it is difficult to for hospital staff to see the normal outcomes which frequently occur in the home (Leone et al. in press; Vedam et al. 2012). It is important to help those with no homebirth experience become aware of the many healthy birth outcomes that occur at home, and not just the transfers (Dahlen 2012b; Leone et al. in press). Cheyney and Everson (2009) interviewed one doctor who pointed to the prevalence of high-risk homebirths being a cause of scepticism about the evidence for homebirth safety. Because their experiences do not match the research findings, it is difficult for them to trust the evidence that demonstrates homebirth as safe for low risk women when attended by professional midwives. Midwives interviewed in the same study (Cheyney & Everson 2009) conversely felt judged unfairly by doctors, feeling that doctors evaluated their professionalism by a few exceptional cases instead of by the majority of positive outcomes.

Summary

This chapter has described what the literature tells us about the views and experiences of caregivers involved in the transfer of a woman from a planned homebirth to

hospital, including obstetricians, midwives and ambulance paramedics. This provides a background to the findings of this study which may assist in the identification of systemic or operational issues which could be addressed to improve transfer processes.

The next chapter will describe the findings of the literature review on women's experiences of transfer from a planned homebirth. Women's choices around place of birth are complex, involving social perspectives and personal definitions of risk and safety. Despite high transfer rates, many women will continue to choose homebirth. Understanding the views and experiences of women who are transferred to hospital after planning a homebirth is important because it may help to inform the development of woman centred care practices when unexpected complications occur.

CHAPTER THREE: LITERATURE REVIEW OF WOMEN'S EXPERIENCES

Introduction

This chapter explores what has been published about women's experiences of intrapartum or early postpartum transfer from planned homebirth to hospital obstetric units, using a meta-synthesis approach. The chapter essentially presents the meta-synthesis article in its published form, from the International Journal of Childbirth. Permission was granted by the publisher to reproduce it here.

Publication reference:

Fox, D., Sheehan, A. & Homer, C.S.E. 2014, 'Experiences of women planning a homebirth who require intrapartum transfer to hospital: A meta-synthesis of the qualitative literature', *International Journal of Childbirth,* vol. 4, no. 2, pp.103-119.

Reproduced published metasynthesis of women's experiences:

Experiences of Women Planning a Home Birth Who Require Intrapartum Transfer to Hospital: A Metasynthesis of the Qualitative Literature

Deborah Fox, Athena Sheehan, and Caroline Homer

Recent evidence supports the safety of planned home birth for low-risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place. The purpose of this article is to synthesize the qualitative literature on the experiences of women planning a home birth, who are subsequently transferred from home to hospital. A metasynthesis approach was selected because it aims to create a rich understanding of women's experiences of transfer by synthesizing and interpreting qualitative data. Three categories were synthesized: "communication, connection, and continuity," "making the transition," and "making sense of events." Quality and clarity of communication, feeling connected to the backup hospital, and continuity of midwifery carer helps make the transfer process as seamless as possible for women. Arriving at the hospital is a time of vulnerability and fear, and retaining the care of a known midwife is reassuring. New caregivers must also be sensitive to women's need to be reassured and accepted. The reasons for transfer need to be clearly communicated both at the time of transfer and in more detail during the postpartum period. Women need to talk through their experience and to acknowledge their feelings of disappointment in order to move forward in the next phase of their lives. Continuity of carer enables this to be done by a known caregiver in a sensitive and individualized manner. Further qualitative research to examine home birth transfer issues, specifically in the Australian context, is currently being planned as part of the Birthplace in Australia project.

KEYWORDS: midwifery; home birth; transfer of care; women's experiences; metasynthesis

INTRODUCTION

Recent evidence supports the safety of planned home birth for low-risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place (Brocklehurst et al., 2012; Catling-Paull, Coddington, Foureur, & Homer, 2013; de Jonge et al., 2013; de Jonge et al., 2009). Despite the low rates of home birth in many developed countries, there remains a demand for home birth services (Catling-Paull, Foureur, & Homer, 2012). The recent Birthplace in England study (Brocklehurst et al., 2012) demonstrated no difference in adverse perinatal outcomes for low-risk multiparous women who planned a birth at home, in birth centers, or in an obstetric unit. For primiparous women, there was again no difference when comparing adverse perinatal outcomes with birth centers or obstetric units; however, an elevated risk of poor perinatal outcomes was identified for those primiparous women who had planned a home birth. Brocklehurst et al. (2012) and other studies demonstrate a trend for larger proportions of primiparous women to be transferred than multiparous women (Blix, Huitfeldt, Øian, Straume, & Kumle, 2012; Brocklehurst et al., 2012; Johnson & Daviss, 2005; Tyson, 1991; Wiegers, van der Zee, & Keirse, 1998). Available data shows a four to five-fold increase in transfers for women having their first baby when compared with women who have given birth before (Table 1).

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TABLE 1 Findings of Quantitative Papers Examining Transfer Rates

AUTHOR, DATE, COUNTRY	TOTAL TRANSFER RATES	PRIMIPAROUS WOMEN TRANSFERRED	MULTIPAROUS WOMEN TRANSFERRED	URGENT TRANSFERS
Amelink-Verburg et al., 2008, The Netherlands	29.3% transfer rate	—	—	—
Anderson & Murphy, 1995, United States	9.8% transfer rate (8% in labor, 0.8% postpartum, 1% neonatal)	—	—	1 in 1,000
Blix et al., 2012, Norway	12.1% transfer rate; transfers occurred during intrapartum period or within 5 days after birth.	31.7%	6.3%	Primiparous women: 1.4% of all planned home births Multiparous women: 0.9% of all planned home births
Brocklehurst et al., 2012, England	21% transfer rate	45%	12%	—
Catling-Paull, Dahlen, & Homer, 2011, Australia	Excluded; sample < 20	—	—	—
Cheyney, 2011, United States	12% transfer rate	—	—	—
Creasy, 1997, England	Excluded; sample < 20	—	—	—
Dahlen, Barclay, & Homer, 2010, Australia	Excluded; sample < 20	—	—	—
Davies, 1997, England	14% uneventful transfers	—	—	None
Durand, 1992, United States	11.9% transfer rate	—	—	—
Janssen et al., 2002, Canada	16.5% during labor (before birth)	—	—	3.6% of all planned home births
Janssen et al., 2003, Canada	23.1% transfer rate	—	—	3.4% of all planned home births
Johnson & Daviss, 2005, United States and Canada	12.1% transfer rate	25.1%	6.3%	Primiparous women: 5.1% of all planned home births Multiparous women: 2.6% of all planned home births
Lindgren et al., 2008, Sweden	12.5% transfer rate	—	—	—
Lindgren, Radestad, & Hildingsson, 2011, Sweden	14.15% transfer rate	—	—	—
Murphy & Fullerton, 1998, United States	10.2% transfer rate: 8.3% in labor, 0.8% PN, 1.1% neonatal	27%	5.7%	—
Tyson, 1991, Canada	16.5% transfer rate (intrapartum or to 4 days postpartum)	40%	8%	—
Wiegers et al., 1998, The Netherlands	—	40.1%	11.6%	—

Note. Empty cells denote no data available.

Women's approaches to making decisions about where to give birth are complex, multifaceted, and derived from manifold formal and informal sources. It is clear from the literature, however, that choice and control is important to women in childbirth (Creasy, 1997; Janssen, Carty, & Reime, 2006; Vedam, Goff, & Marnin, 2007) and that social and familial reasons are significant in most women's choices to give birth at home (Bailes & Jackson, 2000). Women choosing home birth may value alternative forms of knowledge and undergo a process of challenging hegemonic biomedical paradigms (Cheyney, 2008), which are widely accepted in society and commonly exploited in the media. Despite the fact that hospitals may provide the technological means to monitor and treat problems in childbirth, awareness of this is not reassuring to some women. Such women value the natural processes of their bodies more highly than scientific and technocratic approaches to birth, choosing to birth in what they perceive as the safety of their own homes (Davis-Floyd & Sargent, 1997).

Quantitative studies examining transfer rates for women planning home birth highlight several reasons for transfer. Most transfers are reported to occur for nonurgent indications, such as delayed progress in labor (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Davies, Hey, Reid, & Young, 1996; Johnson & Daviss, 2005; Lindgren, Hildingsson, Christensson, & Rådestad, 2008; Murphy, 1998), the woman's request for pharmacological pain management (Amelink-Verburg et al., 2008; Johnson & Daviss, 2005), or the unavailability of her midwife (Lindgren et al., 2008). Small numbers of women (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Johnson & Daviss, 2005) are transferred because of potentially life-threatening emergencies such as postpartum hemorrhage (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Davies et al., 1996; Durand, 1992; Johnson & Daviss, 2005; Lindgren et al., 2008; Tyson, 1991) or neonatal respiratory distress (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Durand, 1992).

Some women find transfer distressing, whereas others do not. For example, Wiegers et al. (1998) found that women who were transferred from planned home birth to hospital in The Netherlands were as positive as women who had planned a birth in hospital regarding their birth experience, their midwife, and the 10 days postnatal period. However, these findings are in contrast to those reported by others who have found that transferred women were less satisfied with their experience. Lindgren, Rådestad, and Hildingsson (2011) identified that women who were transferred from planned home birth to hospital in Sweden were less satisfied than those who gave birth at home. Similarly, Christiaens, Gouwy, and Bracke (2007) found that transferred women in Belgium and The Netherlands were less satisfied than those who had planned a hospital birth. This study included women who planned a home birth at or after 30 weeks' gestation. No difference was found in satisfaction levels between the women transferred in pregnancy or women transferred during labor. Most of the transferred women felt they had made an appropriate choice about place of birth, but fewer were sure they would choose home birth again next time. Communication issues and organizational factors (such as the inability of the home birth midwife to remain as caregiver in hospital) were the main contributing reasons for their dissatisfaction.

In many western countries, women will continue to choose to plan a home birth despite the challenges involved. Some of them, and/or their babies, will require transfer to hospital during labor or soon after birth. Although guidelines exist for the processes of transfer, we do not fully understand how women experience this emotionally and psychologically. Therefore, the aim of this metasynthesis is to review and synthesize, from the current literature, the views and experiences of women in developed countries who have planned a home birth and subsequently been transferred to hospital during the intrapartum or early postnatal periods.

METHODS

Design

A metasynthesis approach to the qualitative literature on the views and experiences of women planning a home birth, who are subsequently transferred from home to hospital during labor or in the early postnatal period, was undertaken. This approach was selected because it aims to create a rich understanding of women's experiences of transfer by analyzing and synthesizing qualitative data.

A metasynthesis attempts to explore phenomena related to a specific research question to illuminate and enrich understanding of the chosen phenomenon. More than a summary of available evidence, it seeks to analyze existing research in a way that enables new insights, synthesizing between the studies, determining comparisons and contrasts between them, and identifying relationships and refutations which may be either apparent or implied. This results in a holistic analysis (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004; Walsh & Downe, 2005) that is derived from an interpretive paradigm (Noblit & Hare, 1988). The aim of a metasynthesis is to develop knowledge in and increase understanding of a phenomenon of interest (Thorne et al., 2004).

Various approaches to metasynthesis are seen in the literature (Thorne et al., 2004). Most are informed by the metaethnographic approach of Noblit and Hare (1988), considered a seminal work on the method (Thorne et al., 2004; Walsh & Downe, 2005). Noblit reminds us that qualitative research is the ". . . juxtaposition of the author's perspective with the perspectives of those studied" (Thorne et al., 2004, p. 1347). The synthesis of qualitative research adds a further layer, that of the interpretation of the synthesizer, who seeks to relate ordinary concepts from the data to existing discourse (Thorne et al., 2004).

The structure of this metasynthesis has been influenced by the approaches of Schmied, Beake, Sheehan, McCourt, and Dykes (2011); Walsh and Downe (2005); and Noblit and Hare (1988). Beginning with

a focused literature search, it then combines findings from studies that have employed different methodologies. The original analyses and the authors' interpretations contained within the studies, and the relationships between the studies are used to create new interpretations. These interpretations are further related to contemporary discourse, striving to make the result richer than the sum of its parts (Thorne et al., 2004; Walsh & Downe, 2005).

Definitions

For the purposes of this study, *planned home birth* is defined as when the planned place of birth at the onset of labor is the woman's home, with care from a private or publicly funded registered midwife. It does not mean a birth at home unattended by a professional midwife or a birth before planned arrival to hospital. *Transfer* is defined as the transport of a woman who has planned a home birth, and/or her baby, from home for referral to an obstetric hospital. This may have occurred after the onset of labor or within several days after birth. The transfer may occur because of complications or risk factors emerging during the labor or immediate postpartum period, and/or the woman may have requested a transfer because of social reasons or the desire for pharmacological pain management. This study does not include women for whom consultation with a medical practitioner is sought on the telephone but subsequently remain at home for birth and the early postpartum period.

Inclusion and Exclusion Criteria

Qualitative studies or only the qualitative section of mixed method studies that explored the views and experiences of primiparous and multiparous women planning a home birth, who are subsequently transferred to hospital during labor or in the early postnatal period, were included. Literature on free birthing (Dahlen, Jackson, & Stevens, 2011) and home births in developing countries (Ghazi Tabatabaie, Moudi, & Vedadhir, 2012; Radoff, Levi, & Thompson, 2012) were excluded because these bring unique and complex issues that are beyond our primary aim. Also excluded was literature about women who, at the onset of labor, plan to give birth in a hospital but unexpectedly gave birth before reaching the hospital. In addition, search terms *embryo, in vitro fertilization (IVF),* and *blastocyst* were specific keyword exclusions. This was decided after an initial search which drew hundreds of hits related to assisted reproduction.

Search Strategy

For the purposes of a larger PhD study, a systematic search was undertaken for all literature pertaining to home birth transfer using the following databases: Academic Search Complete and CINAHL (Ebsco), Informit, Cochrane Library (Wiley), Intermid, Maternity and Infant Care, Medline (Ovid), Pubmed, Scopus, ScienceDirect (Elsevier), ANL Trove (theses), and ProQuest Dissertations and Theses. Search terms included *homebirth* OR *home birth* AND *transfer*. These broad search terms were used to encompass the wider scope of the aforementioned PhD project. Only research published since 1990 in English was sought because home birth practice has undergone many changes over the past 20 years in many countries because of political issues and midwives' access to indemnity insurance. The search attracted 1,520 hits; 333 relevant titles were chosen for abstract review and following abstract review, 196 abstracts remained. The full texts of those papers were sought and reviewed for relevance. After full text review, 18 papers relating to intrapartum or early postpartum transfer remained. Of these 18 papers, 14 were quantitative and 4 were qualitative studies. All the qualitative studies specifically addressed women's views and experiences of intrapartum or early postnatal transfer during a planned home birth (Catling-Paull et al., 2011; Creasy, 1997; Dahlen et al., 2010; Lindgren et al., 2011). A further paper was later added which was published just after the search, which included a section on the experiences of two transferred women (McCourt, Rayment, Rance, & Sandall, 2012). Quality appraisal of these five papers was undertaken using the Critical Appraisal Skills Programme (2010) "Qualitative Research checklist." Five papers that included data from 89 women remained after quality appraisal (Figure 1).

Analysis

The seven-step process of metaethnography proposed by Noblit and Hare (1988) was used as a basis for this analysis. The seven steps are illustrated in Figure 2, and details of the steps as they applied in this study appear in the following text. Three categories were synthesized: "communication, connection, and continuity," "making the transition," and "making sense of events." Each

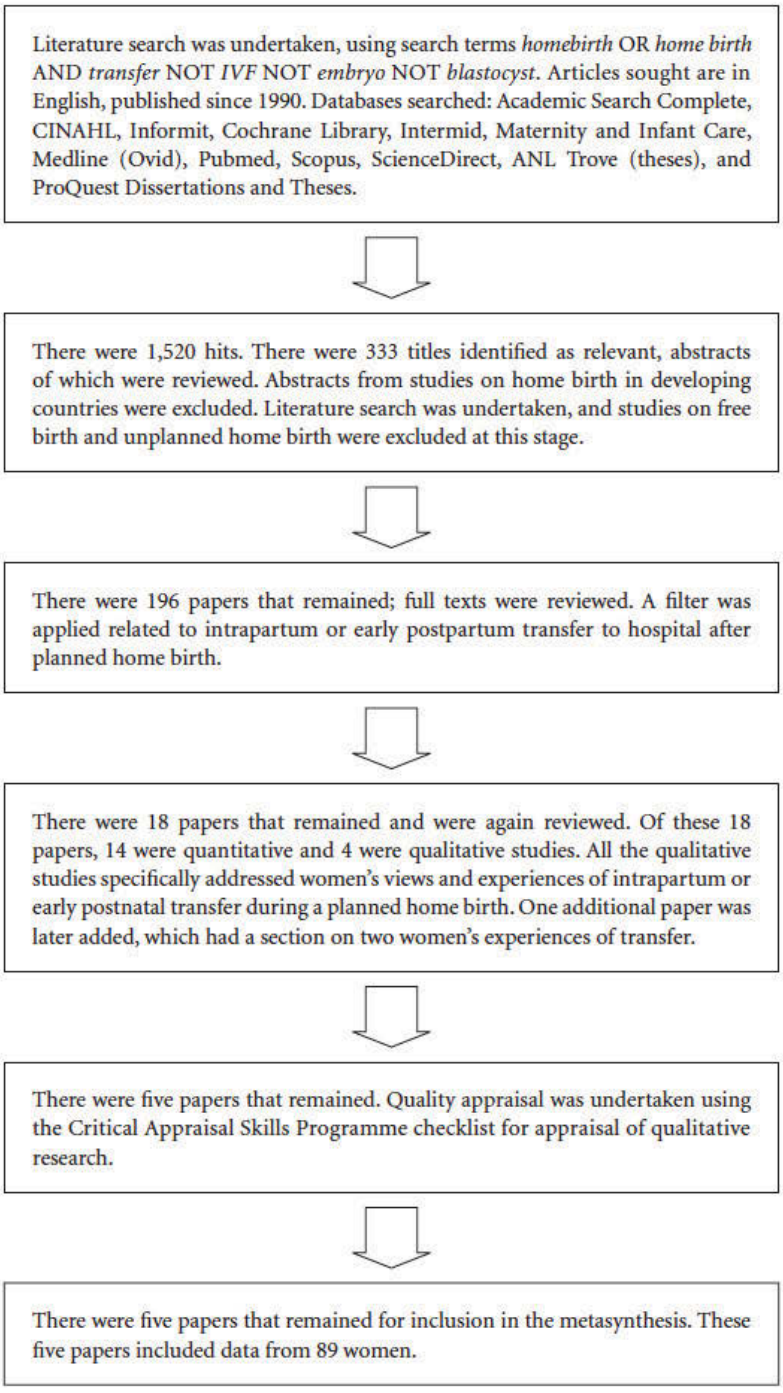

FIGURE 1 Selection process of papers for inclusion in metasynthesis.

1. Identification of topic of interest
2. Deciding what is relevant to that interest
3. Reading and repeated reading, noting themes and concepts inherent in the text
4. Determining relationships between the studies; discerning similarities, connections, and contrasts
5. Translation of the studies into each other
6. Synthesizing the translations
7. Expressing the synthesis

FIGURE 2 Seven-step process of metaethnography (Noblit & Hare, 1988).

category was identified in at least two of the papers synthesized (Table 2).

1. *Identification of topic of interest*

From background reading during the initial literature search on transfers from planned home birth, it was identified that synthesizing the views and experiences of women would be a prudent starting point for understanding the issues surrounding the processes of transfer.

2. *Deciding what is relevant to that interest*

The subject matter to be analyzed in the metasynthesis was particularly pertaining to the following:

a. Women's views and experiences (not caregivers' or partners')
b. Intrapartum or early postpartum transfer (not antenatal transfer)
c. Qualitatively analyzed empirical studies

As described in the search strategy, qualitative studies that specifically addressed women's views and experiences of intrapartum or early postpartum transfer were drawn from the larger search. Mixed method studies that included a qualitative section were also useful.

3. *Reading and repeated reading, noting themes and concepts inherent in the text*

Ideas started to form about how the studies related by reading and rereading the studies. Copious pencilled notes were made on a hard copy of each paper, about the themes and concepts emerging from each individual paper.

4. *Determining relationships between the studies; discerning similarities, connections, and contrasts*

From notes on the themes and concepts of each study, ideas began to formulate about which studies were saying similar things (e.g., women felt they were met with negative attitudes upon arrival at hospital), which studies were saying things which were connected (e.g., the different ways in which the benefits of continuity of midwifery carer emerged from the data), and which studies found contrasting things (e.g., in some studies, the home birth midwife was not able to continue caring for the women in hospital, and in other studies, this was expected). A table was constructed to reflect the themes and concepts and the related quotations from women (raw data) representing this (Table 3). A table describing the main elements of each study was also formulated (Table 4).

TABLE 2 Themes and Categories Identified and Related Synthesis Statements

THEMES	SYNTHESIZED CATEGORIES	SYNTHESIS STATEMENTS
Communication of information (antenatal) Connectedness with a hospital Continuity	Communication, connection, and continuity	Quality and clarity of communication, feeling connected to the backup hospital, and continuity of caregiver helps make the transfer process as seamless as possible for women.
Hostile behaviors Negative attitudes	Making the transition	Arriving at the hospital is a time of vulnerability and fear for women, and retaining the care of a known midwife is reassuring. New caregivers must also be sensitive to women's need to be reassured and accepted.
Understanding why transfer occurred (intrapartum) Acknowledging feelings of disappointment Moving forward	Making sense of events	The reasons for transfer need to be clearly communicated at the time of transfer. Women also welcome the opportunity to understand the circumstances in more detail during the postpartum period. Women need to talk through their experience and to acknowledge their feelings of disappointment to move forward in the next phase of their lives. Continuity of carer enables this to be done by a known caregiver in a sensitive and individualized manner.

TABLE 3 Synthesized Categories, Themes, and Related Quotations From the Data

COMMUNICATION, CONNECTION, AND CONTINUITY	RELATED QUOTATIONS
Communication of information	"Originally when I asked for a home delivery and talked to the GP about it, he was sort of fairly honest in explaining . . . because it was a first birth that there was a reasonable chance that I'd end up in hospital" (Creasy, 1997, p. 35). "I needed to know absolutely everything about how it [publicly funded home birth] worked" (Catling-Paull et al., 2011, p. 125). "I don't like the polarization *[sic]*; being at home or at the hospital. More communication would have made it easier for everyone involved" (Lindgren et al., 2011, p. 103).
Connectedness with a hospital	". . . knowing that if I didn't want to go ahead with it then I could always back out and still go to the hospital. I was fine, I was very relaxed about it" (Catling-Paull et al., 2011, p. 125). "Some of my family thought it was really nice and really good that I was already a patient there and transfer would be really smooth. If I had to transfer it would be ok" (Catling-Paull et al., 2011, p. 125).
Continuity	"I just like the idea of the backup there, the continuity. I just like the fact that I go to hospital for my appointments and the hospital is the one looking after me" (Catling-Paull et al., 2011, p. 125). ". . . I just wished that my homebirth midwife had been allowed to stay with me" (Lindgren et al., 2011, p. 103). ". . . [Midwife, C] always kept me very focused and in control of the situation, we were . . . worked very well together as a team" (McCourt et al., 2012, p. 8).
MAKING THE TRANSITION	
Hostile behaviors	"When we came to hospital we felt like aliens, the atmosphere was hostile and I was scared" (Lindgren et al., 2011, p. 103). "The doctor looked me in the eyes and said 'What would have happened if you hadn't had the option of coming here when things went wrong?'" (Lindgren et al., 2011, p. 103).
Negative attitudes	"It was hard to meet people at the hospital, and being confronted with their negative attitudes towards homebirths" (Lindgren et al., 2011, p. 103). "When we came to the hospital I was exhausted and needed to rest but everyone was so upset about my homebirth that I didn't get a chance to sleep" (Lindgren et al., 2011, p. 103). "In the postnatal ward we met a midwife who had given birth at home herself, and that was the first time at the hospital I felt that someone had understood me" (Lindgren et al., 2011, p. 103).
MAKING SENSE OF EVENTS	
Understanding why transfer occurred	"The waters broke, and . . . she very calmly just said, 'Right, the baby has poo-ed inside you, it's not a big deal, it's fine. All we have to do now is call an ambulance,' So I said, 'OK, that's fine, not a problem'" (McCourt et al., 2012, p. 8). "The placenta was fixed to the womb, so it couldn't have come away anyway . . . I did the important bit myself" (Creasy, 1997, p. 36).
Acknowledging feelings of disappointment	"I felt like I wasn't good enough and I felt disappointed that my body didn't do what it was supposed to do" (Lindgren et al., 2011, p. 103). "I think there's disappointment or a sense of loss too. Part of me feeling disappointed in my body . . . Loss of not doing it as I thought I could do it" (Dahlen et al., 2010, p. 1982). "Giving birth at home was a dream for me. I thought of it as the best start for the baby, so it was disappointing having to finish the birth at the hospital" (Lindgren et al., 2011, p. 103).
Moving forward	"For eight weeks I did not embrace motherhood . . . I wouldn't completely let go of my old life without a baby and not being a mother" (Dahlen et al., 2010 p. 1982). "I was just busting because I couldn't talk enough about this . . . I got sick of talking about it too, but it was unresolved" (Dahlen et al., 2010, p. 1981). "They would say oh! You've got to get on with it. And it was like I don't need to hear that. I'm going to get on with it but I'd like to also say it's not that easy" (Dahlen et al., 2010, p. 1982). "This time I needed some help but next time I'll do it at home all the way!" (Lindgren et al., 2011, p. 103). "I still strongly think that home is the place to be, yes I still will definitely plan another homebirth" (Catling-Paull et al., 2011, p. 126).

TABLE 4 Characteristics of Five Included Studies

AUTHOR, DATE, COUNTRY	SCOPE AND PURPOSE	DESIGN, METHODS	SAMPLING, PARTICIPANTS	ANALYTIC STRATEGY	NUMBERS OF WOMEN PROVIDING RAW DATA (89 IN TOTAL)
Dahlen et al., 2010, Australia	To explore first-time mothers' birth experiences	Qualitative, grounded theory design; in-depth interviews 6–26 weeks after birth, lasting between 20 min and 3 hrs	Purposeful and theoretical sampling; 19 primiparous women, 7 planned home births, 1 transferred from planned home birth to a hospital, forceps birth	Grounded theory	There was one woman interviewed.
Catling-Paull et al., 2011, Australia	To explore multiparous women's choices and experiences of publicly funded home birth	Interpretivist; semistructured interviews lasting 1 hr, using open-ended questions, in their homes, 6–26 weeks postpartum: Interviews were audio taped.	There were 10 multiparous women, all English speaking—3 were transferred to hospital during intrapartum period. Participants de-identified during transcription from audio tapes.	Thematic analysis, constant comparative method of analysis, categories formed	There were three women interviewed.
Creasy, 1997, England	To explore women's experience of transfer from community care to consultant obstetric care in Sheffield, England	Mixed method; during a 6-month period, 122 women booked for community care (GP unit or home birth) were followed prospectively. Consent was obtained at 32 weeks from 112 women. Questionnaires were sent during antenatal and postnatal periods. Women who were transferred were invited for semistructured interviews lasting 30 min. The average timing of interview was 30 days postnatal.	The qualitative part of the study employed purposive sampling. There were 14 women who had been transferred to consultant care in late pregnancy or labor who were invited to participate in a semistructured interview lasting 30 min. There were 12 who agreed. There were 10 who had planned to birth in GP unit; 2 planned home births (1 was transferred in labor for failure to progress and had a ventouse, 1 was transferred postnatally for removal of retained placenta).	Taped interviews were transcribed and analyzed according to grounded theory.	There were two women interviewed.
Lindgren et al., 2011, Sweden	To compare the experiences of women planning a home birth who were transferred and those who completed birth at home	Positivist; quantitative data collection, mixed method analysis	There were 674 women planning a home birth between 1998 and 2005 who were invited to participate. Each of the 671 women who agreed received one questionnaire. There were 95 who were transferred. There were 81 women who responded to open-ended survey questions about their experience of transfer.	Mixed method analysis: quantitative SPSS and qualitative content analysis	There were 81 women who responded to open-ended survey questions.
McCourt et al., 2012, United Kingdom	To explore organizational and professional issues impacting on safety and quality of care in four different birth settings in the United Kingdom	Qualitative; ethnographic case studies	There were 156 interviews with women and partners, care providers, and stakeholders. There were 50 practice observations and review of 200 documents.	Case study method using interpretive systems approach: Thematic and framework analysis identified five areas. NVivo8 was used to catalogue data.	There were two women interviewed.

Note. GP = general practitioner; SPSS = Statistical Package for Social Sciences.

5. *Translation of the studies into each other*
This stage looked for more nuanced connections between the raw data from individual studies; what the authors' interpretations of the data were offering; and how different authors' interpretations were similar, connected, or contrasting. One example of this was consideration of the contexts of the five papers and the focus each author placed on their interpretation. Despite the studies possessing different foci, emanating from different countries and cultural contexts (United Kingdom, Sweden, Australia), and different groups of women (primiparous women, multiparous women, women in private and publicly funded models of care), it was possible to draw similarities and contrasts between the papers. The identification of these similarities and contrasts enabled connections to be made and draft categories to be developed. Each category identified emerged from in two or more of the papers examined, from quotations of the women (the raw data), and/or interpretations of the individual authors.

6. *Synthesizing the translations*
A more in-depth synthesis, this phase was a final fermentation process of "connecting the dots." Consensus (or otherwise) with the authors' interpretations of their data, adding further layers of interpretation from the data and adding further layers of synthesis to the authors' interpretations of their data, was achieved. In addition, it was examined whether one author's interpretation may have illuminated the interpretation of another. An example of this is that issues around continuity of care emanated from all the papers as a determinant of the quality of women's experiences of transfer. This manifested in various ways, but it was possible to contemplate how the presence or absence of continuity of carer could influence a woman's experience during transfer.

7. *Expressing the synthesis*
Qualitative research may be expressed in a variety of ways for a range of audiences (Noblit & Hare, 1988). In this case, the expression of the synthesis is in a written form, specifically aimed at a professional journal audience.

FINDINGS

Of the papers, two used grounded theory (Creasy, 1997; Dahlen et al., 2010), two used thematic analysis (Catling-Paull et al., 2011; Lindgren et al., 2011), and one was an ethnographic case study (McCourt et al., 2012). Two papers were from Australia (Catling-Paull et al., 2011; Dahlen et al., 2010), one from Sweden (Lindgren et al., 2011), and two from the United Kingdom (Creasy, 1997; McCourt et al., 2012).

Communication, Connection, and Continuity

Women felt reassured during the antenatal period when they received information about the likelihood and processes of potential transfer. Feeling connected to a hospital during pregnancy helped women feel prepared because they had some knowledge of their destination if transfer were to occur. This category encompasses the themes "communication of information," "connectedness with a hospital," and "continuity."

Communication of Information
Communication of information by caregivers during the antenatal period was an important component of feeling prepared for home birth. Women and families appreciated when caregivers encouraged them to remain open-minded and flexible in their approach to unexpected outcomes.

> *Originally when I asked for a home delivery and talked to the GP about it, he was sort of fairly honest in explaining . . . because it was a first birth that there was a reasonable chance that I'd end up in hospital (Creasy, 1997, p. 35).*

Women wanted honest and open information on the reality and likelihood of transfer, the practical mechanisms of transfer, the role of the midwife after transfer, and the potential interventions which may occur in hospital. Women provided with such information were more understanding and accepting of events in hospital when transfer occurred. Data from the papers highlighted this, for example,

> *I needed to know absolutely everything about how it [publicly funded home birth] worked (Catling-Paull et al., 2011, p. 125).*

Women also conveyed that the style of the care in hospital felt different from that received in their home. One woman felt that better communication may have ameliorated this by saying,

> *I don't like the polarization; being at home or at the hospital. More communication would have made it easier for everyone involved (Lindgren et al., 2011, p. 103).*

Connectedness With a Hospital

Belonging to a publicly funded home birth program promoted feelings of connectedness with the hospital, although there was only one study exploring this specifically. Confidence in the hospital as backup was evident for one woman because she felt she already belonged at the hospital when she went there for antenatal appointments, as highlighted here:

> *I just like the idea of the backup there, the continuity. I just like the fact that I go to hospital for my appointments and the hospital is the one looking after me (Catling-Paull et al., 2011, p. 125).*

Another woman in the publicly funded home birth program had expressed (during her antenatal period) that if she had to transfer, she felt she would be all right. Her family was also reassured by the connectedness with the hospital, as in this quote:

> *Some of my family thought it was really nice and really good that I was already a patient there and transfer would be really smooth. If I had to transfer it would be ok (Catling-Paull et al., 2011, p. 125).*

Flexibility was provided by a sense of belonging to the hospital and the ability to change place of birth plans at any time if necessary or desired:

> *. . . knowing that if I didn't want to go ahead with it then I could always back out and still go to the hospital. I was fine, I was very relaxed about it (Catling-Paull et al., 2011, p. 125).*

Continuity

One of the reasons home birth was chosen by women in the studies was because of the continuity of caregiver that is integral to the model of care. Continuity or lack thereof remained an important determinant in coming to terms with being transferred. When the home birth midwife was not able to continue caring for the woman in hospital, this was seen as a negative (Lindgren et al., 2011):

> *. . . I just wished that my homebirth midwife had been allowed to stay with me (Lindgren et al., 2011, p. 103).*

Known caregivers provided reassurance by being able to communicate in a way that was appropriate to the individual woman. Explanations which were tailored to a woman's individual needs and to her state of mind and body at the time were more helpful. Women were more trusting of information given by a caregiver with whom they had a rapport:

> *. . . [Midwife, C] always kept me very focused and in control of the situation, we were . . . worked very well together as a team (McCourt et al., 2012, p. 8).*

Making the Transition

The phase of making the transition from home to hospital was often made more difficult for women because of hostile behaviors and negative attitudes displayed by hospital staff. These themes are reflected here.

Hostile Behaviors

Hostile behaviors displayed at the hospital added to women's feelings of vulnerability and fear upon arrival. There were several quotes conveying this:

> *When we came to hospital we felt like aliens, the atmosphere was hostile and I was scared (Lindgren et al., 2011, p. 103).*

> *The doctor looked me in the eyes and said "What would have happened if you hadn't had the option of coming here when things went wrong?" (Lindgren et al., 2011, p. 103).*

> *. . . I wish they had been more accommodating (Lindgren et al., 2011, p. 103).*

Negative Attitudes

Negative attitudes displayed by hospital staff about home birth caused one family to feel marginalized in the hospital setting, with two women saying,

> *It was hard to meet people at the hospital, and being confronted with their negative attitudes towards homebirths (Lindgren et al., 2011, p. 103).*

> *When we came to the hospital I was exhausted and needed to rest but everyone was so upset about my homebirth that I didn't get a chance to sleep (Lindgren et al., 2011, p. 103).*

On the other hand, one woman met a midwife on the hospital postnatal ward who had herself had a home birth. This appeared to reduce her feelings of alienation. She said,

> *In the postnatal ward we met a midwife who had given birth at home herself, and that was the first time at the hospital I felt that someone had understood me (Lindgren et al., 2011, p. 103).*

Accepting and appreciating the care of the hospital staff was a positive coping strategy used by some women. The ability to adopt this attitude, however, was dependent on the woman's personality and the circumstances surrounding the transfer (Creasy, 1997).

Making Sense of Events

The category involves three themes: "understanding why transfer occurred," "acknowledging feelings of disappointment," and "moving forward."

Understanding Why Transfer Occurred

Information and preparation provided by the midwife at the time of transfer enhanced the women's sense of control (Creasy, 1997; Lindgren et al., 2011). Women found it important to understand clearly why the transfer needed to occur. Transfer to hospital was seen by some as a threat to their ability to listen to their body in labor, and this in turn threatened their sense of control over the situation (Lindgren et al., 2011). Women who understood that there were clear cut indications for transfer and interventions seemed to feel more easily ready to accept the situation (Creasy, 1997). They were more likely to believe that the clinical picture was beyond their control, for example,

> *The placenta was fixed to the womb, so it couldn't have come away anyway . . . I did the important bit myself (Creasy, 1997, p. 36).*

> *The waters broke, and . . . she very calmly just said, "Right, the baby has poo-ed inside you, it's not a big deal, it's fine. All we have to do now is call an ambulance." So I said, "OK, that's fine, not a problem" (McCourt et al., 2012, p. 8).*

Acknowledging Feelings of Disappointment

A sense of loss of the plans to give birth at home and feelings of disappointment were common. Women described feeling that their bodies had not performed to their expectations. Some examples of this include the following:

> *I felt like I wasn't good enough and I felt disappointed that my body didn't do what it was supposed to do (Lindgren et al., 2011, p. 103).*

> *I think there's disappointment or a sense of loss too. Part of me feeling disappointed in my body . . . Loss of not doing it as I thought I could do it (Dahlen et al., 2010, p. 1982).*

Disappointment at not having the baby at home and disappointment in their bodies manifested feelings of lost dreams (Dahlen et al., 2010; Lindgren et al., 2011), which were often profound. These lost dreams seemed to create a sense of failure, that the woman's body was not good enough, and did not do what it was supposed to do (Lindgren et al., 2011). Women expressed this by saying

> *Giving birth at home was a dream for me. I thought of it as the best start for the baby, so it was disappointing having to finish the birth at the hospital (Lindgren et al., 2011, p. 103).*

> *For eight weeks I did not embrace motherhood . . . I wouldn't completely let go of my old life without a baby and not being a mother (Dahlen et al., 2010, p. 1982).*

Moving Forward

This theme was about the women being able to process what had occurred, by talking it through as much as they felt was needed. One woman described feeling that she couldn't talk enough about it but simultaneously was sick of talking about it because she felt the issues remained unresolved. This process was a type of retrospective sense making, a justification for events.

> *I was just busting because I couldn't talk enough about this . . . I got sick of talking about it too, but it was unresolved (Dahlen et al., 2010, p. 1981).*

> *They would say oh! You've got to get on with it. And it was like I don't need to hear that. I'm going to get on with it but I'd like to also say it's not that easy (Dahlen et al., 2010, p. 1982).*

All the women in the publicly funded home birth program, including those transferred, said they would choose home birth again (Catling-Paull et al., 2011). As part of the acceptance process, women looked forward to trying again for a home birth with the next pregnancy. This may be regarded as a way of helping to validate their choice of home birth.

> *This time I needed some help but next time I'll do it at home all the way! (Lindgren et al., 2011, p. 103).*

> *I still strongly think that home is the place to be, yes I still will definitely plan another homebirth (Catling-Paull et al., 2011, p. 126).*

DISCUSSION

This analysis identifies, from women's perspectives, several potential improvements in care during transfer to hospital from a planned home birth. Preparation of women, through the provision of information during the antenatal period; optimal communication and professional behavior at the time of transfer; and the provision of postbirth counselling may significantly improve women's levels of coping with unexpected outcomes. Optimizing opportunities for the provision of continuity of midwifery care and building a sense of connection between women planning a home birth and their backup hospital are organizational aspects which may be addressed.

The findings show that receiving information during the antenatal period is important to women. The literature also demonstrates that antenatal education increases maternal satisfaction with the birth experience (Walsh, 2012), reduces anxiety levels for women, and increases partner involvement in labor and birth (Ferguson, Davis, & Browne, 2013). The potential for quality antenatal education to prepare couples emotionally for childbirth appears to be at the heart of this association. Both cognitive and affective aspects are equally important to the preparation of women and their support people (Ferguson et al., 2013), and this may logically be assumed to apply when assisting women to feel ready for the possibility of transfer during or after planned home birth.

Gaining familiarity, during the antenatal period, with the personnel, processes, and environment of the backup hospital seems to enhance confidence in women and reassure their families. When women planning a home birth were prepared during pregnancy for the possibility of transfer, and were familiar with the hospital processes and environment, it created a sense of safety and security for them and their families. This familiarity may have created more realistic expectations, which may be important for primiparous women who have a higher likelihood of transfer than do multiparous women. This sense of security was evident in the paper about publicly funded home birth (Catling-Paull et al., 2011). Although the Catling-Paull et al. (2011) study was limited to multiparous women, the women's comments displayed a strong sense of confidence in the hospital with which they felt connected.

The findings include quotes from several women who described meeting with negative attitudes toward home birth among hospital staff. This finding is of particular concern because the behavior described contravenes the International Confederation of Midwives (ICM) International Code of Ethics for Midwives (2008). According to the code, midwives must support the right of women and families to participate in decisions about

their care and must also respond to the psychological and emotional needs of women seeking care, whatever their circumstances.

As Dahlen et al. (2011) suggest, it may be more appropriate for maternity care providers to reflect on why women choose to birth outside mainstream hospital services, than to make negative judgements about their choices. Widely recognized is that opposing paradigms exist around perceptions of risk and safety in relation to maternity care (Anderson & Murphy, 1995; Ashley & Weaver, 2012; Bick, 2012; Blix, Oian, & Kumle, 2008; Cheyney & Everson, 2009; Foley & Faircloth, 2003; Homer, 2010; McMurtrie et al., 2009; Walsh, 2000). Polarization of attitudes to the safety of home birth is a key concept in the literature (Catling-Paull et al., 2012; Chervenak, McCullough, Brent, Levene, & Arabin, 2013; Cheyney & Everson, 2009; Dahlen, 2012; Homer, 2010). Issues such as hostile behaviors displayed toward women after transfer from planned home birth are perhaps implicitly buried in this paradigmatic problem.

Women who have chosen home birth commonly face challenges in advocating for their decisions, the reasons for which are complex (Cheyney, 2008). The process of choosing and planning a home birth involves working outside accepted norms and navigating around obstacles in an established maternity care system (Cheyney, 2008). Communicating with relatives, friends, and/or health professionals about their choice of birthplace is often problematic because the decision to have a home birth challenges hegemonic biomedical beliefs (Cheyney, 2008; Jordan, 1997). A range of belief systems may exist concurrently in any particular sphere. Some views will dominate, either because they are more efficacious or because they carry a stronger structural power base, often both. When one view gains acceptance, alternative types of knowledge may become devalued. Individuals who subscribe to alternative, nonhegemonic belief systems are then sometimes seen as uninformed, naïve, or pestilent (Jordan, 1997). Cheyney (2011) describes choosing home birth is an act of resistance, demonstrating avoidance of a "doctor-up, mother-down hierarchy" (p. 531).

Cheyney (2008) applies the notion of a "systems-challenging praxis," a term derived from the critical medical anthropology work of Singer (1995). According to Cheyney (2008), cultivation of this praxis involves three stages. The first stage involves questioning accepted public narratives around childbirth, the second constructing counternarratives to become empowered and, finally, belonging to and becoming supportive of an alternative collective belief (Cheyney, 2008). This very process may play a role in the difficulty some women experience during a transfer to hospital and may even, in some cases, result in their reluctance to be transferred. The transfer, occurring during labor, a vulnerable time for most women, involves a fundamental paradigm shift to begin to accept the very systems and values they had previously resisted. Hostile behaviors by hospital staff are likely to exacerbate women's feelings of fear and vulnerability as they make the transition to being cared for in hospital.

Access to clear and accurate information at the time of transfer is beneficial, especially for those experiencing complications of a traumatic nature. Unexpected and dramatic events, which may disrupt a woman's belief systems and sense of control, are likely to be psychologically distressing (Gamble & Creedy, 2009). Women value the opportunity to talk about events, to accept feelings of disappointment and move on to the next phase of their lives. This next phase will include either transition to parenting or embarking on grief reactions, neither of which are insignificant experiences. Resolving issues around the birth itself is therefore imperative. In a study by Creedy, Shochet, and Horsfall (2000), one in three women reported a stressful birth, as well as demonstrating three or more symptoms of trauma within 6 weeks of birth. Of the women surveyed, 5.6% were also diagnosed with an acute posttraumatic stress disorder (PTSD). Midwives have the opportunity to provide emotional and psychological support for women experiencing such distress during the postpartum period. Postbirth counselling has been explored in the literature and found to be beneficial for many women (Fenwick et al., 2013).

For some women, transfer was largely a negative event that resulted in varying degrees of disappointment and loss. Questions emerge as to whether a more positive attitude to transfer could be constructed by negotiating women's expectations differently. Transfer in and of itself is not a poor clinical outcome. In some settings, early labor assessment is done at home, and no firm decisions need to be made regarding place of birth until labor has established (Brintworth & Sandall, 2013; McCourt et al., 2012). Conversely, the findings show that access to continuity of carer and the standard of care received in hospital has an important impact on the way women experience transfer (Creasy, 1997; Lindgren et al., 2011).

Finally, the concept of continuity of carer and its implications for women's experiences emanates from all three categories in various ways. One of the reasons home birth is chosen by women is because of the

continuity of caregiver that is integral to the model of care (Longworth, Ratcliffe, & Boulton, 2001). The value of rapport, trust, and confidence that women develop with a known midwife is widely recognized as being associated with improved outcomes and higher maternal satisfaction. A Swedish quantitative study (Lindgren et al., 2008) found that women having their first baby and planning a home birth were four times more likely to be transferred to hospital if the midwife attending the home birth was different from the midwife they had seen during pregnancy. Although the provision of continuity of carer may not be possible in all transfer settings, all of the time, the findings suggest that optimizing opportunities for continuity of midwifery carer for women through the transfer process is beneficial. There is inherent value in personalized maternity care and this would inevitably add to the quality of support felt by women being transferred (Creasy, 1997). In the late 20th century, concern grew that maternity care in many settings was becoming increasingly fragmented (McCourt, Stevens, Sandall, & Brodie, 2006). A groundswell of midwifery literature evidencing and discussing the value of midwifery continuity of care was published around the start of the new millennium (Hatem, Sandall, Devane, Soltani, & Gates, 2008).

A known midwife has the capacity to enhance communication and provide individualized information to women at all three of the crucial stages of childbearing (antenatal period, time of transfer, and postbirth). During transfer, providing continuity of carer provides the midwife, at the very least, the opportunity to enable a smooth handover to hospital staff. At best, women need not lose the care of their known midwife simply because they require transfer. One might argue that this is a vulnerable time when a woman needs support and advocacy from her known midwife more than ever. Follow up from a known midwife during the postnatal period facilitates an opportunity for women to talk about their experience with a trusted caregiver.

FURTHER RESEARCH

Further research is needed to explore how home birth midwives view and experience transfer and how hospital staff encounter receiving women who are transferred from planned home birth. Gaining understanding of health care providers' views and experiences may clarify the challenges involved in transfer processes and illuminate how a more collaborative service may ameliorate some of the challenges faced.

Empirical research is needed in the Australian setting to explore the views and experiences of women and health professionals involved in home birth transfers. Publicly funded home births in the Australian setting will be examined specifically in relation to transfer to hospital, as part of the Birthplace in Australia project.

The reasons for a four- to fivefold increase in the likelihood of transfer for a primiparous women in comparison to a multiparous woman needs further exploration to investigate any association with poorer outcomes for primiparous women and their babies.

CONCLUSION

This study will hopefully stimulate further discourse around home birth transfer processes. Women's choices around place of birth are complex, involving social perspectives and personal definitions of emotional safety. Despite high transfer rates and perinatal mortality rates in some studies, many women will still choose home birth. Understanding the views and experiences of women who are transferred to hospital after planning a home birth is important because it may help to inform the development of woman centered care practices and help to improve the attitudes and behaviors of health professionals involved. Maximizing opportunities to provide women with continuity of midwifery carer, especially from home to hospital, may help to streamline the transfer process and improve safety and well-being for women and babies in such situations. Improving the quality of care during and after transfer and maintaining safety for women choosing home birth is paramount. Quality and clarity of communication, feeling connected to the backup hospital, and receiving continuity of midwifery care helps make the transfer process as seamless as possible for women. Arriving at the hospital is a time of vulnerability and fear for women and the presence of a known midwife will provide valuable support at this time. New caregivers must be sensitive to the woman's need for reassurance and acceptance. The reasons for transfer need to be clearly communicated to women at the time of transfer and the circumstances fully understood in more detail during the postpartum recovery period. This can be done in a sensitive and individualized manner by a known caregiver. Women need to talk through their experience and to acknowledge their feelings of disappointment to move forward in the next phase of their lives. This synthesis aims to create a starting point toward understanding, from women's perspectives, how home birth transfer processes may be improved.

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CHAPTER FOUR: METHODOLOGY AND METHODS

Introduction

The aim of the study was to find out 'What are the views and experiences of women who at the onset of labour, plan to birth at home, and subsequently require intrapartum or early postpartum transfer to hospital, and what are the views and experiences of caregivers involved in such transfers?' As the research developed iteratively, the interactions and processes occurring during and after transfer from planned homebirth became the focus of the study, rather than the experiences of individuals. This is aligned with theoretical sampling, unique to ground theory methodologies. Theoretical sampling will be explained later in this chapter.

This study used a qualitative approach, aiming to investigate the way in which humans experience a given phenomenon, the meanings they may attach to it and the social context in which they may experience it (Denzin & Lincoln 2011). Grounded theory is a qualitative methodology that emphasises the conceptualisation of social interactions and processes involved in such human experiences and formulates theory grounded in the data (Charmaz 2014; Dey 2004; Hall, Griffiths & McKenna 2013; Roberts & Taylor 2002; Skeat 2010).

Quantitative research methods are deductive; in that they aim to prove or disprove a given hypothesis. Qualitative research is usually an inductive process, in which no firm hypothesis is formulated prior to the research. Constructivist grounded theory differs in that it is abductive. Abductive analysis tests all plausible hypotheses of a finding in the data, through the techniques of constant comparison and theoretical sampling (Charmaz 2011), that is, rigorous testing of the findings from the inductive process (Charmaz 2014; Dey 2004).

Constructivist grounded theory emphasises the interaction between the researcher and the research participants in the generation of data, to the extent where it is impossible to separate the researcher from the researched. The researcher and

participants co-construct the data (Charmaz 2014; Ghezeljeh & Emami 2009; Mills, Bonner & Francis 2006) and, therefore, researcher reflexivity is an essential part of ensuring that the research process is trustworthy. Co-construction of the data is one of the things that sets constructivist grounded theory apart from earlier objectivist versions of grounded theory, as this quote from Charmaz (2008a) demonstrates:

Objectivist versions of grounded theory assume a single reality that a passive, neutral observer discovers through value-free enquiry. Assumptions of objectivity and neutrality make data selection, collection and representation unproblematic; they become givens, rather than constructions that occur during the research process (Charmaz 2008a, pp.401-402).

This chapter provides an overview of the methodology I have selected for this study. After an explanation of the history of grounded theory over the past 50 years, my philosophical positioning and reflexivity will be addressed. The interspersing of methodology and reflexivity in this chapter is unavoidable because they are inextricable. The choice of methodology is enveloped within a framework of my philosophical positioning. The chapter concludes with an overview of the ethical considerations and details of Human Research Ethics Committee (HREC) approvals associated with this study.

History of Grounded Theory

To illuminate the significance of grounded theory's metamorphosis, I will explain the different versions of grounded theory that have emerged over the past fifty years. An explanation of the context of scientific research discourse at the time of the emergence of grounded theory informs the understanding of its objectivist roots. Qualitative research experienced strong opposition in the 1960s; it was not seen at the time as a legitimate form of scientific research. Quantitative approaches dominated and, at best, qualitative work was seen as a way of gathering data rather than an

analytic process (Charmaz 2014). Fortunately, this view has altered over the past 50 years, as this chapter will explain.

Glaser and Strauss

Grounded theory was originally conceived in the 1960s by Barney Glaser and Anselm Strauss, as a qualitative method of enquiry within the discipline of sociology. During their study on the process of dying, Glaser and Strauss (1965) developed the methodology in order to formulate a theory that was grounded in the data. Their first publication seeking to explain the methodology appeared two years later (Glaser & Strauss 1967).

Glaser and Strauss' brave and successful foray into challenging the hegemony of the quantitative research paradigms of the mid-twentieth century provided fertile ground from which qualitative research has since flourished. Qualitative research owes much to Glaser and Strauss for illuminating the approach at a time when only quantitative research methodologies were respected (Charmaz 2008c).

The epistemological approach taken by Glaser and Strauss was objectivist. Epistemology is defined as the study of ways in which we understand knowledge, *'how we know what we know'* (Blaikie 2007, p. 18) or *'the understanding…of what human knowledge is, what it entails and what status can be ascribed to it'* (Crotty 1998, p.2). An objectivist epistemological approach is one that assumes the existence of an objective truth about a given phenomenon. Framing grounded theory in objectivist terms may, perhaps, have been key to its survival at the time (Charmaz 2014), although epistemology was never addressed by Glaser and Strauss themselves, as Charmaz (2008a) described: *'Glaser and Strauss did not attend to how they affected the research process, produced the data, represented research participants, and positioned their analyses. Their research reports emphasized generality, not relativity, and objectivity, not reflexivity'* (Charmaz 2008a, p399).

Influenced by positivists including Paul Lazarsfeld at Columbia University, Glaser aimed to develop ways to codify qualitative data in a similar vein to the way in which Paul Lazarsfeld codified quantitative data. Strauss came from the Chicago School of pragmatism, which informed symbolic interactionism. The original Glaser and Strauss (1967) text is known to be complex and difficult to read (Morse et al. 2009; Stern 2009), a view I share. Many felt at the time that the only way to learn how to do grounded theory was to be a student of the authors at the University of California San Francisco (UCSF) (Morse et al. 2009; Stern 2009), where Glaser and Strauss ran small tutorial groups and guided their students closely.

Anselm Strauss later collaborated with one of his students, Juliet Corbin, in the writing of a book of guidelines for students wishing to use grounded theory. The next section describes how this caused a rift that led to Strauss ceasing the aforementioned collaboration with Glaser; and eventually the formation of a post-positivist approach to grounded theory.

Strauss and Corbin

Strauss and his student, Juliet Corbin, wrote *'Basics of qualitative research: Grounded theory procedures and techniques'* (Strauss & Corbin 1990) primarily as a response to the demand from students and researchers seeking analytic guidelines for grounded theory. Their aim was to provide novice researchers with a step by step approach to assist them in the processes of using grounded theory (Corbin 2009). The text became recognised for its clear procedural instructions (Dey 2004), however, the authors had not expected the book to become as popular as it did (Corbin 2009). Despite the unexpected success of the book, Strauss and Corbin (1990) have been critiqued for being overly prescriptive (Hall, Griffiths & McKenna 2013). At the time of its publication, Glaser strenuously opposed this adaptation of what he regarded as 'classic grounded theory', claiming that Strauss and Corbin's (1990) prescription forced data to fit pre-conceived notions (Charmaz 2006; Dey 2004; MacDonald 2001).

Glaser also objected to what he saw as a modification of his intellectual property, calling for its retraction (Charmaz 2008a). In 1992, Glaser published a harsh critique of Strauss and Corbin's 1990 text. As a result, Barney Glaser and Anselm Strauss had an acrimonious parting of company. During this time, grounded theory evolved into what one of their students, Phyllis Stern, referred to in 1995 as either 'Glaserian' or 'Straussian' versions of ground theory (Morse 2009).

Corbin and Strauss

Anselm Strauss died in 1996. Corbin's 1998 and 2008 publications of the methodology since Strauss' death have honoured his contribution and influence by being posthumously co-authored. The authorship of the 1998 book was attributed to Strauss and Corbin and the 2008 book to Corbin and Strauss. Until the 2008 version, Corbin followed the post-positivist underpinnings of the original 1990 version. Corbin's 3rd edition (Corbin & Strauss 2008) leans much closer towards constructivism with the acknowledgement that data is co-constructed (Corbin 2009; Hall, Griffiths & McKenna 2013), as Corbin herself described in 2009:

> I wasn't delineating a whole new method. I was modernizing [sic] the method I had grown up with, dropping a lot of the dogma, flexing up procedures…it is impossible for me…to talk about the methodology in the way that I did ten or fifteen years ago. I can't say that this is Strauss's version of grounded theory…I wanted to emphasise the interaction that occurs between the researcher and the data and to demonstrate how it is a combination of the data and the researcher's interpretation of them that guides and stimulates the ongoing research process (Corbin 2009, pp. 42-43).

Second generation grounded theorists

The self-named group of 'second generation' of grounded theory methodologists were all students of Glaser and Strauss. In 2007, they gathered in Banff, Alberta, Canada, for what they called a 'Grounded Theory Bash'. The purpose of the gathering was to *'discuss grounded theory, its developments, its controversies, and its forms'* (Morse et

al. 2009, p.9). To their surprise, 200 people attended. The group had planned to publish the presentations as a paper, after the conclusion of the 'bash'. The ensuing discussions were so rich, however, that it turned into an entire book edited by Janice Morse (Morse et al. 2009). The book illuminates how the second generation moved ahead many of the basic premises and strategies of grounded theory and branched out into variants such as Situational Analysis (Clarke 2009) and Constructivist grounded theory (Charmaz 2006).

I have added Australian nursing academics, Jane Mills and Melanie Birks to my definition of the 'second generation' of grounded theorists. A paper by Mills, Bonner and Francis (2006) on constructivist grounded theory was an influential paper that is frequently cited, as are the widely-respected texts on grounded theory by Birks and Mills (2011; 2015).

Constructivist grounded theory is derived from constructionist epistemology, acknowledging that the researcher is situated within the analysis. The researcher interprets data received by the participants, as well as that gleaned from observation, and delves for implicit meanings and tacit assumptions. This contrasts with Glaser's concept, which is that a researcher starts with a mentally blank slate without perspectives of his/her own. A constructivist perspective believes that, no matter how hard we try, it is impossible to come to a research project without a preconceived standpoint toward the questions being asked (Charmaz 2006). Glaser's grounded theory in fact demands a lack of perspective. Glaser's method deals with variables, comparing a central concept with a contrasting variable, in order to develop a generalised theory grounded in the data. Charmaz instead looks for potentially multiple understandings of a range of concepts, to develop a theory grounded in the data (Charmaz 2006; Charmaz 2014).

All versions of grounded theory do these things:

- 'Compare data with data as we develop codes
- Compare data with codes

- Compare codes and raise significant codes to tentative categories
- Compare data and codes to these tentative categories
- Treat major codes as concepts, lifting them towards abstraction and nascent theory
- Compare concept with concept, which may include comparing concept with disciplinary concepts' (Charmaz 2011, p. 361).

Constructivist grounded theorists differ in the following ways. They:

- 'Treat the research process itself as a social construction
- Scrutinise research decisions and directions
- Improvise methodological and analytic strategies throughout the research process
- Collect sufficient data to discern and document how research participants construct their lives and worlds…This includes defining tacit meanings and implicit actions' (Charmaz 2008a, p. 403).

During my PhD candidature, I was privileged to have met with two internationally recognised second generation constructivist grounded theorists, Kathy Charmaz in 2014 and Jane Mills in 2016. My understanding of the constructivist form of the methodology solidified when I attended six days of workshops with Kathy Charmaz in Melbourne in March 2014. In 2016, I met with Jane Mills at Royal Melbourne Institute of Technology (RMIT) where she is Professor of Nursing. Both gave me enormous inspiration and impetus to move ahead with my analysis.

The following table illustrates the divergence in method between the different versions of grounded theory and is reproduced here with kind permission from the authors, Melanie Birks and Jane Mills (Birks & Mills 2015). The constructivist grounded theory methodology I have used is most closely aligned with Charmaz (2014), whose approach is outlined in the final line of Table 5.

Table 5: Comparison of grounded theory methods

(Birks & Mills 2015, Table 6.1: Map of conceptual terminology). Reproduced with permission from the authors.

	Concepts				
	Codes	***Categories***	***Properties and dimensions***	***Core category***	***Methods of theoretical abstraction***
Glaser and Strauss (1967)	Coding incidents	Categories	Properties	Systematic substantive theory	Common sociological perspective
Glaser (1978)	Open coding that moves to selective coding of incidents once the core variable is identified	Categories which are interchangeably referred to as concepts	Properties and typologies	Core variable that explains a basic social process	Theoretical codes
Strauss (1987)	Coding paradigm: conditions, interactions, strategies, tactics, and consequences. Open, axial and selective coding	Categories	Properties and dimensions	Core category	
Strauss and Corbin (1990)	Coding paradigm: cause, context, action/interactions, and consequences. Open, axial and selective coding	Categories and sub-categories	Properties and dimensions	Core category is a central phenomenon	Storyline and the conditional matrix
Strauss and Corbin (1998)	Coding paradigm: conditions, actions/interactions and consequences. Open, axial and selective coding	Categories and sub-categories	Properties, dimensions and coding for process	Central category	Storyline and the conditional/ consequential matrix
Clarke (2005)	Codes	Categories	Seeking variation in the situation of enquiry through: situational maps, social worlds/ arena maps and positional maps	Multiple possible social processes and sub-processes	Situational maps, social worlds/arena maps and positional discourse maps and associated analyses
Charmaz (2014)	Initial and focused coding	Categories	Properties	Theoretical concepts	Theoretical codes

Reflexivity as trustworthiness

The co-construction of data between researcher and participant is central to the constructivist grounded theory approach. Both are agents who bring background assumptions to the data and both are integral to the data generation process. It is recognised that another researcher might bring a different interpretation to the same data (Charmaz 2014, Finlay 2002b). The process of reflexivity (Finlay 2002b) is a dynamic reflection upon the relationship between researcher and participant, alongside awareness of the discursive knowledge that shapes the research process. Trustworthiness in the data is managed in this way.

Reflexivity has been defined as *'thoughtful, conscious self-awareness'* (Finlay 2002b, p.532) and is a course of action that is exploratory and speculative. Various styles of reflexivity may be adopted, sometimes overlapping. Finlay (2002a) conceived five different styles of reflexivity; namely introspection, intersubjective reflection, mutual collaboration, social critique and discursive deconstruction. Intersubjective reflection and mutual collaboration (Finlay 2002a) are two styles of reflexivity that are aligned with the constructivist approach of this study. Intersubjective reflection examines the meanings that emerge from the relationship between researcher and participant. Mutual collaboration, most commonly used in participatory research methodologies (Finlay 2002a), also holds relevance for this study because the research accounted for multiple and conflicting voices.

Reflexivity was a constant and ongoing process that continued, for me, from the beginning of choosing the topic of study until the final analysis and reporting. Reflexive research practice was enacted in thought, conversation, memo writing and reflective journal writing. The following paragraphs aim to illuminate the personal and professional stance that I brought to the subject matter of the research.

My passion in research and practice is twofold. One is enhancing multidisciplinary collaboration to promote woman centred care and optimise normal labour and birth

for childbearing women who experience variations from normal, expected trajectories. The other is putting evidence in to the hands of women so that they may make informed decisions for their childbearing. These interests are grounded in my background as a midwife and childbirth educator, and in five years of experience working in partnership with an obstetrician and an all risk cohort of women seeking normal birth with minimal intervention in Singapore. My view is that the positive birth outcomes, reported elsewhere (Fox et al. 2013) could not have been achieved for women with risk factors by the provision of either a midwifery model or an obstetric model alone, that only collaboration could have achieved it. The uniqueness of the model was that women could choose one to one obstetric led care (required for all women in Singapore) and one to one midwifery care. This model was the only way women in Singapore could access midwifery continuity of carer and led to my developing Singapore's first caseload midwifery model of care.

My Master's research explored the promotion of normal labour and birth for women experiencing complications. Part 1 of the thesis was a systematic review of the literature on enabling freedom of movement and positioning and water immersion for these women, with the use of cordless waterproof Cardiotocography. Part 2 explored the processes of embedding this technology into an obstetric unit, using the framework of Diffusion of Innovation theory (Rogers 2003). During my Masters' study in the UK, I was keenly following the progress of the Birthplace in England project, the results of which began to emerge in 2011 at the end of my Masters' study. As expected, the results became internationally important evidence that now informs women's choices around place of birth, and maternity care policy and practice. I held a secret wish that such a study might one day be done in Australia and that I could be somehow involved. In early 2012, I discovered that Professor Caroline Homer was leading a large Birthplace in Australia study. I immediately contacted her in the hope that it might be possible for me to apply to do a PhD attached to the study.

The perspectives that I brought to the research include the belief that childbirth is usually a normal, physiological process that has significant psychosocial and emotional

implications for a woman and her family. Furthermore, I believe that as human individuals we possess unique perspectives of risk and safety that may differ from those of other individuals. I support each individual woman's right to make informed choices about her reproductive health and the health and well-being of her baby.

The assumptions about the safety of homebirth that I brought to this study were influenced by the evidence but also by my personal experiences as a midwife of homebirth and of transferring women from home to hospital. All these transfers were safe and positive experiences for the women I cared for. I have also had the experience of caring for numerous women labouring and giving birth in a hospital who did not require or receive any medical intervention whatsoever. Finally, I also witnessed the tragedy of a sudden unexpected stillbirth at term in a tertiary hospital. The baby was the daughter of a healthy, young, low risk woman who was in early labour at the time of the baby's demise. Nothing the tertiary setting could have done would have changed that outcome, and no reason was ever found for the baby's death. Hospitals do not always save lives; they do their best; nature is not perfect. Births out of hospital are equally not perfect, but are in many cases planned by women as an emotionally and physically safer choice for their families. Women choose homebirth for a range of reasons, not least to have their family around them in a homely environment with low rates of intervention and minimal iatrogenic risk.

Whilst respecting and acknowledging the reasons why a person may hold a biomedical perspective of childbearing, my perspective is more aligned with midwifery perspectives and grounded in the social model of health. I am also aware that, in any setting, obstetric emergencies can occur rapidly, which may cause serious morbidities or mortality for women and/or babies. My belief is, however, that most women and their families have the capacity to make informed choices and weigh up the benefits and risks, when provided with evidence based information. I believe that all childbearing women benefit from midwifery care and that some women also require obstetric expertise as part of their care. The aim of this research is to improve knowledge and evidence, so that women can make informed choices about planned

place of birth, and midwives and obstetricians can collaborate effectively to care for them.

When I commenced this PhD in 2012, questions remained unanswered around what happens to low risk women who plan an out of hospital birth and experience complications during the intrapartum period. There had been very little qualitative research done to explore the impact upon women and babies of this occurrence. Even less research had been done to explore the processes and interactions from the perspectives of both homebirth midwives and hospital staff, during such an event. My goal from the outset was to investigate the interactions and processes involved when women are forced to change their planned place of birth during the intrapartum period. In 2012 there was a paucity of Australian guidelines for the management of homebirth transfers. What little there was focussed upon clinical indications for transfer rather than the processes involved. In the 12 months prior to submitting this thesis, the Australian College of Midwives (ACM) released two valuable documents, *'Transfer from planned birth at home guidelines'* (ACM, 2016) and the *'Birth at home midwifery practice standards'* (ACM, 2015). I was pleased to be able to contribute to the compilation of these documents by being a member of the ACM Professional Practice Advisory Group in 2015.

I will now outline the areas of reflexivity that relate to my journey towards embracing the constructivist version of grounded theory methodology.

My early methodological interest

I came to this topic originally with an interest in using hermeneutic phenomenology, as an approach to exploring the lived experience of women transferred during labour to hospital, from a planned birth at home or in a birth centre. I had studied phenomenology during my Masters study, with a view to using it for my PhD. This methodological approach stemmed from a desire to explore women's experiences in an in-depth manner, as a foundation for a later exploration into the way in which systemic processes and the interactions of caregivers influenced women's experiences.

My expectation was that women's stories would lead me to the specific areas of process and interaction that I needed to investigate, in a later phase of the research.

Encouragement to explore grounded theory

My primary PhD supervisor encouraged me to consider using grounded theory as a methodology for my study. I found this initially to be a challenging methodological shift from phenomenology, particularly as my early readings of grounded theory were of the objectivist version (Glaser & Strauss 1967). Learning more about grounded theory involved reading a wide range of approaches including Strauss and Corbin (1990; 1998), Corbin and Strauss (2008), Strauss (1969), Dey (2004), Charmaz (2006) and Birks and Mills (2011). My initial exploration of Glaser and Strauss (1967), and Strauss and Corbin (1990; 1998), left me wondering how I was going to work with the methodology, given their objectivist underpinnings were so contrary to my own constructionist stance. Much later, I was relieved to read that I was not alone, as the following quote demonstrates:

Those of us who adhered to a relativist epistemology never concurred with grounding grounded theory in Glaser's mid-20th century positivism…Strauss and Corbin's methodological procedures gave grounded theory an objectivist cast (Charmaz 2008a, p.401).

As I continued to read through the numerous versions of grounded theory that had morphed from the 1960s until the 21st century, my understanding and acceptance of the methodology began. In 2012, I realised that my theoretical and methodological approach to this area of enquiry was found to be most closely aligned with constructivist grounded theory. I became convinced that constructivist grounded theory was specifically the appropriate choice of methodology for this study, because of the way it emphasises social processes, social psychological processes and social interactions.

Ontology and epistemology

The process of designing the framework of this study was informed by Crotty (1998), whose text recommends the early identification of epistemology, theoretical perspective, methodology and method. The researcher's understanding of these elements, and how they are congruently embedded in the research question, provides a platform upon which to build a consistent and defensible thesis.

Constructing such a framework is not a linear process, but, rather complex and contextual (Crotty 1998). Identifying this framework was a particularly important element of my journey during the first 12-18 months of my PhD. I was dedicated to the task because of my belief that without an integrated, consistent and whole philosophical foundation to my study it would be difficult to lift the analysis to a level of theoretical abstraction that had integrity. The following table (Table 6) displays the framework from which my philosophical approach and design of this study may be scrutinized. For clarity; the terms ontology, epistemology, theoretical perspective, methodology and method are defined and explained as they are used in this thesis; because these are concepts that are often understood, or misunderstood, in different ways (Crotty 1998) (Table 6).

Table 6: Philosophical framework of this study

Definition/explanation:	My perspective:
Ontology is our understanding of the nature of reality, or the study of being (Blaikie 2007; Hall, Griffiths & McKenna 2013; Ramey & Grubb 2009). For example, ontology asks: Is reality 'real' or is it 'relative', is it an objective concept or is it constructed from within a specific context? (Lincoln, Lynham & Guba 2011).	**Relativist -** Acknowledging and accepting that different individuals inhabit different worlds with different meanings and realities (Crotty 1998). The way we view the world is determined by the ways in which we interpret it, and the social and historical context in which we live.
Epistemology refers to the ways in which we understand knowledge (Crotty 1998). For example, epistemology asks: *How* do we know what we know? (Blaikie 2007; Ramey & Grubb 2009) and explores the relationship between knowing and the knower (Denzin & Lincoln 2011). The epistemology underpinning a study is buried in the theoretical perspective, the methodology and the research question we are asking (Crotty 1998).	**Constructionist -** Subject and object are partners in the generation of meaning. The woman-centred philosophy of care that underpins contemporary midwifery is overtly constructionist, as it recognises the multiple ways of knowing and understanding possessed by individual women. Homebirth transfer, birth, risk and safety are all objects which subjects experience in different ways.
Theoretical perspective is the philosophical stance with which the research process may be substantiated (Crotty 1998). Theoretical perspectives outline the assumptions about reality that we bring to our research, providing a context for the logic and criteria of the methodology (Crotty 1998). Grounded theory is traditionally underpinned by the theoretical perspective of Symbolic Interactionism (Charmaz 2014; Hall, Griffiths & McKenna 2013).	**Interpretivist** – **Symbolic interactionist** - Symbolic Interactionism was influenced by Chicago School pragmatist George Herbert Mead and Blumer. Language and other communication of feelings and perceptions are meaningful symbols with which we interact. Humans act towards things according to the meaning that they hold. Meaning is derived from social interactions with other humans, and is interpreted in individual ways. Researchers see things from the standpoint of others (Crotty 1998).
Methodology is the structure of the study design, forming a platform from which the methods emerge, and unifying them with the ontology, epistemology, theoretical perspective and the aims and objectives of the research question (Crotty 1998; Ghezeljeh & Emami 2009; Mills, Bonner & Francis 2006). Positivist grounded theory (Glaser and Strauss 1967) is such that the analysis is seeking one truth – a core category and basic social process – from the data. Post-positivist/ pragmatist grounded theory (Strauss and Corbin 1990, 1998) seeks one reality but accepts uncertainty about whether it can be considered an absolute truth.	**Constructivist grounded theory.** *'Constructivism describes the individual human subject engaging with objects in the world and making sense of them'* (Crotty 1998, p.55). I was influenced by Charmaz (2014); Mills, Bonner & Francis (2006) and Birks and Mills (2015). Researcher generates data by co-construction of the data; this is different from objective collection and analysis of data. Multiple realities are accounted for. The implicit is made explicit; taken-for-granted assumptions are critiqued and challenged. Not necessarily one basic social process or a single core category, instead multiple processes and conceptual categories may be identified.
Methods are the procedures and techniques used to collect and analyse the data, for example, interviews, focus groups and coding (Crotty 1998). Examples include quantitative methods such as statistical measurement, or qualitative such as participant observation, focus groups, interviews etc.	**Qualitative data generation** (different from data collection and analysis). Simultaneous, back and forth collection and analysis, not a linear process. Semi structured interviews, audio recorded and transcribed immediately. Face to face interviews when possible because visual cues such as body language and facial expressions are important data, in addition to the words of the participants. Initial and focused coding, memo writing. Constant comparison, categorisation, theoretical coding, theory generation. Analysis was done by hand and using NVivo 10 software.

As I have already emphasised, grounded theory is a family of methodologies stemming from a variety of epistemological perspectives (Charmaz 2009; Hall, Griffiths & McKenna 2013; Morse 2009; Thornberg & Charmaz 2014). I argue that identifying a philosophical approach is especially important when attempting grounded theory because it is these very epistemological differences which cause much confusion (Hall, Griffiths & McKenna 2013), in relation to the differences between the positivist (Glaser & Strauss 1967), post-positivist (Strauss & Corbin 1990; Strauss & Corbin 1998) and constructivist (Charmaz 2014; Birks & Mills 2015) versions of the methodology. I concur with Mills, Bonner and Francis (2006), who said, *'It is the researcher's ontological and epistemological position that determines the form of grounded theory they undertake'* (Mills, Bonner & Francis 2006, p.9).

This research is grounded in a constructionist epistemology, stemming from the view that childbearing is a complex phenomenon involving the interplay of many clinical, environmental and psychosocial factors. Crotty (1998) describes a constructionist perspective as one in which *'subject and object emerge as partners in the generation of meaning'* (Crotty 1998, p.9). In the context of childbirth, the subject may be seen as the mother/baby dyad, and the object as the system of care. The system of care may include the approach to caring, the use of technology, the influence of midwifery, nursing and/or obstetric professional paradigms and the environment in which birth takes place. Partnering the subject and object provides an approach that acknowledges the physical, emotional, psychological, cultural and spiritual aspects of a woman's experience. This view echoes contemporary midwifery literature by authors such as Davis-Floyd (2007), Downe and McCourt (2008) and Page (2000). Similarly, the researcher and participant emerge in the interview process *'as partners in the generation of meaning'* (Crotty 1998, p.9).

Theoretical perspective: Symbolic interactionism

Grounded theory is traditionally underpinned by symbolic interactionism (Bluff 2006a; Charmaz 2014; Crotty 1998; Layder 1982; MacDonald 2001; Skeat 2010; Thornberg &

Charmaz 2014). Symbolic interactionism is concerned with the dynamic ways in which human individuals interact with each other. Interaction may occur directly and indirectly using symbols such as language, non-verbal communication and visual stimuli. Symbolic interactionism focuses on how human interactions, and interpretations of those interactions, may influence behaviour and the construction of an individual's world view and understanding of society (Charmaz 2006; Crotty 1998; MacDonald 2001; Skeat 2010).

Symbolic interactionism has been critiqued in the literature for its lack of attention to the influence of societal structures upon human action, and is often thought to focus upon micro processes as being more central to human existence than macro structures. That is, the intentionality and agency of individuals are believed to exert more influence than do institutions and organisations (for example; culture, the family, religious bodies, educational systems, or governments).

MacDonald (2001) asserts that symbolic interactionism fails to deal in a meaningful way with social and organisational contexts, deliberately excluding the influences of dimensions such as power, culture, economics, race, ethnicity and gender upon the actions of individuals (MacDonald 2001). The symbolic interactionist perspective has been described as *'astructural, ahistorical, apolitical and acultural'* (MacDonald 2001, p.118) and was similarly critiqued decades earlier by Layder (1982). Bourdieu also objected to notions placing either agency or structure in isolation, preferring a view of the world which embraces the influences of micro interactions, macro structures as well as a contextual understanding of the processes and dimensions which link them (Webb, Shirato & Danaher 2002).

For the above reasons, I initially deemed symbolic interactionism to be an unsuitable theoretical framework for this PhD study. Exploration of how women and caregivers experience both micro and macro processes involved in transfer is crucial to the research, therefore this omission of the macro level of analysis seemed problematic.

This issue was resolved, however, in discussion with Kathy Charmaz in 2014, when I crystallised my understanding of the relationship between constructivist grounded theory and symbolic interactionism. Charmaz (2014) believes that symbolic interactionism has the capacity to encompass the interface between language, action, environment, context and meaning. Furthermore, Charmaz claims that symbolic interactionism and constructivist grounded theory together afford the opportunity to take what is real as problematic, look for multiple definitions of reality and examine how experience is constituted and structures are enacted (Charmaz 2014). Until that point, this issue had been a major sticking point in my ability to embrace grounded theory. Charmaz convinced me that the beauty of the relationship between constructivist grounded theory and symbolic interactionism was, as she also stated in 2009, *'to show the connections between the macro and the micro levels of analysis and thus link the subjective and the social'* (Charmaz 2009, p.131). She recommended that I read *'Masks and Mirrors'* (Strauss 1969) to see an example of how Strauss had managed the interplay between structure and agency. I followed her recommendation, and reading *'Masks and Mirrors'* was another pivotal point in my ability to resolve this issue.

Methodology: Constructivist grounded theory

The constructivist approach to grounded theory was used for this study because of its capacity to facilitate the exploration of views and experiences of women and their caregivers, the views of caregivers regarding other caregivers, as well as the processes of interaction and the contexts and environments in which they occur. Constructivist grounded theory is also able to account for the structural backgrounds from which these aspects are derived.

The main influences upon my approach are Charmaz (2014); Mills, Bonner and Francis (2006) and Birks and Mills (2015). In the 1990s, Charmaz coined the term constructivism to describe her approach because she felt that the work of her constructionist colleagues failed to acknowledge the role of the researcher in the co-construction of data (Charmaz 2014, pers. comm. March 18). 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).

The pursuit of a single basic social process

The identification of a single basic social process has become an expectation often associated with all grounded theory research. 'Basic social process' is not an original grounded theory concept but is one that is derived from pragmatists of the Chicago School of Sociology, predating grounded theory and influencing Strauss (Morse et al. 2009). In classic Glaser and Strauss (1967) grounded theory, seeking a basic social process was a primary aim (Charmaz 2008a). The identification of a basic social process was disavowed by Glaser, however, in 2002, when he stated that this forces the data (Charmaz 2008b). Charmaz (2008a) explicitly rejects the necessity of identifying a single basic social process and argues that in the pursuit of one, the researcher may be blinded to other processes that may be constructed from the data. The notion of identifying social processes is promoted by constructivist grounded theorists as a heuristic device in the analytic process (Charmaz 2014), but never adopted by them as something that had to take centre stage in the final analysis or constructed theory.

Although the basic social psychological process of intergroup conflict underpins the grounded theory of my study, it was impossible to identify a single basic social process that would fit the experiences of the diverse range of participants in my study. Multiple social processes emerged from the findings chapters, including, for example, 'reducing uncertainty', 'fostering relationships', 'managing changing expectations', 'moving out of one's comfort zone' and 'making a psychological journey'. They are all social processes that are linked to each other and to the other theoretical concepts of the analysis, however, privileging one basic process was simply not possible. The presence of multiple basic social processes is derived from the complexity of the analysis, resulting from the heterogeneous sample and the constructivist nature of the methodology. My analysis would have been limited by trying to 'force' the data into

only one basic social process. Therefore, as will be seen later in the Findings and Discussion chapters, I chose not to identify a single basic social process.

Seeking a core category

In earlier versions of grounded theory, Strauss (1987) and Strauss and Corbin (1990) advocated the concept of identifying a core category. In their 1998 text, Strauss and Corbin changed the name 'core category' to 'central category' (Birks & Mills 2015). Constructivist grounded theory integrates categories into 'theoretical concepts' that are woven into a substantive theory, rather than limiting the analysis to a single core category (Birks & Mills 2015; Hall, Griffiths & McKenna 2013). This can be seen in Table 5. As Thornberg and Charmaz explain, *'Seeking one core category can limit the analytic rendering of the data and the theoretical usefulness of the completed report'* (Thornberg & Charmaz 2014, p.158). The structure of the analysis in this thesis is aligned with Charmaz' notion of theoretical concepts, in that the findings are structured into four categories which are linked and overlapping. The theoretical concepts emerging from those categories were synthesised with theoretical codes from the extant literature, to form the substantive grounded theory.

Diversity of the sample

Another reason why identifying one basic social process and/or one core category was inappropriate for this study was the diversity of the sample and the resulting complexity of the analysis. I have not simply analysed participants' views and experiences, nor have I analysed the interactions of one homogeneous group. I have sought the views and experiences of five heterogeneous groups of participants about their involvement in homebirth transfers, focusing upon the interactions between the individuals and the processes arising from and contributing to events and experiences. The five groups comprise women, midwives working in private practice, midwives working in publicly funded homebirth programmes, core midwives working in hospital birth units, and obstetricians. I have analysed the processes and interactions that occurred between them, examined each participant's sense of social identity, challenged their taken-for-granted assumptions about their roles and routines,

investigated their implicit and explicit paradigms of childbearing and analysed the multiple realities that existed in the homebirth transfer milieu. Thus, several social processes and theoretical concepts have emerged from the categories of analysis, as described in the findings and discussion.

Method

Data generation (collection and analysis)

The term 'data generation' is used in constructivist grounded theory, differentiating itself from other qualitative approaches which separate qualitative data collection and data analysis into two discrete processes. In grounded theory, these processes occur simultaneously. Thirty-six semi-structured interviews were conducted with women, midwives and obstetricians in 2014 and 2015. The interviews were audio recorded and transcribed immediately. Field notes were taken, to describe the setting and context of the interview, and to make note of significant non-verbal actions and interactions. 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).

Sampling

Grounded theory methodology involves two phases of sampling, namely initial sampling and theoretical sampling. The latter is a form of sampling unique to grounded theory (Skeat 2010) that will be explained in more detail later.

Initial sample

The initial sample proposed was 10 women and 20 caregivers. Ten women and five obstetricians were interviewed, as planned. Due to the sample including different groups of midwives (midwives from private homebirth, public homebirth and hospital settings), who offered rich and complex data, theoretical saturation was not reached until I had interviewed 21 midwives. This meant that the study was extended to include a total of 36 interviews.

Initial sampling was purposive, meaning that the participants were required to have experience of the phenomenon being investigated (Bluff 2006b). The participants were chosen because they could provide rich data on the phenomenon (Liamputtong 2010) of planned homebirth transfer to hospital, either as a woman or caregiver. Participants were recruited from private midwifery practices, two publicly funded homebirth programmes and personal networks, across four states of south eastern Australia; New South Wales, Victoria, South Australia and Tasmania. Initially I planned to interview five ambulance personnel with experience of transferring women to hospital but ethics approval was not possible.

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. Seven women who, in the past three years, had planned a homebirth with a privately practising midwife and were subsequently transferred to hospital during labour or with their baby soon after birth.
2. Three women from publicly funded homebirth programmes 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.
3. Seven privately practising midwives who, in the past three years, cared for women as described above (1) at home.
4. Six midwives from publicly funded homebirth programmes who, in the past three years, cared for women as described above (2) at home.
5. Eight midwives working in a hospital who, in the past three years, experienced receiving women as described above (1 and 2).
6. Five medical staff working in a hospital who, in the past three years, experienced receiving women as described above (1 or 2).

Recruitment

Formal approaches to key stakeholders of publicly funded homebirth programmes were made during the ethics application process in late 2013/early 2014. Several publicly funded homebirth programmes were approached and demonstrated interest, however, only two responded formally. Ethics approval was granted by these two health services and by the UTS HREC by May 2014.

Approaches were made to midwifery managers of the two publicly funded homebirth programmes to seek their involvement. The midwifery managers kindly arranged for a meeting to engage the midwives' participation. They also recruited obstetricians and hospital based midwives in their health services whom they felt might be willing to be interviewed. The homebirth midwives' sought involvement was two-fold; they were asked to be interviewed about their views and experiences of transfer, and they were also asked to identify women who had been transferred and who might be willing to be interviewed. The midwives asked the women if they were willing to be contacted by me, or passed my contact details on to interested women and invited them to call me. Privately practising midwives and women who had engaged privately practising midwives were recruited through my own personal networks and those of my primary supervisor. Snowball sampling also occurred within these groups once this process began. All who volunteered to participate were included.

Theoretical sampling

Theoretical sampling is the process of identifying and refining nascent theoretical ideas and pursuing them in future interviews (Birks & Mills 2015). The data generation process in Constructivist grounded theory involves simultaneous data collection and analysis, constant comparison of data and codes and memo writing. These processes enable theoretical sampling and create the abductive process. Abduction is a combination of induction and deduction, in which the research commences inductively, nascent theoretical concepts are developed, and then tested deductively through theoretical sampling. Concepts may emerge which demand checking back with participants to clarify or elaborate upon certain points. Identified gaps in the data

may require further sampling with more focussed questioning and/or more purposive sampling of participants. The sampling process evolves and the interview questions are refined as data is analysed (Charmaz 2014; Dey 2004; Skeat 2010).

Theoretical saturation

The purpose of theoretical saturation is to identify recurring properties of emerging theoretical categories. Theoretical saturation occurred when data no longer revealed any new theoretical understandings. This contrasts with saturation of data in some other qualitative methods, in which saturation occurs when similar events or narratives reappear (Charmaz 2014; Liamputtong 2010). Saturation of theoretical concepts is important in grounded theory because the aim is the development of theory.

Data generation: collection

Semi-structured interviews were conducted in participants' homes or workplaces, or by telephone if this were preferred by the participant. A few women with babies at home preferred to be interviewed on the telephone while their baby was sleeping, however, face-to-face interviews were conducted if possible. The advantages of face-to-face interviews include rapport building and observation of non-verbal communication, both enhanced by eye-to-eye contact (Bluff 2006b). By the interviewer sharing ideas, an interactive conversation is created (Rapley 2004) that aims to elicit the participants' reflections and perspectives (Bluff 2006b). Active listening techniques are used to hear not only what is said, but also to observe the manner in which it is said. The interpretation of the participant's silences, non-verbal communication, body language and the processes occurring in the environment all inform the data and may induce further exploration (Serry & Liamputtong 2010).

According to Rapley (2004), research interviewing techniques vary, depending on the approach and perspective of the study. The style of in-depth interview chosen for this study was influenced by Rapley's notion of *'engaged, active or collaborative interviewing'* (Rapley 2004, p.26). The interview format involved asking a few open-ended questions, listening actively, clarifying and/or following up on areas of interest

the participant broaches and allowing the participant *'space to talk'* (Rapley 2004, p.25).

A facet of Constructivist grounded theory interviewing is being open to explicit data and sensitive to implicit meanings conveyed by the participants' words and actions (Charmaz 2014). Interviews are not approached impartially, nor are they hierarchical; they are reflexive and reciprocal, minimising power imbalances. There is co-construction of the data and of meaning by researcher and participant, however, the researcher seeks to challenge assumptions and routines, *'searching and questioning for tacit meanings about values, beliefs and ideologies'* (Mills, Bonner & Francis 2006, p.10).

In this study, the interviews lasted between approximately 30 minutes and two hours. A time limit of two hours was imposed based on the experience of antenatal and postnatal discussions in which more than two hours became emotionally exhausting for the woman. This is consistent with Bluff (2006b), who notes that one to one interviews tend to last 15 minutes to two hours.

The interviews were audio recorded and transcribed immediately. Transcribing was assisted with an Olympus transcription kit operated with foot pedals. In September 2014, it became necessary to employ a paid transcription service, when a large number of interviews were held in a short space of time. I felt that transcribing them all myself would have stalled the data generation process unnecessarily, as the transcribing process was, for me, very slow.

Data will be stored securely with no identifying features for seven years, in line with NHMRC guidelines (NHMRC 2007). Hard copies are stored in locked filing cabinets in my study. Computers and data stored in the UTS Oxygen cloud are password protected.

I underwent training in the use of NVivo 10 software at UTS in 2013. The NVivo 10 software has limited application in grounded theory as an analytical tool, due to the

'ground up' nature of the analysis in grounded theory. NVivo is designed for a funnel shape approach, more suited to thematic analysis and other qualitative methods. The software was useful, however, for the systematic storage of data and codes.

Data generation: coding

After transcribing the data, the coding of each interview took place in two main phases, initial line-by-line coding and focussed coding. Metaphorically, one might approach this as seeing the trees now (initial coding) and the forest later (focussed coding). The first phase of coding was done by hand (pen and paper). Later, the transcripts and focussed codes were uploaded into NVivo 10. A second phase of focussed coding occurred in mid-2015, with pen, paper, envelopes and plastic pockets.

Initial coding

Initial coding began as soon as the first two interviews were transcribed. Line-by-line initial coding demanded that fragments of data were selected and labelled in a concise manner. The benefit of this approach was that by attaching codes to each line of data, my conceptual analysis was not restrained by sentence or paragraph structures. Identification of ideas emerged which could have been lost if I had been looking at larger sections of data. Line-by-line coding enabled close reading of the participants' meanings and encouraged delving for analytic ideas. Provisional analytic ideas were further pursued later, through theoretical sampling. By repeated interaction with the data, it was possible to revisit it from a range of different perspectives, asking new questions and making comparisons with other data at every reading. I looked for how the participants understood their experiences and circumstances. Acknowledgment of prior perspectives through reflexive processes was important, to ascribe such perspectives as belonging to me; alongside those, but not imbued within, those of the participants (Charmaz 2014).

The use of gerunds during the initial coding phase of analysis is recommended by Charmaz (2014). A gerund is the noun form of a verb. The use of gerunds is a heuristic device that emphasises the actions and processes involved in the data, as well as the

connections between structures apparent in the data. This is in contrast, she asserts, to most other forms of qualitative coding that seek to identify topics and themes (Charmaz 2014).

In vivo codes are another form of initial coding, in which terms and phrases used by the participants are used as codes (Charmaz 2014). By deconstructing the participant's usage of words and/or phrases that hold significance for them, it becomes possible to look for implicit meanings and challenge taken-for-granted assumptions.

Charmaz (2014) warns against analysing the data from a set of routine principles or professional discursive frameworks, as this may cause the analysis to leap conceptually beyond the participants' meanings. If disciplinary terms are used later in the analytic process to describe conceptual constructs they must be used consciously and deliberately, not as a routine mechanism.

Constant comparison was used at every stage of the analysis, looking for both similarities and differences in pieces of the data. This involved comparing elements of each interview, comparison between data from interviews with the same participant or between data from interviews with different participants. Further contrasting and comparing occurred in the second stage of coding, known as focussed coding.

Focussed coding

The focussed coding process examined the most significant and/or most frequently used initial codes. The initial codes were interrogated critically to ascertain their adequacy and to reject ones that contained less analytic substance. The aim was to work towards forming larger categories, potentially leading to nascent theoretical ideas. Focussed coding did not occur in a linear way; it was often chaotic, requiring tolerance of ambiguity. Constant comparison occurred throughout; comparing data with data, data with codes, and codes with codes. Some implicit responses became explicit during this phase of the analysis, when one code or piece of data illuminated another.

Memo-writing

Memo writing was a constant flow of free writing, reflections and notes that were produced as the coding unfolded. As recommended by Charmaz (2014), they were written quickly, as thoughts emerged, without concern for formal writing. Many of these memos later become the foundation of the theoretical coding and formal analysis (Charmaz 2014; Roberts & Taylor 2002).

During analysis, the data were interrogated from a range of perspectives. Examples of the questions I asked of the data are listed here:

- What's happening here? What are the social processes? What are the psychological processes?
- How do the social processes emerge?
- What meanings do different participants attribute to the processes? Are there any hidden assumptions?
- How do the participants talk about their views and experiences? What do they emphasise? What do they leave out? What do their actions tell us?
- From whose point of view is a given process fundamental? From whose point of view is it marginal? (Charmaz 2006)
- What structures and conditions are in place which impact upon all the above?
- Who exerts control over the social processes? Under what conditions?
- Are there opportunities for participants to exercise agency through their interactions with others? How?
- Are there constraints upon the participants' ability to apply agency? Why?

Extant theoretical codes

All initial and focussed codes, sub categories and categories were data driven. After the data were analysed and formulated into theoretical concepts and categories (Birks & Mills 2015; Thornberg and Charmaz 2014), extant theoretical codes were derived from outside the data. It was important not to force extant theory upon the data too

early in the analytical process. This quote describes the integration of data and extant theory:

> *Theoretical codes consist of ideas and perspectives that researchers import to the research process as analytic tools and lens… [they] refer to underlying logics that could be found in pre-existing theories…Researchers should investigate all kinds of extant theories that they encounter in different research disciplines or domains to figure out for themselves their embedded theoretical codes…Abduction supplies the main underlying logic in theoretical coding. Researchers explore their knowledge base of theoretical codes and compare them with their data and their own constructed codes and categories. Then they choose (or construct) and use the 'best' theoretical codes as analytical tools to relate categories together and integrate them into a grounded theory* (Thornberg & Charmaz 2014, pp.159-161).

In this study, extant theories about intergroup conflict (Tajfel & Turner 2001) and uncertainty in illness (Mishel 1997) were used to enrich the understanding and analysis of the theoretical concepts *'us and them'* and *'reducing uncertainty'* that emerged from the data.

Summary

In this chapter, I have explored the metamorphosis of grounded theory since its inception in the 1960s. In so doing, I have demonstrated the influences upon the development of constructivist grounded theory and the reasons why it is an appropriate methodological approach with which to explore the interactions and processes involved in the intrapartum transfer of women from a planned homebirth to hospital. More specifically, I have illuminated the perspectives of the contemporary second generation grounded theorists who have influenced my approach, including Charmaz (2014), and Birks and Mills (2015). The chapter concludes with a description of the pertinent ethical considerations and Human Ethics Research Committee

approvals that were received prior to the commencement of the empirical phase of the study.

Ethical considerations

The four principles of ethical practice in healthcare proposed by Beauchamp and Childress (2009) are autonomy, justice, beneficence and non-maleficence. These principles inform the ethical framework of this study, in addition to the mandatory guidelines for ethical research practice in Australia (NHMRC 2007). Participants were assured that their participation was voluntary and there was no pressure to participate. Informed consent was received from all participants, who were told that they were autonomously able to withdraw from the study at any time. The participants' real names will not be used in any dissemination of the research, to ensure privacy and confidentiality. Participants are represented by pseudonyms throughout the thesis.

Non-maleficence refers to the principle of doing no harm. Researchers must act in the best interests of participants at all times, over and above the needs of the research. The only risk anticipated from this research was the potential for a participating woman to become emotionally distressed when describing her birth experience. In the event of a woman becoming distressed when describing her birth experience, the plan was for the research interview to be discontinued, so as to provide immediate emotional support to the participant. Referral to the participant's local community or hospital mental health service would have been offered, so that further counselling may take place outside the research arena. This never occurred during any of the interviews.

People whose primary language is other than English (LOTE), people under the age of 18, people with an intellectual or mental impairment and Aboriginal and/or Torres Strait Islander peoples were excluded due to the additional psychosocial burden during their childbearing phase which could affect their experiences in unique ways. Creating an additional burden of being interviewed is also of concern for these groups of

women. People highly dependent on medical care were not eligible, as this would exclude them from a low risk homebirth programme.

Interviews with women contained questions such as:

- 'Tell me at what stage of your labour were you were transferred to hospital during your planned homebirth?'
- 'Are you able to describe to me why the transfer needed to occur?'
- 'How did you feel at first about needing to transfer?'
- 'Did your midwife accompany you to hospital?'
- 'How did you travel to hospital from home/ how was the trip for you?'
- 'How was the experience of arriving at the hospital?'
- 'How did you feel about your birth experience?'
- 'How long did you stay in hospital after the birth? How was that for you?'

Midwives and obstetric staff were asked questions such as:

- 'Why did the transfer need to occur? How did it feel having to transfer the woman to hospital, knowing that she had planned a homebirth? How did you support her during this time?'
- 'How do you feel about caring for women who arrive at hospital during labour after planning to birth at home?'
- 'How is the experience of working with midwives who have attended a woman at home prior to transfer into hospital?'

Conclusion

This chapter has described the constructivist grounded theory methodology employed for this study, encompassing the broader framework within which it sits; that is, the relativist ontology, constructionist epistemology, the theoretical perspective of Symbolic Interactionism and the interview methods utilised. Reflexivity was also addressed, as a major element of trustworthiness.

The next section is a Preamble to the findings of the study, followed by Chapter 5. Chapters 5 to 8 explore the findings and analysis of the four categories, *'Fostering relationships and reducing uncertainty', 'Transferring out of the comfort zone', 'Us and them'* and *'Celebrating a successful transfer'*. The Discussion and Conclusion chapters (9 and 10 respectively) follow the Findings.

PREAMBLE TO FINDINGS

Four categories were constructed from the analysis of findings, each exploring the interactions and processes involved in transfer from a planned homebirth. The four categories are: *'Fostering relationships and reducing uncertainty', 'Transferring out of the comfort zone', 'Us and them'* and *'Celebrating a successful transfer'.* Each category is explained in turn, in chapters 5 to 8. Theoretical codes are explained in the Discussion (Chapter 9). The grounded theory, *'Supporting woman centred care during homebirth transfer'* is overarching. The following is a visual representation of the analysis underpinning the theory (Figure 3).

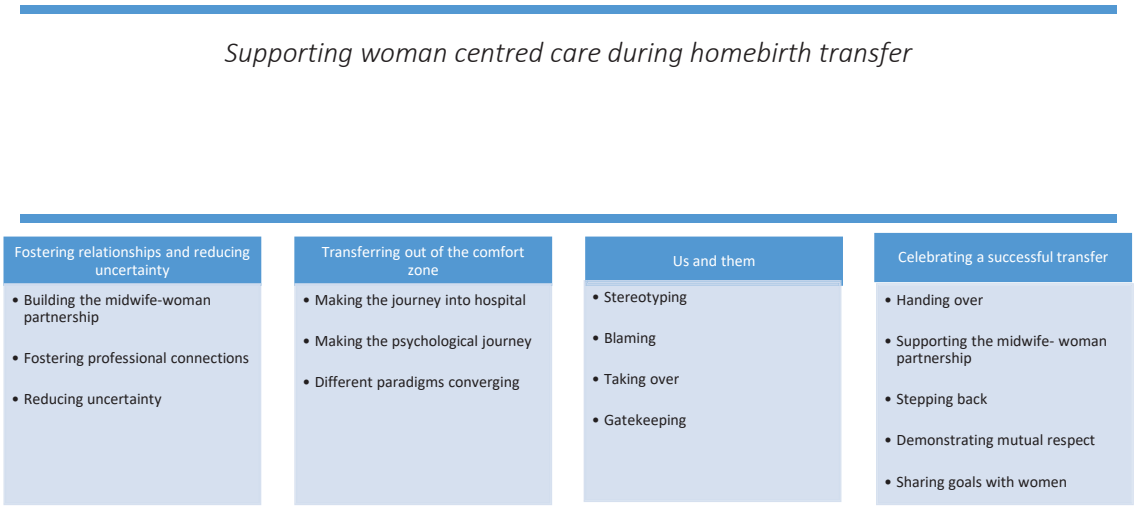

Figure 3: Structure of the data analysis underpinning the grounded theory

Chapter 5, *'Fostering relationships and reducing uncertainty',* explores the unique relationships women develop with their midwives during pregnancy when planning a homebirth, and the main processes and interactions that occur in relation to preparing for the possibility of transfer to hospital. This category also addresses the ways in which midwives form connections with a team of health professionals to enable smooth referral, consultation and transfer processes when required. *'Fostering relationships and reducing uncertainty'* is comprised of three sub categories, which are, *'Building the midwife-woman partnership', 'Fostering professional connections'* and *'Reducing uncertainty'.*

Chapter 6, *'Transferring out of the comfort zone'* analyses the processes involved in making the journey to hospital, and the psychological journey women take as they manage changing expectations and adjust to the clinical environment of the hospital. The different paradigms of childbearing that converge on the birthing room as caregivers congregate to care for transferred women are also explored. There are three sub categories in this chapter, *'Making the journey into hospital', 'Making the psychological journey'* and *'Different paradigms converging'.*

Chapter 7, *'Us and them',* deals more specifically with interactions in the birthing room between homebirth midwives and hospital staff, as they seek to clarify their roles and responsibilities. Four sub categories, *'Stereotyping', 'Blaming', 'Taking over'* and *'Gatekeeping'* explore the main ways in which *'us and them'* dynamics manifested.

Chapter 8, *'Celebrating a successful homebirth',* reframes transfer as a successful outcome, rather as a failed homebirth. Successful transfers may optimise the health and well-being of each individual woman and her baby, when clarity is achieved about the roles and responsibilities of caregivers, mutual respect is demonstrated and a willingness to collaborate towards woman centred goals is in place. *'Celebrating a successful transfer'* comprises 5 sub categories, *'Handing over', 'Supporting the midwife-woman partnership', 'Stepping back', 'Demonstrating mutual respect'* and *'Sharing goals with women'.*

Throughout Chapters 5 to 8, the real names of the participants are replaced by pseudonyms, to protect their confidentiality. In brackets after each quote, the pseudonym is followed by a description of the participant, for example, homebirth woman, publicly funded homebirth midwife, privately practising homebirth midwife, hospital midwife or obstetrician. The roles that are not self-explanatory are defined in Chapter 1, in the section entitled Definitions. The following table displays the sample of participants according to the recruitment group to which they belong (Table 7).

Table 7: Sample groups recruited

	Privately practising midwives	Publicly funded homebirth programme	Hospital based
Women who planned a homebirth	7	3	
Midwives	7	6	8
Obstetricians			5

CHAPTER FIVE: FINDINGS 'FOSTERING RELATIONSHIPS AND REDUCING UNCERTAINTY'

Introduction

This chapter describes the first category of the analysis which encompasses two linked and overlapping concepts, *'Fostering relationships and reducing uncertainty'*. The interactions involved in fostering relationships helped to reduce uncertainty for participants, and likewise, processes of reducing uncertainty brought about interactions that fostered relationships. Both the processes of reducing uncertainty and the interactions involved in fostering relationships contributed to building trust between caregivers, as well as between women and caregivers. How well levels of uncertainty were reduced and relationships were fostered determined the levels of trust that were formed between those involved in homebirth transfer events. High levels of trust meant that, in the event of transfer, collaboration and communication was more seamless. Low levels of trust created uncertainty, which had the potential to generate tension and hostility.

The category *'Fostering relationships and reducing uncertainty'* comprises three sub categories. The first sub category, *'Building the midwife-woman partnership'* explores the relationships that were developed between women planning a homebirth and their homebirth midwives. The second sub category, *'Fostering professional connections';* investigates the ways in which caregivers interacted in both formal and informal ways, focusing upon the ways in which homebirth midwives were pro-active in fostering relationships with hospital colleagues. This pro-activity was seen as a particularly necessary component of private midwifery practice, to bring about the development of smooth processes of consultation, referral and transfer with hospital colleagues they saw infrequently. The third and final sub category, *'Reducing uncertainty'* examines the mechanisms of preparing for transfer that midwives encouraged women to undergo, to help them open up to the possibility that they may experience a transfer to hospital from their planned homebirth.

Sub category: Building the midwife-woman partnership

When a woman chose a midwife to support and care for her to give birth at home, she usually would expect to develop a strong, trusting one-to-one relationship with her throughout pregnancy, labour, birth and the postnatal period. The midwife's role went beyond that of a clinical caregiver, it was a partnership with the woman that was built over months during pregnancy, and built on the principles of woman centred care; encompassing support, understanding and reciprocal trust. One woman described, '*I think it was fantastic…getting to know your midwife is really valuable. And them getting to know you…I trusted them'* (Felicity, homebirth woman).

Women talked about the importance of *liking* their midwife as a person, and saw their midwife as a professional friend whom they trusted; one who helped them to feel comfortable and safe. The following vignettes demonstrate women's recollections of choosing their homebirth midwife:

> *We met at her house for a cup of tea, and I instantly just liked her, felt really comfortable with her and hoped that she would be the midwife that was there for the birth of my child. I liked her and I felt her present and I felt really comfortable with her. So it was a really good fit* (Joanna, homebirth woman).

> *I was about 20 weeks [pregnant] when I first saw [my homebirth midwife]. And she was really good…I think the personality of the midwife… [was] really important. I felt like from the first conversation… she's very grounded, she's very straightforward. And I felt like I would be safe in her hands…had I not felt really comfortable with the midwife, I don't think I would have attempted to do a homebirth...I really liked her. I like her a lot* (Felicity, homebirth woman).

> *We had chosen her as our homebirth midwife very early on, so basically from the point when I had a bump, I knew I had a person to help me. So she was absolutely amazing, she was there with us for months and months…we trusted her implicitly, she knew exactly what we wanted, we knew exactly that she could help us through every stage wherever it is was we were, it was lovely and*

> *not also for me but also my husband. He had lots of good conversations with her too…It felt like family* (Naomi, homebirth woman).

When a midwife was asked whether she felt the relationship between a midwife and a woman planning a homebirth was a partnership, she replied, *'Very much'* (Iris, privately practising homebirth midwife). Privately practising midwives talked about needing time to foster their relationships with women. They felt that when they met women late in their pregnancy, there was not enough time before the birth to sufficiently develop the midwife-woman partnership, *'you just don't have that time in the first two trimesters…that's when you get to know the person'* (Trish, privately practising homebirth midwife). Irene concurred:

> *[In our practice we have] had women try and hire us when they are 39 weeks pregnant and we've said no…They have to be prior to 36 weeks pregnant because you've got to have the birth plan meeting and you've got to have a few antenatal visits…we're doing this because we want to provide a good service to birthing women* (Irene, privately practising homebirth midwife).

The midwife-woman partnership was a relationship that was highly valued by both women and homebirth midwives. Reciprocal trust was an essential element of their relationship. Both the homebirth midwives and the women needed to feel safe and comfortable, and to trust each other. *'That's what it [the midwife-woman partnership] is all about really, the trust, isn't it?'* (Irene, privately practising homebirth midwife). Women trusted their midwives' knowledge and skills whilst midwives reciprocally displayed trust in women's capacity to give birth. *'She trusted in my ability to birth my baby'* (Joanna, homebirth woman). The trust embedded in the midwife-woman partnership helped women to feel safe and was crucial to their ability to stay calm and confident during labour, as Kate described, *'There was never a worry, I just trusted [my midwife]'* (Kate, homebirth woman).

Transferred women said that having their trusted homebirth midwife's expertise in the hospital birthing room helped them to feel safe. *'I felt like having them as my*

advocates in the hospital made all the difference…having them there, with all of their knowledge and support' (Tess, homebirth woman). Advocacy from the midwife helped women manage their changing expectations and the associated uncertainty they were experiencing; and helped to communicate women's needs to hospital staff. *'I think the fact that I had a midwife with me…made a big difference….if she wasn't with me, I would've felt much more bullied into things…She was my advocate…she was <u>with</u> me'* (Joanna, homebirth woman). Mary, who had given birth to several babies before, some in hospital and some at home, was adamant that the trusted people she chose to have around her for each of her births had been paramount in maintaining her sense of safety, saying:

> *I had my people around me, I felt safe…I did that with every baby, cos that's how I like to give birth, is with my women [midwives and family] around me. It was <u>everything</u> to me, it was everything, it was really everything. That's what kept me strong and confident and safe* (Mary, homebirth woman).

Transparent communication was intrinsic to the reciprocal trust that was built into the midwife-woman partnership. Sharing information openly and honestly in pregnancy laid the foundation for ongoing woman centred communication, as one midwife said, '*between myself and the woman, transparency is really important, to get the best out of each other'* (Kim, privately practising homebirth midwife). Making important information explicit to each other optimised the quality of their partnership. Midwives found that, *'women just really appreciate the transparency'* (Kim, privately practising homebirth midwife). A sense of transparency strengthened women's capacities to engage in informed decision making throughout their childbearing continuum, especially in the context of a transfer to hospital. Informed decision making encompassed women hearing their midwife's recommendations, maintaining the right to consent to or decline a transfer, and understanding the midwife's role in the decision-making process and the transfer. Kim would articulate this clearly to women, by saying:

> *I'm happy to support whatever choices you make around this but sometimes I will argue both sides of the argument because what I want you to do is interact within that decision-making process, think about what the pros and cons of either side and then make your informed decision* (Kim, privately practising homebirth midwife).

It was important to women that they could trust their midwife to recommend and implement a transfer if, and when, it became necessary. One woman said, for example, '*I knew that she would actually transfer me if she was worried about anything, so there was never going to be an argument about whether I transferred'* (Kate, homebirth woman). Women trusted their homebirth midwife to assist them in their decision making, saying, *'I didn't mind others advising me if I had a relationship of trust with them. That was the critical thing with me'* (Mary, homebirth woman). Knowing that her decision making could be guided by her trusted midwife was important to Belinda:

> *I would rather have someone I trust that can use their medical judgement and say 'I think you definitely need this now'. So I was even okay with a caesarean if I needed it. We said that right from the start, if I need a caesarean give it to me* (Belinda, homebirth woman).

Homebirth midwives were aware that the process of building the midwife-woman partnership during pregnancy played a key role in women's decision making, if a transfer became necessary: *'It is unusual…that a woman won't transfer if we encourage it, because they tend to trust us…we develop that trust through the pregnancy'* (Kim, privately practising homebirth midwife). Women valued it when hospital staff respected their need to consult with their homebirth midwife and support people, saying, for example, '*Anytime I had to make a decision about anything, I always asked [the hospital staff] if I could have some time with my team to discuss it, and they left us alone'* (Tess, homebirth woman).

Another facet of decision making for women was trusting their midwives not to suggest transfer without significant indication. Women liked to know that their midwives would support them to give birth at home, if it was safe to do so: *'One of the reasons why I wanted her to be my midwife too, was that I knew she would try to keep me out of there [hospital] as much as possible, unless it was really necessary'* (Tess, homebirth woman). Midwives understood that giving birth at home was important to most of the women in their care, as Irene articulated, *'We build a relationship [with women] so…they know before they even go into labour that we're not going to transfer them…lightly, we know that their preference is to stay at home'* (Irene, privately practising homebirth midwife). Homebirth midwives worked with that awareness, whilst remaining within the parameters of safety, saying that, '*we will work with them to have that but also we have a professional duty of care to them to keep them safe'* (Irene, privately practising homebirth midwife).

Co-ordinator of care: A different form of partnership

In one publicly funded homebirth program, the relationship between a woman and her primary midwife was a different form of partnership. The midwife's role was as a co-ordinator of the woman's care, rather than a continuous caregiver. Two midwives described this system in which they worked:

> *They all have a named primary midwife and that primary midwife's responsibility is to co-ordinate all her care. Now that doesn't mean do all her care, but is ultimately responsible for the journey that that woman goes on* (Kath, publicly funded homebirth midwife).

> *I think most of us in our booking visit will give them a synopsis of the group and how it works…We try and give them the sense that you know we may not be available 24/7. But if we are not available for their labour and birth then obviously we try and give them a lot of positive encouragement* (Nina, publicly funded homebirth midwife).

Instead of building the strong midwife-woman partnership that was common in private practice settings, midwives in this particular publicly funded homebirth practice shared a lot of the care:

> *I had been away for 3 days and I had a young woman…[who] appeared to have a bit of an APH [antepartum haemorrhage] while I was away…I transferred that information to a colleague that was working and said, 'Could you please sort this?' and the expectation was that I continued my days off* (Kath, publicly funded homebirth midwife).

Kath felt that most women she cared for in the publicly funded model were happy with the sense that their midwife was their co-ordinator, rather than their partner. She acknowledged, however, that, *'some women…will identify right up front that they don't like it…the only choice is that they go privately then…. They want their own midwife 24/7. They don't want to know or meet or interact with anyone else'* (Kath, publicly funded homebirth midwife).

The ability for midwives to share the workload was seen to be what made the practice sustainable, because it enabled midwives to have more work-life balance, *'I am doing caseload with a life that keeps me healthy so that I can serve women, as opposed to the 2-year burnout of the midwives that don't actually have a life'* (Kath, publicly funded homebirth midwife). Midwives felt that the standard of care was high because the philosophy of care was shared amongst the midwives in the practice:

> *I think the women get a good deal…they are getting a publicly funded homebirth system that would normally cost them five to seven thousand dollars [in the private sector] …They are getting a primary midwife who then has colleagues with the same philosophy…I don't think…the women would get a lesser experience or lesser care or a different philosophy from my colleagues in my greater team than what they would get from me* (Kath, publicly funded homebirth midwife).

> *[We say to women] 'If the midwife that turns up isn't someone you know, they are part of the team and that we are always communicating with each other and definitely have the same philosophy and will see to the birth plans'* (Nina, publicly funded homebirth midwife).

This publicly funded homebirth program also had a policy of not being able to guarantee continuity of carer to women who were transferred to hospital during pregnancy or the intrapartum period. Their care would be taken over by hospital staff. Unfortunately, the midwives in this program were unable to recruit any transferred women who had planned to give birth at home for this study, and so I was unable to gain women's perspectives on this. The issue of continuity of midwifery carer will be addressed further, however, in Chapter 6, in the sub-category *'Making the psychological journey'.*

Sub category: Fostering professional connections

Midwives agreed that collaboration and mutual trust was fundamental to all midwifery practice, whether in a hospital, health service or private practice. '*Trust is really important in midwifery…because you never practise on your own'* (Cassie, hospital midwife). Fostering professional connections with colleagues was an investment in developing a network of partners with whom to collaborate in the event of an intrapartum transfer. *'I have a real issue with being regarded as an independent practitioner. I am a privately practising midwife. I don't intend to work on my own…there's nothing about my practice that's independent'* (Kim, privately practising homebirth midwife).

Publicly funded homebirth midwives appreciated that familiarity with colleagues was incorporated into their system, and that this created a sense of connection between them. For example, *'I think, because I know them all, that I don't really get hassled'* (Yolande, publicly funded homebirth midwife). Obstetricians also appreciated the benefits of this familiarity with publicly funded homebirth midwives, saying, *'Usually we have quite a good relationship with the [publicly funded homebirth] midwives to*

begin with. We've known them…they're very familiar with you…they feel quite comfortable to come on in' (Blair, obstetrician).

Being pro-active in fostering professional connections with hospital colleagues was seen as a fundamental component of a private midwifery practice, to enable smooth processes of consultation, referral and transfer. *'It's got to be a relationship between the homebirth midwife, the homebirth practice and the hospital…you have to be prepared to…work that way…[it] comes back to the midwives to lead it a little bit'* (Iris, privately practising homebirth midwife). Whilst hospitals needed to make the channels of communication accessible, the responsibility for being pro-active in initiating the connection was seen to lie with the privately practising midwife, as Thea articulated:

> *If you want to be an independent midwife doing homebirths you have a professional responsibility to find out, in your area, where are you going to go. So it does have to come from the midwife initially. Hospitals have got to respect that and make it easy for them but the bottom line is if you are going to look after a woman you need to introduce yourself to the hospital, find out all the pitfalls, try and get some communication contact going. That's better for everybody really, isn't it?* (Thea, hospital midwife).

Privately practising midwives valued the partnerships they fostered with obstetricians, saying, *'I'm not scared to have a chat with an obstetrician or learn something from them, ask their opinion…I've got to meet some really intelligent and collaboratively minded clinicians'* (Kim, privately practising homebirth midwife). Kim regarded obstetricians as part of the team who would be there to provide medical care to women who needed it, saying:

> *Obstetricians, they're a really important part of the care that I provide. A lot of the time I don't access them because their skills for that particular woman aren't required….I know that I [may] need them at any particular point, even for a woman who I think is going to be terrifically well and normal and healthy.*

> *Sometimes things happen and I'll need that. Fostering those relationships is really key to those women getting good care* (Kim, privately practising homebirth midwife).

Privately practising midwives used a variety of strategies to foster interpersonal connections with other health professionals. Formal and informal methods were useful, as Jill recognised, *'all…methods of communication and connection with colleagues are really helpful'* (Jill, privately practising homebirth midwife). Hospital midwives valued opportunities to meet and connect with midwives who were from outside their hospital, *'to have regular contact socially and in training sessions and things like that between the homebirth midwives and the hospital midwives, [is helpful] in order to establish relationships and to gain trust'* (Cassie, hospital midwife).

Formal opportunities for connection included attending professional development events, or arranging formal meetings with senior midwives, obstetricians and managers. Demonstrating professional skills and exchanging knowledge during professional development events was a way of reducing the uncertainty of others about one's midwifery competence, for example, '*going along to simulation training…those clinicians have exposure to you as a midwife and your practice and your dedication to professional development and excellence and practice'* (Kim, privately practising homebirth midwife). In the implementation phase of their private midwifery practice, Irene's colleague had identified key stakeholders with whom to foster partnerships, saying she had *'developed her networks and done some research and worked out who to go and see and who to talk to'* (Irene, privately practising homebirth midwife).

Meeting with hospital management was another formal approach used to foster these connections, for example, *'I…approached the DON [Director of Nursing] to try and establish a relationship…and we had a new Unit Manager…looking to enhance the relationship with us and the hospital and…the medical staff'* (Iris, privately practising homebirth midwife). One tangible result of the meeting was that *'we were able to reinstate the booking in process'* (Iris, privately practising homebirth midwife) which

had been abolished by the previous Unit Manager. There was a flow on effect which benefited all the privately practising midwives in the area, *'we had this really good working party. It wasn't just for our practice. She involved the…other midwives from the area…too, to establish this collaborative process, relationship building'* (Iris, privately practising homebirth midwife).

Informal interactions were an equally effective way in which homebirth midwives fostered connections with hospital colleagues. *'You can be seen around the place…have a chat at the desk. You can ring the delivery suite often to get information from them'* (Jill, privately practising homebirth midwife). Kim liked to use humour and chatting to maintain rapport, saying, for example, '*"G'day, how are you going, how's your kids?" Just having that face around, joke around, "Hey, I'm working across here, I'm aiming not to give you any more work!"* (Kim, privately practising homebirth midwife). *'Being inclusive'* (Kim, privately practising homebirth midwife) in this way broke down barriers between different groups of caregivers and helped to avoid divisive attitudes and behaviours from emerging. *'Building those relationships [is valuable]. I've got such a good relationship with a lot of those clinicians…obstetric… other midwives…managers'* (Kim, privately practising homebirth midwife).

The strength of the relationships and connections between privately practising midwives and hospital staff varied. Perhaps surprisingly, even a modicum of familiarity made some difference to midwives' ability to collaborate with hospital colleagues. Just knowing each other's faces from the past led to a sense of confidence that they would be able to interact in a positive manner, as Barbara explained:

> *We did know each other from before…even though I might not have worked with them for a while, at least we knew each other's faces…for them it was good…they thought, 'Oh yeah, that's handy. Right, we'll be right. I can, we can, I know how we can relate'* (Barbara, hospital midwife).

Being known in the area, and having a positive reputation, also helped enable a welcoming reception from hospital staff when transferring a woman into hospital:

> *The reception I get the best is [at] my local hospital…they're always lovely. And most midwives [there] I've never met…but obviously midwives must talk amongst themselves…they know that I'm a homebirth midwife in this area…I didn't even know any of those midwives when we went there yesterday, but they all knew me and said, 'Oh I know who you are'… they were lovely* (Trish, privately practising homebirth midwife).

When a privately practising midwife who transferred in with a woman had previously worked at the hospital, midwives had the sense that *'we are all on the same wave length'* (Thea, hospital midwife). There appeared to be an implicit sense of trust that emerged from a shared understanding of the hospital system. Having been employed in the hospital set a standard, in the minds of the hospital staff, for the type of practice that could be expected from the privately practising midwife, reducing uncertainty and fostering connections, as Thea described:

> *I felt more comfortable that she knew what the rules were…she had obviously gone through the appropriate criteria to be employed there and hadn't done anything to stop that, there was nothing that worried me, she was a current member of staff, no-one was concerned about her practice* (Thea, hospital midwife).

Hospital midwives simply felt more familiar with the way the homebirth midwife practised if they had worked together before, and this strengthened their connection. For example, *'It was a lot more seamless. It wasn't the same amount of angst, you knew how that midwife worked… I remember more harmonious relationships between everybody in those situations'* (Nancy, hospital midwife).

Understanding the way that hospital staff were required to work in the system enhanced the sensitivity of homebirth midwives towards collaborating with them. Privately practising midwives acknowledged that working in their back up hospitals in the past had not only fostered relationships but also given them insight into the ways

in which the system worked, providing them with a perspective that was valuable in transfer situations, as Kim described:

> *I've learnt a lot of really great things having worked in the hospital and in the couple of group practices within that same health service… from a systems perspective it has been valuable to have learnt the way things are done. The other thing is from a relationships perspective, having, being around, being known, is really is a great advantage for me as a privately practising clinician now* (Kim, privately practising homebirth midwife).

Smooth transfer processes depended upon open and transparent lines of communication and a sense of connection between homebirth midwives and hospital staff, *'It would be wonderful if there was more transparency…everybody then could be on the right wave-length'* (Thea, hospital midwife). Kim was not complacent about maintaining relationships with hospital staff and was committed to continuing the connections that had been established. The primary reason for this was the belief that improved connection and collaboration with hospital staff would ultimately optimise the care and transfer experience for women, *'for women that makes the biggest difference… [my] being known, being around…When my women transfer…"Oh that's just Kim [transferring in with a woman]…be sure to support them and make this transition nice and smooth"'* (Kim, privately practising homebirth midwife).

Privately practising midwives who enjoyed smooth and successful transfer experiences most of the time had all put in time and effort to foster connections with hospital staff, during transfer episodes and also outside the times of the transfers. Fostering such relationships built trust between them, which was beneficial in reducing uncertainty in transfer situations. Having a pre-existing rapport had the potential to strengthen the privately practising midwife's role, as Kim expressed, *'In some ways I can push things further than other practitioners that haven't developed those relationships… so fostering those relationships is really important'* (Kim, privately practising homebirth midwife). The findings showed clearly that, for midwives working in homebirth

settings, there was value in being pro-active in fostering connections with hospital colleagues.

Conversely, a lack of connection increased midwives' sense of uncertainty about how even simple social interactions might unfold in the birthing room. Midwives from homebirth and hospital settings meeting each other for the first time gave examples of their thoughts, such as, *'Ooh, I don't know what they're like'* (Kim, privately practising homebirth midwife) or *'I did hope that she wouldn't be difficult…Because they were not employed by us we didn't have any sort of connection with them professionally at all'* (Thea, hospital midwife). In the sensitive context of caring for a birthing woman, tension may easily emerge as caregivers proceeded cautiously with unfamiliar colleagues: *'If somebody walks in that they don't know, they're unsure how they're going to be greeted…they…can put up a bit of a barrier and you can find you've got to chip that barrier down'* (Barbara, hospital midwife).

In clinically urgent situations, obstetricians acknowledged that, *'to try to communicate in the acute setting, with somebody you've never met before, about something dire that's happening…[when] you need to act now…can be one of the challenges* (Thalia, obstetrician). The feelings of uncertainty that arose from a lack of connection had the potential to breed contempt, as this quote demonstrated, *'They* [homebirth midwives] *will say 'they treated me like dirt'. Well we only do that because we don't know anything about you'* (Thea, hospital midwife). Privately practising midwives who regularly fostered connections with hospital colleagues were aware of the hazards of not doing so, as Trish verbalised:

> *There's a few midwives…who, when we have meetings they go, 'Oh they were awful and they treated me really badly'. And I thought, 'I think it might be them'. Because I've never ever had that except at* [hospital name] *where they didn't know me. Mostly it's the exact opposite, they couldn't be nicer* (Trish, privately practising homebirth midwife).

The quote above strengthens the notion that there is value, especially for privately practising midwives, in being pro-active in fostering relationships and building effective connections with hospital colleagues. Hospital midwives who had experienced the value of familiarity and rapport with a homebirth midwife were motivated and *'happy to build new relationships'* (Kay, hospital midwife) with new or unfamiliar homebirth midwives coming in to the birth unit. This required a commitment from privately practising midwives, too. *'It is about familiarity… if you are new to a system, you can…work to become familiar'* (Jill, privately practising homebirth midwife). After a few positive experiences, there appeared to be a snowball effect, resulting in an increased openness and more sophisticated understanding of how to foster connections and develop collaboration. This was a result of discovering how these interactions helped to reduce uncertainty for everyone involved. The next sub-category, *'Reducing uncertainty',* explores this notion of uncertainty in more detail.

Sub category: Reducing uncertainty

The possibility of experiencing variations from the normal, healthy pathway that women were hoping for, and needing transfer to hospital, brought feelings of uncertainty. In situations of uncertainty, humans have a fundamental need to seek and receive information about why, what, how, where, when and who with events might occur for them. Receiving information reduced uncertainty by helping women to develop a lens through which to comprehend what transfer might be like and to attach meaning to their understanding. Engaging emotionally with the possibility of transfer on a deeper level was a further way of reducing uncertainty, which some women were encouraged to do by their midwives.

During pregnancy, women asked their midwives questions such as, *'What if I did need to be transferred, what would happen?'* (Belinda, homebirth woman). Such questions led to discussions about the practicalities and processes of transfer, which reduced uncertainty about managing variations of normal. '*We had a lot of conversations about what that [transfer process] might entail, if things didn't quite go right…what that might look like and then what might happen'* (Tess, homebirth woman). Such conversations helped women to feel well prepared for their homebirth. '*She [the*

midwife] was very clear on what would happen if we needed a transfer…we were so prepared' (Belinda, homebirth woman). Women liked to know that the process of accessing admission to hospital was not difficult, saying for example, *'If there was cause for concern that they would recommend that I transfer…I knew that that could happen. It could be quite easy, it didn't need to be an emergency'* (Dianne, homebirth woman).

Midwives described to women the most common indications for transfer, such as delayed progress in labour, meconium stained liquor, a third-degree perineal tear, postpartum haemorrhage or fetal distress. Extremely rare occurrences were not routinely discussed in detail, so as not to engender unnecessary anxiety in women, for example: *'I probably don't talk heaps but I do let them know that things can go wrong at home that are out of our control'* (Yolande, publicly funded homebirth midwife). Prior to discussions with their midwives, women often worried about the likelihood of experiencing a complication at home that required an urgent response, saying, *'My concern, when we first started talking about it was, if there's an emergency'* (Felicity, homebirth woman). Midwives helped to reduce uncertainty for women by communicating the evidence that most transfers are not emergencies, and drawing upon their own professional experiences, as Kim described, '*We can highlight how, almost never, do we need to transfer in such a hurry that it's life or death, for her or her baby'* (Kim, privately practising homebirth midwife). The midwife's explanation of reasons for transfer gave women a clear sense of the more likely situations that could occur. Knowing that emergency transfers were rare was reassuring to women, as described here: *'[My midwife] talked me through…how, actually, for the vast majority of the time if you end up going in it because it [the labour] is too slow. It's not because something has happened'* (Felicity, homebirth woman).

Publicly funded homebirth midwives tended to align their information sharing about transfer with hospital and/or state policies. Some would ask women to read the clinical practice guidelines (CPGs) to ensure that they understood the parameters within which publicly funded homebirth programs must work, for example: '*I get them to…look at the CPGs and look at the list of reasons to transfer…so they know the policy*

as well as I do' (Margie, publicly funded homebirth midwife). The CPGs created an important framework for midwives and obstetricians working in publicly funded homebirth programmes, giving them a sense of working within *'clearly defined boundaries'* (Blair, obstetrician). The CPGs were also seen as an intrinsic part of preparing the women for homebirth and the possibility of transfer, because they provided a document that outlined *'what their limits are at home and what they can and can't do there'* (Blair, obstetrician).

Women often sought other background reading to help them understand the likelihood of transfer and the monitoring and interventions that may ensue. This understanding reduced their uncertainty and gave them a foundation for discussion with their midwives, as illustrated in these two quotes:

> *I did a lot of reading…so I had a lot of background about all the various interventions and a pretty clear idea in my head of what I thought would be acceptable in whatever circumstances. And I just did have a lot of time that I discussed that with [my midwife]* (Tess, homebirth woman).

> *I knew from the stuff I've read that with your first baby there's quite a high likelihood of you being transferred in. So, I knew that was a possibility. But we thought, why not? Why not give it a go?...You can always go in if you need to* (Felicity, homebirth woman).

Homebirth midwives chose a range of ways to schedule the topic of transfer into their antenatal discussions. Some tended to individualise the timing of the conversations about transfer, depending on the priorities of the woman and her partner, for example:

> *Sometimes it might not be the conversation that you have when you first meet them, sometimes [it is] about them developing that trusting relationship with you, so it might be the second or third visit… other times it actually forms part*

of that booking process, that really early stuff (Kim, privately practising homebirth midwife).

Other midwives incorporated the discussions about transfer into their ongoing care, so it was *'a process that continued on through pregnancy'* (Iris, privately practising homebirth midwife). Integrating transfer issues into the whole picture of planning the homebirth meant that, *'right from the onset, we're educating women that we <u>may</u> need to transfer at some point*' (Iris, privately practising homebirth midwife). A checklist was often used to ensure that all the necessary aspects were covered over the course of the pregnancy. During each antenatal visit, the midwives would choose several points on the list for discussion, *'crossing things off [the list] …not dwelling on it, not turning it into a huge negative in their pregnancy, but just addressing the possibility and preparing them'* (Iris, privately practising homebirth midwife). Informing women in this way meant that transfer was addressed progressively, over a period of months, embedding the possibility of transfer into the preparation for birth.

Booking in: a mechanism of reducing uncertainty

The conversations women had with their midwife during pregnancy reduced their uncertainty about what might happen if they were transferred, and usually led them to undergo practical mechanisms of preparation for transfer. Activities such as booking in to a back-up hospital, constructing a transfer birth plan and getting ambulance cover were all mechanisms for assisting them to reduce their uncertainty about potential transfer.

In publicly funded homebirth programmes, booking in with a caregiver, booking a place of birth and booking a back-up hospital was an automatic, integrated process. This integration often meant there was reduced uncertainty. For privately practising midwives and the women they cared for, booking in to a back–up hospital was implemented separately at an appropriate hospital near to the woman's home. Ensuring these processes were in place was integral to providing quality midwifery care, '*[it was] part of providing what we thought was best practice…to have a backup booking in a tertiary hospital*' (Tracy, privately practising homebirth midwife). Booking

in to a back-up hospital reduced uncertainty in several ways; for women, for homebirth midwives and for hospital staff.

For women, booking in to their chosen back-up hospital reduced their uncertainty, by increasing their engagement with the possibility of transfer and their familiarity with the hospital environment. Both these elements were part of the process of formulating their expectations for birth. As Iris explained, *'it was all part of that big picture, the preparation of planning to birth. They've chosen homebirth, ok; but we are also mindful that we have also got this back-up hospital booking'* (Iris, privately practising homebirth midwife). Having ambulance cover was another mechanism of preparation that women were asked to enact, *'the ambulance cover and the back-up hospital booking all went hand in hand, in case there was a transfer required'* (Iris, privately practising homebirth midwife).

From a hospital midwife's perspective, having information on file about a woman who was transferred in reduced uncertainty, as Nancy explained, *'even if it is very limited information, there's at least bits and pieces that we actually need'* (Nancy, hospital midwife). 'Bits and pieces' that hospital midwives found useful included a hospital booking number, blood results and antenatal records. One midwife explained her priorities: *'I don't care if you don't want your baby to have Vitamin K but I would like to know what your blood group was'* (Thea, hospital midwife). *'If the woman's booked in as a back-up then we do get their blood results…[and] the antenatal record, a copy of that sent through'* (Ellen, hospital midwife). Women were usually happy to provide whatever clinical information the hospital required, in order to make the potential transfer go smoothly, *'everyone wanted to make sure that they had all the information that they might need'* (Joanna, homebirth woman).

Reducing uncertainty for hospital staff meant lowering their stress, thereby enabling them to focus on caring for the woman and negotiating their working relationship with the homebirth midwife. Transfer would be more seamless when booking in was in place, as the hospital had documented the information that was provided, as Iris explained:

> *Once that booking in process was there, you go in, they'd have their folder, they'd have all their details, they'd have their date of birth, they'd have all their personal details. If it was their first baby… it's just primiparous, but otherwise it's got the date of their babies, whether they had a vaginal birth and the date of their babies, the weight of their babies* (Iris, privately practising homebirth midwife).

Most privately practising midwives understood this, *'It makes it easier for the staff to have her entered into [the database], and have her medical records number'* (Trish, privately practising homebirth midwife). The booking in process contributed indirectly to ongoing collaboration between caregivers, as privately practising midwife, Kim, explained, *'I'm passionate about…collaboration…[so] I ask each of my women to book into the [hospital] as their back-up space'* (Kim, privately practising homebirth midwife).

Women and their homebirth midwives appreciated it when the hospital midwife conducting the booking in process demonstrated respect for the woman's choice to plan a homebirth. One woman explained, *'[The hospital midwife we saw] was absolutely brilliant… she was very, very supportive'* (Naomi, homebirth woman). Women enjoyed hearing that the hospital was familiar with their homebirth midwife, saying, *'I was happy to hear that they knew [my midwife]. All good reports'* (Tamara, homebirth woman). Hearing this enhanced their sense of connection between themselves, their homebirth midwife and the hospital, *'they knew [my midwife] there, so there was a good relationship, so everyone knew everyone'* (Naomi, homebirth woman). The language the hospital midwives used at the booking in appointment demonstrated their attitudes towards homebirth. Trish appreciated the positive interactions that women usually reported to her about their booking in experience, such as, *'Oh the midwife is lovely…when I left she handed me my yellow card slip, "Oh, I hope I never get to see you again." They always say that…that's really nice'* (Trish, privately practising homebirth midwife).

The booking in appointment was an opportunity for women to prepare by becoming familiar with the hospital environment, thus addressing one element of their uncertainty, *'We had a look around the hospital…and just became familiar with it…you know where you're going'* (Joanna, homebirth woman). Hospital midwives and obstetricians valued the fact that women who had booked in were more likely to feel connected to the hospital, *'they have engaged with the hospital…we're not so foreign to them…they've at least got some vague idea of where they're going when they come, and that we're okay* [laughing]*'* (Nancy, hospital midwife). Even minimal familiarity with the hospital had the potential to improve the woman's transfer experience, *'at least one visit during their pregnancy… [so] this is then not a totally foreign kind of alienating environment…changes the impact of that potential transfer'* (Tabitha, obstetrician). Feeling connected with the hospital was advantageous to women in the event of transfer. Joanna described her feelings during pregnancy about her back-up hospital:

> *I felt like I knew where [the hospital] was, I knew that [my midwife] worked there and had a relationship with them. I felt like I had a few connections to the hospital. I'd been there a few times actually before the birth, so I felt familiar with it* (Joanna, homebirth woman).

Proximity of the hospital to women's homes not only meant short travelling time but also reduced their uncertainty by enhancing their sense of connection with the hospital, as one woman described, '*I went to my nearby hospital…said, "I want to book myself in…so that… I'm linked up to you guys should I need to transfer." I was happy with that*' (Tamara, homebirth woman). Whether they eventually gave birth at home or needed to transfer, they knew they would give birth within their own community:

> *We have a local hospital it's 10 minutes away…I had gone there previously and registered myself with that hospital so they had all of my details…and they knew [my midwives] there, so there was a good relationship, so everyone knew everyone and it was very close* (Naomi, homebirth woman).

Most women were honest with the hospital midwife they met about the fact that the booking in was for back-up only. This enabled them to be clear about which services they did not require, saying, *'I have a midwife so I don't want any of the antenatal care and I won't need any postnatal appointments either…I was quite well received. There were no problems with booking in at all'* (Bree, homebirth woman).

The findings showed that the booking-in to a back-up hospital was a relatively simple process that had the potential to reduce uncertainty for caregivers and improve women's transfer experiences in significant ways.

Opening up to the possibility of transfer: a mechanism for reducing uncertainty

When homebirth midwives helped women to be open to the possibility that they may need to transfer to hospital, it encouraged women to be flexible in their approach to managing their expectations and to accept a reduced level of uncertainty. Different homebirth midwives employed different levels of engagement to help women to consider the possibility of transfer. Some helped women to avoid forming rigid expectations about their place of birth by saying, *'We can certainly work with you and we can aim to achieve a homebirth but we cannot guarantee that you're actually going to have your baby at home'* (Iris, privately practising homebirth midwife). Others validated women's ideals whilst gently reminding them that such expectations may not be the eventual reality, saying for example, *'There's the ideal of…a homebirth that's all natural…how you want it, and there's always a chance that…you will need intervention'* (Daisy, privately practising homebirth midwife). During the preparation for homebirth, it was important to midwives that women had realistic understandings of the possibility of transfer, rather than assuming, *'We're gonna have this great natural birth and the birds are gonna sing'* (Daisy, privately practising homebirth midwife). As several midwives said, a smooth labour process *'is just not a reality all the time'* (Daisy, privately practising homebirth midwife). Engaging with the back-up hospital by booking in created a sense of connection with the hospital and increased women's awareness of the possibility of transfer, *'to have that booking in process…was part of preparing the women with the possibility they may need a transfer'* (Iris, privately practising homebirth midwife).

Some midwives worked with women on an emotional level, helping them to engage more deeply with any associated fears or negative feelings they had about potential transfer. From about 32 weeks' gestation, Tamara's midwives worked with her in this way, asking her:

> *Do I have a realistic understanding… to perhaps go in a different direction than what I hoped, hence, the transfer? Would I be happy with that? Am I content with that? Do I have a fear of it? If I do have a fear of it, do we need to work through that?* (Tamara, homebirth woman).

Tamara felt her midwives were preparing her to give birth in whatever place might eventuate, home or hospital, saying that, *'They just want to make sure that you're feeling okay, regardless of the situation'* (Tamara, homebirth woman).

Not all women felt they had been open to the possibility of transfer during pregnancy. Two women felt that, despite being well informed by their midwives, and intellectually understanding that information; they had not fully engaged emotionally with the belief that transfer could happen to them. One example was:

> *I didn't really think through very well about how that would look when that happened, because I was really, in my mind, not thinking about the fact that I would need to transfer…I was set on, 'No, I'm going to have a home birth. This baby's going to be born at home. I'm not going to need to transfer'* (Tess, homebirth woman).

Dianne had for many years been wishing to experience natural births, after hearing stories in her childhood of the negative birth experiences in her family. *'The births that I knew that were close to me were always…something went wrong'* (Dianne, homebirth woman). For this reason, she said, preparation for her own birth was underpinned by an effort to maintain positive thinking. *'I wanted to surround myself in positive birth stories and really, really tried hard'* (Dianne, homebirth woman). Dianne listened to the information her midwives provided about transfer but *'just didn't want to hear any of*

it' (Dianne, homebirth woman). Here she described her lack of engagement with the information:

> *The way that it was portrayed to me was quite calm and we would just transfer if we needed to transfer…I listened, I went okay and I'm not going to think about it again, because I really didn't believe it would happen. And I really didn't want it to happen* (Dianne, homebirth woman).

Dianne reflected in her interview that during her pregnancy, she had not been open to the possibility of transfer. One of the ways this manifested was that it had been important for her to find out if she could decline her midwives' recommendation to transfer. Planning to decline their recommendations furthered her conviction that transfer would not be necessary:

> *[My homebirth midwives] talked about the fact that if there was cause for concern that they would recommend that I transfer. Regardless of their recommendations… if I refused, that was well within my rights and I could refuse. They would still call an ambulance and an ambulance would sit out the front and wait until if they were needed* (Dianne, homebirth woman).

Dianne was eventually transferred during a long labour and gave birth by caesarean section. She took a long time to process her emotions around what was for her a negative birth experience: '*For two years...I think I've been stuck…not wanting to really deal with how I felt around the homebirth'* (Dianne, homebirth woman). The findings suggest that when women were not fully engaged during pregnancy with the possibility that transfer could occur for them, the transfer process may be more difficult.

Joanna had a positive experience of transferring to hospital to give birth to her baby and reflected, '*What else made a difference as far as the transfer? I guess it's your state of mind…being open that it might be a possibility'* (Joanna, homebirth woman). Mary had given birth several times, in hospital and at home, prior to being transferred

during labour with the planned homebirth of her fifth baby. She had almost been transferred for her fourth baby born at home, due to delayed progress in labour. As a result, she had reflected a lot on the potential transfer of her last baby. From her previous birth experiences, she had learnt the importance of an open mind, saying:

> *The homebirth experience is so wonderful but you do need a really good back up system. [For me] there was no, 'this has to happen at home'… I don't think you can go into a homebirth without a willingness to transfer. To me that's unwise* (Mary, homebirth woman).

Encouraging emotional engagement with potential transfer, as well as giving and receiving information about it, was perhaps a vehicle for helping women to open up to the possibility that transfer may occur for them.

Homebirth midwives would usually raise the possibility of transfer again, towards the end of the third trimester of pregnancy. Many homebirth midwives organised a 36-week birth plan meeting in the woman's home, attended by everyone planning to be involved in the birth. Transfer was a topic for discussion, ensuring that everyone was aware of the possibility that it might be needed. Uncertainty was reduced by clarifying the processes that might occur, as explained here:

> *[Preparing women for the possibility of transfer] culminated at thirty-six weeks [when] we had a birthplan meeting…the midwives would attend with the family and any support person that the family intended to have present at the birth…we would be talking again about the risks that may come up and we may need to transfer* (Iris, privately practising homebirth midwife).

In the last month of pregnancy, some privately practising midwives sent updated records across to the back-up hospital to which the woman had booked in, to further reduce uncertainty for staff. '*I send their antenatal record across…at 36 weeks, so that in the event that there is a transfer they've got some [updated antenatal] information about the women that I'm caring for'* (Kim, privately practising homebirth midwife).

Summary

This category *'Fostering relationships and reducing uncertainty'*, explored the processes women and their midwives underwent to build a partnership that was based upon reciprocal trust. The value of fostering professional connections between midwives and obstetricians was explored and the mechanisms for reducing uncertainty for those involved in potential transfer from planned homebirth were described. Antenatal preparation for the possibility of transfer was of benefit to women who did eventually require transfer, especially when they were encouraged to engage with it on an emotional level. The next chapter *'Transferring out of the comfort zone',* examines what occurred when women moved from their homes into hospital from their planned homebirths, and the ways in which caregivers cared for them during the process.

CHAPTER SIX: FINDINGS 'TRANSFERRING OUT OF THE COMFORT ZONE'

Introduction

Most of the processes and interactions explored in the previous chapter, around antenatal preparation for the possibility of transfer, were positive. This chapter explores the category, *'Transferring out of the comfort zone',* which shows that in the intrapartum phase, the physical and psychological journeys to hospital and processes of care in hospital became more complex; both for women and for caregivers. There are three sub categories in this chapter, *'Making the journey into hospital', 'Making the psychological journey'* and *'Different paradigms converging'.*

Women made physical and psychological journeys out of their comfort zone, as they moved from their homes whilst facing the uncertainty of changing expectations for their birth. Midwives and obstetricians found themselves *'transferring out of their comfort zone'* when they congregated in the birthing rooms of transferred women. This was because of the challenges of converging with others who possessed different approaches to the interpretation of evidence, a range of paradigms of safety and risk in birth, and conflicting responses to ethical principles such as women's autonomy and the rights of the fetus.

The first sub category, *'Making the journey into hospital'* explores how homebirth midwives supported the transition from home to hospital by creating a mediating presence between the woman, the ambulance service and the hospital. Firstly, midwives supported women in making decisions about the journey to hospital, and facilitated their safe passage there. Secondly, the midwife created a mediating presence, by sustaining the midwife-woman partnership and providing continuous care, support and advocacy.

The second sub category, *'Making the psychological journey'* explores the ways in which women and homebirth midwives managed the demands of adjusting to a clinical

environment, different approaches to timing the progress of labour, and changing expectations for labour and birth.

The third sub category, *'Different paradigms converging'* represents the way in which all caregivers moved out of their psychological comfort zone as they congregated in the birthing room of a transferred woman. Especially for midwives, grappling with collaboration with unfamiliar people and working out how to fit with the different paradigms converging on the woman's birthing room in hospital was challenging. Even though hospital staff could physically remain in their familiar territory, they also had a psychological journey to make 'out of their comfort zone', due to the different paradigms they encountered in the unique context of homebirth transfer.

Sub category: Making the journey into hospital

All the women in this study were accompanied or followed to hospital by at least one of their homebirth midwives, with one exception when a woman experienced early intrapartum bleeding and met her midwife at the hospital. The transfer journey from home to hospital could occur in two ways. Non-urgent homebirth transfers were often similar to the routine journeys that women make from home to a planned birth centre or hospital birth when in labour, travelling to hospital in their car with their partner. Midwives either accompanied the couple or followed in their own vehicle. Alternatively, if clinically indicated, an ambulance would be used to make the transfer journey.

When an ambulance was required, it was the homebirth midwife's role to call the emergency number (000). A few midwives expressed concerns about the process of speaking to the telephone operator, when calling to request an ambulance. There appeared to be a gap between what the midwives felt needed to be communicated and what the ambulance telephone operator asked them. One midwife explained, *'I was amazed…how much information they want…what's happening, what's the name, what's the address?...They would continue to ask… 'How exactly do you spell her name?' and that kind of stuff'* (Kim, privately practising homebirth midwife). Midwives wanted to be with the woman, rather than on the telephone, and were frustrated by

the number of questions asked and the length of time the call took. Sometimes midwives would try to finish quickly, so they could get back to caring for the woman, saying for example, *'I'm going to hang up now, because I actually need to be with this woman to support her'* (Kim, privately practising homebirth midwife). Due to constraints in obtaining ethical approval, I was unable to explore the perspective of the ambulance service on 000 interactions with midwives.

Participants used a variety of terms to describe ambulance personnel, including 'ambos', 'ambulance drivers' and 'paramedics'. For the purposes of these findings, the term 'paramedic' will be used because that was the term most commonly used by participants. Most midwives reported that they had *'always had positive experiences with…paramedic colleagues'* (Kim, privately practising homebirth midwife), that the paramedics who arrived *'were all very receptive'* (Irene, privately practising homebirth midwife) and enjoyed being involved in birthing events. Ambulance arrival was usually prompt, as Iris said, *'No problem with the ambulance…The response times have always been quite timely'* (Iris, privately practising homebirth midwife). Collaborations between midwives and paramedics seemed usually to be positive.

Most of the women who travelled in an ambulance were happy with the care they received. *'I hated having to be strapped in, but I understood that it had to happen. The paramedics…were lovely*' (Dianne, homebirth woman). In contrast, one homebirth woman, Belinda, had a negative experience with paramedics. She felt that the arrival of the paramedics was an assault on her visual and aural senses. She was distressed by how much noise they made, saying '*all of a sudden there were these ambos there, barking orders…they were loud and they were rude… you can do your job efficiently, without having to be loud about it*' (Belinda, homebirth woman). Belinda's midwife mediated by trying to ameliorate the situation, firstly by reassuring Belinda and secondly by helping the paramedics to adapt their behaviour:

> *[My midwife] was there she was like, 'don't worry about them, I have got it covered' …I feel like because [my midwife] is who she is and because she is*

> *experienced she very graciously told them where to go in some circumstances. I am so grateful for her* (Belinda, homebirth woman).

Non-urgent ambulance trips were usually calm and controlled, without the need for lights and sirens or excessive speed. The presence or absence of lights and sirens during the ambulance journey played a symbolic role in women's interpretation of their safety, as one woman articulated, *'The other thing that eased my thoughts a little bit, in the ambulance they'd asked, "Did they need the sirens on?" The midwife said, "No, it's fine" '*(Dianne, homebirth woman). The lights and sirens were a vivid part of Mary's memories of her journey to hospital. She said, '*All I remember is that I just heard the siren the whole way, and it was fast, and we kept going through lights and everything, it was a real hurry'* (Mary, homebirth woman). She remembered wondering at the time if she was, *'sicker than I know or in more danger than I know'* (Mary, homebirth woman). Mary felt that more direct verbal communication from midwives and paramedics about the lights and sirens may have reassured her, as she recalled:

> *If they said, 'Look Mary, we just want to get you there as quickly as we can, we're just going to pop the sirens on', I think that would have informed me…Even someone just saying that quietly in my ear [might have helped me to think], 'Ok, it's just they want to get me there quickly'* (Mary, homebirth woman).

One privately practising midwife would prepare women for interactions in the hospital by helping them to understand *'how best to approach hospital staff…how best to get that information from them and to get across what you want from them…so that you get some clarity'* (Jill, privately practising homebirth midwife). Jill would give clear examples of the conversations that might ensue, *'so the woman gets what she needs from the hospital situation'* (Jill, privately practising homebirth midwife). Promoting informed decision making for women was Jill's aim when she gave scenarios to women before transfer, such as this example:

> *If the doctor comes in and says, 'Well, we'd like to do [X]'…then you might like to ask the doctor, 'What is the evidence around [X], and what is that going to do for me? And how is that going to help me…are there disadvantages to doing [X]? Do I actually need one? And what if I don't have [X]? What is that going to mean?'* (Jill, privately practising homebirth midwife).

At the time of data collection, in the four states of Australia in which participants were interviewed (NSW, Victoria, South Australia and Tasmania), privately practising midwives could not continue to undertake clinical responsibility for the woman's care in hospital when she was transferred from a planned homebirth. Privately practising homebirth midwives were obliged to step back into the role of support person, whilst the hospital staff took clinical responsibility for her care.

As a result of their conversations during pregnancy, women understood their midwives' professional roles in in the event of transfer to hospital, '*They told me that legally, they wouldn't be able to do any of their midwifery things when they were at the hospital, that they would basically be my…emotional…support people'* (Tess, homebirth woman). Hospital staff had an expectation that the homebirth midwife's diminished role would be understood by women before they came in, saying that, '*I think that is the most important thing…the woman is aware that [the homebirth midwife] is going to sort of then have to step back into more of a supportive role'* (Thea, hospital midwife).

Women talked about how vital it was, to their sense of emotional safety, for their homebirth midwife to accompany them as they made the journey to hospital, saying, *'I still felt very safe because I had [my homebirth midwife] there [in hospital]* (Mary, homebirth woman) and *'I felt very safe with [my homebirth midwives] and my partner there with me'* (Tess, homebirth woman). Tess felt it was empowering to know she had her two homebirth midwives with her to advocate for her in the hospital setting:

> *I felt really empowered, actually, having my midwives there…having them as my advocates in the hospital made all the difference, having them there with all of their knowledge and support* (Tess, homebirth woman).

The sense of empowerment that resulted for women, from having their homebirth midwife advocate for them, was described by women as having a midwife whom they knew was 'on their side', *'I knew they were 100% on my side… 100% committed to a healthy baby and a healthy mum…so whatever needed to happen on the day happened'* (Mary, homebirth woman). Having their midwife 'by their side' and 'on their side' became especially important when they arrived at the hospital, as Tess described:

> *I knew they were on my side…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 whatever you have to do to pay for it* [laughing]…*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).

Homebirth midwives provided important support by providing a continuous professional presence. As an example, when Naomi was being transferred, having her homebirth midwife with her enabled her to feel that she could continue her labour and birth in hospital. Her homebirth midwife knew what was important to her and would be there as her advocate, as she said here:

> *It was good to know that she would always be there and be our advocate…she could stand up for us…she was the support structure for us and knowing she would be with us… in the hospital, was brilliant* (Naomi, homebirth woman).

Most midwives saw that continuous presence was paramount to women at the time of transfer, saying that, *'I'm the continuity, I'm the continuous person'* (Irene, privately

practising homebirth midwife). The midwife-woman partnership was crucial to the women's emotional safety, at the time of transfer, because this was when women were perhaps most vulnerable, as Jill expressed: '*[Midwives] 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, privately practising homebirth midwife).

A strong sense of partnership with their homebirth midwife helped transferred women to feel protected from any potential negative impacts of the clinical atmosphere of the hospital. This sense of protection was ingrained a woman's trust in her homebirth midwife, as shown here:

> *[My midwives] protected me… just because of their presence, because of the relationship we had and the relationship we had built in that time of them coming to my home, spending two hours at a time and developing that lovely bond, just to have them present there kind of kept that icy, more industrialised approach [at a distance]* (Tamara, homebirth woman).

Homebirth midwives often adopted a mediating role during the transfer journey, by acting as a communication 'go between', between the paramedic, midwifery and/or medical staff and the woman's family, *'She knew our wishes and she would be able to interpret everything and be able to explain it for us if there were any issues'* (Naomi, homebirth woman). Kate was unwell after the birth of her baby and remained in the hospital's delivery suite whilst her baby was taken to special care nursery for observation. Her homebirth midwife was mediating by *'relaying what was going on between the nursery and delivery suite'* (Kate, homebirth woman), providing a constant communication pathway for Kate about her baby's health. Midwife Tracy spoke about her motivation to provide a communication pathway as part of her mediating role:

> *I wanted to assure the family…translate what [the] plan was, what was going on, what was being discussed. They were nervous about what was going on and I had that relationship with them so wanted to be part of that communication to them, [to] relate to them* (Tracy, privately practising homebirth midwife).

Sub category: Making the psychological journey

When facing a transfer to hospital, women made not only a journey by road, but also a psychological journey, as they confronted changing expectations for their labour and birth. As one obstetrician acknowledged, *'when plans change, that's a psychological journey for people to travel'* (Thalia, obstetrician).

Women who were transferred from a planned homebirth usually met with a different philosophy of midwifery care in the hospital, compared to care from their known midwife at home, as one midwife expressed: *'often times that's why they choose us, because it is a different philosophy of care'* (Kim, privately practising midwife). Different approaches may be driven by several factors, including the culture of the unit in which they work and/or the philosophy of individual midwives, as Kim said, *'It can be a different philosophy and that can depend on which midwife is allocated to you, and their ideas about privately practising midwives'* (Kim, privately practising midwife). Hospital midwives were aware of this too, '*there's a different idea of decision making and risk, in terms of the two cares'* (Cassie, hospital midwife). Homebirth midwives acknowledged that this may be related to the different systemic pressures hospital midwives worked under, saying, *'You can't give the same kind of care, no matter what your philosophy is, if you're caring for two or three women at one time'* (Kim, privately practising midwife).

All the women in this study had their midwife transfer with them and stay with them in the hospital, however, several midwives and obstetricians described instances in which women were transferred to hospital without their known midwife in attendance. As described in Chapter 5, *'Fostering relationships and reducing uncertainty',* one publicly funded homebirth programme had a policy that it was not always possible to follow transferred women on their journey to hospital. Despite an awareness that *'women would prefer us to stay with them after transfer'* (Kath, publicly funded homebirth midwife), the view was that *'it's not viable for us to do that, as disappointing as that is for the woman, simply from a staffing point of view'* (Kath, publicly funded homebirth midwife). Kath went on to explain the rationale for restricting continuity of carer

during transfer, which was primarily to keep the service open for other women who may go into labour:

> *The intention is never to shut the unit because of staffing…I suppose there's this fine line, if you stay with that woman she gets what she wants and needs, but then you close the service which means that nobody else [other women] gets what they need…I think you have to take a step back from the emotional side…The women are working from that emotional side, I understand that, but from a…professional's point of view you have to take a step back from that emotional side* (Kath, publicly funded homebirth midwife).

The midwives in this publicly funded program felt that when transfer was required, it was appropriate for the hospital staff to take over the care of that woman. There was an implicit suggestion that hospital midwives were more accustomed to dealing with the interventions that may be needed. Kath admitted that the handover to new staff was not always a smooth process:

> *I need someone who has that expertise, even though I carry the expertise, to take over from me and…make it as calm a transfer as possible for that woman, from one carer to another. I would be a liar if I sat here and said that that happened smoothly all the time because it doesn't* (Kath, publicly funded homebirth midwife).

Women unanimously expressed the value of having their known midwife accompany them on their journey to hospital and stay with them there throughout labour, until after the birth of their baby.

Two privately practising midwives had worked previously in a publicly funded homebirth service where continuity of carer during transfer was not guaranteed to women. Both midwives described the reasons why they were dissatisfied when the policy to not provide continuity of carer to transferred women was introduced. They

shared their strong beliefs that women who were transferred from a planned homebirth needed midwifery continuity of carer more than ever:

> *I can feel my blood boiling just thinking about this…. If a woman is transferred…because her blood pressure's gone up or something, I feel very, very strongly that she deserves and needs…her midwife that she's seen for the last 7 months…to go with her* (Jill, privately practising midwife, formerly employed in a publicly funded homebirth programme).

> *That's the time [homebirth transfer], apart from any other time in a whole woman's journey, that she needs you…I feel very strongly that those are the times that they need you and they need their trust, their continuity…and I know that lots of my colleagues feel similarly about that* (Kim, privately practising midwife, formerly employed in a publicly funded homebirth programme).

Jill felt that there was a reluctance by some of the publicly funded homebirth midwives to provide continuity of carer, which she felt was related to trying to avoid working in the tertiary hospital. *'It can be facilitated but the midwives don't want to…We did do it for a period of time…some midwives would put their hands up to go, and other midwives would not'* (Jill, privately practising midwife, formerly employed in a publicly funded homebirth programme). Jill explained further why she felt the midwives were trying to avoid the tertiary environment, saying: *'It's got to do with the culture…they would see the hospital delivery suite as a big intervention machine. It's high risk, it's high acuity'* (Jill, privately practising midwife, formerly employed in a publicly funded homebirth programme). Jill felt that midwives facilitating homebirths *'need to familiarise themselves…[to] feel as if they can practice in that environment. So they can put an epidural up…they can do [an urgent] caesarean'* (Jill, privately practising midwife, formerly employed in a publicly funded homebirth programme). Being comfortable transitioning into an environment where intervention was common was part of being able to support women who require transfer, and part of the commitment and responsibility the midwife had to each woman's care, in Jill's opinion:

> *They [homebirth midwives] need to be able to follow women through when those…scary scenarios happen to women. The women need the person they know and trust…It behooves us as midwives to familiarise ourselves to that [hospital] environment…get our arses over there and advocate for our women and support our women in that environment* (Jill, privately practising midwife, formerly employed in a publicly funded homebirth programme).

Making the psychological journey to a new environment

Adjusting to the clinical environment of the hospital was another part of the psychological journey women faced. Labouring and birthing in the comfort zone of their home helped women choosing homebirth to feel safe. Women said that giving birth in their home environment was *'one of the biggest reasons I had wanted a homebirth. I had spent weeks preparing my birth room [with] candles and red lamps and a big red curtain to block out the daylight'* (Tess, homebirth woman). When a woman was moved to a hospital environment, the contrast was stark: *'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). The clinical environment of the hospital made women feel that they had moved out of their comfort zone, as Tess described: *'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 unhomely'* (Tess, homebirth woman). Joanna described wondering how her labour would progress in such an environment: *'I just didn't know how I was going to labour in this room with cold hard floors, a big raised bed and a narrow bath'* (Joanna, homebirth woman).

Sensory issues like smells and noise in hospitals were challenging to women and to homebirth midwives, as this midwife described, *'The consultant came in…all stinking of perfume on her scarf …all unwrapping…this stuff they have and you can hear all the packets, and the clang, clang, clang* (Trish, privately practising midwife). Some hospital midwives were sensitive to the fact that being in the hospital environment could be disempowering for homebirth midwives:

> *She [homebirth midwife] must've felt that she had lost that sense of control…she probably felt like a fish out of water in the delivery suite…She was obviously very comfortable in that environment at a person's home, whereas coming into a delivery suite, which was obviously vastly different to her preferred place of practice, would've possibly been quite intimidating* (Nancy, hospital midwife).

Sometimes hospital staff were confused as to why the environment mattered so much to women and homebirth midwives. There was a perception by some that women planning homebirths were overly focused on the quality of their labour and birth experience, for example: *'A lot of the talk around…people who book homebirths is that they are obsessed with the journey and not with the destination, that it's all about, 'How am I going to get there?'* (Kay, hospital midwife). An obstetrician illustrated her perspective that the quality of the labour and birth experience sometimes, in her view, overrode safety considerations:

> *It feels as though people [women] are in the pursuit more of 'the birth', a sense of 'I am a better woman if I can have a vaginal birth'… There is a lot of pressure placed on women now about their birth story… An overriding drive to pursue a vaginal birth…compromise[s] their insight… [They may fail to have seen that] a caesarean section was the safest way* (Tabitha, obstetrician).

From an obstetric perspective, caesarean section may often appear to be the safest way for a baby to be born, however, women's perspectives of a good outcome extended beyond simply expediting the birth by performing surgery. Women often felt that their birth experience was undervalued in the hospital setting, for example, *'You're just a piece of meat and here we go and here's another one. That whole beautiful transition of becoming a mother and the whole birth experience wasn't honoured at all'* (Tamara, woman). This was in stark contrast to the comfort of labouring and giving birth in their home environment.

Making the psychological journey into different parameters of time

Freedom of time to labour was another common reason that women chose to plan a homebirth, '*What I love about homebirth is not being put on a time limit, not being put on hospital protocol, not being checked, that was really important to me'* (Belinda, homebirth woman). Women were mindful of the time parameters that were prevalent in hospitals in relation to the progress of labour, and this was another major psychological adjustment in their journey. Women felt they were 'on the clock' in hospital, as Tess related:

> *The doctor came in and said that soon she would need to do a VE to see if the labour had progressed. I was on the clock. I asked her if we could put it off a bit longer but she felt she really needed to do it as soon as possible, to determine the next course of action* (Tess, homebirth woman).

Joanna described what was said to her soon after she was transferred, *'when we got in [the bath], she said, 'You need to start pushing, you're on a timer. You need to get him out. It's time'* (Joanna, homebirth woman). Women saw routine observations such as vaginal examinations as being linked with decisions to speed labour up. '*I didn't want someone's hand up my clacker*, because there is no reason for it if things are going well'* (Belinda, homebirth woman). [*The expression 'clacker' is an Australian colloquialism for 'vagina' or 'anus'. 'Someone's hand up my clacker' is interpreted here to mean 'having a vaginal examination'.]

The psychological journey women travelled when being transferred to hospital involved trying to manage their changing expectations for how labour and birth might unfold. Caring for transferred women required a sense of *'being aware, sensitive [to]…managing changing expectations'* (Thalia, obstetrician). Effective communication with women about the clinical changes that were occurring was key in the homebirth transfer context, as one obstetrician explained:

> *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).

After transfer to hospital, women benefited from being given time to manage their changing expectations and psychological journey. It was important that caregivers provided women time to participate in informed decision making processes. Thalia explained her rationale for this:

> *We know that for how people cope with things afterwards, half the time it's not what actually happens to them, it's how it was communicated to them, if time was available, if they had time to think about their choices and to think, to participate in those decisions* (Thalia, obstetrician).

Taking time to consider all options was clinically prudent as well, according to one obstetrician, who said: *'The right approach is to calm everybody down, see the state of the baby, [then] decide what the safest thing to do is'* (Charles, obstetrician). Even in urgent situations, it was usually still possible to enable women to have a few minutes to process what was occurring, as another said: *'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). Women valued having time to think about their options as it helped them to process the psychological impact of their decisions. The opportunity for informed decision making was enhanced for women by having time to converse with their trusted homebirth midwife, partner and support team. Women appreciated it when hospital staff gave them the time and space to do so, as Tess illustrated:

> *Anytime I had to make a decision about anything, I always asked them [hospital staff] if I could have some time with my team to discuss it, and they left us alone and gave us space, as much as we needed. I was able to talk things over with*

> *[my homebirth midwives] and my partner and make decisions…I found that really, really excellent* (Tess, homebirth woman).

After an obstetrician had recommended an epidural to Tess, she had many questions for her homebirth midwives. She asked them: *'What do you think? The doctor's saying I need an epidural. What is this?'* (Tess, homebirth woman). She was afraid that having an epidural may increase the likelihood of further intervention, again asking: *'Is this just the beginning of the end? The beginning of the domino effect, or is this actually something that you would suggest?'* (Tess, homebirth woman). Her primary homebirth midwife was sensitive to the psychological journey Tess was making and to her changing expectations when she answered her questions. Tess described here what her midwife had said to her:

> *Look, there are risks with having an epidural, but at this point, it may actually help your cervix relax and let that baby come through… while it's not really ideally what you wanted, this may actually be the thing that can make it possible for you to have a natural birth* (Tess, homebirth woman).

After talking it through, Tess decided to have an epidural, *'I did end up having to have an epidural, which was something I clearly did not want'* (Tess, homebirth woman). Tess followed her midwife's suggestion of planning to allow some of the anaesthetic effect to wear off, prior to pushing her baby out. Her midwife had said to her:

> *If the epidural does relax the cervix and [baby] comes down, then…we can then stop the epidural drug from going into the system and you could get your movement back in time to be able to naturally birth her* (Tess, homebirth woman).

Tess did give birth to her baby vaginally and was grateful for their guidance she had received, '*thankfully for me, it went really well, and I think that that was a lot to do with the fact that I had my midwives there'* (Tess, homebirth woman). The guidance

from her midwives had helped her to make her psychological journey to accepting the need for intervention.

Conversely, several women were not given time to psychologically process their journey and changing expectations and were offered a caesarean section as their first option. For example, one woman described that when the doctor came to assess her, *'one of the first things he did was invite me to a voluntary caesarean, [to which I replied] "No, I won't be needing that"'* (Joanna, homebirth woman). Joanna agreed instead to intravenous hydration and an epidural and progressed to a normal vaginal birth. Naomi also declined the immediate surgery she was offered by *'the first doctor that inspected me'* (Naomi, homebirth woman). At the time, her baby was well and her cervix was 9 centimetres dilated. She wondered at the time, *'if that [recommendation of a caesarean] was a reaction to homebirth or not.'* Naomi later discovered that every other woman labouring in the hospital that night had given birth by caesarean section. She said, *'Thankfully he left…and another doctor took over the next day, I felt very comfortable with [the second doctor] …That issue went away'* (Naomi, homebirth woman). In the absence of emergency indications, women were perturbed by the suggestion of immediate surgery. Joanna commented on the importance of having her trusted homebirth midwife with her in hospital to support her decision to decline interventions, *'Without a doubt, had she not been there, I know I would've been under a lot more pressure'* (Joanna, homebirth woman).

Naomi continued labouring until there was a clear indication for a caesarean birth the following day, when her baby began to become distressed. She explained, *'I was trying for a long time and monitoring him on and off and he was starting to get stressed and the moment that happened we said, "Okay, now is the time for a caesarean"'* (Naomi, homebirth woman). She felt more comfortable with the second doctor because he hadn't wanted to rush straight to theatre. By then she had time to process her psychological journey and had tried for as long as possible for a vaginal birth. She was happy with the outcome because she had participated in the decision making, saying, *'I ended up with a caesarean, and a very, very healthy, happy and active baby. It was very, very good'* (Naomi, homebirth woman).

Hospital cultures did not tend to accommodate women taking some time to make their psychological journey. Hospital staff were more used to expediting the birth process, as this quote demonstrates: *'Transfer from a homebirth…the doctor would come and assess very quickly. Certainly, you wouldn't be putting them in a back room and letting everyone muddle along'* (Thea, hospital midwife). Hospital staff often perceived that women should be psychologically ready to receive immediate intervention by the time they arrived, saying that, *'by the time they make that step [to transfer] they have had to accept that there is something to be done. They can't stay in the situation they are in'* (Charles, obstetrician). Conflict ensued because of women needing time and hospitals needing labours to progress, as one midwife described: '*The thing that was challenging was the two different modes…the doctors obviously wanted to assist this baby out, and the midwife was still trying to almost have it like it was at home'* (Nancy, hospital midwife). As the endpoint of the transfer occurred in hospital territory, there was an assumption that the hospital way would prevail, '*of course in a tertiary referral hospital that wasn't entirely how we did things'* (Nancy, hospital midwife).

From the time of the initial decision making at home, during the journey to hospital and after arrival, homebirth midwives were helping women adjust psychologically to the fact that their labour and/or birth process have diverged from the normal, healthy pathway they had expected. *'The midwife and the woman had to negotiate a lot of stuff themselves about what was going to happen now, because things had changed compared to what was normal at home'* (Kay, hospital midwife). Initial reluctance to agree to technological monitoring or resisting immediate intervention were ways in which women could buy some time to process psychologically what was occurring. Hospital midwives were often confused by this, however, and wondered why the women and homebirth midwives were resisting their medical assistance, as stated here:

> *As midwives that work in this environment all the time, we'd like to put a monitor on and make sure that baby is okay and yet the woman will say, 'No I*

> *don't want one.'…They just say they don't want it. They won't give you a reason* (Laura, hospital midwife).

Consenting to only one small intervention at first, before women were ready to face the full spectrum of intervention that may have been needed, was another way of buying time to process their psychological journey. Kay told the story of a woman she cared for in hospital, who had been declining her midwife's recommendation to transfer all day. Eventually the woman had agreed to go to hospital, saying, *'Okay, I will agree to go in but they are not going to do a Caesar!'* (Kay, hospital midwife). When she eventually arrived at the birth unit she was adamant that, *'I am coming in because I am going to have an epidural and have a rest for a couple of hours then we will work out what we are going to do'* (Kay, hospital midwife). In the clinical context of the baby being well in utero, the obstetrician said, *'Let's just let some time pass and there's no reason why she can't have some fluid resuscitation and an epidural…she will need one anyway [in the event of a caesarean]'* (Kay, hospital midwife). Having time meant that *'she and her partner worked through it all'* (Kay, hospital midwife) and the woman later felt ready to consent to a caesarean section. The homebirth midwife was the person who was best placed to mediate, by assisting the woman to manage her changing expectations and to minimise the fear that arose from her uncertainty. The way in which Kay supported the midwife-woman partnership was key to the success of this approach:

> *He [the obstetrician] wanted me to maintain my relationship with the woman and the [homebirth] midwife…and work with them, because in his mind he really thought that this woman had to have a caesarean. But he knew that she had to come to that, she had to make the journey in her head* (Kay, hospital midwife).

The ways in which women tried to buy some time to manage their changing expectations were often poorly understood. Hospital midwives were sometimes left wondering why the woman had transferred in to hospital at all, *'She just didn't want intervention, and that's what came through strongly. [I thought], 'Why did you come in*

the first place?' (Thea, hospital midwife). Ellen reported sometimes feeling similarly frustrated, thinking to herself, *'Why are you here?...You don't agree with the hospital system but your situation has changed that you need us…if you're not going to [accept our help], then don't come!'* (Ellen, hospital midwife). Obstetricians sometimes struggled when women arrived in hospital still needing more time to process their psychological journey, as Blair illustrated in recalling her thoughts towards a woman in such a situation:

> *'I've reassured you that the baby's okay. But my next recommendation might be that to try at least, to achieve your [desired] outcome [of a vaginal birth], we might want to help you along with some synto.' And if you have resistance to that, well then I feel like, 'Why did you come?'* (Blair, obstetrician).

Collaboration worked best when hospital staff allowed time and space for the homebirth midwife to support the woman in managing her changing expectations. In this way, the hospital staff were ostensibly supporting the midwife-woman partnership to flourish, rather than merely trying to relate to the woman in their routine way.

Sub category: Different paradigms converging

Women, midwives and obstetricians who congregated in the birthing room of a transferred woman possessed different paradigms of childbearing. Contrasting approaches to intrapartum care underpinned the complexities of transfer to hospital during a planned homebirth, as different paradigms converged on the birthing space. The following quote from a midwife articulates this issue:

> *The transfer of women into the hospital is so interesting, because of the different philosophies underlying the two different contexts of care, which are so different…. It's like going from one era into a different era…hospital midwives in a tertiary setting, how they view the parameters and the risks of birth is very different to how a homebirth midwife does* (Cassie, hospital midwife).

These findings support the argument made in the Background, and shown in the Literature Review of this thesis, that conflicting paradigms of childbearing are ubiquitous. One of the most fundamental contrasts was that of physiological versus pathological understandings of childbearing. Women and homebirth midwives commonly saw labour and birth as a natural physiological process. *'It's a natural thing that I was doing… [my midwife] sees birth as a natural thing…I know the hospital system doesn't see it like that at all'* (Joanna, homebirth woman).

Viewing birth as a physiological process meant that women believed in their body's capacity to give birth, having *'faith that my body knew what to do'* (Joanna, homebirth woman) and *'I trust my body…I see myself as normal'* (Kate, homebirth woman). Women valued the fact that their homebirth midwives supported their belief in themselves, *'…she trusted in my ability to birth my baby'* (Joanna, homebirth woman) and were willing to maintain an expectant approach if labour was proceeding normally, and mother and baby were well.

Physiological perspectives encompassed an expectant approach, whereby the labour and birth was expected to go well until proven otherwise. Conversely, an alternative paradigm, the pathological view, was that when a woman was labouring, something could go wrong at any moment, which meant that '*normal labour and birth is only ever diagnosed retrospectively'* (Ellen, hospital midwife). Participants who held a physiological view of childbirth saw the obstetric perspective as pathological, and at the opposite end of the spectrum, for example, *'Doctors don't look at birth as a normal physiological process…because they're taught, this can go wrong, that can go wrong and that's what they think'* (Ellen, hospital midwife), and, *'there is still that feeling that having a baby is an abnormal part of a woman's life…pregnancy is seen as an illness'* (Kate, homebirth woman).

The hospital staff who held pathological beliefs about childbirth often held negative views about the safety and risks of homebirth, and made implicit judgemental comments about those who practice homebirth, for example, *'As a midwife, I would never do [homebirths]… I've worked in this environment for too long and I've seen*

disasters happen...With a click of the finger, things can go horribly wrong' (Laura, hospital midwife). One senior obstetrician held a conviction that the majority of women would require intervention during labour and birth. This was not only his experience but also his interpretation of the evidence. He said:

> *If you look at 100 nulliparous women setting out on the journey of an attempt at, in labour…. Only between 25 and 30% will achieve a spontaneous [vaginal] delivery… And no model of care that's ever been devised in the Western world has been able to improve on those figures* (Keith, obstetrician).

For some, women were regarded as naïve and/or ill-informed if they believed that their labour and birth was going to be straightforward. Keith was concerned that women often did not commence labour with what, for him, were realistic expectations of their birth outcomes, saying:

> *Women are often not properly briefed…for example if you look at the likelihood of a nulliparous woman achieving a spontaneous vaginal delivery. Most people fail to appreciate that at best only 30% of them will achieve a spontaneous delivery. I don't think the women are informed….in my humble opinion, that's wrong…they're misled. They think that more than likely they'll have a spontaneous delivery, when in truth that's unlikely…If people were briefed properly before the labour about what the likely outcomes were, then they shouldn't be disappointed by being transferred. Because they should be almost expecting it…probably 50/50 at least* (Keith, obstetrician).

Different paradigms seemed to be accompanied by different cognitive processes that influenced communication styles. Obstetricians were perceived to be thinking *'…in a much more concrete way'* (Jill, privately practising midwife) than women and homebirth midwives. Midwives observed that their choice of language when speaking with women differed from obstetricians, saying that, '*their language is very different to the language that we use'* (Ellen, hospital midwife). Often the language that obstetricians used was seen to be rooted in a pathological approach, having the

potential to engender fear in women, for example, *'Sometimes the doctors will come in and just scare them [women]. And they'll think, "Oh, I don't want to endanger my baby"'* (Kris, publicly funded homebirth midwife). Instilling fear about the baby's well-being was seen as a successful way to gain compliance from women: *'Obstetrics, they have this hold on women and it's a fear based thing'* (Daisy, privately practising midwife). Fear based language was seen to be used by some, to convince women of their clinical recommendations:

> *I think they are taught from a very early stage that you must go in scrubs so you 'look like a doctor' and also, use the language so that when you explain what you need to do or what should happen that they're going to comply with that because 'otherwise your baby will die'* (Ellen, hospital midwife).

Women said that they felt sensitive to the use of language whilst they were in the vulnerable state of labouring and giving birth: *'[Birth] is such an emotionally laden situation that the subtle hint of the language can make a huge difference to the way people adjust to their decision-making process…language is very important'* (Naomi, homebirth woman).

Depersonalised language was commonly used by women and midwives to describe their perceptions of obstetric presence; words and phrases such as, *'birth is [seen as] a mechanical process'* (Kay, hospital midwife) in the spirit of an *'icy, more industrialised approach'* (Tamara, homebirth woman). There was a belief that obstetricians were *'objective scientists…the mechanics there making it happen'* (Kay, hospital midwife), and that they regarded woman as containing a *'baby that needs to be extracted'* (Kate, homebirth woman). These beliefs again highlighted the different paradigms of childbearing. One midwife expressed the different approaches to the use of technology, *'Experienced midwives don't have any anxiety about the woman not having technology, whereas medical staff only know technology and intervention'* (Lily, hospital midwife).

The ways in which different paradigms impacted styles of caregiving affected the degree to which caregivers felt they needed to intervene during a normal physiological labour and birth process. Obstetricians recognised that the midwifery view was to *'let nature take its course until it's necessary to do something'* (Charles, obstetrician), whereas the obstetric approach was to be *'very much more proactive'* (Charles, obstetrician). Being proactive meant that by intervening, it was possible to improve upon a natural labour and birth process. This was a major difference between midwifery and obstetrics, as one obstetrician said, *'Although I support the [publicly funded homebirth programme], I am actually quite the opposite of them… [letting nature take its course] is a paradigm that clashes with the existing [obstetric] paradigm'* (Charles, obstetrician). Women who had planned to give birth at home were often seen as a marginalised group, who possessed unusually rigid views:

> *I think if you actually did a profile of most homebirth women, they do fall into a fairly unusual cohort in terms of their world view. So they're not the women who have a fairly phlegmatic attitude about life and a flexible attitude to what they want and will accept what's recommended. They tend to be women who absolutely know what they want. Have fairly inflexible birth plans, have all sorts of restrictions and restraints on when various relatively routine things can be done* (Keith, obstetrician).

Midwives acknowledged that differences in attitudes towards homebirth were somewhat dependent upon which obstetrician they were interacting with, saying: *'It depends who is on…there are some consultants that are very old fashioned…not anti-homebirth so much, but it's this foreign thing that they don't want to know anything about'* (Barbara, hospital midwife). Another midwife noted that, *'Some of the doctors are very good and supportive, others…they want to be in control and monitor every step of the way'* (Kris, publicly funded homebirth midwife). One obstetrician said that she saw no difference between caring for a woman transferred from a planned homebirth and caring for a woman coming in from home during labour, for a planned hospital birth:

It's not an issue to me where people who come in, who transfer, come from. I see people coming through the door who have a need for assessment and care, and I provide that assessment and care… I don't see that any different to the person who comes in off the street in the ambulance for something that's happened at home when it wasn't a planned homebirth…homebirthing is often presented as this completely different thing, all the things that happen from homebirth happen everywhere else; so it's not different (Thalia, obstetrician).

In constructivist grounded theory, extreme cases from the data must be interrogated, not discarded. The following vignette illustrates an extreme case, showing the ways in which the interpretation of evidence is used and understood in different ways in the context of childbearing. The discussion chapter will draw upon recent literature to show how the epistemological and paradigmatic differences among those who provide maternity care impacts upon the homebirth debate and ultimately upon the care of women and babies in the homebirth transfer context. This lengthy quote is from one obstetrician who felt that midwifery research is often flawed:

If they [homebirth midwives] want to be part of the medical model, then they need to be like every other medical procedure…they need to be able to stand up for themselves and accept the fact that they'll be critiqued and robust discussion will occur, that's just part of, 'If you don't like the smoke, get out of the kitchen'. People get all precious about it sometimes. They're not special, they're not exempt from audit and critique. I think they would argue that it's perhaps sometimes unfair or ill informed. The way to defeat that sort of thing is to have good data to back up your claims. If I'd have any criticism of the people that advocate low or midwifery, midwifery group practice or some of these non-medical models, it is that sometimes their data is a bit flaky. So, they'll often present uncontrolled data, which is very easy to demolish when they're challenged. So, you've got to be careful of that. People will often just present raw data about outcomes without controlling for-- That can be infuriating, so they'll say, 'Oh well the doctor's Caesarean rate is 40% and our Caesarean rate's 10%', without any attempt to control for acuity or complexity. Well that's,

frankly insulting to do that. That's just provoking people. I mean a good example of how there can be some mischievous presentation of data, is the reluctance for them to separate nulliparous women from multiparous women. So, the homebirth movement will quite often fail to distinguish the difference between the nullips and multips. Because in fact, if you look at them, 'cause they will make a claim for example that the assisted vaginal delivery rate in homebirths is lower than in hospital based deliveries. But without properly stratifying for risk. 'Cause once you do that in fact, the differences disappear … You shouldn't become upset if you're found out. Everyone will try and present their results in the best possible light, but if it's seen through - if people see through it, then you can't get all upset about it (Keith, obstetrician).

My next question for Keith was, *'Are you familiar with the Birthplace in England study?'* to which his reply was*, 'No'* (Keith, obstetrician). This was a surprising response, given the international prominence of the Birthplace in England study in the field of place of birth research.

Summary

This concludes Chapter 6, *'Transferring out of the comfort zone'.* For a woman being transferred from a planned homebirth *and* all the caregivers involved in her care, there were journeys to be made, out of the comfort zone, where expectations for birth and ways of working were more familiar and predictable. Whether the process went smoothly or not, the transfer journey created uncertainties and psychological challenges for all concerned. The category described in Chapter 7, *'Us and them',* shows in more detail how different paradigms converging on the birthing room of a transferred woman impacted upon the processes and interactions that followed thereafter.

CHAPTER SEVEN: FINDINGS 'US AND THEM'

Introduction

This chapter analyses the range of ways in which *'us and them'* dynamics developed during and after the transfer of women to hospital from planned homebirth. When caregivers with different paradigms about risk and safety and place of birth allowed prejudicial attitudes towards others to emerge; tension and animosity resulted and the potential for effective collaboration broke down. This phenomenon was more pronounced for privately practising midwives and the hospital midwives receiving them, than it was for hospital and homebirth midwives working in publicly funded homebirth settings. Four sub categories, *'Stereotyping', 'Blaming', 'Taking over' and 'Gatekeeping'* explore the main ways in which *'us and them'* dynamics manifested.

Midwives who congregated in the birthing rooms of transferred women usually worked in a variety of settings; for example, working shifts in a hospital birthing unit, privately in women's homes, or in publicly funded group practices providing continuity of carer in birth centres, hospitals and women's homes. Each midwife naturally focussed on her/his different individual role, but sometimes this meant that respect for the roles, responsibilities and expertise of others may have been lacking. They also came from different educational backgrounds resulting in a range of perspectives on childbearing; for example, some were hospital trained, some were university trained as a nurse and then as a midwife, and others were university trained midwives.

When midwives categorised themselves by making delineations between themselves, such as 'hospital' and 'homebirth', it was common for *'us and them'* dynamics to manifest, as one hospital midwife described, '*You do get that animosity sometimes between them and us. It's not nice when that happens'* (Laura, hospital midwife). Privately practising midwife, Daisy, expressed, *'…it seems there is this you and us thing'* between midwives in a homebirth transfer situation, noticing that, *'in the background there is a bit of tension'* (Daisy, privately practising midwife) when *'us and them'*

behaviours and attitudes developed. There was a perception that, due to the range of roles and settings that midwives work in, they didn't support each other as well as doctors were observed to do, as Daisy expressed: '*Some of the midwives are just shocking…that's the sad thing we don't stick together like the doctors'* (Daisy, privately practising midwife). This had the potential to result in a lack of advocacy and mutual respect between hospital and homebirth midwives in the transfer context. A surprising finding was that *'us and them'* behaviours were observed to be more likely to occur between midwives than between midwives and doctors, *'a bit with the doctors, bit more with the midwives…like us and them'* (Daisy, privately practising midwife). One midwife described how she would have liked to have seen more of a team spirit between homebirth and hospital midwives, in the setting in which she worked:

> *They [hospital staff] don't see what we do, they think we don't do very much…Everyone only thinks about their own perspective and what they have got to do. I suppose everyone is guilty of that aren't they? So, that's probably why the attitudes go the way they are…My partner said…the other day, 'If you guys were a football team you would lose every game…because you don't have a team, you don't back each other up'* (Ursula, publicly funded homebirth midwife).

Publicly funded homebirth midwives recalled that an *'us and them'* dynamic was particularly evident in the early stages of establishing the programme. As the programme strengthened, and time passed, some felt that the sense of delineation eased. *'[Publicly funded homebirth] is more of an accepted norm now…to start off with, there was a lot more them and us'* (Yolande, publicly funded homebirth midwife). Acceptance of homebirth as part of mainstream care was seen to be key to developing collaboration.

One of the behaviours that often resulted in the generation of *'us and them'* dynamics, was stereotyping and prejudicial attitudes towards those who were considered to have conflicting perspectives on childbearing.

Sub-category: Stereotyping

Stereotyping is a fundamental way in which humans reduce uncertainty about complex social interactions with those they consider to be different, because it helps simplify their own world view. Stereotyping and prejudice were ways of strengthening identification with those who held similar beliefs about childbearing, whilst distancing themselves further from those perceived as 'other'. Unfortunately, stereotyping often leads to conflict, hostility and *'us and them'* dynamics. There were many examples of this in this study.

Stereotyping was common, with midwives reporting that they were *'very aware of the stereotypes surrounding women who had [planned] homebirths'* (Kay, hospital midwife). The homebirth transfer context meant that hospital staff were thrust into a situation of caring for a woman who, in their view, may have made an unsafe choice about her planned place of birth in the first place. Midwives overheard prejudicial comments said, such as, '*Why do women want to birth at home?...Why would they put themselves at that risk?'* (Barbara, hospital midwife); *'You seem like such a sensible woman, why have you booked for a homebirth?'* (Kay, hospital midwife) and *'Oh look, here's another one that hasn't worked out'* (Barbara, hospital midwife).

Women who are transferred in from a planned homebirth are often stereotyped with an expectation that their labour will end in surgery, *'There are some interesting stats around homebirth transfers…quite low caesarean section rate. It is the stereotype that they all end up getting the chop [caesarean section] and it's just not the case'* (Kay, hospital midwife). Negative attitudes and stereotyping were identified as key barriers to the success of a homebirth transfer for women and the midwives that care for them, as Thalia articulated:

> *That's where the biggest issue is really* [attitudes to homebirth] *…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 and women's options and our past experiences with transfers, with homebirth, with decision making* (Thalia, obstetrician).

Other examples of stereotyping included perceptions that homebirth women and their midwives considered themselves to be *'all homebirth and natural'* (Ellen, hospital midwife) and that some tended to look 'alternative'. Women planning homebirths were perceived to have a certain appearance, for example, *'a hippy with flowers in my hair'* (Belinda, homebirth woman) or having *'dreadlocks and… [a] rainbow scarf'* (Thea, hospital midwife). Hospital staff were much quicker to stereotype the women and midwives who did look alternative. *'Those women…might dress a little differently…might look a bit alternative…it is much easier…to then put them in a box'* (Kay, hospital midwife). Women and midwives who looked like 'hippies' were sometimes perceived to be ill-informed or uneducated. One privately practising midwife sensed an *'underlying feel'* that hospital midwives were thinking, *'they're the homebirth hippy midwives and we [hospital midwives] are the well-educated…we know right from wrong'* (Daisy, privately practising midwife).

Judgemental attitudes often resulted in a *'general prejudice against people who thought they would have a baby at home'* (Kay, hospital midwife), who were seen to be, *'questioning the whole system by wanting care outside of it, <u>then</u> turning up on the doorstep!'* (Kay, hospital midwife). The following quote demonstrates a common stereotype about the capacity of women to make informed decisions:

> *It is almost sometimes like they [homebirth midwives and women] have got blinkers on. They want to see the normal, they don't want to see [any variations of normal]. 'Oops, no if I don't think about that, that won't happen.'…I'm sure they're aware but they don't think about it* (Laura, hospital midwife).

Midwives who worked in the homebirth setting noted the contrary, that most women planning a homebirth gave a lot of thought to making informed decisions, as illustrated here:

> *Most women [planning a homebirth] are very sensible about it. I think women that plan homebirths are actually the ones that have thought about it [their*

> *choices] the most. They are the ones that have researched it and are sensible* (Margie, publicly funded homebirth midwife).

> *[A] woman who has chosen a homebirth has not made that decision lightly…the last [thing] she needs…is to go to hospital and be judged about her decision* (Iris, privately practising midwife).

Prior negative encounters with homebirth transfers often established the stereotypes that created prejudice against those choosing to plan a homebirth, for example: *'If they [midwives] have had a bad experience, their future practice is certainly then moulded so they won't have to face that experience again'* (Ellen, hospital midwife). Nancy concurred, saying, *'I guess those [negative] experiences always colour our perceptions'* (Nancy, hospital midwife). These prior experiences were not always low risk women transferred in a timely manner by registered midwives. Some were free births, or high risk women who had planned homebirths, however, all 'homebirths' tended to be regarded in the same prejudicial manner, as Thalia described:

> *If your only ever experiences while you're training are from catastrophic transfers for women that generally you would think, it's a really left field decision to birth at home, that's going to shape every experience that you've ever had on how you interact with women who are having homebirth transfers* (Thalia, obstetrician).

Another form of prejudice against women who were transferred from a planned homebirth was that they were often perceived to be less compliant than other women. They were often stereotyped and labelled as '*people that were difficult*' (Charles, obstetrician), and *'patients that are quite hard work and resistant to advice and won't take direction'* (Keith, obstetrician). There was a general expectation that women who planned homebirths would be more burdensome to care for than women who chose to give birth in hospital. Examples given were that transferred women *'don't want to listen to any advice'* (Ellen, hospital midwife) and were *'very hard to look after, sometimes, because they are not prepared to bend or compromise…it does*

become quite difficult' (Laura, hospital midwife). Most hospital staff had had experiences in which they had struggled to deal with what they saw as resistant behaviour from women.

As explored in the previous category, *'Transferring out of the comfort zone',* the reasons why transferred women resisted intervention was usually to buy some time to make their psychological journey and manage their changing expectations. When tension and animosity arose in the birthing room due to resistant behaviours from women that were not understood by caregivers, everyone felt uncomfortable, *'It makes our lives difficult, I'm sure they think it makes their lives difficult'* (Laura, hospital midwife). For this reason, caregivers who were sensitive to women's need for time to manage their psychological journey and make informed decisions were more easily able to collaborate in the transfer setting.

The perceived burden of caring for transferred women meant that they were often not a popular allocation for hospital midwives. Kay described a common prejudicial reaction from her colleagues when a woman was transferred in: *'Homebirth transfer (roll your eyes), who is going to look after her?'* (Kay, hospital midwife). Due to difficult past interactions hospital midwives had experienced, caring for women transferred in from a homebirth had become associated with negativity, for example, *'I have tried to avoid being allocated to these women…If I could avoid a homebirth transfer I would'* (Ellen, hospital midwife). There is no suggestion here that poor interactions were the fault of the woman or either midwife, merely an illustration that most hospital staff found the complexities of caring for women who had transferred from a planned homebirth demanding. Medical staff appeared to feel the same reticence, as they were seen *'bargaining with each other about who was going to go in the room. They were worried about being yelled at'* (Kay, hospital midwife). Midwives noticed that they would often support each other by *'going in pairs'* (Ellen, hospital midwife) into the birthing room of a woman and her homebirth midwife.

Privately practising homebirth midwives were stereotyped as practitioners who worked in isolation, *'you're out there on your own, I think it's a pretty tough call'* (Lily,

hospital midwife). They were often perceived to practice without any back up or consultative processes with colleagues:

> *There's an idea that homebirth midwives are acting by themselves. That they don't have any professional or collegial back up and that's actually not the case, not actually true in practice, at all…there's a common belief that they're a little bit…renegade* (Cassie, hospital midwife).

As shown in Chapter 5, privately practising midwives were usually, in fact, pro-active in developing a network of health professionals with whom they collaborated, saying, *'I have a real issue with being regarded as an independent practitioner. I am a privately practising midwife. I don't intend to work on my own…there's nothing about my practice that's independent'* (Kim, privately practising homebirth midwife).

The sense that homebirth midwives acted in isolation and were renegade may have led to stereotyping them as poor collaborators. Hospital midwives sometimes made negative comments to this effect at their work station or in the tea room. There were '*heaps of judgements passed all the time'* (Kay, hospital midwife). Hospital midwives usually acted professionally in front of women, however, stereotyping attitudes were displayed freely to colleagues. There were frequent derogatory comments heard, for example: '*You hear that a lot, you do hear midwives, "Oh, that bloody homebirth midwife", or things like that'* (Cassie, hospital midwife).

Hospital midwives often felt they were the victims of stereotyping by homebirth women and midwives; expressing that, '*sometimes the [homebirth] midwives are a bit patronising'* (Kay, hospital midwife) and *'they look down at you because you've chosen to go hospital based'* (Ellen, hospital midwife). Stereotyping of this nature had a negative impact upon midwives' interactions because they conveyed a lack of respect, as Kay observed: *'Sometimes they [hospital midwives] felt very badly treated by the independent midwives and that they were patronised or told that they didn't know what they were doing, or they were nasty to them'* (Kay, hospital midwife). Women also displayed these types of attitudes at times, '*if they've had caesareans before and*

they've been to some of the support groups…they all think we've got two heads and we want to do caesareans on everybody' (Lily, hospital midwife). Ellen found it annoying when overtly disrespectful behaviours were displayed, saying that, '*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, hospital midwife).

'Feeling like the bad guys' was an expression often used by hospital staff to describe the '*us and them*' dynamics they experienced with homebirth midwives and women, for example, *'we're sometimes left to feel as if we're the bad guys in the whole thing, having to…be the bad guy that's doing the thing that they didn't want'* (Keith, obstetrician). Upon entering the hospital birthing room, hospital midwives sometime felt unwelcome in the room, as they sensed that women and homebirth midwives were thinking, *'Oh, you're back!',* or, *'What are you doing still here?'* (Ellen, hospital midwife).

Hospital midwives reported that it would *'get their back up'* when they felt that a homebirth midwife was not supporting their clinical role and responsibilities. Once this irritation occurred, *'us and them'* dynamics developed because the hospital midwives felt much less willing to cooperate: *'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, hospital midwife). Midwives found lack of support from another midwife very difficult to accept, as Laura expressed, *'…to be quite honest it would get my back up. If she wasn't backing and supporting what I was saying, as a midwife, I think she is not doing her job'* (Laura, hospital midwife).

The next sub-category, *'Blaming',* is closely related to stereotyping, because it represents the way in which homebirth midwives were often seen to be lacking competence, and blamed for the complications experienced by the women they cared for.

Sub-category: Blaming

There was a common tendency for hospital midwives to blame homebirth midwives, believing that women would have better outcomes if it were not for the perceived misdemeanours of homebirth midwives. Hence, blaming was another manifestation of *'us and them'* dynamics, *'I think generally they [hospital midwives] feel that the homebirth midwife has done something wrong and that is why the homebirth woman has been transferred'* (Cassie, hospital midwife). Hospital midwives sometimes made negative comments about privately practising midwives at their work station or in the tea room. Even when they acted professionally in front of the woman, the stereotyping attitudes were displayed freely to colleagues, '*Out at the desk there is bitching going on'* (Barbara, hospital midwife) and *'there were things talked about on the floor, [for example] "Oh this woman should have been brought in earlier"'* (Kay, hospital midwife). Negative attitudes were often directed towards the decision making of the homebirth midwife, not the woman:

> *They kind of blame the midwife…It's not about the woman… It's more about 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, hospital midwife).

Privately practising midwives felt blame being apportioned towards them, sometimes to the extent that they felt harassed, as this example demonstrates, *'I felt like I was being intentionally intimidated and bullied…I think that they [doctors] were looking to see if I had done something wrong so they could pin it on me'* (Tracy, privately practising midwife). There appeared to be a culture of antagonism toward homebirth, in some hospitals, that resulted in bullying of homebirth midwives by doctors. Bullying behaviours had the potential to develop when stereotyping attitudes and '*us and them*' dynamics could flourish. Iris described the treatment she received from a doctor once, after transferring a woman to the same hospital as Tracy had described. The doctor was suggesting that she was of unsound mind for planning a homebirth with the woman:

> *[The woman] was assessed and then I hear this little voice in the passage, the obstetrician calling me…he starts abusing me in the passage… 'Are you mad? You've lost your bloody head!' I said, 'I haven't lost my head', and he said, 'You have lost your bloody head'. Funny now, it wasn't funny [then]* [laughing]… *[There was] political motivation [for his behaviour] … RANZCOG [Royal Australian and New Zealand College of Obstetricians and Gynaecologists] do not support homebirth. So therefore, it is something we shouldn't have been doing* (Iris, privately practising midwife).

Midwives expressed concern for the woman's well-being when *'us and them'* dynamics created *'tension in the room, between ourselves and the hospital staff'* (Iris, privately practising midwife), saying that, *'there was so much tension in the room. I don't know now how the parents would have felt about all of that…everyone was on adrenaline'* (Nancy, hospital midwife). Midwives regretted that some of the women they had cared for in a transfer had *'sensed that there's been some animosity'* (Iris, privately practising midwife).

Sometimes homebirth midwives also behaved aggressively to hospital staff, appearing to blame them for the high levels of uncertainty that arose in a transfer. Nancy retold an extreme example of hostility during a homebirth transfer she had experienced: *'She [privately practising midwife] was absolutely angry. Furiously angry. And her language was colourful…obviously, she was stressed. I was more stressed, just being in the room with this other person that was so much more dominant'* (Nancy, hospital midwife). Others observed homebirth midwives to behave *'in a very hostile way'* during transfers, noting that *'they need to get over that before it [becomes] not helpful to the woman'* (Thea, hospital midwife). Sensitivity to the influence upon women and their labouring process that is intrinsic to a woman centred midwifery approach, may have restrained more overtly negative behaviours. By focusing upon the needs of the individual woman, perhaps blaming attitudes might dissipate.

The next sub category will explore how roles and responsibilities were negotiated when privately practising midwives lost their clinical rights to practice and hospital midwives were required by policy and asked by their superiors to 'take over'.

Sub-category: Taking over

Hospital midwives often adhered to the notion that they had a responsibility to *'take over'* the care of women transferred in from a planned homebirth. This was supporting, in principle, hospital policies which stated that clinical rights and responsibility in the hospital did not exist for privately practising midwives in a transfer situation: '*The hospital protocol was that they [privately practising midwives] were there as support person only…we were then responsible for that mother and dad and baby'* (Nancy, hospital midwife). Negotiating the roles of the two or more midwives involved in a transferred woman's care was complex. Hospital midwifery managers directed hospital midwives to take over the care of women who transferred in with privately practising midwives, *'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'.* Hospital midwives then faced a challenging process, '*trying to negotiate that relationship between the midwife and the woman and then the relationship between me and my midwife in charge and the medical staff as well'* (Kay, hospital midwife).

This sub-category, *'Taking over',* relates primarily to privately practising midwives, the women they transferred into hospital, and the hospital staff receiving them. Issues of role negotiation were ameliorated to a greater or lesser extent in publicly funded homebirth programmes, due to a number of factors. The familiarity of staff, the fact that the homebirth midwife remained primary carer of the women in hospital and because the publicly homebirth programme and the tertiary hospital were under the umbrella of the same health system, *'us and them'* dynamics were broken down, as described here: *'An essential component of the public homebirth programmes is that we view them...[and] that they view themselves, as part of our greater service…one of the birthing services that are offered under the [health service] umbrella* (Thalia, obstetrician). In health services with publicly funded homebirth programmes, hospital staff often referred to the homebirth midwives as *'our staff',* saying that *'we all know*

each other and we work under the same policies' (Lily, hospital midwife). Mutual respect and trust usually emerge from this sense of community. *'Everybody gets to know everybody and respect everybody'* (Barbara, hospital midwife). Hospital staff liked feeling that the publicly funded homebirth midwives knew what to expect when they arrived at the hospital, they knew what their role would be, and what steps to take:

> *Our hospital midwives that go out and do homebirths…when they decide to bring a woman into hospital, they know exactly what's going to happen and how they are going to care for the woman and how they are going to be received by the permanent staff here* (Laura, hospital midwife).

Prior to joining a publicly funded homebirth practice, midwives often spent some time working in hospital roles, to help them become more familiar with the staff and the systems and processes: *'We try to actually have those midwives in delivery suite for a time before they go into [publicly funded homebirths]. So, they're well aware of the systems and they're better prepared'* (Lily, hospital midwife). Publicly funded homebirth midwives were trusted by the hospital staff to make good decisions around transfers, in terms of appropriate clinical indications and timeliness of transfer: '*We know if they're coming in then there's a real reason that they need to bring the woman in…and we'll get good communication…so we can be prepared'* (Lily, hospital midwife).

Privately practising homebirth midwives accepted the loss of their clinical rights upon hospital admission but strived to maintain their role in their partnership with the woman. This meant continuing to provide her with emotional and physical support and advocacy. For privately practising midwives, negotiating their role in the hospital birth space was complex because hospital staff often expected to take over the woman's care in every sense, clinically and emotionally. Hospital midwives who were sensitive to the power of the partnership noticed that, '*even though they get demoted in the eyes of the clinicians at the hospital…they don't give up. They've still got beliefs and they also advocate for the woman'* (Cassie, hospital midwife).

Hospital midwives sometimes perceived '*taking over*' as being similar to their routine experience of receiving the care of a woman at a change of shift, as this quote demonstrates, *'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, hospital midwife). When one midwife finishes a shift and hands over to another midwife who is starting a shift, the former midwife then goes home. The next midwife then proceeds to take over the care of the woman. The difference in the context of a homebirth transfer is that the homebirth midwife usually does not go home, and the midwife-woman partnership remains the primary source of emotional support for the woman, rendering it inappropriate for hospital staff to be simply *'taking over'*.

Privately practising midwives found it irritating when hospital midwives would try to take over the emotional support role, as one described, *'occasionally you get 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'* (Trish, privately practising midwife). When hospital midwives tried to *'take over'* the entire role in this way, homebirth midwives were excluded from the caregiving team, making it virtually impossible for them to participate in the woman's care:

> *The midwives that are coming in are just pushed to the side, they are not allowed to do anything… there's no discourse of communication… that I'd have with a midwife, normally…with my colleagues on a shift. So, they're not even given a say, so I don't think trust can be built in that setting, whatsoever* (Cassie, hospital midwife).

The approach of simply stepping in and '*taking over*' in a homebirth transfer was problematic because it overlooked the fact that the privately practising midwife was going to maintain the role of supporting the transferred woman emotionally, providing guidance and advocacy. Even more problematic for the dynamic was the power of the midwife-woman partnership, from which hospital midwives felt excluded.

Chapters 5 and 6, *'Fostering relationships and reducing uncertainty',* and *'Transferring out of the comfort zone'* respectively, explored the value of the midwife-woman partnership. In the birthing room, the midwife-woman partnership was identified as a powerful force that impacted upon the dynamics between caregivers. The strength of the partnership sometimes created uncertainty for hospital midwives and obstetricians who were unaccustomed to working with such a partnership. Uncertainty around ways of enacting midwifery roles and responsibilities had the potential to cause at best, discomfort, and at worst, conflict and animosity. For hospital staff, understanding the strength and nuance of the midwife-woman partnership was sometimes difficult, perhaps because it went beyond the traditional medical model of a therapeutic relationship. When health professionals did not understand the partnership, they felt unsure of how to work within that context, as these two quotes illustrated:

> *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 at all in that situation* (Kay, hospital midwife).

> *They've had the relationship together for 10 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? I cannot assess that in 10, 15 minutes, half an hour in a room. In 10 or 15 minutes, you're trying to ask a woman to trust you. That it's important that you help her have her baby. And you can't break down all of that in that short space of time* (Blair, obstetrician).

Emotional support and relationship building was integral to the philosophy of midwifery and highly valued by midwives from all settings. Hospital midwives became adept at developing, in a very short amount of time, rapport with the labouring women they met for the first time. *'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, hospital midwife). Nevertheless, they were aware that the relationship

between the woman and her homebirth midwife was long-standing and based on reciprocal trust. '*It's an enviable position they're in…. I can understand that if you've known someone for the whole pregnancy, you are gonna be more trusting of what that information's about'* (Lily, hospital midwife).

A variety of strategies were used by hospital midwives to try to quickly develop rapport with transferred women. Some would *'try to develop an alliance with the woman, as if, "It's okay now, darl…you are safe here, you have come to your senses, you have come to the hospital" '* (Kay, hospital midwife). Sometimes their language and behaviours appeared improper to homebirth midwives, who were more used to slowly building relationships with women over many months during pregnancy. '*The [hospital] midwife was so inappropriate, draping herself over the partner all the time…taking them into the bathroom together, away from the support people. It was really odd'* (Trish, privately practising homebirth midwife). Often these behaviours were interpreted as the hospital midwife trying to drive a wedge between the woman and her homebirth midwife, in order to develop rapport with the woman, as Iris described:

> *One of the things that I found really hard, and I think professional behaviour was reflected in the attitude of these midwives towards the women, calling them 'darling'. They'd never met this woman before and suddenly it's darling this and darling that and* [laughing] *I used to shudder because I think it's them trying to come in over us…When you look on the other side, you've got this woman and midwife coming in and they've got this relationship, this really trusting relationship, and they understand each other. And then you've got this midwife… and they've suddenly got to erode our relationship and get in really close to this woman so she becomes their 'darling'* (Iris, privately practising homebirth midwife).

The hospital staff in the aforementioned setting struggled to work with the power of the midwife-woman partnership, as Iris described, *'The hospital staff had expressed a concern that they were not being given a fair hearing by the woman when doing the*

assessment' (Iris, privately practising homebirth midwife). They requested that privately practising midwives *'leave the room and allow them to have total access, privacy, with the client…when the assessment's being made, because we were intimidating to them'* (Iris, privately practising homebirth midwife). The hospital staff eventually resorted to making a formal complaint to their management, claiming that it would make it easier for them to fulfil their role if the privately practising midwife were to leave the room; however, the suggestion was never implemented in policy by the hospital.

Hospital midwives noticed that *'taking over was awkward, because they [homebirth midwives] don't want to let go'* (Thea, hospital midwife). In essence, what she noticed was that both privately practising midwives and women *'don't want to let go'* of their midwife-woman partnership, that in fact, transferred women need the partnership more than ever. Women were disempowered when they felt that their labour and birth process was being completely taken over by the hospital, 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, and now she's got this whole medicalised model taking over. And yes, in some instances, the medicalised model needs to be involved. But they don't have to take over, they could work alongside* (Barbara, hospital midwife).

Regardless of how successfully midwives negotiated their roles and responsibilities, women were likely to look primarily to their homebirth midwives for support, and did not want to their care to be taken over. Privately practising midwives were keenly aware of this, saying, '*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, privately practising midwife). Hospital midwives simply stepping in and *'taking over'* care in a routine way failed to account for the power of the midwife-woman partnership which was a powerful force for hospital staff to reckon with. No less influential, however, was the power of the clinical rights and responsibility held by the hospital midwife. As a

result, interactions between midwives were often not co-operative; power imbalances quickly emerged and *'us and them'* dynamics prevailed in the birthing room.

The hospital policies stating that hospital midwives must take over clinical responsibility for the care of transferred women was clearly defined. Unfortunately, however, there was no guidance as to how hospital midwives might approach their interactions with the midwife-woman partnership. If early interactions were negative, collaboration was more difficult to implement because *'they [hospital staff] would very easily be riled by it [the strength of the midwife-woman partnership], irritated by…that power, ego thing happening in the room'* (Jill, privately practising midwife). Kay described how she managed to work through negative interactions with homebirth midwives:

> *It's probably been with midwives who I haven't known very well…I had this sense that I was the dumb hospital midwife who didn't know anything. I wanted to quickly establish that actually I am an okay person and there are some nice people in here and…we really, 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, hospital midwife).

Hospital midwives often relaxed when they saw that the privately practising midwife was initially willing to step back into a support role, as it reduced their uncertainty about how they would delineate their roles: *'The ones that work well, they are well aware that that is going to happen…they come into hospital then the midwife drops back into the sort of doula role'* (Thea, hospital midwife). As the collaboration unfolded, hospital midwives sometimes became gradually more comfortable with the privately practising midwife being involved in the clinical care of the woman, despite an awareness that this was against hospital policy. '*Taking over*' in these instances was a more nuanced concept that was carefully negotiated between them.

Sub-category: Gatekeeping

Hospital midwives often referred to a phenomenon in which they felt privately practising midwives overstepped their advocacy and support role, behaving instead as 'gatekeepers'. *'Gatekeeping'* meant that *'us and them'* dynamics would emerge because hospital staff felt unable to communicate directly with women. An example of *'gatekeeping'* was described by one hospital midwife as, *'using her own authority in the room…by telling everyone how they feel, by making explicit statements about what "their woman" wants and doesn't want and what they feel is reasonable [or] unreasonable'* (Kay, hospital midwife). Homebirth midwives would sometimes contradict what was being said to the woman, *'like she [homebirth midwife] was negating some of what we were saying…I felt she was quite obstructive, particularly when the doctors were talking to the parents'* (Nancy, hospital midwife). When hospital staff felt unable to communicate directly with a woman, there was the potential for delay in assessment or treatment:

> *Sometimes you're not allowed to speak to the woman and it has to go through the [homebirth] midwife and she has to translate it. And that can lead you down the pathway of the Swiss cheese and the baby's even further compromised* (Lily, hospital midwife).

Another form of *'gatekeeping'* reported to have occurred in publicly funded homebirth settings was shutting the doctor out of the birthing room: *'Sometimes doctors have been known to knock on the door and go in, and they get told to go away'* (Laura, hospital midwife). Lily told a similar story:

> *[A hospital midwife or doctor] will tell you, 'Oh they have shut the door and put the wedge behind the door and I couldn't get in there.'…That's a, 'I'm making myself fully responsible and I'm excluding you,' thing, and that should never happen* (Lily, hospital midwife).

One obstetrician related experiences in which she felt she was *'met with resistance before I've even passed the curtain'* (Blair, obstetrician). Instead of preventing the

doctor entering the room, the midwife responded by being unnecessarily unpleasant as a way of *'gatekeeping'*. Understandably, *'us and them'* dynamics emerged rapidly:

> *I have had encounters where I will knock on the door and say, 'Hello, it's Blair here, the doctor on. Is a midwife with you?'… And I'm answered with, 'Not one that you want to know.' That was a dead true answer* (Blair, obstetrician).

Another hospital midwife felt she was coerced into allowing a privately practising midwife to catch the baby during a transfer. There was a pre-existing relationship which had instigated an imbalance of power between them on this occasion. *'Gatekeeping'* behaviour and a lack of respect from the privately practising midwife left the hospital midwife feeling disempowered and bullied, as she described here:

> *I wasn't doing what I should have been doing but I felt powerless to do anything else because [the privately practising midwife] had already put me in my place. [Catching the baby] absolutely wasn't her role as the transfer midwife, she was there supposedly as a support person* (Ellen, hospital midwife).

Ellen, an experienced midwife in a senior position, felt upset by this incident, describing her thoughts at the time as, *'Can we just get this [birth] done? I wanna go'* (Ellen, hospital midwife). Unfortunately, this experience has left her with a lasting negative view of caring for women who are transferred in for a homebirth, saying, '*If I could avoid a homebirth transfer I would'* (Ellen, hospital midwife).

The following vignette describes an extreme case. It is the experience of one woman that demonstrates how a lack of respect and low levels of woman centredness can impact upon a woman giving birth:

> *I had fully dilated and there was a sign of meconium, so the registrar started to freak out and…took a photo of it…I didn't know why she did [take the photo]. I didn't know that she did it until afterwards. No, [she didn't ask for my consent to take a photo] …There was something about the heartbeat of the baby had*

dropped, not significantly, it was just I think the registrar was new, perhaps it had dropped a little bit…It wasn't a panic scenario... [my midwife] was able to say 'That's just normal'. And the registrar was getting in a bit of a flurry, getting quite stressed, and her team were getting a bit stressed. And I'm thinking, 'Oh my god, if I have to look at people having a panic, and stressing out'. Then the [consultant] obstetrician came in and she was all very 'Here I am and here's my team!' My legs were up in stirrups…and she just came in between my legs and said 'Right, this is what's going to happen. I may have to do an episiotomy on you. We're going to use forceps or maybe vacuum'…All of a sudden, I didn't have any say. I thought, 'Ok, I've seen this, I did my research. I knew that this was going to be the scenario'. I kind of felt empowered with that knowledge so…I said 'I don't want an episiotomy. I don't want you to use forceps'…I just said, 'Look, if you would all just be calm, I'd be calm, and then the baby would be calm. Can you all just stop freaking out?'

The obstetrician didn't really care about what I was saying and she just said 'I'm going to have to probably give you an episiotomy. You're going to have forceps', and all that sort of thing…mind you, this was during contractions! As the obstetrician turned around to unpack her tools, [my primary homebirth midwife] was standing up in my ear on my right side…and she said 'Can you feel your contractions, honey?' and I said 'Yes'. And she said 'Okay, are you ready to push?' and I said …'Yes, I'm ready'. They were watching the monitor as well, and they said 'Okay'…I just did two big breaths, hypnobirthing breaths and the baby started to crown. And then the midwife said 'The baby's coming'. And the obstetrician…partially turned around, and the next thing the baby's head was out. The obstetrician was quite in shock, and she came up and said 'Oh' and then the baby was out and on my chest.

Yes, it was really great, and then the obstetrician said 'Well done, congratulations. That's the first time I've ever seen a first-time delivery done naturally'…I felt at first that was a very patronising thing to say anyway, but I just thought, put that patronising thing aside, I think about what she just said, that's the first time she's ever seen a first-time delivery done naturally, I thought 'Oh my god'. Because she was ready to go in and do the whole

episiotomy and the forceps and whatever else that might have needed to be done, and I said 'If you allowed women to just – if you didn't come in first of all with the panic and the alarm bells and everything, and if you just allowed women to be and do what comes naturally as much as possible, probably you would see more natural births'…It was a bit disheartening as well, because they're women – and they're coming in saying 'We're going to do this, we're going to do this to you' and you're saying 'No'. It didn't matter what I said, they were going to do it anyway. No [they were not listening to me], not at all (Tamara, homebirth woman).

'Gatekeeping' behaviours had a negative impact because they suggested a lack of respect, an unwillingness to co-operate, and were associated with hostile communications. Collaboration was difficult to foster from within a space where gatekeeping activity was enacted.

Summary

This category, *'Us and them',* showed how a range of negative behaviours and attitudes emerged in the birthing rooms of transferred women. By allowing *'stereotyping', 'blaming', 'gatekeeping'* or a sense of *'taking over'* to develop; caregivers created an *'us and them'* dynamic which was then difficult to manage. The next chapter, *'Celebrating a successful transfer'* will examine the processes and interactions that were shown to result in collaborative approaches towards successful homebirth transfers that optimised the care of women and their babies. Instead of viewing transfer as a 'failed homebirth', safe and smooth homebirth transfers will be reframed as successful outcome resulting in a healthy mother and a healthy baby.

CHAPTER EIGHT: FINDINGS 'CELEBRATING A SUCCESSFUL TRANSFER'

Introduction

The last chapter explored the category, *'Us and them',* showing a variety of ways in which caregivers responded to working with each other in homebirth transfer settings, and how negative interactions had the potential to result in conflict. This chapter addresses the category, *'Celebrating a successful transfer',* and examines the behaviours, attitudes and communication styles that were shown to ameliorate *'us and them'* dynamics, support woman centred care and create smooth professional collaboration. *'Celebrating a successful transfer',* comprises 5 sub categories, *'Handing over', 'Supporting the midwife-woman partnership', 'Stepping back', 'Demonstrating mutual respect'* and *'Sharing goals with women'.* This category draws upon the positive experiences of homebirth midwives 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.

Sub-category: Handing over

The sub category *'Handing over'* analyses handover interactions between homebirth midwives and hospital staff, in both private and public settings. Handover communication emerged as one of the most crucial events in the transfer continuum, because effective handover established more effective ongoing collaboration. Verbal and documentary handover interactions were identified as being smoother between publicly funded homebirth midwives and their hospital colleagues than they were between privately practising midwives and hospital staff, due to a number of flaws existing in processes for the latter.

As handover processes during homebirth transfer were very different for privately practising and publicly funded homebirth midwives, the findings will be presented separately. This illustrates the comparison between the ease of handover in the

publicly funded setting and the challenges for both privately practising midwives and hospital staff in privately practice transfer settings. There is no suggestion that privately practising midwives are at fault, merely that there are systemic flaws in the process. Headings will delineate the separate findings by professional groups.

Communicating handover in publicly funded homebirth programmes

Prior to transfer, there was a positive sense of collaboration between hospital staff and publicly funded homebirth midwives when they engaged in telephone conversations from a woman's home. Multiple communications often occurred during this phase, before the transfer became a definite plan. Homebirth midwives would call their birth unit colleagues *'to share ideas'* (Barbara, hospital midwife) during the decision-making phase, saying, for example, *'this is happening, I'm thinking of bringing her in'* (Barbara, hospital midwife).

After the decision to transfer had been made, there was a preliminary telephone handover from the midwife at the woman's home to the hospital. Midwives calling from the woman's home were very comfortable with this process, *'We have a strong communication pathway, so as soon as it's identified that we are going to have to transfer, that involves speaking to the nursing unit manager at the delivery suite'* (Kath, publicly funded homebirth midwife). From the hospital midwives' perspectives, this communication pathway reduced uncertainty for everyone involved, as Barbara explained:

> *The [publicly funded homebirth midwives] liaise really well with the delivery suite midwives and the medical officers. And so everyone is aware the woman's coming in and why she's coming in. Is it pain relief or is it for another reason? ...So the people that are going to help the MGP midwife are all sort of on the same track* (Barbara, hospital midwife).

Reciprocally, publicly funded homebirth midwives found their hospital colleagues to be supportive and respectful, saying that, *'I don't feel any reservation about ringing…the message I get from them is, "Thank goodness you are transferring when you need to"'*

(Margie, publicly funded homebirth midwife). Communication processes were clear and straightforward because everyone knew what to expect, '*It would be unusual to get someone who doesn't know our processes on the desk and most of them would say, "Yes that's fine, see when you arrive"'* (Kath, publicly funded homebirth midwife). In emergency situations, hospital midwives in publicly funded homebirth settings would reiterate the standard hospital policies and procedures to the homebirth midwife on the telephone, saying for example, *"Have you done A, B, C, and D?"* Homebirth midwives appreciated that their hospital colleagues were supporting them by, *'being clear that what could be done at home has been done, prior to the transfer'* (Kath, publicly funded homebirth midwife). Clear communication about an emergency meant that hospital resources were ready when the woman arrived, enabling hospital staff to be ready to act quickly if clinically necessary, *'just to be able to get everything prepared, get the right people available, to wait for that woman to come through the door, and if you need to be able to have an operating theatre on standby'* (Thalia, obstetrician).

Publicly funded homebirth midwives reported that their hospitals were always ready to receive and admit transferred women in a timely manner, especially in emergencies: '*Rang [the hospital], they were aware that we were coming in and from arrival, I think she was in theatre within 3* minutes' (Ursula, publicly funded homebirth midwife). Midwives transferring a woman in felt respected when their telephone handover was taken seriously and acted upon, because: *'They just went on what I said was going on …I felt very trusted…with what I was telling them clinically'* (Margie, publicly funded homebirth midwife).

Hospital staff were most accustomed to receiving handovers from colleagues who also worked for the same health service, such as when a publicly funded homebirth midwife transferred a woman in from a planned homebirth or when a routine shift handover occurred from one midwife to another. In such cases, all documentation, policies and guidelines are shared between the parties giving and receiving handover. Midwives felt that handover documentation processes were seamless in publicly

funded homebirth programmes because *'our medical record is owned by the tertiary hospital and we come under an umbrella'* (Kath, publicly funded homebirth midwife).

Challenges for privately practising homebirth midwives

Conversely, the handover process was often not so smooth for privately practising midwives, who experienced a range of responses from hospital staff on the telephone. The interactions were described as: '*mixed, very mixed…sometimes can be very curt. Sometimes it will be, "No problem…we'll see you" … very dependent on the staff member and their workload'* (Iris, privately practising homebirth midwife). Privately practising midwives were not able to form consistent expectations of interactions with hospital staff, which raised their uncertainty and left them feeling that it was *'always circumstantial on what else might be going on'* (Iris, privately practising homebirth midwife). This inconsistency may suggest that women transferred in with privately practising midwives were sometimes seen by hospital staff as external 'patients' who did not belong to 'us', and were therefore a burden when the unit was already busy with labouring women who were seen to 'belong'.

Some privately practising midwives called the back-up hospital to inform them whenever a woman commenced labour at home, saying, for example:

> *I'm [name] from [private midwifery practice], I'm with [woman's name], she's in labour. We hope we're not going to see you, we will ring and let you know if we need you or when the baby's born and the placenta, [and] when we're going home* (Irene, privately practising homebirth midwife).

The homebirth midwife would then call the hospital after the birth to let them know that everything was fine and they would not be coming in. Irene did this with every woman she cared for, to reduce uncertainty in the event of transfer, saying, *'We pride ourselves in the communication we have and it's very important…so the hospital knows that [a woman is] in labour and they know when they can stand down'* (Irene, privately practising homebirth midwife).

There was no data to support or refute the notion that hospital staff 'stood up' or 'stood down' when privately practising midwives informed them of a homebirth in this way. Nevertheless, hospital staff from small rural settings said that it was advantageous to have information about women labouring in the community, from the perspective of resource planning. Having a 'heads up' enabled them to arrange to have midwifery or obstetric staff on standby. Nancy worked in a small rural facility and had this to say:

> *If we know that there's someone out in the community that's labouring…that helps us to plan a little bit. We might get someone on call…we have to plan…not necessarily the immediate shift, but potentially the next couple of shifts, to have extra staff. And that's a huge challenge for us…we'd be more than grateful to hear that they're not coming!* [laughing] (Nancy, hospital midwife).

Hospital midwives who worked in large tertiary facilities had a different view, that being informed about every planned homebirth created an unnecessary workload. Midwives felt, *'you only want to know if something [that may indicate transfer] is going on'* (Kay, hospital midwife) and that knowing a woman was labouring and planning to birth at home *'would be just an added bit of knowledge that you possibly don't need'* (Ellen, hospital midwife).

Once the transfer decision was made, however, such a call was helpful. Hospital staff stated that they felt better prepared for the woman's arrival, when they had been informed that she was transferring in. Hospital staff reported that most privately practising midwives would *'ring before they transferred…they'd ring up and tell you they were going to bring a lady in, reasons why. So you'd be prepared, you'd have somebody ready to look after that woman'* (Barbara, hospital midwife). Most homebirth midwives said they would always call ahead, '*We…had rung [local hospital] to give them the heads up that we would be coming...it felt like a very smooth, timely transfer'* (Tracy, privately practising homebirth midwife).

Women appreciated the sense that the hospital was waiting for them to arrive, '*there was somebody waiting there with a wheelchair for me…the nurses knew I was coming so they just waved at me and directed the wheelchair into the right room'* (Naomi, homebirth woman).

Hospital staff perceived documentation to be problematic when receiving a transfer from a privately practising midwife, saying, *'They can't write in the case notes, because they're not employees'* (Lily, hospital midwife). This resulted in feelings of uncertainty around the validity of the documentation, '*how that transfer of information stays accurate throughout the course of that woman's journey, is very concerning'* (Lily, hospital midwife). Hospital midwives valued written handover information because '*if I missed something when someone's telling me, it's written down and I can read it as well, and it would probably be a bit clearer'* (Nancy, hospital midwife). Written information provided them with a clearer clinical picture and a better opportunity to assist women in their decision making, '*So you can make good, informed decisions with the woman… something that shows what's happened and what the fetal heart rate has been like, to the point that she's come in'* (Lily, hospital midwife). A clear midwifery handover and antenatal booking in of the woman seemed to reduce uncertainty for hospital staff, both clinically and administratively; thereby ensuring a more successful transfer.

All the privately practising midwives who participated in the study were required to provide a professional handover at the time they simultaneously lost their clinical rights to practice in the hospital. Due to a lack of guidelines and the diminished professional status of the privately practising midwife, the hospital staff could ostensibly make an individual choice whether to take any notice of the handover or not. When privately practising midwives felt that their handover was disregarded by hospital staff, they were concerned about the potential impact on the woman's care, as in this example:

> *I did think that we would've been met with a bit more 'ready to go, ready to do'…I did have a handover with [the doctor] …explained what we had done,*

what drugs we had given at home… there was still a casualness (Tracy, privately practising homebirth midwife).

Usually the handover from privately practising midwives was verbal, sometimes written documentation was also provided. Often this was driven by preferences of the individual hospital staff on duty, rather than policy. Tracy described the process she experienced when arriving *'into one of the birth suites, there's midwives to receive. I establish who wants a handover, the midwife who's been allocated us'* (Tracy, privately practising homebirth midwife). Most privately practising midwives were happy for the hospital to have copies of their documentation, saying, '*They could photocopy any of our notes, and they often would photocopy the partogram'* (Iris, privately practising homebirth midwife). Offering copies of their documentation was part of a transparent and collaborative approach to reducing uncertainty for the hospital staff, because, '*The more information people have to work with the better the story is going to be. So, I'm really willing to share [my documentation]'* (Kim, privately practising homebirth midwife).

Privately practising midwives sometimes gave women a standardised hand held document such as the 'yellow card' in New South Wales, or the Victorian Maternity Record (VMR) in Victoria. One midwife encouraged women to present their hand-held document, saying that *'when we go to the hospital that's all they want to see….it does make it easier when you transfer if they have one'* (Trish, privately practising homebirth midwife). Hospital midwives reported that they found this type of record useful: *'An independent midwife who would do homebirths would have some sort of handheld record that the women could then share. That's the sort of level of professionalism you would expect'* (Thea, hospital midwife).

Clarity of the handover communication was paramount for obstetricians because it reduced their uncertainty about the woman's clinical situation. Some obstetricians were keen to interact with the homebirth midwife for a direct formal handover, in the presence of the woman, *'even if somebody isn't going to continue care',* obstetricians felt it important to have a *'handover in front of the woman about, "This is who it is, this*

is what's going on, this is where we are at"' (Thalia, obstetrician). Although obstetricians found handover easier if they were familiar with the homebirth midwife, clear and direct communication did more to reduce their uncertainty about the clinical picture, saying that, '*the main thing is…the skill of the communication about the current issue, rather than any relationship'* (Thalia, obstetrician). Several obstetricians believed that a clear handover directly from the homebirth midwife to the obstetrician was integral to safety in a homebirth transfer situation, rather than the information going via the midwife in charge. Obstetrician Thalia explained her strong feelings about the process of the transfer handover communication:

> *From my perspective as a doctor who receives transfers, it's really important to recognize that communication is not just with the unit, but it's actually a practitioner handover…The woman's not going to be cared for by a unit, the woman is cared for by individual practitioners…These women are all getting transferred for medical care, because they don't need to be transferred for midwifery care, they already have midwifery care…That clarity of communication between the midwife who has recognized the complication and made the decision to transfer; that person needs to be directly talking to the medical officer…There's lots of opportunities for miscommunication or misunderstanding if that doesn't happen* (Thalia, obstetrician).

Thalia had experienced situations where she lacked trust in the handover information because it had passed verbally through several parties, as she described here:

> *The midwife who's transferring has called the Midwifery Team Leader, to let them know that somebody's coming, but then there hasn't been a contact with the medical officer. And so, then you get a third hand rumour about who's coming and what's happening, and people are setting all their expectations about what is or isn't happening based on third hand rumour. And we all know that direct one on one communication is much more effective* (Thalia, obstetrician).

Two privately practising midwives who had previously worked in their local hospital setting were striving to streamline handover processes for transfer. They were motivated by an awareness of the roles and responsibilities of the core staff in those settings and wanted to reduce uncertainty for their hospital colleagues, making it as easy as possible to collaborate: '*We developed…an official transfer form…that did facilitate things…that would give all the relevant information, the onset of labour and the stages of labour and where you were at'* (Iris, privately practising homebirth midwife). Others were looking at ways in which they could share their electronic notes with the hospital, '*I'm setting up systems so that happens nice and smoothly…looking at buying a little portable printer…the information…I can just print out [the documents] from my car…so they can have the most up to date information'* (Kim, privately practising homebirth midwife).

Handover went more smoothly when a 'booking in' visit to the hospital had occurred during the woman's pregnancy. Publicly funded homebirth programmes provided women with an in-built connection with the hospital, to which booking in was automatic. This meant that at the time of transfer the woman's records were readily available to whomever required them. Privately practising homebirth midwives talked about the perils of a lack of booking in when transfer became necessary: *'They [women] didn't have any connection with the hospital at all. I do believe that it did impact on them'* (Iris, privately practising midwife). When women had not been able to book in, handing over was more difficult, because, *'there was nothing, there was no information whatsoever…I can honestly say it was awful* (Iris, privately practising midwife). Unnecessary questioning was seen to be detrimental to the woman's labour, *'They are going in in labour and they are getting thrown with all these questions, which would have already been documented [at a booking in appointment]'* (Iris, privately practising midwife). Homebirth midwives were frustrated that this had not been able to occur during pregnancy, and felt powerless to take this burden away from the woman, saying, *'We would try and advocate for them as much as we could, but there were certain things that they had to directly answer themselves and it was very unpleasant, going in cold'* (Iris, privately practising midwife).

Tess related the sense of frustration that she felt upon her hospital admission, due to the fact that she had not done a back-up booking. When she arrived at the hospital she had to answer questions in the emergency department before being able to go to the birth unit to continue labouring, as she described here:

> *[The staff in the hospital emergency department] took some personal details down and all of that, asking me really stupid questions...I remember just feeling so frustrated…I really just wanted to get to the place where I was going to be able to continue the labour…in reality, it was probably only five minutes that I was in that room, but it felt like forever to me because I just felt like I couldn't really let go and just…get back into the swing of the labour* (Tess, homebirth woman).

A lack of booking in fractured the already limited documentary continuity that existed in homebirth transfer situations. When hospitals discontinued pre-existing booking in processes, midwives from both home and hospital settings were irritated: *'It's really irresponsible that it stopped, because in terms of safety it was an excellent means of some thread of continuity…I know that homebirth midwives that I spoke to liked it as well… for those reasons'* (Kay, hospital midwife). The following quote illustrates a similar perspective from a privately practising homebirth midwife:

> *Had a little bit of an issue with [name of hospital], they just decided to not book women in any more… they said no, no just come…we don't need any paperwork. What's involved is the woman going in… and having a one and a half hour booking visit…I've asked for that to happen, the [hospital] said, 'We don't have time'…luckily I haven't had a transfer [there since] because that doesn't feel right to me* (Trish, privately practising midwife).

Hospital midwives found it difficult to care for transferred women without any booking in documentation because they had a limited understanding of her medical and obstetric history, and no administrative details. Obstetricians also experienced high levels of uncertainty and stress when booking in had not occurred:

> *It's often frantic for a little while, assessing what's going on without information for somebody that you've never heard of, who has never booked at the hospital, and who really isn't in the state to give you information about what's happened* (Thalia, obstetrician).

Hospital midwife, Thea, described an example of a woman who was transferred in by ambulance with her baby, some hours after her homebirth. Compounding the lack of antenatal booking in, the homebirth midwife did not accompany the woman and did not provide any telephone handover. Thea found the resulting level of clinical and administrative uncertainty quite stressful, as this vignette demonstrates:

> *We knew nothing about this woman, she had never booked in…she obviously had no plan B basically. What was interesting is obviously the homebirth midwife hadn't either…not to have any written anything was, I felt, just wrong. If you want to have a homebirth I really think you need to make a bit easy…I sort of jumped in with my boots on, to try and work out what had gone on. We had no information at all from the homebirth midwife, no documentation, no nothing, nothing written, nothing verbal, no follow up phone calls, no nothing…We then had to create a totally new written record for this woman…it just makes it so difficult when you end up with a client who's possibly not terribly well and everything was anecdotal…we had to pick through the pieces as much as we could* (Thea, hospital midwife).

Telling this story was important to Thea. The way in which she related it revealed how distressing it had been for her. It demonstrated the levels of stress that can emerge for hospital staff when lines of communication and connection between the woman, the midwife and the hospital are not open. Booking in processes and handover from privately practising midwives to hospital staff are areas in which communication processes need to be refined and standardised in transfer situations. Guidelines were lacking as to how to notify the hospital of potential transfers; how to communicate the handover, verbally or in writing; and to whom the handover should be addressed. The

resulting lack of clarity had the potential to cause conflict between health professionals, ultimately influencing the quality of care for women.

Sub-category: Supporting the midwife-woman partnership

Chapter 5, *'Fostering relationships and reducing uncertainty',* explored the development of the midwife-woman partnership during women's pregnancies. The strength of this partnership took time to build, it was built on reciprocal trust and promoted informed decision making. Chapter 6, *'Transferring out of the comfort zone',* showed how important the partnership was to women when transfer to hospital was required. In Chapter 7, *'Us and them',* the partnership was identified as a powerful force in the birthing room which was often poorly understood by other caregivers. The following sub category, *'Supporting the midwife-woman partnership',* explores the ways in which hospital midwives supported the midwife-woman partnership. Their ability to do so often determined how well they could ameliorate *'us and them'* dynamics in transfer situations. Recognising that the woman and her homebirth midwife functioned as one entity was seen to be key to a successful transfer, *'[Transferred women] have such a relationship with that [homebirth] midwife*…y*ou can't separate [them]…it's all one unit…The midwife and the woman…have belief in themselves [as a partnership]'* (Cassie, hospital midwife).

The relationships developed between hospital midwives and women were different from the midwife-woman partnership that had grown over months of pregnancy. The reciprocal trust that was inherent in the partnership meant that the capacity for the known midwife to support the woman was greater than it was for a midwife whom the woman has just met. Labouring women wanted to interact mostly with their known homebirth midwives, saying that, *'[My midwives] were mainly interacting with me…they knew their position. They were now in a different place where they didn't really have the authority, but they were my support'* (Tamara, homebirth woman).

In a homebirth transfer, the midwife-woman partnership had the capacity to be a powerful force in the birthing room, from the perspective of the way in which outsiders could feel excluded, *'Continuity of carer is really powerful…it's not necessarily*

power and authority…the woman and her support team have actually built a trust in the independent midwife' (Ellen, hospital midwife). Some midwives recognised, however, that it was possible for both partnership and rapport to co-exist in transfer situations, for example:

> *We tried to work very much with her [homebirth midwife], without getting in her way…the homebirth midwife did one set of obs…then the hospital midwife did another set of obs. You were then building up that rapport with the woman, that we were both caring for her in this setting where she wasn't necessarily expecting to be* (Nancy, hospital midwife).

Being mindful of the partnership was the way one midwife described how hospital staff could work well with women and their homebirth midwives:

> *They're so mindful of the relationship and what's best for the woman. The obstetric registrar was very mindful of not to kind of stepping in or been too pushy with his ideas, he would consult with the woman and then kind of look either side…asking both of us what we thought* (Trish, privately practising homebirth midwife).

Women valued highly the hospital midwives who understood how to support the midwife-woman partnership. The hospital midwives said to Naomi, *'You trust her [homebirth midwife] the best, she'll help you'* (Naomi, homebirth woman). Naomi perceived that throughout her labour and birth, the hospital midwives were supporting her homebirth midwife to, in turn, support her during her labour and birth, saying:

> *To have the nurses 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).

As hospital midwives became accustomed to caring for transferred women and their midwives as one unit, their work became easier. Kay reflected upon the rewarding journey she had taken, since struggling with the initial challenges: *'I just developed professionally…being really challenged and then finding that really satisfying when there were some lovely outcomes, where people had some intervention and then had normal births'* (Kay, hospital midwife). After openly discussing with colleagues the positive experiences she had caring for transferred women, Kay became known as the midwife in her team who would be the one to receive such women. At first, when she heard the midwife in charge say, *'There is a homebirth coming in…you can have her'*, she felt *'like they were having a go at me'* (Kay, hospital midwife). As she gained experience over time, Kay began to value the opportunity to work with homebirth women and midwives saying that looking after them, *'became my niche'* (Kay, hospital midwife). Kay illustrated her perspective on supporting the midwife-woman partnership as a pathway to woman centred care and teamwork in homebirth transfer:

> *Hospital midwives should be functioning as a support for the midwife and the woman, really, and there should be a team approach…. we should be really involving independent midwives 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 and it means that their outcomes are better….[The] medical role is very much the tricky complicated stuff [doctors] will deal with and the normal and the relationship stuff is what the midwife's role is…Independent midwives are much more likely to have that ongoing, through their continuity and through the sort of care they give with women and we should be harnessing it…using it…[in working as] a good team* (Kay, hospital midwife).

In Chapter 6, *'Transferring out of the comfort zone',* the clinical environment of the hospital was identified as one of the challenges women have to adjust to during transfer. Modifying the birthing space was a way that homebirth midwives tried to recreate a comfort zone for women, upon their arrival in the hospital birthing room. Assisting them with this was a practical activity that some hospital midwives

participated in to demonstrate their support, and to offer a welcoming approach: '*They [homebirth midwives] do try to recreate the space very quickly in hospital…to make it better for the woman, so she is on the floor on a mattress…just thinking of those situations [is a way of helping them]'* (Kay, hospital midwife). Helping the homebirth midwife was a tangible way to ameliorate any *'us and them'* dynamic that might be emerging. These changes to the environment were important to women, and they were appreciative of the hospital midwives' efforts to adjust the space, as Tess felt after her baby was born:

> *After the birth…the hospital midwives even got…us a couple of mattresses to put on the floor, because I didn't want to have to put [my baby] up in the little capsule thing. I wanted her with me, and wanted to be next to my partner, so she got us a couple of mattresses to put on the floor so we could all snuggle up together. She was really supportive in that way, I thought that was really nice* (Tess, homebirth woman).

Recreating the environment was a simple and practical activity that homebirth and hospital midwives could utilise to instigate collaboration towards a shared woman centred goal, early in the transfer event.

When hospital and homebirth midwives developed some familiarity, transfer interactions went more smoothly because communicating the woman's needs became much easier. *'Knowing we could talk about what my role would be in the room…the midwife would say, "Oh isn't this great, Kay's here…we can just tell her what you want to do and what you don't want to do"* (Kay, hospital midwife). A sense of trust in each other's practice grew as they became more familiar, breaking down the potential for *'us and them'* attitudes to develop. Hospital midwives grew to expect a certain standard of practice from the privately practising midwives they knew, *'Getting to know some of the [privately practising] midwives…There was just immediate trust between us when they came in…I knew that they were making timely transfers'* (Kay, hospital midwife). Trust was built as Kay enjoyed being appreciated for the effort she made in collaborating with transferred women and midwives, '*there is nothing like*

someone bringing a woman in and going, "Oh, thank goodness you are here" … It was so nice being appreciated, they were absolutely relieved that I was there… I was very happy' (Kay, hospital midwife). Supporting the midwife-woman partnership was a unique form of woman centred practice for hospital midwives, which involved stepping back and observing, thereby learning what was needed to support each partnership:

> *The way I dealt with that most of the time in the early days was just to be silent and to just be there…it did work, it was really good and then I actually ended up learning so much about the power of that relationship really, between a woman and her midwife* (Kay, hospital midwife).

The next sub-category, *'Stepping back'* will examine the advantages of acknowledging that homebirth transfer was a unique clinical situation, in which caregivers had to step back from their usual roles and responsibilities.

Sub-category: Stepping back

Midwives who almost always enjoyed smooth collaborations during transfers understood that everyone needed to be *'stepping back'* from their usual routine ways of working, which were no longer appropriate in the unique context of a transfer. Their attitudes were underpinned by a sensitive understanding of the dynamics of collaboration: *'If you've got someone [a midwife] that works in partnership, then you can actually still meet a lot of the couple's needs and wishes for their birth. And it's all done in collaboration'* (Barbara, hospital midwife). Effective communication and a positive dynamic between the midwives set up the opportunity for them both to be *'stepping back'* from their usual roles, and to be sharing the care. This contrasted with the notion of the hospital midwife *'taking over'* as was described in Chapter 7. One hospital midwife said:

> *If the midwife who is coming with her is prepared to stand in as a mediator and discuss it, so we discuss it as a group and it is not like 'them and us'. If we can*

> *come together and talk about it without any animosity on either side, well then that would be fantastic* (Laura, hospital midwife).

Homebirth midwives usually accepted the requirement to step back from their clinical duties, whilst striving to retain the emotional support role which was integral to women's well-being, *'We had to step back, as a support person, so we could not do any clinical…work. We were just there to [provide] emotional support and…physical support…to the women'* (Iris, privately practising midwife). For hospital midwives, stepping back required a willingness to let go of the emotional support role they usually played when caring for women in labour. Their capacity to support the midwife-woman partnership was of more value, often resulting in true collaboration and woman centred care.

For a hospital midwife, *'stepping back'* often meant, *'disappearing into the background if things were okay and literally, putting gloves on when the baby was about to come'* (Kay, hospital midwife). One homebirth midwife described the role of the hospital midwife as a 'clinical conduit': *'Most [hospital] midwives understand the importance of the relationship between the homebirth midwife and her client. And they see their role purely as…a clinical conduit'* (Trish, privately practising midwife). Stepping back and being the 'clinical conduit' had not troubled Irene (now a privately practising midwife) when she had worked as a hospital midwife; in fact, she found that it made her work easier, saying:

> *I always love it when they've got a doula or a midwife because I know that they have a relationship with somebody that's supporting them and it takes the pressure off me having to do everything…you can do a really good job on the obs [observations]…and leave her to her support people'* (Irene, privately practising midwife, reflecting on her experiences working as a hospital midwife).

Homebirth midwives appreciated it when hospital midwives were sensitive to the value of supporting the midwife-woman partnership, saying, for example:

> *My job is to support her emotionally once we go into that environment and I admire the [hospital] midwife that gets that. So, she doesn't spend time when she's in the room trying to connect with the woman, because that's my job. Her job is to come in, do her observations, and liaise with us all as a team of people looking after her, on what the next step is or isn't* (Trish, privately practising homebirth midwife).

Women also valued it when hospital midwives took this approach, saying, *'To have the nurses [midwives] respect her [my homebirth midwife] and respect our relationship with her was amazing, it was unexpected, it was so wonderful, it just provided a seamless passage'* (Naomi, homebirth woman). The following vignette describes, from a woman's perspective, the process of this type of midwifery collaboration:

> *I don't have any…strong feelings about any things that they [hospital midwives] did when they were there, and I think that was because they tried to just do what they had to do and stay away as much as possible…the last midwife only came in just before I was starting to push…she just stayed right back, and [my homebirth midwives] were the ones by my side at that point…There were things…that she [hospital midwife] was legally obliged to do, she did those things, but she spoke very calmly with me…most of the time she just was quietly over in the corner and she was doing the paperworky things and just let us do what we needed to do. I felt like they were really great, really supportive in that way* (Tess, homebirth woman).

Homebirth and hospital midwives who were motivated to collaborate would reframe their group identities, not as *'us and them'* or 'homebirth and hospital', but as woman centred midwives working together. Hospital midwives sometimes felt caught, however, between their desire to be woman centred and their need to retain allegiance with hospital policies. They would sometimes find themselves colluding with the homebirth midwife to bend the hospital rules, by sharing the clinical duties. Their motivation was that this was clearly the most woman centred approach to caring for women in homebirth transfer situations. Initially, homebirth midwives might offer to

help with small tasks, to demonstrate their willingness to establish a collaborative approach, for example:

> *I might say 'You want me to quickly take her blood pressure while…you're putting up the next bag?' We work together. I might say, 'Oh I'm just gonna replace the paper on the CTG machine.' Or I might say, 'I've got no idea about how that pump works, that epidural - you'll need to look after that'. We're just all looking after her* (Trish, privately practising midwife).

Privately practising midwives who also worked in the casual pool at the hospital were usually trusted to adopt clinical roles, even though this involved bending the rules: '*She really took over the birth, which probably wasn't technically hospital policy but as she was already employed doing night shifts with us I didn't have an issue with that*' (Thea, hospital midwife). Another example of bending the hospital rules, was to enable the privately practising midwife to perform clinical duties for the woman, out of sight of the hospital staff. The 'sneaky VE' was one example, when a woman asked for her homebirth midwife to examine her in hospital, asking, *'Can you please do an examination? See where the baby's at?'* (Tess, homebirth woman). When the privately practising midwife declined, saying that it was not permitted by hospital policy, the hospital midwife's response was stepping outside the room, which was perhaps motivated by knowing what was best for the woman:

> *'It's your body, I'm just going to go and do something over here', and she disappeared out of the room for a few minutes. My partner watched the door and [my primary midwife] did an examination. It was very sneaky…I wouldn't like to get her into trouble for that* (Tess, homebirth woman).

When an inclusive dynamic was in place, bending the hospital rules often occurred, for example: *'Occasionally the [hospital] midwife will say, "Look, you examined her at home before you came in - it would make sense that you examine her next time"'* (Trish, privately practising midwife). Hospital midwives would not necessarily document the findings of an examination as being performed by the homebirth

midwife, *'I don't think it is documented in the notes, they're just doing what's right for the woman, and it is nicer for the woman for me to do the ongoing VEs'* (Trish, privately practising midwife).

Midwives were cautious when relating stories of when they had bent hospital rules, particularly in relation to catching babies. One example was when hospital midwives would document the actions of privately practising midwives as if they were their own. Despite being aware of the risks they were taking; midwives would agree that this was the most woman centred way of proceeding. Kay described an example when she trusted that, for the woman, the privately practising midwife would be the best person to be the accoucheur. Kay, the hospital midwife, was present and observing. She later signed the hospital documentation as if she were the accoucheur:

> *I think she might have even caught the baby in the end, which was fine…No, [I did not inform the midwife in charge that the privately practising midwife had caught the baby]. I was [documented as] the accoucheur, because that midwife isn't on the computer system* (Kay, hospital midwife).

Successful collaboration between privately practising midwives and hospitals was a two-way process. When hospitals provided avenues whereby privately practising homebirth midwives and women may engage with referral, consultation and transfer processes, homebirth midwives could be pro-active in fostering connections. *'Whilst I do believe there can be good relationships with midwives and hospitals, it's a two-way thing, so you've <u>both</u> got to be working together to get that relationship and that process going'* (Iris, privately practising homebirth midwife). Being negative about what occurs was pointless, one needed to be willing to contribute in a positive way, as Iris said, there is, *'…no point in digging your toes in and whinging and grizzling about the hospital if you're not prepared to try…to go out and bridge that gap'* (Iris, privately practising homebirth midwife).

Equally, stepping back was a two-way process that created a pathway to building bridges to collaboration. When both hospital and homebirth midwives were willing to

step back and negotiate their roles and responsibilities, collaboration could ensue, resulting in a successful transfer experience for all concerned.

Sub-category: Demonstrating mutual respect

Communication styles and behaviours that demonstrated mutual respect were important elements of collaborative interactions. Respectful interactions between midwives, from the onset of their initial greetings in the birthing room, and their handover exchanges, opened up the possibility for them to negotiate how they might optimise the quality of care for the woman. As a privately practising midwife coming into the hospital environment, Trish felt that she had a key role in modelling 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'* (Trish, privately practising homebirth midwife). Her approach when she arrived at a hospital with a transferred woman was as follows:

> *The energy around the transfer is…I'm asking for their help. That's why we've come. I've come to them for help, because we can't facilitate the birth at home and we know that this is the best place for her to be…Whenever I mirror the behaviour that I want back then it's usually gonna go well. If I go in there and be a bit cocky or act like a bit of an asshole they're gonna…treat me that way back…It may not even be a spoken word…I'm always…behaving that I'm very grateful. I would say 'I'm so glad you're on tonight.' So, it makes them feel like they're a bit special, and then they treat the woman differently. And sometimes I'm not grateful it's them, but I'm would never say that. So, you kind of butter them up just a little bit without them really knowing that that's what you're doing. And so, I think that helps in future transfers as well* (Trish, privately practising homebirth midwife).

Trish was an experienced privately practising midwife who almost always had smooth interactions during homebirth transfers, in a variety of hospitals. She was motivated by her woman centred philosophy to collaborate with hospital staff. Her approach was to

generate positive interactions, to optimise the care of the transferred women she cared for.

Acknowledging that different caregivers had different expertise, specific to their main area of work, was key to demonstrating mutual respect, *'It is about respecting each other as clinicians and respecting that we need each other'* (Kim, privately practising homebirth midwife). Mutual respect was an important part of the process of identifying roles and responsibilities: *'I don't see a problem…as long as we can say, "Alright, I see what you're doing and accept you for that and glean what I can from you because that's your expertise"'* (Daisy, privately practising homebirth midwife). Feeling respected engendered a willingness to collaborate, and broke down *'us and them'* dynamics because, as one midwife stated: *'I think if there's mutual respect I think then you would certainly help out where you can, more'* (Ellen, hospital midwife).

Hospital midwives felt respected when advocacy for women displayed by homebirth midwives was balanced with a sense of advocacy for their midwifery colleagues. Ellen described how a homebirth midwife she enjoyed working with managed to do both: '*She would actually advocate for the hospital midwife as well as the woman…I didn't feel that we were the bad guys'* (Ellen, hospital midwife). In Chapter 7, *'Us and them'* there was a story about a difficult interaction Ellen had experienced with a privately practising midwife, one that left her distressed and reluctant to care for other transferred women. Ellen did, however, remember a privately practising midwife with whom she had enjoyed a sense of mutual respect and collaboration. Being grateful was an important element of respect, *'She was grateful of the support that we offered and that's what she showed'* (Ellen, hospital midwife). Privately practising midwives also talked about the value of being grateful: *'I always behave in that I'm very grateful for their expertise…'cause I am very grateful. We've come there because we do need them. I want it to work out well for the woman'* (Trish, privately practising homebirth midwife).

The actions that made hospital midwives feel respected and able to provide woman centred care were often simple courtesies, such as, *'She remembers your name…that's probably a huge thing… Beautiful, respect all the way with her, she was always lovely. She would always come and thank you afterwards, she would write a letter'* (Ellen, hospital midwife). Writing a thank you letter was something many homebirth midwives tried to do, to display respect and gratitude for the help the hospital had offered them and the women they cared for:

> *I will…often write to the NUM [nurse unit manager] afterwards and say, 'We had a transfer last night, everyone was so lovely you must be proud of your staff. It was a very positive experience for her, and thank you'…because the next one, you want to be just as positive as that one* (Trish, privately practising homebirth midwife).

Women felt respected when they felt that their wishes were taken seriously by hospital staff, feeling as if they were, *'on my side, and trying their best to do what was right for me'* (Tess, homebirth woman). Tess had initially felt quite *'sceptical about what the midwives might be like'* because she had heard *'so many horror stories [about hospitals]'* (Tess, homebirth woman). She was very happy with the way the hospital staff interacted with her, saying:

> *We got a really good run of midwives. There were three over the time I was there…they'd all read my birth plan…One of the hospital midwives did actually come to me and say, 'Look, before we actually go ahead and call, I want to just double-check, you've said on your birth plan that you really didn't want to have an epidural and didn't even want to be offered one, I just want to make sure that you do clearly want to have this and go through with it'…that really helped a lot…they were really great* (Tess, homebirth woman).

Effective communication seemed to create a pathway to avoiding animosity and overcoming *'us and them'* behaviours. By *'demonstrating mutual respect'* for the

expertise of others, a willingness to listen and skills in clarifying roles and goals, successful homebirth transfers could be facilitated.

Sub-category: Sharing goals with women

This final sub category, *'Sharing goals with women'* emphasises the ways in which identifying, defining and sharing goals was key to successful homebirth transfers. Whilst identifying a shared goal of a healthy mother and a healthy baby was unproblematic, agreeing upon a definition of what 'healthy' meant was less straightforward. In non-urgent situations, the solution lay in a woman centred approach, that is, respecting the woman's definition of her health and well-being as paramount.

Urgent transfer situations were usually handled well, with minimal conflict, because the physical safety of the women and her baby was an immediate common goal that everyone focussed upon: *'In an emergency situation…the whole process is different…you just need to act'* (Kath, publicly funded homebirth midwife). In emergencies, roles and responsibilities seemed clear and decision making was straightforward, which tended to override to any *'us and them'* dynamics. *'Emergency [transfer] situations we know, you just get on and do it'* (Barbara, hospital midwife). This was the sense one woman had around her urgent emergency caesarean:

> *I wasn't badly received at the hospital when I got there… they recognised that I needed help… so they didn't really have time to pass judgement or anything prior to surgery because it was pretty quick* (Bree, homebirth woman).

In non-urgent situations, there was more time to consider a range of options for care and for different paradigms to cause conflict. Despite this, all the participants agreed upon identifying that the *'primary goal is to have a healthy mother, healthy baby'* (Charles, obstetrician). Safety for women and babies was paramount for women, midwives and obstetricians, *'I think that people have to presume that we're all wanting to do the same thing and have good outcomes for women'* (Lily, hospital midwife). Putting the woman and her unborn child at the centre of the care was key to sharing

the goal of a healthy mother and a healthy baby, *'ultimately, really it's about the mum, the baby, and the safety of that'* (Nancy, hospital midwife). Team work was an important pathway to achieving shared goals, *'Ok, we want you to have a safe birth and a healthy baby as well, but your parameters have changed, so let's work together'* (Ellen, hospital midwife). Working as a team to support the women and her homebirth midwife was recognised as a positive strategy towards healthy outcomes, as Laura expressed:

> *[Working as a team] is the ideal situation because even though we [hospital staff] are responsible for the woman's care because she's here, as her [homebirth] midwife who has been with her all through her pregnancy and labour so far, why not…work together as a team?* (Laura, hospital midwife).

Whilst a 'healthy mother and a healthy baby' was a shared goal, sharing a definition of what this meant was less straightforward. For midwives, the definition of a healthy outcome extended beyond simply mortality and morbidity, *'[The] outcome hopefully… is a live mother and a live baby, but at the same time you also want to have experiences where the women feel ok about the whole thing'* (Cassie, hospital midwife). Healthy outcomes and optimal experiences for women were not mutually exclusive, as Barbara emphasised:

> *This woman's made the choice [to plan a homebirth]. So, this [transfer] is what's happened, let's go on and help her to have a nice baby now…and a birth as great as we can give…and a safe mother and baby at the end of it* (Barbara, hospital midwife).

Midwives felt that being woman centred was fundamental to the success of a homebirth transfer, and for the safety and well-being of the woman and her baby, saying, *'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, hospital midwife). Positive relationships were key to providing a good experience to women who were transferred, 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. Because that's so important – and without making the mum feel like she's a failure because she had to come to the hospital…. if they don't have this experience that they dreamed of because of circumstances that are often outside their control…they still need to be able to enjoy the experience of having their baby, even with some assistance* (Nancy, hospital midwife).

As previously discussed, different paradigms of childbearing in the birthing room meant that views about safety and risk, and the priorities of care during labour and birth were varied. The ways of knowing that influenced women's decision making for their birth and their baby needed to be respected by caregivers, even when different paradigms of risk and safety were involved. Thalia described her views on this:

> *What I perceive as risk, and what I perceive as an adverse outcome, will be different to you, will be different to everybody else. And at the end of the day the person who's taking that risk of having that adverse outcome is the woman who's having a baby* (Thalia, obstetrician).

Most obstetricians reported that they were committed to providing informed decision making processes to women, for example, *'I try to be very clear about what I would recommend. I recommend you have a caesarean or whatever but you don't have to take my advice'* (Charles, obstetrician). Thalia concurred, saying:

> *It's not my job to tell somebody, 'You should do this' or, 'You should do that'. It's nothing I have that's compulsory or nothing I have that somebody has to do. Everything I've got is an option, or this is, "What I offer… This is what I recommend", but people…have their own choices. So, they're independent adults, and as long as you're giving them the information; we need to respect the rights of people to make their own choices* (Thalia, obstetrician).

Respecting a woman's right to make informed choices about her birth and for her baby, and respecting her goals for the outcome, was central to a successful transfer: *'It's remembering that the woman is in the centre of everything, it's not actually about everyone else - it's about her'* (Trish, privately practising homebirth midwife). Being woman centred meant being able to respect women's choices even when her world views were incongruent with one's own, *'It's about responding to individual women, caring for individual women but also [remembering] that their journey isn't always your journey'* (Kay, hospital midwife). Women's decisions were based upon 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, modifies that. But some women will always have strong beliefs, and no matter what we talk to them about, they will continue to make their decisions and as long as those decisions are informed decisions…evidence based information about risks and benefits of alternative decisions. At the end of the day, women make their choices* (Thalia, obstetrician).

Providing smooth processes for timely, safe and woman centred care in the setting of a transfer from planned homebirth to hospital enabled healthy outcomes for women and babies. The following quotes illustrate the ways in which transfers were framed as successful:

> *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. You've had a go at a homebirth… we discussed previously [that] there was quite a good chance that you might need a helping hand, we're now gonna make that happen - efficiently, effectively and there's no risk to you or the baby* (Keith, obstetrician).

> *She [midwife] was thrilled with how it turned out, she [said], 'That was such a good decision, we had a really good result'. [There] was no sense of it being a failed homebirth at all, it was a great result* (Mary, homebirth woman).

> *If the birth is successful, then every step of it was successful. Some of the paths could have been more successful but the fact that you have a healthy baby at the end, means it was a successful birth, regardless of where it was and regardless what happened* (Naomi, homebirth woman).

A homebirth transfer to hospital resulting in a healthy woman and a healthy baby was seen as a successful outcome, even though it was not what may have been expected: *'When transfers happen in a timely fashion, because variations off the normal pathway have happened, that's the system working. I actually think that's really a positive thing'* (Thalia, obstetrician). Framing a transfer to hospital as a 'failed homebirth' was not a helpful approach:

> *So, 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, <u>that's</u> a failure in the system* (Thalia, obstetrician).

Several women framed their successful homebirth transfers as 'having the best of both worlds', as Tamara said, *'It's just really great as far as homebirth is concerned, when you have two professional private midwives…who are linked to a hospital should you need to be transferred…you've got the best of both worlds'* (Tamara, homebirth woman). The best of both worlds is an apt way to describe the provision of safe, woman centred care for low risk women who choose to plan to give birth at home and then require transfer to hospital. For Felicity, having a high standard of midwifery care,

and continuity of carer throughout her transfer, was more important than the place in which she ended up giving birth, *'having midwives who were very, very supportive and experienced…was more important than where [I gave birth]* (Felicity, homebirth woman). Mary was another woman who felt elated about her homebirth transfer experience, thinking afterwards, *'Wow! How well did that work?'* (Mary, homebirth woman). She elaborated on the reasons why she thought about it so positively, saying:

> *What an exceptional experience that was, a privileged, professional but also personal [experience]… I had the best care, the absolute best care…What I saw was how well the homebirth midwives…the ambulance, the hospital, and the after-care… they all worked so professionally amongst each other to give me and my baby the best care* (Mary, homebirth woman).

Most women who choose to give birth at home, in the care of registered midwives, will labour and give birth safely, with little or no intervention. Smooth referral, consultation and transfer processes ensure that when women experience variations from their expected labour and birth trajectory, they can access timely and appropriate medical care in a hospital setting. The well-being of women, and their babies, is protected when caregivers and health systems understand how to provide care for them, whatever their choice of place of birth.

Summary

This chapter, *'Celebrating a successful transfer'* reframed smooth intrapartum transfers as a success of the system, rather than as failed homebirths. The strategies that were shown to facilitate successful homebirth transfer outcomes were outlined. The main strategies were shown in each of the sub-categories. *'Handing over'* underpinned the importance of the handover interaction in establishing collaborative dynamics. Ways in which handover in homebirth transfer may be streamlined will be addressed in Chapter 10, in Implications for Practice; where a template that incorporates the unique requirements of transfer situations will be proposed. *'Supporting the midwife-woman partnership'* explored the notion of supporting the woman and her midwife as one unit; *'Stepping back'* addressed the unique roles and

responsibilities of midwives in transfer settings; *'Demonstrating mutual respect'* showed how fostering positive exchanges between caregivers facilitated collaboration; and *'Sharing goals with women'* demonstrated the value of respecting each individual woman's definition of her health and well-being, as a pathway to effective communication and safe outcomes.

CONCLUSION OF FINDINGS

This concludes the findings section of the thesis. Chapter 5, *'Fostering relationships and reducing uncertainty'* explored the ways in which uncertainty was reduced during pregnancy, in order to prepare women for the possibility of transfer from their planned homebirth. The midwife-woman partnership was a strong relationship built over months in the pregnancy and underpinned by reciprocal trust. Homebirth midwives developed connections with their hospital colleagues outside actual transfer events, as a way of building a collaborative woman centred practice. When hospitals enabled booking in processes, women could form connections with their back up hospital that helped them reduce their uncertainty, in the event that they were transferred. Booking in processes also reduced uncertainty for hospital staff when they received women were transferred in during labour.

Chapter 6, *'Transferring out of the comfort zone',* described the physical and the psychological journeys that were made by women, midwives and obstetricians in the homebirth transfer context. The findings showed that the impact of the psychological journey for women and caregivers played a significant role in the processes and interactions that emerged in the birthing room.

Chapter 7, *'Us and them'* explored the ways in which interactions between midwives could easily be plagued by negative attitudes and behaviours. *'Us and them'* dynamics emerged when *'stereotyping', 'blaming', 'taking over'* or *'gatekeeping'* behaviours were able to manifest.

Chapter 8, *'Celebrating a successful transfer',* synthesised the positive behaviours, attitudes, processes and interactions that contributed to smooth and successful

transfer experiences for women and for caregivers. By celebrating a successful transfer that resulted in a healthy mother and a healthy baby, women could move forward into parenthood without feeling they had failed. Caregivers who honoured woman centred care and valued women's birth experiences promoted optimal journeys for women and babies, regardless of their mode and place of birth. The next Discussion chapter will explain the grounded theory emerging from the synthesis of key findings with the extant literature.

CHAPTER NINE: DISCUSSION

Introduction

The analysis of the findings produced four theoretical categories, as explained in Chapters 5-8, 'Fostering relationships and reducing uncertainty', 'Transferring out of the comfort zone', 'Us and them' and 'Celebrating a successful transfer'. The first category, 'Fostering relationships and reducing uncertainty', explained the ways in which women and their midwives prepared for the possibility of intrapartum transfer to hospital. Although the focus of the study was upon transfer during the intrapartum period, the antenatal phase was included because the preparation women and midwives undertook had an influence upon the processes and interactions that unfolded if and when transfer eventuated. Preparation for the possibility of transfer had the capacity to reduce uncertainty, as did fostering a range of relationships and connections between women, homebirth midwives and hospital personnel. Particularly powerful was the capacity of the midwife-woman partnership to be protective of women's sense of safety and well-being.

The second and third categories, *'Transferring out of the comfort zone',* and *'Us and them'* explained the challenges for women and for caregivers that occur during and after the intrapartum transfer of a woman from a planned homebirth to hospital. It elucidated the notion that, during a homebirth transfer event, it was not only women who transferred out of their comfort zone of their home into hospital. Homebirth midwives and hospital staff also shifted to a different way of working and of interacting than that to which they were accustomed. This study adds to the understanding of the experiences of midwives and obstetricians who receive women who are transferred because it demonstrates how their attitudes and behaviours influence the interactions and processes that ensue. In other words, homebirth transfer is a social process that disrupts and challenges the status quo for everyone involved, not only for the woman and the homebirth midwife.

When individuals involved in homebirth transfer strived to maintain their status quo, conflict often resulted. For example, when homebirth midwives continued to focus only upon the woman's needs and not upon the roles and responsibilities of the hospital staff, conflict arose. Likewise, when hospital midwives maintained their routine way of caring for a woman who had planned a hospital birth, conflict arose. Constructivist grounded theory is a particularly useful critical approach with which to analyse taken for granted assumptions and the ways in which they influence social processes (Charmaz 2014), as was borne out in this study.

The fourth category, *'Celebrating a successful transfer'* explored what works well and how challenges were overcome. It focused upon the positive attitudes and behaviours that caregivers used to bring about smooth processes and interactions during homebirth transfer.

Many published qualitative studies use grounded theory methods but do not culminate in the production of a theory grounded in the data (Charmaz 2014). From the outset of my PhD journey, it was important to me to aim for the construction of a theory, for several reasons. Firstly, to pay due respect to the rich data that the participants so generously provided. Secondly, to honour the four years I have spent grappling with the methodology. Thirdly, it was important to me to produce a fresh theoretical perspective that might make a difference to practice. By improving women's birth experiences and caregivers' ability to collaborate in the face of conflicting paradigms of childbearing, childbirth may ultimately become psychologically, socially, emotionally, spiritually and culturally safer for women. This was important because, whilst in the Western world childbirth has arguably never been physically safer for women and for their babies, much maternity care in the 21st Century is systemically failing to support women and their babies psychologically, socially, emotionally, spiritually and culturally. Until we understand what each individual childbearing woman needs, to ensure her safety and well-being, this problem will likely not shift.

In constructivist grounded theory, developing a substantive theory that is grounded in the data often involves the synthesis of the analysis with theoretical codes that have been sought from extant theory (Birks & Mills 2015; Morse et al. 2009). In this thesis, I have pulled the findings together with theoretical perspectives from other areas of health, including Uncertainty in Illness theory (Mishel 1984; Mishel 1997), literature on inter-professional communication in the operating room setting (Smith, Cyna & Tan 2011) and anthropological perspectives (Cheyney 2008; Cheyney, Everson & Burcher 2014). From the discipline of midwifery, theoretical perspectives on continuity of carer and the midwife-woman partnership (Guilliland & Pairman 1995; Page 2000) were influential. The main theories I synthesised with the analysis of findings, however, were perspectives on intergroup conflict (Sherif 2010; Tajfel & Turner 2001), drawn from the discipline of Social Psychology. This was pertinent because intergroup conflict explains the *'us and them'* dynamics that often emerged in the birthing spaces of women transferred to hospital from planned homebirths.

This grounded theory is a unique construct because it is the first time that intergroup conflict has been synthesised with qualitative data about transfer from planned homebirth to hospital. The potential for application of the theory reaches beyond the homebirth transfer context, into the broader maternity care milieu, in which obstetricians, midwives and others must collaborate to care for women experiencing unexpected outcomes and complications during childbearing. The theory is displayed in Figure 4.

Intrapartum transfer from planned homebirth results in a convergence of women, midwives and obstetricians who possess conflicting paradigms of childbearing; derived from a range of educational, professional and life experiences. Polarised perspectives of risk and safety in childbearing mean that the evidence, particularly in relation to place of birth, is interpreted in a variety of ways. This issue has the capacity to reconstruct women's labour and birth experiences during homebirth transfer into complex and unique clinical circumstances.

Women make a psychological journey out of their comfort zone when transferring from home to hospital. Their psychological journey encompasses managing their emotions and changing expectations, adapting to a new environment, interacting with strangers, and dealing with the temporal parameters of an institutionalised healthcare system. The midwife-woman partnership has a powerful capacity to support or ameliorate many of these challenges for women.

The convoluted context of homebirth transfer also necessitates caregivers to move out of their comfort zones. Dealing with unfamiliar colleagues and their different paradigms, managing the power of the midwife-woman partnership, and coping with shifting roles and responsibilities means that high levels of uncertainty arise. Human responses to uncertainty vary enormously. Behaviours such as exercising control, driving personal agendas by stereotyping, and blaming others for their feelings of uncertainty manifest in creating *'us and them'* dynamics, which can be difficult to manage.

Supporting woman centred care in homebirth transfer means respecting the expertise of other caregivers and working towards shared goals that prioritise each woman's unique needs. Understanding the value of the midwife-woman partnership, communicating respectfully, and collaborating towards the universal goal of 'a healthy mother and a healthy baby', are key. 'A healthy mother and a healthy baby', commonly defined as 'physically alive and well', is easily agreed upon, however, the preferred ways to achieve this outcome may differ. Furthermore, for women giving birth, the notion of 'healthy' often encompasses deeper meanings that emerge from psychological, emotional, social, cultural and spiritual domains.

Smooth collaboration will ensue when the definition of 'healthy mother and healthy baby' is based upon respect for what this means to each individual childbearing woman. From the perspective of Australian law, health care policy, human rights principles and woman centred philosophy, the woman's definition has authority and is unimpeachable. Seeking clarity about the woman's definition of her health, safety and well-being, and that of her baby, may create greater collaborative focus and establish a path to more respectful care for women and their babies.

Figure 4: Grounded Theory: 'Supporting woman centred care in homebirth transfer'

The remainder of the chapter will show how the grounded theory was constructed, by examining how the categories of findings were aligned with the current literature on homebirth transfers. Perspectives from literature from the disciplines of anthropology and social psychology are then synthesised with the analysis of the findings, followed by a statement of the strengths and limitations of the study.

Firstly, the reasons why homebirth transfer brings such a unique set of circumstances to the clinical environment are explained.

Transfer is a unique clinical situation

Caregiving processes and social interactions that emerged for health professionals during homebirth transfers were unique. For these reasons, homebirth transfer is a clinical circumstance that cannot simply borrow or adapt guidelines from other clinical events or settings.

Health professionals faced many challenges in the homebirth transfer setting that generated high levels of uncertainty and had implications for their work satisfaction and for the quality of the care they offered to women. The findings of this study add to what is known about planned homebirth, by illustrating the complexity of the processes and interactions that transpire in the context of intrapartum transfer to hospital.

As rates of planned homebirth are rising in many countries, and the evidence for the safety of planned homebirth for low risk women is building, it is vital that homebirth transfer processes are evidence based and woman centred. To underpin what is outlined above, the ways in which the homebirth transfer situation is clinically unique in the hospital setting needs to be understood. The unique characteristics of homebirth transfer are listed in Figure 5.

- Most women who choose homebirth are well informed and aware of their rights to make informed decisions, however, are paradoxically viewed as naïve and ignorant by those who believe homebirth is dangerous.
- Women who plan to give birth outside the mainstream hospital system are often regarded as 'alternative', potentially leading to stereotyping attitudes and behaviours being displayed towards them.
- A woman planning a homebirth has done so with the desire to labour and give birth without medical intervention or pharmacological pain management. Whilst she is at home there is no possibility of these events occurring. After the need for transfer to hospital is identified, there is a high likelihood of technological monitoring and medical intervention occurring. This creates significant changes for women's expectations of labour and giving birth.
- Homebirth transfer brings high levels of uncertainty, due to issues such as clinical uncertainty, changing expectations for the labour and birth, social and environmental unfamiliarity, differing paradigms of risk and safety in childbearing, different philosophies of care, different views about place of birth, different approaches to time and progress in labour, differing styles of handover communication and documentation, allegiance to conflicting professional guidelines and/or divergent views of accountability to the woman or the institution. In the face of uncertainty, women need time to adjust to their changing expectations and process what is occurring, however, hospital staff may be more accustomed to expediting the progress of labour and birth.
- The parameters of risk and safety in a hospital are bio-medically driven. The parameters of risk and safety in a homebirth setting stem from physiological expectations and have clinical, emotional, psychological and social dimensions. These differences are integral to the way in which the paradigms that underpin midwifery led homebirth care contrast with those of obstetric led hospital care.
- A woman planning a homebirth usually has a strong, pre-existing relationship with her homebirth midwife. This relationship, unique in the health care setting, is traditionally known as the midwife-woman partnership. This partnership is more powerful than the rapport developed between birthing women and caregivers in traditional fragmented models of hospital maternity care. It also has different characteristics from the traditional therapeutic relationship with which many health professionals are familiar. The midwife-woman partnership is based on reciprocal trust and shared understanding. Conversely, traditional fragmented models of care might rely on notions of caregiver expertise and expectations of compliance from women.
- Interactions between midwives in the birthing room of a transferred woman are complex. The strength of the homebirth midwife-woman partnership makes it difficult for hospital midwives to develop their normal rapport with women. Women will naturally look to their homebirth midwife for support and advocacy. Often hospital midwives are left wondering how and where they fit, and how they might manage the social dynamics in the room.
- The woman's homebirth midwife is her primary caregiver throughout pregnancy up until the time of transfer, however, may not be employed or insured by the hospital. The homebirth midwife may therefore lose clinical rights and responsibilities for practice upon transfer. Paradoxically, the privately practising midwife is required to give a professional handover after losing such clinical rights and responsibilities.

Figure 5: Unique characteristics of homebirth transfer

Reducing uncertainty

In Chapter 5, *'Fostering relationships and reducing uncertainty',* reducing uncertainty for women and for midwives was illustrated by two mechanisms, represented in the sub-categories, *'Booking in'* and *'Opening up to the possibility of transfer'*. Assisting women to open up to the possibility of transfer included providing information, helping them to develop a sense of connection and familiarity with the back-up hospital, and engaging them emotionally with the possibility of transfer. Women's desire to be given information during pregnancy in order to develop their awareness of the possibility of transfer has also been recommended elsewhere (Catling-Paull, Dahlen & Homer 2011; Creasy 1997; Fox, Sheehan & Homer 2014; Hollowell et al. 2015; Lindgren, Radestad & Hildingsson 2011). Information about transfer is especially important for women having their first baby, because a wide range of quantitative studies, conducted over the past two decades, show that women having their first baby have a much higher likelihood of transfer than women having their second or subsequent babies (see Chapter 3, Table 1).

Homebirth transfer was identified as producing high levels of uncertainty for women. From the perspective of theoretical work from the nursing literature on uncertainty in illness, this is a state that can be a source of stress, anxiety and depression (Mishel 1997). Feelings of uncertainty usually accompany the process of hospitalisation; however, this may be alleviated in acute settings by social support (Mishel 1984). The benefit of continuous midwifery support during homebirth transfer is therefore further reinforced (Mishel 1997).

Although Mishel's theoretical work was done within the context of nursing and illness, there are parallels that may be drawn with experiences of women in labour being hospitalised, after planning to birth at home. Elements of uncertainty associated with hospitalisation included coping with an unfamiliar environment and difficulty communicating with medical staff (Mishel 1984), both of which emerged from this study as challenges for women being transferred. By framing transfer as an acute event during a woman's labour, the synthesis of this evidence strengthens the

argument made in this study and by Ball et al. (2016) that emotional support and continuity of midwifery carer for women being transferred from a planned homebirth is vital to their well-being and the quality of their birth experience.

The benefit of becoming familiar with the back-up hospital is supported by the literature showing that feeling connected to a hospital during pregnancy helps women feel prepared for the possibility of transfer (Catling-Paull, Dahlen & Homer 2011; Fox, Sheehan & Homer 2014). Stress upon admission to hospital is known to increase, especially for those with no previous life experience of hospitalisation (Mishel 1984). The implications are that booking-in and becoming familiar with the hospital environment are especially important mechanisms of preparation for women who have never been hospitalised before.

In the context of the UK, Hollowell et al. (2015) recommended that information given to women includes evidence on the time it takes to arrange a transfer and to travel to hospital. The median time of a transfer from a planned homebirth in the Birthplace in England study was 49 minutes from decision to transfer until the first assessment in hospital (with a median of 42 minutes for clinical situations deemed to be potentially urgent). Notably, the median transfer time from planned homebirths was significantly shorter than the median transfer time from freestanding birth centres (Hollowell et al. 2015). In The Netherlands, Ravelli et al. (2011) showed that mortality rates and/or adverse outcomes increased when the actual travelling time on the road was greater than 20 minutes. This was measured by geographical calculations of the postcode of the woman's home to the postcode of the hospital. A limitation of the study was that no measurements of decision making, ambulance arrival or handover time were recorded. To simply measure the travel time by road is omitting crucial information that may make a significant contribution to the understanding of transfer, such as the quality of communication and collaboration.

The findings of this study showed that most midwives felt the ambulance response was timely. In the Australian context, data about travel time in homebirth transfers is scarce, so providing evidence to women may be difficult. Data recently published

shows the travel time for a small sample of 23 women who were transferred from a planned homebirth during the intrapartum period. The median length was eleven and a half minutes from the time of the phone call to the ambulance service until the arrival of the ambulance at the woman's home. All women except one were transported to hospital within 32 minutes of the ambulance arrival (McLelland et al. 2016). The consensus of most publicly funded homebirth programs in Australia is that 30 minutes expected travel time from a woman's home to hospital, in an ambulance with lights and sirens on, is an acceptable distance. This is one of the criteria by which women are accepted as suitable for a publicly funded homebirth, alongside their clinically low risk status (National publicly-funded homebirth consortium 2015, pers. comm., April 9). Further research is needed to gain a better understanding of homebirth transfer times in the Australian context.

Handover as a determinant of reducing uncertainty

Handover communication between health professionals from different disciplines is known to be problematic, due to the different goals and priorities of those interacting. Handovers have the capacity to delay or expedite care and may act as a barrier or facilitator of the reduction of uncertainty. Rather than being guided by policy, which is often lacking; successful handovers occur simply due to the presence of trusting inter-professional relationships (Smith, Cyna & Tan 2011). In the homebirth transfer context, handover interactions have the capacity to provide the ground roots of collaboration between homebirth and hospital caregivers, by establishing the patterns of communication that follow. Chapter 7, *'Us and them'* showed that a lack of clarity around roles and responsibilities, especially for midwives, had the potential to cause stress and conflict. Hospital midwives often perceived the need to take over, whilst homebirth midwives were often striving to continue to support and advocate for the woman. With clear and transparent communication during the handover process, this could be ameliorated. By including not only a handover of knowledge and information about the woman but also a handover of professional responsibility, the handover communication may embrace the management of uncertainty and engender a willingness to collaborate.

The unique challenges faced by women during transfer means that content in the handover also needs to acknowledge the woman's psychological journey. In the Implications for Practice section, principles for best practice are proposed to address the unique characteristics of homebirth transfer handover. The principles have been adapted from a model for handover between anaesthetists and other health professionals in the operating theatre setting (Cyna et al. 2011).

Timely referral, consultation and transfer, and smooth collaboration between caregivers is especially important for the safety and well-being of women and their babies (Simpson, James & Knox 2006), especially when place of birth and caregivers change (Downe, Finlayson & Fleming 2010). The quality of the handover communication has the capacity to influence the level of collaborative interactions and processes that ensue thereafter. This is aligned with the findings in the literature on transfers from midwife led birth centres in the UK (Rowe et al. 2012).

Building the midwife-woman partnership

During pregnancy, women and homebirth midwives built partnerships that were exemplified by transparent communication, shared understanding and reciprocal trust. This was seen in Chapter 5, *'Fostering relationships and reducing uncertainty',* in the sub-category, *'Building the midwife-woman partnership'.* These findings support the large body of literature exploring the midwife-woman partnership as a unique relationship involving trust and mutual understanding (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 my 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. Continuity of carer was crucial to women during transfer because having their trusted midwife with them made them feel safe, in an otherwise vulnerable situation. Most midwives recognised that transfer is a time when women need their known midwife perhaps more than any other, to support, care and advocate for her wishes. Although

the findings showed that this is not always feasible, due to fatigue or lack of resources, it is overwhelmingly clear that prioritising continuity of midwifery carer is congruent with woman centred care during homebirth transfer.

Chapter 6, *'Transferring out of the comfort zone',* illuminated how the presence of the midwife-woman partnership became a valuable contributor to women's health and well-being in the homebirth transfer setting, when hospital staff could embrace its value. When the partnership is not understood, it may simply create perceived barriers for hospital staff trying to engage with the woman. Hence, the quality of the partnership may be at once of immense value to the woman and her midwife whilst simultaneously a nuisance to outsiders. The midwife-woman partnership has the potential to become a mechanism of the development of *'us and them'* dynamics in the hospital birthing room.

Transferring out of the comfort zone

Chapter 6, *'Transferring out of the comfort zone',* highlighted the essence of the woman's home as her comfort zone where she had planned to labour and give birth to her baby. Being at home meant being in her familiar environment, with her family, chosen midwife and support people around her, with a low likelihood of unwelcome interruptions. When the decision was made to transfer to hospital, women felt that they were moved out of their comfort zone into a clinical environment where they were met by unfamiliar caregivers and restrained by strict time restrictions placed upon the progress of labour.

Women and some homebirth midwives found it difficult to adapt to the clinical environment of the hospital, after shifting from the comfort zone of the woman's home. Homebirth midwives greatly appreciated when hospital midwives acknowledged this issue by helping to adapt the birthing space. By so doing they demonstrated a willingness to accommodate the needs of homebirth women and midwives in a tangible way, perhaps sending a powerful symbolic message of intent to collaborate.

Recent qualitative research has highlighted the impact of birthing environments upon labouring women and their midwives (Burns 2015; Hammond et al. 2013). Burns (2015) refers to the spiritual dimension of the relationship women have with their home when planning a homebirth. The meaning of 'home' becomes deeply integrated with their thoughts and feelings about their labour and birth, and therefore part of their comfort zone. For midwives, feelings and behaviours are affected by the space in which they work, thereby influencing the way in which they care for birthing women and their interactions with others within that space (Hammond et al. 2013).

This strengthens the findings of this study that environment may be an important element of managing changing expectations for transferred women. Being sensitive to the impact that the change of environment has upon women may highlight the value, for hospital staff, of demonstrating a willingness to adapt the birth space. As part of transfer birth planning, it may be helpful for women to plan the items they might bring to hospital in the event of transfer, to help bridge the spiritual dimension of their comfort zone across into the hospital.

There are limitations, however, to how 'homely' a hospital birthing space can become, argue Burcher & Gabriel (2016). Planning to give birth at home is not simply a matter of women wanting a homely environment but also related to the sense of safety, security and personal control one feels in one's home environment. In planning to give birth at home, a woman looks forward to labouring in the environment of her choosing, one that affords her the greatest possible privacy and freedom to become introverted. She plans to be surrounded by the people of her choosing, and cared for by the midwife with whom she has built a partnership over months during pregnancy, with no threat of intrusion by strangers (Burcher and Gabriel 2016).

In contrast, hospitals are institutional settings in which a functional level of efficiency is necessary, potentially creating an 'assembly line mentality' (Burcher and Gabriel 2016, p. 152). A woman, with her midwife and family, being transferred to hospital after planning a homebirth enters an institution in which 'family goals become secondary to the institutional goals' (Burcher & Gabriel 2016, p. 161). Compromises inevitably occur

in areas such as privacy, individualised care and autonomous decision-making for women, which add to the challenges of managing the psychological journey of a transfer.

Needing time to make the psychological journey

Transferred women were often perceived by hospital staff to be resistant and non-compliant and, therefore, labelled as 'difficult'. Hospital staff members were often left wondering why women had transferred into hospital at all, when they seemed not to want the medical assistance being offered. Some hospital staff felt that many women have unrealistically high expectations of a having physiological birth, and that women were naïve if they believed that they had a high likelihood of a positive birth outcome. This is aligned with the perspective that individuals who subscribe to alternative, non-hegemonic belief systems may be seen as uninformed, naïve or pestilent (Jordan 1997). It is possible that women with low expectations of their outcomes and/or less assertiveness around making informed choices appear more compliant to hospital staff and therefore easier to care for. There is an interesting tension between desire for compliance from some hospital staff, and promotion of informed decision making by homebirth midwives that may have implications for the care of transferred women, and for many other women who may face changing expectations during planned hospital and birth centre births.

Obstetricians sometimes found it difficult to understand why, after making clear recommendations for her care, a woman might wish to discuss her options privately with her trusted homebirth midwife. From a woman's perspective, continuing the processes of informed decision making they had become accustomed to sharing with their homebirth midwife was important. Time was needed to manage changing expectations, consider available options and make informed decisions.

This study adds new perspectives on why women transferred from a planned homebirth may appear 'difficult' to care for. Even women who were well prepared and open to the possibility of transfer during pregnancy needed time to process what was

occurring for them during transfer. In many cases, good communication with health professionals, adequate time to process events, and being involved in decision making will improve women's abilities to accept interventions and procedures that are associated with complex care planning in hospital settings.

Anthropological perspectives

Anthropological perspectives provide insights into the prevalence and problematic nature of conflicting beliefs about childbirth (Cheyney 2008; Cheyney, Everson & Burcher 2014; Cheyney & Everson 2009; Davis-Floyd & Davis 1997). One example is from Cheyney (2008), who applies the notion of a 'systems-challenging praxis' to homebirth decision making, the cultivation of which involves three stages. The first stage involves questioning accepted public narratives around childbirth, the second constructing counter-narratives in order to become empowered and, finally, belonging to and becoming supportive of an alternative collective belief (Cheyney 2008). Homebirth may be seen as an alternative collective belief to which the midwives whose practice is dedicated to it also belong. In the event of transfer, this may lead to the birthing room becoming a *'contested space'* (Cheyney, Everson & Burcher 2014, p.451).

I propose that the presence of the midwife-woman partnership in the birthing room of a transferred woman further contributes to the sense of the *'contested space'* (Cheyney, Everson & Burcher 2014, p.451), due to the social dynamics of the interactions between midwives who possess different, and sometimes competing, views about their relationships and rapport with women. Synthesising this anthropological perspective with the concept of intergroup conflict, derived from social psychology, has the potential to move the discussion even further. By addressing the social dynamics that occur between individuals, as well as the psychological and cultural influences that may drive their behaviours, a deeper understanding of collaboration in maternity care may be gained.

In Chapter 7, *'Transferring out of the comfort zone',* the findings explored the types of conflict that occur in the birthing rooms of transferred women, supporting the notion of a *'contested space'* (Cheyney, Everson & Burcher 2014, p. 451). The authors who coined the term 'contested space' identified three contributing mechanisms that occur in the homebirth transfer setting, all of which illuminate the polarisation between medical and midwifery approaches to childbearing. Firstly, homebirth is regarded by many as being more dangerous than research evidence demonstrates and secondly, that health professionals receiving the care of transferred women are often fearful of taking responsibility for the poor outcomes that may result. The third mechanism they identified is of primary interest to this study, that is, the challenge for caregivers regarding their interactions and patterns of inter-professional communication. Interactions with other caregivers in the homebirth transfer setting were often tense or hostile. Some perceived that they were having to deal with personalities that were 'difficult', whilst others sometimes felt attacked or insulted. Communication barriers included perceptions that documentation that was poorly written, that psychosocial information recorded by homebirth midwives was unnecessary, and that different cultural conventions around the terminology used caused confusion (Cheyney, Everson & Burcher 2014).

Identifying challenges is important because it provides the first step towards finding solutions (Cheyney, Everson & Burcher 2014). The exploration of these three mechanisms provided a significant addition to what was previously known about homebirth transfer processes that may provide a pathway to the development of more integration in maternity care in general (Cheyney, Everson & Burcher 2014). This study builds upon that knowledge by addressing an additional perspective from social psychology. Hence, I argue that the issues extend beyond personality and culture, to the influences of *'us and them'* dynamics, derived partly from contrasting fundamental beliefs about knowledge and evidence about childbirth.

How epistemology drives *'us and them'* dynamics

Epistemology was defined in detail in Chapter 4, *'Methodology and methods'* as 'how we know what we know' (Blaikie 2007; Ramey & Grubb 2009). Epistemology is deeply seated in the human psyche, whether we are aware of it or not. It is rooted in the way we view the world and the way we understand knowledge. This is where we seem to get 'stuck' in maternity care systems, because caregivers, researchers and policy makers are driven by conflicting epistemological approaches. These different perspectives influence the ways in which we perceive risk and safety, interpret the evidence, and ultimately, therefore, the way we care for women. Unfortunately, women's voices are often lost in the process.

Intrapartum homebirth transfers resulted in the congregation of women, midwives and obstetricians who were likely to possess different epistemologies and approaches to the interpretation of evidence (Downe 2016; Licqurish and Evans 2016; Roome et al. 2016), a range of paradigms of safety and risk in birth (Anderson & Murphy 1995; Ashley & Weaver 2012; Bick 2012; Blix, Øian & Kumle 2008; Chadwick & Foster 2014; Cheyney & Everson 2009; Cheyney, Everson & Burcher 2014; Coxon, Sandall & Fulop 2014; Foley & Faircloth 2003; Homer 2010; McMurtrie et al. 2011; Vedam et al. 2014; Walsh 2000) and conflicting responses to ethical principles such as women's autonomy and the rights of the fetus (Kruske et al. 2013). These differences were derived from diverse social and personal influences and had the potential to manifest in the development of *'us and them'* dynamics, as personal agendas were being driven.

Professional guidelines are often aligned with goals for healthy mothers and healthy babies, however, different professional groups have polarised views around how to achieve such outcomes (Simpson, James & Knox 2006). Comparisons of position statements from professional colleges exemplify the notion that obstetricians possess a biomedical perspective that prioritises the physical safety of the fetus whilst midwives are seen to give precedence to the autonomy of the woman and her choices in relation to her birth (Licqurish and Evans 2016; Roome et al. 2016). The degree of conflict between these documents underpins the epistemological contrasts between health professionals illustrated in this study. Women's beliefs, however, are not

usually so polarised. Usually they seek both physical safety for themselves and their unborn child, and the autonomy to make decisions in the best interests of their well-being and that of their baby (Downe 2016).

Putting women at the centre of their care enables the possibility that their individual needs may be considered. Polarised professional views are likely to remain a source of conflict, until women's views about their care play an explicit role in decision making. The current silo approach to maternity care is not progressing the debate in a positive direction and women are caught in the middle trying to make informed choices. A transdisciplinary approach to developing joint statements on place of birth and transfer issues, that involves both women and caregivers as stakeholders, may be a step forward. Chapter 8 of the findings, 'Celebrating a successful transfer', shows that by reducing uncertainty, fostering relationships, communicating effectively and being willing to move out of their comfort zones; women, midwives and obstetricians were able to participate in smooth and safe collaborations, despite the challenges.

The following discussion of epistemology is written in the spirit of the goal of constructivist grounded theory, which is to 'try to locate participants' meanings and actions in larger social structures of which they may be unaware…[and] make them explicit' (Charmaz 2009, p.131). Those with biomedical perspectives on childbearing often possess an objectivist epistemology, seeking objective truths based upon quantitative measurements of risk and safety. Whilst upholding sophisticated statistical understandings of safety and risk, they may resist accepting that women possess a range of personal perspectives on such issues. Obstetricians talked about the value of being pro-active in intervening to assist the progress of labour. This pro-active approach is aligned with findings from an American study in which obstetricians talked about being 'aggressive' in their management of the progress of labour, specifically in the use of artificial oxytocin. Obstetricians in their study discussed their feelings of frustration with the less aggressive approach to labour of their nursing [midwifery] colleagues (Simpson, James & Knox 2006).

Woman centred midwifery perspectives, on the other hand, are based upon a philosophy that accepts that there are multiple realities in the world; respecting that all humans have individual priorities and different perceptions of risk, safety, health and well-being. The philosophy of woman centred care is congruent with a constructionist epistemological approach because both perspectives acknowledge the existence of multiple realities. Embracing a woman centred approach means accepting the unique needs and priorities of each individual woman. A clear illustration of this is Lesley Page's well known *'5 Steps to Evidence Based Midwifery'* (Page 2000). The first step involves finding out what is important to the woman, prior to the second step of gaining a clinical history. Gaining information in this order prioritises the woman's needs, whilst not diminishing the importance of the clinical aspect of her care. The third step is finding evidence on any issues that pertain to steps 1 and 2. Step 4 is talking it through with the woman and the fifth and final step involves reflection (Page 2000).

Woman centred care respects that women make choices in the best interests of the health and well-being of themselves and their babies, even when such choices are not congruent with those of the caregiver. Whether midwives with constructionist epistemologies are drawn to woman centred philosophies, or whether woman centred midwives adopt a constructionist stance as they form their professional identity, is difficult to determine. Nonetheless, by definition, woman centred midwifery care is congruent with a constructionist epistemological approach because it acknowledges the existence of multiple realities. This is particularly relevant to perceptions of safety and risk in relation to planned place of birth.

This fundamental contrast underpins thought and communication and language. Epistemologies are not easily adapted; we may not simply be able to 'meet in the middle'. Our differences can, however, be mutually respected, and the ways we work with and communicate to each other can be positive. The harder we resist 'meeting in the middle', the more we experience *'us and them'*. The more respectfully we communicate and collaborate, the more integrated our work might become. Hence this epistemological issue can be a determinant of *'us and them'* dynamics.

Families planning their place of birth co-construct perceptions of risk and safety in complex ways (Chadwick & Foster 2014; Cheyney 2008; Coxon, Sandall & Fulop 2014). The process of choosing and planning a homebirth involves working outside the accepted norms of an established maternity care system (Cheyney 2008). Communicating with health professionals about their choice of birthplace is often arduous, as the decision to have a homebirth challenges hegemonic biomedical beliefs (Chadwick & Foster 2014; Cheyney 2008; Jordan 1997). The autonomy of women to make individual choices for themselves and their babies may be questioned, and even pitched against perceived rights of the fetus.

In the context of childbirth, one may broadly identify with others who share a pathological, biomedical, institution based philosophy that emphasises objective definitions of physical safety and risk; or alternatively, with a physiological, woman centred, social model that prioritises individual women's needs and choices as paramount. In the latter, a woman's choice encompasses not only her physical safety and that of her baby, but also her psychological, social, emotional, cultural and spiritual needs. As explored earlier, a constructionist epistemology is intrinsic to the capacity to be woman centred.

Biomedical approaches were consistently shared between the obstetricians in this study. They all possessed a more or less medicalised perspective towards childbirth, characterised by their professional discourse. Among midwives, however, there were wide variations of perspectives on childbirth. Hunter (2004) highlighted that hospital midwives often work with different ideological demands than midwives who work primarily in community settings; and that there are emotional challenges for midwives in dealing with such conflicting ideologies in the workplace. In the transfer context, this had the potential to manifest in *'us and them'* behaviours and attitudes between hospital and homebirth midwives.

Chapter 7, *'Us and them',* showed that, although all midwives ascribed to a woman centred approach to care, the practice of some hospital midwives was more implicitly rooted in traditional nursing perspectives. This meant that they tended to focus upon

potential pathology during childbirth, and held fears about what could go wrong at any moment. Others reflected a more contemporary understanding of woman centred midwifery, trusting in the physiological process of childbirth until clinical indications suggested otherwise. This meant that when midwives converged on the birthing room of a transferred woman, they faced challenges to their routines and uncomfortable interactions with others, contributing to the aforementioned notion of the birthing room as a *'contested space'* (Cheyney, Everson & Burcher 2014, p.451). Caring for a transferred woman challenged normal expectations of roles and routines, necessitating midwives to move out of their comfort zone. This had the potential to lead to either collaboration or conflict. By respecting different perspectives and being willing to make a journey out of their epistemological comfort zones, even if only temporarily, midwives and obstetricians have the potential to enable effective collaboration. This is aligned with the following quote by a member of the Homebirth Collaboration Task Force in the United States, Holly Powell Kennedy (2011):

Skilled collaboration fosters seamless care transitions when required…not always easy, especially within daunting hierarchal institutions…It requires the recognition that all who enter a collaborative relationship are human beings with individual beliefs and values shaped by their culture, education and experience (Kennedy 2011, p x111).

Chapter 8 showed that 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 empathy, mutual respect 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.

Social-psychological perspectives

Interactions such as *'stereotyping', 'blaming', 'taking over'* and *'gatekeeping'* in the birthing room of a transferred woman were characterised in Chapter 7 as generating *'us and them'* dynamics. *'Us and them'* interactions are referred to by social

psychologists as ‘intergroup conflict’ (Hogg & Abrams 2001). The social psychological literature shows that to increase confidence and self-esteem, humans align themselves with groups of like-minded individuals and may 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 gender, race, religion or sporting team; and favour our group over another. In settings where high levels of collaboration or negotiation are required, the presence of intergroup conflict may prove to be a major barrier. The homebirth transfer context is one such setting.

Social psychology is said to have begun in 1898 with an experiment by Norman Triplett, who discovered that cyclists competing with others achieved faster times than those who were cycling alone and being timed. Triplett conducted other experiments such as one which showed that children winding a fishing line in the presence of others wound faster than when they did the task alone (Gough, McFadden & McDonald 2013).

The study of intergroup relations seeks to analyse human interaction by situating individuals within the social processes they partake in, making distinctions between personal identity and group identity (Gough, McFadden & McDonald 2013). Like the broader discipline of social psychology from which it is derived, it has evolved very much within the limits of a modern western philosophical construct (Gough, McFadden & McDonald 2013), however, this is appropriate to this study, which is located in a modern western setting. Intergroup relations have been explored by a range of social psychologists including Muzafer Sherif in the 1950s (Gough, McFadden & McDonald 2013; Platow & Hunter 2012) and Henri Tajfel in the 1970s (Gough, McFadden & McDonald 2013; Spears & Otten 2012). Other more recent work in the field has been done by Michael Hogg and colleagues (Hogg & Abrams 2001; Hogg & Vaughan 2005; Vaughan & Hogg 2011). Recent work by Hogg (2015) examines the relationship between uncertainty and group identity, and the ways in which effective leadership may ameliorate intergroup conflict between subgroups (Hogg & Adelman 2013).

The framework of intergroup relations provides explanations for the ways in which humans strengthen their self-esteem by identifying with certain groups, examining the ways in which humans engage in intergroup conflict and the ways in which such conflict may be ameliorated. In the healthcare literature, intergroup conflict has been shown to affect the quality of teamwork in healthcare settings (Bartunek 2011). Several papers in health disciplines have examined social identity and intergroup conflict theory, in relation to the professional identity of nurses (Willetts & Clarke 2014), intergroup processes between nurses and doctors in the operating theatre (Greer et al. 2012), in the prevention and treatment of cancer (Harwood & Sparks 2003) and in the context of communication in maternity care (Watson et al. 2012). Given the polarisation of attitudes towards risk and safety in childbearing, particularly in relation to place of birth; attention to the understanding and management of social-psychological dynamics between maternity caregivers is urgently needed in the transfer context.

Intergroup conflict is relevant to homebirth transfer because of the convergence of different paradigms of childbearing that occurs when a woman is transferred. The midwife-woman partnership, the woman's partner and her other support people usually possess strong trusting relationships and are likely to identify with each other as an in-group. They may view hospital staff who display disapproval of homebirth, or highly medicalised approaches to care, as an out-group. Women who perceive that their goal of a natural birth is not shared by others will pitch them as an out-group. Hospital staff, who may view the homebirth community as possessing an alternative collective belief (Cheyney 2008) may also view the woman transferred in, and her support team, as an 'out-group' that is to be dominated or controlled.

In a homebirth transfer situation, women and homebirth midwives face a power imbalance for several reasons. Firstly, the subordination of the homebirth midwife occurs through the loss of her clinical rights to practice in the hospital. Secondly, the unavoidable fact that they are on hospital territory is disempowering, and thirdly because of the belief by some that women choosing homebirth are naïve or ill-informed. All these factors may fuel attempts to dominate and control women. Those

in positions of power are known to identify more strongly with the attitudes of their in-group, than do members of marginalised groups; and are less likely to individualise their perceptions of those they consider to be subordinate (Operario & Fiske 2003). Lack of individualisation of others leads to stereotyping, examples of which were explored in Chapter 7, *'Us and them'.*

Chapter 5, *'Fostering relationships and reducing uncertainty',* shows the ways in which women and their homebirth midwives sought to reduce uncertainty where possible during pregnancy, both for themselves and for hospital staff. Reducing uncertainty was a mechanism of preparing for the possibility that transfer may occur. Chapter 6, *'Transferring out of the comfort zone'* and Chapter 7, *'Us and them',* explores how and why homebirth transfer is a situation that brings high levels of uncertainty, for women and for the health professionals who care for them. Seeking a group identity is known to be an effective way to reduce feelings of uncertainty (Hogg & Abrams 2001; Hogg and Adelman 2013; Vaughan & Hogg 2011) because it enables individuals to predict the behaviours of others and plan their actions accordingly. The need to seek a group identity often motivates individuals to adopt negative behaviours such as stereotyping that are associated with intergroup conflict.

Social categorisation forms the building blocks of stereotyping (Tajfel & Turner 2001) and helps us to simplify our world view, by making it seem more 'black and white'; thereby catalysing *'us and them'* dynamics (Operario & Fiske 2003). In the context of homebirth transfer, social psychological perspectives offer theoretical explanations as to how different caregivers, possessing different ideologies, categorise themselves into in-groups and out-groups, thereby potentially creating *'us and them'* interactions and hostility.

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 homebirth midwives adopted a strong advocacy role for the women they cared for. Women valued highly the continuous presence of

their homebirth midwife when transferred. Conversely, out-group derogation is known to lead to stereotyping, prejudice, poor communication and prejudicial use of language (Tajfel & Turner 2001). The findings showed examples of all these behaviours.

Oxytocin: Neuro-hormonal perspectives on 'us and them'

The argument for applying the framework of intergroup conflict to the homebirth transfer context is strengthened by the evidence that hypothalamic release of oxytocin, a neuropeptide produced by women in labour, may enhance group identification and intergroup conflict (Van IJzendoorn & Bakermans-Kranenburg 2012). Continuous support for women during labour and birth is widely known to improve outcomes for women and babies (Hodnett et al. 2013). When trust, support and co-operation is shown towards a person, hypothalamic oxytocin release is stimulated (de Dreu et al. 2010), adding a neuro-hormonal dimension to the findings that the partnership between a woman and her homebirth midwife is a powerful bond.

The effects of oxytocin have been widely studied since seminal research published in the journal 'Nature' by Kosfeld et al. (2005), which demonstrated that exogenous oxytocin administered via intranasal spray increased levels of trust felt by humans. More recently, several studies have shown this effect to be dependent upon the social context and the level of connection with people involved in the interaction (Bartz et al. 2011; Buckley 2015; de Dreu et al. 2010; Declerck, Boone & Kiyonari 2010; Mikolaczak et al. 2010; Van IJzendoorn & Bakermans-Kranenburg 2012). Oxytocin, when released by the hypothalamus, facilitates empathy with familiar others and appears to increase in-group trust and co-operation (Bartz et al. 2011; de Dreu et al. 2010; Van IJzendoorn & Bakermans-Kranenburg 2012). Increased attention to social cues occurs in the presence of oxytocin and is amplified in the presence of familiar persons (Bartz et al. 2011). Only minimal levels of familiarity (as little as one prior meeting) were required for in-group identification to be magnified by oxytocin (Declerck, Boone & Kiyonari 2010). The relevance to this study is that the concept of trust emerged in Chapter 5 as a significant element of the processes of building the midwife-woman partnership, fostering professional connections and reducing uncertainty.

Oxytocin is known to elevate defensive behaviour toward an out-group (de Dreu et al. 2010) and decrease out-group cooperation. When a person is perceived as untrustworthy, oxytocin will not enhance feelings of trust (Mikolaczak et al. 2010), suggesting that negative feelings towards those perceived as the out-group will not be improved by the presence of oxytocin. In the homebirth transfer context, women transferred during labour may experience feelings of defensiveness and lack of cooperation towards hospital staff members who are perceived as belonging to an out-group, the levels of which are increased due to oxytocin production. Prosociality is reduced towards those perceived as members of an out-group. Diminished prosociality also occurs in situations of uncertainty (Bartz et al. 2011), homebirth transfer being one such situation. This study did not include the measurement of oxytocin levels, however, this could be the subject of further research, as is explained in Chapter 10 Implications for Practice.

Summary of 'us and them' conflict

This section of the discussion has shown that social psychological perspectives on intergroup conflict are relevant to the social dynamics in the birthing room of a woman who has been transferred to hospital from a planned homebirth, for several reasons. Both evidence from the literature and from the findings support the view that dichotomous paradigms and conflicting approaches to childbirth are prevalent. The homebirth transfer setting is a salient example of those paradigms converging, resulting in the hospital birthing room of a transferred woman having the potential to become a *'contested space'* (Cheyney, Everson & Burcher 2014, p.451). The relationship between a woman who has planned a homebirth and her midwife is a strong partnership built on trust, enhancing their formation of an in-group. Additionally, there is evidence to show that oxytocin, produced by women in labour, enhances in-group favouritism and out-group derogation (Bartz et al. 2011; de Dreu et al. 2010; Van IJzendoorn & Bakermans-Kranenburg 2012). Finally, the theoretical link between stereotyping behaviours and intergroup conflict was made explicit by the findings in Chapter 7, *'Us and them',* describing that such attitudes and behaviours occurring frequently in the transfer setting.

Ameliorating intergroup conflict

Social psychological perspectives also provide a framework with which to analyse the amelioration of intergroup conflict. It is theoretically possible that the notion of intergroup conflict theory could be applied in the homebirth transfer context in the future. Shifting or re-categorising the boundaries of group identity is one way to reduce conflict (Tajfel & Turner 2001). Often a sense of identity may be dependent on context, a notion referred to as *'situational identity'* (Strauss 1969, p.152). Levels of group identity are fluid and can be strengthened or weakened with a reassessment of experience (Strauss 1969). Re-categorising the boundaries of conflicting groups may trigger a reassessment, thereby reducing in-group identification and intergroup hostility. In the homebirth transfer context, midwives' identities have the capacity to be fluid and situational. They may align themselves with other members of the midwifery profession, with the hospital protocols, with the obstetrician or with the woman. This is significant because the group with which midwives choose to identify may not always be fixed, which therefore may be beneficial to the amelioration of intergroup conflict.

In the context of homebirth transfer, this means that if midwives categorise themselves as belonging to 'hospital' or 'homebirth' they may accentuate their differences; however, if they categorise themselves as belonging to the one profession of midwifery, and sharing a woman centred approach, their differences may be de-emphasised. Examples of the re-categorisation of group identities may include shifting towards an overarching sense of 'being midwives' and/or 'being woman centred'. By focussing on their professional commonalities rather than their workplace differences, midwives are well placed to influence the amelioration of intergroup conflict. Examples of conversation that may stimulate this may include:

- Being midwives: acknowledging professional similarities
    - Where did you study/train in midwifery?
    - Did you attend the recent midwifery meeting/seminar/conference, wasn't it great?
    - Have you heard about the … that the ACM is planning?

- Being woman centred: how can we help this woman optimise her sense of safety and well-being?
    - What can I do in a practical sense to help you fulfil your role?
    - Do we perhaps need to consider bending the rules a little?

Minimisation of aggressive body and facial cues, and an increase of non-aggressive cues such as laughter, may help to ameliorate intergroup conflict (Vaughan & Hogg 2011). A friendly approach, small talk and joke sharing may be ways in which caregivers may interact, whilst remaining respectful of the women's birthing space as paramount.

Sharing women's goals

In Chapter 8, 'Celebrating a successful transfer', a birth outcome resulting in a 'healthy mother and a healthy baby' was a goal ostensibly shared by all women and caregivers. This notion is not new, the goal of a healthy mother and healthy baby was also identified as a shared goal in maternity care by Simpson, James and Knox (2006) and discussed by Downe, Finlayson and Fleming (2010) in their study of collaboration in maternity care. How midwives and obstetricians interpret the ways to achieve that outcome, however, is often not shared (Simpson, James & Knox 2006).

From an intergroup conflict perspective, a superordinate goal is a shared goal that is a solution to a problem that cannot be facilitated by one group alone, but requires the co-operation of both groups in order to resolve it (Sherif 2010). If in the homebirth transfer context, the shared goal of a 'healthy mother and a healthy baby' was explicitly reframed as a 'superordinate goal', both the homebirth midwife and hospital staff would plainly identify their need to collaborate, in order to achieve a good outcome. By transferring, the woman is acknowledging that her labour and birth could no longer continue successfully at home, and therefore the need for medical care in hospital is accepted. Likewise, by acknowledging that the woman needs the presence of the midwife-woman partnership to provide emotional support, advocacy and guidance in hospital, the role of the homebirth midwife will be respected.

Chapter 8 shows that a variety of definitions of 'healthy mother and a healthy baby' were rooted in disciplinary epistemologies and paradigms of risk and safety that were incongruent. These epistemologies and paradigms amongst caregivers implicitly influenced the ways in which they interpreted the evidence and the ways in which they enacted their caring. Defining shared goals required shared understanding. To reach a woman centred understanding of 'healthy mother and healthy baby', the voice of the woman needs to be heard.

Handover is an opportunity to identify superordinate goals and discuss options for ways in which they may be achieved. The proposed principles for handover, outlined in Chapter 10 in the Implications for practice, draws attention to the ways in which handover communication may address such issues. The initial style of interaction that occurs between hospital and homebirth midwives during handover may establish a prevailing social dynamic, which determines whether intergroup conflict can flourish or is dissipated.

A technique known as 'perspective giving' is known by social psychologists as a useful communication strategy for ameliorating intergroup conflict in situations where there is a power imbalance between groups (Bruneau & Saxe 2012). Members of the dominant group empower the non-dominant group by allowing them to express themselves. A shift in social dynamics results in a communication give and take, where the non-dominant group is feeling heard and the dominant group is listening (Bruneau & Saxe 2012). In some transfers, women did not feel heard and did not feel that the hospital staff listened to their homebirth midwives as well as they might. 'Perspective giving' shows how hospital staff may better support the midwife-woman partnership, simply by listening to them. In particular, respecting what is said by the homebirth midwife during handover has the potential to engender this positive shift from the outset, as does respecting the woman's individual needs. This is aligned with the findings in Chapter 8, *'Celebrating a successful transfer',* about the value of demonstrating mutual respect and supporting the midwife-woman partnership as a unit.

Supporting woman centred care in homebirth transfer

Every human being has the right to determine what will happen to his or her body. This is enshrined in health care policy, human rights principles and Australian law. Every woman, whether or not she is pregnant, maintains basic human rights such as personal autonomy and self-determination and has the same right to make informed decisions in healthcare settings as any other legally competent adult (Kruske et al. 2013; McLean & Petersen 1996; Olsen & Clausen 2012). An unborn child has no legal rights; therefore, it is irrelevant and futile to consider that there may be any legal balance between a woman's autonomy and the rights of her fetus (McLean & Petersen 1996). A woman is therefore the only person with the authority to make informed decisions about what is best for the health and well-being of herself and her unborn baby (Kruske et al. 2013; Olsen & Clausen 2012). Evidence suggests that this is poorly understood, from both ethical and legal perspectives, by many caregivers (Kruske et al. 2013).

The notion of respect for the informed decision making of childbearing women is supported by several bodies governing the practice of health professionals and rights of consumers in Australia. Examples of these include two statements from the Australian College of Midwives, the *'Midwifery Philosophy'* (ACM 2011) and the *'Position Statement on Homebirth Services'* (ACM 2016); the *'Position Statement on Person Centred Care'* by the Australian College of Nursing (ACN 2014); the Australian Commission on Safety and Quality in Healthcare (ACSQHC), *'Australian Charter of Healthcare Rights'* (ACSQHC 2008); and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) College Statement on *'Collaborative Maternity Care'* (RANZCOG 2016).

The *'Australian Charter of Healthcare Rights'* (ACSQHC 2008) and the philosophies of woman centred or person centred care are aligned with respect for a women's own personal definition of what constitutes her health and well-being, acknowledging that a woman's informed decisions are made in the context of her individual parameters of risk and safety. For many women, safety encompasses not only medical definitions but also social, cultural, emotional, psychological and spiritual dimensions.

Strengths of the study

A strength of this study is the theoretical focus upon the processes and interactions occurring during homebirth transfer. This is the first time, to my knowledge, that the concept of intergroup conflict from social psychology has been synthesised with data from research on homebirth transfer. Given the wide use of the intergroup relations concept in areas of political and racial conflict, and the existing level of the polarisation of views about safety and risk in maternity care, it is a salient framework to adopt here. The potential for application of the theory reaches beyond the homebirth transfer context, into the broader maternity care milieu, in which obstetricians, midwives and others must collaborate to care for women experiencing unexpected outcomes and complications during childbearing. This has been addressed, in relation to communication between maternity care professionals, by Watson et al. (2012).

Another key strength of the study is the explanation of why women transferred from a planned homebirth are often labelled 'difficult'. By recognising the need for women to have time to process their psychological journey, and facilitating that time, health professionals may find women to be more willing to accept intervention. This perspective may extend to other areas of maternity care where women experience variations from their expected labour and birth trajectory.

The recognition of the midwife-woman partnership as a powerful contributor to the *'contested space'* (Cheyney, Everson & Burcher 2014, p. 451) of the birthing room is another strength of the study. The midwife-woman partnership has been well researched since the seminal work of Guilliland and Pairman (1995) and Page (2000) and is a widely understood concept in the discipline of midwifery. This study adds to what is known by highlighting the way in which others may understand or misunderstand the value of the partnership. It also may enhance comprehension of the relationship between women and their midwives or doulas in planned hospital and birth centre births.

In Chapter 10 that follows, in the Implications for Practice section, two sets of principles are proposed. One is in relation to preparation for the possibility of transfer,

which is a 10-step process designed to assist midwives and women in their preparation for this sometimes overlooked area of planning a homebirth. The second is a set of proposed principles for handover communication in the homebirth transfer context, which encompasses the unique needs of women and caregivers in the homebirth transfer setting.

Finally, a strength of the study is that it reframes a transfer event as a success to be celebrated, rather than what is often regarded as a 'failed homebirth'. Chapter 8, *'Celebrating a successful transfer',* refers to the rich data coming from many caregivers and women who have experienced positive transfers. A high standard of handover communication, *'supporting the midwife-woman partnership'*, *'demonstrating mutual respect'*, *'stepping back'* rather than *'taking over'*, and *'sharing goals with women',* who are at the centre of the birthing experience, are all strategies that have been proven to work. Furthermore, they are strategies that are aligned with decades of controlled experiments and research in other settings by social psychologists.

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 will hopefully provide a step towards that ideal.

Limitations of the study

One limitation of this study was the lack of access to data from paramedics and other ambulance service personnel. There is no qualitative literature on homebirth transfers in Australia from the perspectives of the ambulance service, although it has been acknowledged here and in the literature, that this is needed, in order to fully understand their role in the process (McLelland et al. 2016). Ethical approval from the Ambulance Service, to interview paramedics for this study was not possible. Despite keen interest in the study from management personnel, and assurance that

interactions between paramedics and midwives was of primary interest, the Ambulance Service research committee took the view that confidentiality of clients would be threatened by this research. The committee felt that homebirth transfer clients are vulnerable due to the level of media interest the topic attracts. Anecdotally, it seems that the Ambulance Service is less cautious in its approach to granting approval for quantitative research, possibly due to a perception that clients would be less identifiable in a quantitative analysis than they would in a qualitative one.

Homebirths in Australia are small in number, 0.3% of all births in 2013 (AIHW 2015). This could be seen as a limitation of the research, however, until more is known about safety in planned homebirth in Australia it is not likely to expand. I was able to collect 36 semi-structured interviews which is a substantial number for a qualitative study, especially given the size of the overall population of women planning homebirths.

A further limitation was that I was only able to collect data in urban and regional areas of four states of Australia; Victoria, New South Wales, South Australia and Tasmania. Due to the methodological importance of conducting interviews face to face (Charmaz 2014), I prioritized interviewing in person wherever possible and resources to travel further were not available. A few interviews were conducted by telephone for the convenience of the participant, but mostly with participants whom I knew, or with whom I had an initial face to face conversation when gaining consent. There were no participants from rural and remote settings, or from the Australian Capital Territory, Western Australia, the Northern Territory or Queensland. A recently published study exploring the experiences of homebirth midwives involved in transfers in Western Australia is a useful complement (Ball et al. 2016). Many of the findings of their study, discussed in the literature review in Chapter 2, are aligned with the findings from homebirth midwives in this study.

In general, participants' experiences were more positive than we expected. Although I was very grateful for the assistance provided by midwives and managers in publicly funded homebirth programmes in the recruitment process, I acknowledge the potential risk that they may have consciously or unconsciously adopted a gatekeeping

role when assisting me with recruitment. Due to ethical restraints, I was unable to directly recruit women who had given birth in publicly funded homebirth programmes. I relied upon the midwives' generosity, time and effort to provide connections with suitable women. Hence, it is possible that the women who were contacted by their midwives for recruitment were those women who had more positive transfer experiences. Midwifery managers may also have consciously or unconsciously chosen obstetricians for interviews who were more sympathetic to the provision of homebirth services. It is also conceivable that to protect the survival of homebirth services, midwives may have tried to portray their views and experiences as positively as possible.

Although data was collected on the postnatal experiences of women following a homebirth transfer, it was decided not to include this in the thesis, due to the large amount of rich data that pertained to the antenatal and intrapartum periods. Neonatal transfers were also excluded, because it became apparent from early interviews with midwives that issues surrounding the transfer of a baby to a hospital neonatal unit after being born at home were significantly different from transfers of a labouring woman to an obstetric unit in hospital. An additional barrier was that neonatal staff members were not forthcoming in the recruitment process. More research is needed on the transfer of babies to neonatal services after planned homebirth.

Conclusion

This chapter has demonstrated how the synthesis of the findings that were grounded in the data were integrated with theoretical codes to formulate the grounded theory of 'supporting woman centred care in homebirth transfer'. Theoretical codes were drawn from the concept of intergroup conflict, principles of human rights and the midwifery philosophy of woman centred care. The theory, although grounded in data about homebirth transfer processes, may have broader reach and implications for maternity care. The theory suggests, perhaps controversially, that from a number of perspectives, applying the midwifery philosophy of woman centred care in childbirth is indefensible. Even in the context of incongruous epistemologies, neither the rights of the fetus, nor the preferences of any health professional, nor objectivist views of risk

and safety may override the respect for a woman's individual informed decisions during her childbearing journey. Furthermore, this view is underpinned by healthcare policy in Australia.

This thesis may pave the way for transdisciplinary conversations about what may constitute a more successful approach to women's choices about place of birth and other contested areas of maternity care. This matters, because it may offer new possibilities for meeting the challenges of inter-professional collaboration in maternity care in Australia and other settings. Greater levels of professional collaboration may pave the way for better access to the choice of place of birth for women and their families.

Chapter 10 will conclude the thesis, firstly discussing implications for practice, then proposing areas for further research in the field. The reference list will follow.

CHAPTER TEN: IMPLICATIONS AND CONCLUSION

Introduction

This chapter outlines implications for practice and further research and draws a conclusion to the thesis. Implications for practice relate to five areas; the transfer journey by road, transfer documentation, preparation for the possibility of transfer from planned homebirth, understanding women's need for time to manage their expectations, and handover.

Implications for further research relate to five areas; seeking information about the views and experiences of paramedics, the impact of oxytocin upon intergroup conflict, the ways in which different publicly funded homebirth programmes are structured and organised in relation to transfer, the views and experiences of families whose babies are transferred after being born at home, and the potential for a transdisciplinary approach to be applied to the process of compiling joint statements on homebirth transfer from the two relevant Australian professional colleges, the ACM and RANZCOG.

The conclusion section is followed by the reference list.

Implications for practice

As previously stated, implications for practice relate to five areas; the transfer journey by road, transfer documentation, preparation for the possibility of transfer from planned homebirth, understanding women's need for time to manage their expectations, and handover. These will be discussed in turn.

Transfer journey

Many non-urgent transfers take place in private cars, in a similar way to the journey to hospital during labour for a planned hospital birth. Avoiding an ambulance may help transferring women to reduce uncertainty around their changing expectations by

eliminating unfamiliar caregivers and travel in a strange vehicle. This may reduce emotional stress and help to normalise the event of transfer. Implications for practice are that homebirth midwives may reconsider the need to call an ambulance unless there is a clinical indication. The resource implications of this for the ambulance service are obvious. There is no suggestion here that there be any hesitation to call an ambulance if there are clinical indications for it.

The use of 'lights and sirens' had an emotional impact upon levels of uncertainty experienced by women because their presence had the capacity to cause fear and anxiety about their well-being and that of their baby. The implication for practice is that lights and sirens be used only when deemed clinically necessary, and that if they are necessary, communication with the woman about the reason for their use remains paramount.

Transfer documentation

In 2015, the Australian College of Midwives Professional Practice Advisory Group (PPAG) compiled the *'Transfer from planned birth at home guidelines'* (ACM 2016) which were released after public consultation in March 2016. The guidelines contain algorithms to guide practice and documentation templates that may be used to assist documentary handover to hospital staff. I was a member of the PPAG and a major contributor to the transfer guidelines. In the future, I would like to add value to this document by proposing the inclusion of guidelines for handover in the unique setting of homebirth transfer.

10 steps of preparation for the possibility of transfer

A 10-step pathway to guide midwives and women in their preparation for the possibility of intrapartum transfer from planned homebirth is illustrated in Table 8.

Table 8: Preparation for the possibility of transfer: 10 steps

1	2	3	4	5	6	7	8	9	10
Woman centred care is the overarching goal during all phases. Health professionals provide care for transferred women that is safe, respectful and woman centred (1).	**Midwives provide women with information during their pregnancy, about what would occur in the event of transfer.** This includes providing information on the indications for and processes of transfer, identifying a back-up hospital, clarity of the midwife's role during transfer, and supporting women to engage on an emotional level with the possibility that transfer could occur.	**Booking in** for hospital back up care is enabled by all tertiary and secondary public hospitals, and women are given the opportunity to become familiar with the hospital environment during pregnancy. Women are encouraged to consider other preparations for the possibility of transfer, such as writing a hospital birth plan, getting ambulance membership and packing a hospital bag.	**Communication is open and transparent during all phases,** aiming to reduce uncertainty for all concerned. The reasons for clinical recommendations are clearly communicated to women, and their informed consent is sought.	**Continuity of midwifery carer** is provided during transfer by the primary homebirth midwife, or a known back-up midwife, until after the birth of the baby. Planning for this should not entail any different arrangements than would be in place for a birth at home.	**Handover** encompasses considerations of the unique context of transfer to hospital from a planned Homebirth. For further details please refer to the Principles for Handover below.	**Informed decision making** is enabled. In the absence of emergency, women are given time for decision making in the context of managing their changing expectations. This may include time to discuss options with their known midwife, in private.	**The midwife-woman partnership is respected.** Hospital staff embrace their role in taking clinical responsibility whilst supporting the midwife-woman partnership. This is different from 'taking over'.	**Mutual respect is demonstrated for the expertise, roles and responsibilities of all caregivers and for the expertise of the woman about her own needs.** Stereotyping and 'us and them' attitudes and behaviours are strenuously avoided.	**Transfer is framed as a successful outcome, not a 'failed homebirth'.** Language is appropriate without the capacity to engender fear.

1) Woman centred care encompasses the health, safety and well-being of the woman and her baby from a range of perspectives including physical, emotional, psychological, social, cultural and spiritual priorities of the woman. The woman is recognised as the person with authority to make evidence based decisions for herself and her unborn baby.

Time to manage changing expectations

Chapter 6, *'Transferring out of the comfort zone'* and Chapter 9, *'Discussion',* showed that often when the circumstances of a woman's labour and birth changed, it took time for her to process her changing expectations emotionally and psychologically. This meant that some time needed to pass before she could recommence participating in informed decision making processes. A change of environment and meeting unfamiliar caregivers may have exacerbated the challenges of this psychological processing. Women sometimes resisted monitoring and intervention, in an effort to buy time to process their changing expectations. When caregivers were sensitive to the individual needs of women in regards to their readiness to accept intervention, conflict was usually avoided. This finding is particularly salient to the investigation of homebirth transfer, but also may apply in other contexts in which women face unexpected outcomes in their labour and birth. The way in which a woman's readiness for monitoring and intervention is communicated in handover may assist caregivers to understand her individual needs. This understanding may provide the opportunity to make appropriate decisions by balancing the needs of the woman with the findings of the clinical assessment.

Handover principles

The quality of handover communication at the time of transfer has the capacity to influence the interactions and processes that ensue thereafter, as was shown in this study and elsewhere (Wilyman-Bugter and Lackey 2013). A lack of guidelines for handover communication in the homebirth transfer context is problematic. The recently published documents guiding homebirth transfers in the Australian context (ACM 2016) and the United States Home Birth Consensus Summits (Vedam et al. 2014) provide frameworks for the timeliness and format of handover. I propose, however, that they may be further informed by the nuanced findings and synthesis of this qualitative research.

The first relevant finding is in relation to women having time to process their changing expectations, as outlined above. The second is in relation to women with privately

practising midwives, that is, the importance of hospital staff supporting the midwife-woman partnership as a unit, regardless of their perceived need to take over the clinical care of the woman.

Timely referral, consultation and transfer, and smooth collaboration between caregivers are important for the safety and well-being of women and their babies (Downe, Finlayson & Fleming 2010). The following best practice principles for handover were compiled as a result of the findings of this study and personal conversation with Professor Saraswathi Vedam (Vedam 2016, pers. email comm., 29 February), as follows (Figure 6):

Handover occurs in the presence of the woman, partner/support team, her transferring homebirth midwife, receiving hospital midwife and obstetric staff, and includes the following:

- In the event of a clinical emergency, a clear verbal summary of clinical details is given immediately, to address physical safety concerns for the woman and baby. In the lack of an emergency this information is given as dot point 3.
- A summary of what is important to the woman, this may include handover of a written transfer birth plan. The woman's emotional, psychological, cultural, spiritual and environmental needs are acknowledged.
- Written and verbal clinical information is provided, such as the woman's hand held pregnancy record and/or a written antenatal and intrapartum history.
- A summary of the decision-making process leading up to the transfer, and a discussion with the woman about her emotional and/or psychological readiness to accept medical intervention.
- A discussion of the roles of the midwives who will provide ongoing care of the woman. Hospital staff respect and support the partnership between the woman and her homebirth midwife. Homebirth midwives respect and support the clinical responsibilities and duties of the hospital staff.
- When clinical rights to practice are not available, homebirth midwives continue to care for the woman in the hospital setting in a support and advocacy role. When the midwife is not available due to fatigue, her back up midwife (known to the woman) is provided. When this is not possible, the homebirth midwife spends 30 minutes in the hospital with the woman to complete handover and assist her to make the transition to hospital care.

Figure 6: Best practice principles for handover in the context of transfer from planned homebirth to hospital

Implications for further research

As previously stated, implications for further research relate to the views and experiences of paramedics, the links between oxytocin and intergroup conflict, the ways in which different publicly funded homebirth programmes are structured and organised in relation to transfer, the views and experiences of families whose babies are transferred after being born at home, and the potential for a transdisciplinary approach to be applied to the process of compiling joint statements on homebirth transfer from the two relevant Australian professional colleges, ACM and RANZCOG.

The experiences of paramedics

To my knowledge, there is no qualitative literature exploring the views of paramedics on their experiences of homebirth transfers in Australia. Their perspectives, and that of the operators answering calls from the emergency telephone number (000 in Australia), is needed, to provide a richer perspective on their role in homebirth transfers. As the demand for planned homebirth is expected to continue to rise in Australia, there is a growing need for research on the processes of homebirth transfer that involve paramedics.

Oxytocin and intergroup conflict

The discussion chapter describes how oxytocin production may increase the effects of group identification intergroup conflict (Bartz et al. 2011; de Dreu et al. 2010; Van IJzendoorn & Bakermans-Kranenburg 2012). Women are known to produce oxytocin during labour and birth (Buckley 2015; Fuchs et al. 1991; Moberg 2003). Anecdotally at least, many midwives feel their oxytocin levels increasing when caring for women experiencing physiological labour and birth. Further research involving blood sampling may show whether levels of oxytocin do increase in midwives involved in physiological labours. The feasibility of this research was demonstrated by Blaicher et al. (1999) in their serum testing of oxytocin levels in women before and after sexual arousal. It may be assumed that collecting blood from midwives in a clinical setting would be less complicated than the circumstances of Blaicher's research.

Publicly funded homebirth: Differences between services

Early in the data collection and analysis process, it became clear that there are inconsistencies in the way in which individual publicly funded homebirth programmes are structured. For example, some have policies that support continuity of midwifery carer where possible during transfer and others do not. Some are part of a Midwifery Group Practice that cares for women of all risk and others only for women of low risk. Some provide care in a birth centre that is attached to the main tertiary hospital and others provide care in a free-standing birth centre some distance from the tertiary setting. This was a complex area of investigation that was beyond the scope of this thesis because a comprehensive approach would require HREC approval from a larger number of publicly funded homebirth services. Further research is needed to identify whether these organisational factors affect the care of transferred women and/or the working conditions of midwives. Furthermore, comparisons could be made with private practice around issues such as continuity of care, burnout and staff retention. The PhD work of Rebecca Coddington at the UTS Centre for Midwifery, Family and Child Health, due for completion in 2017, may address many of these issues.

Neonatal outcomes

Interviews with midwives who had experienced neonatal transfers of babies born at home revealed that the processes of neonatal transfer were very different to those of maternal transfer. Neonatal staff members were not forthcoming in the recruitment process so it would have been difficult to balance the analysis. The decision was made, therefore, that this area was beyond the scope of this thesis. Data that was specific to neonatal transfers was excluded. Further research is needed to investigate the experiences of families whose babies have undergone a transfer to a hospital neonatal unit, after being born at home.

Transdisciplinary approaches

An initial exploration of transdisciplinary theory revealed that the approach might provide a pathway to developing solutions that equal more than the sum of the parts of the solutions to problems that currently exist in fragmented maternity care worldwide. A comprehensive understanding of transdisciplinary theory was beyond

the scope of this thesis. Further research is needed to investigate whether this approach may have value in the Australian maternity care setting, by attempting to compile joint protocols and guidelines from professional colleges of midwifery (ACM) and obstetrics (RANZCOG). Internationally, transdisciplinary Home Birth Consensus Summits were held in the United States of America (USA) in 2011, 2013 and 2014. The summits were formulated to develop shared understandings amongst a range of maternity care stakeholders resulting in the establishment of the US Home Birth Summit Collaboration Task Force (Vedam et al. 2014). The success of the project in the USA suggests that consideration of a similar process in the Australian context may be worthy.

A transdisciplinary approach is pertinent in that it attempts to transcend the fragmentation of paradigm boundaries that stem from separate disciplinary approaches, and for this reason resonates with the context of homebirth transfer. In a transdisciplinary process, desegregation of traditional disciplinary boundaries occurs, creating a perspective that is greater than the sum of its parts. Positive communication is key to the process, as traditional boundaries are challenged and the resulting uncertainty is accommodated (Lawrence 2010). Transdisciplinary theory distinguishes itself from interdisciplinarity, which is defined as *'the bringing together of disciplines which retain their own concepts and methods that are applied to a mutually agreed subject'* (Lawrence 2010, p.19). Multidisciplinarity is defined as *'research in which each specialist remains in their own discipline and contributes using disciplinary concepts and methods'* (Lawrence 2010, p.19). Interdisciplinarity and multidisciplinarity rely upon the presence of one co-ordinator whose responsibility it is to draw the contributions of others together and guide the process of achieving a result. A transdisciplinary approach to solving complex problems requires a deeper level of exploration, addressing areas of philosophical commitment such as ontology, epistemology and ethics (Brown, Harris & Russell 2010). Further work in my postdoctoral phase plans to explore practical strategies for creating a transdisciplinary forum in the Australian context, with the goal of formulating joint professional guidelines and policies.

Conclusion

This study aimed to explore the views and experiences of women and caregivers involved in intrapartum transfer from planned homebirth to hospital. At the commencement of the study in 2012, much was known about rates of transfer and the reasons for it, but from a qualitative perspective there little was known in the field. The constructivist grounded theory approach enabled a theoretical focus upon the social processes and interactions that occurred.

This research has confirmed that homebirth transfer is a unique and complex clinical situation that has the potential to cause high levels of uncertainty. The different epistemologies, paradigms, backgrounds, roles and routines of the caregivers who converge to care for transferred women underpin the complexity. Furthermore, the power and value of the midwife-woman partnership in the homebirth transfer context is often poorly understood. The resulting implications upon the social interactions and dynamics in the birthing space of a transferred woman have not previously been studied.

The choice of this PhD topic emerged from a passion for exploring the ways in which a range of maternity caregivers may collaborate in a safe and woman centred manner when a woman's place of birth changes. Homebirth transfers provide salient opportunities to examine this, however, the resulting grounded theory has the potential to reach beyond the homebirth transfer context. The main tenet of the theory *'Supporting woman centred care in homebirth transfer'* has implications for the broader maternity care milieu because the approach to collaboration may be applied to any situation in which a childbearing woman requires referral for medical assistance.

Clinical circumstances often change during the intrapartum period, sometimes rapidly. This fact is often touted as the reason why a hospital is the only safe place to give birth. Perhaps there may be some truth to this, given that the current system is not geared to ensure smooth transfers. The maternity care system needs to more adequately cater for women choosing out of hospital births, by actively promoting

consultation, referral and transfer processes of the highest standard. All women have the right to access quality care from a known midwife and to be able to continue to access it, regardless of the need for additional medical assistance or change of place of birth.

Fresh perspectives brought by this study may enrich understanding of how caregivers may approach a transfer event. There has been a considerable amount of literature published in the past twenty years on the midwife-woman partnership, however, to my knowledge, this is the first time the partnership has been seen as a powerful entity that has the capacity to threaten the role of other caregivers. The findings also extended understanding of some of the reasons why women are labelled 'difficult'. Women who are managing changing expectations for their birth are making a psychological journey that takes time to process, emotionally and psychologically. Understanding this may help caregivers to know that women use a range of methods to buy time while they process their psychological journey, including resisting monitoring and intervention. It is not that their behaviour is simply 'difficult'. The synthesis of intergroup conflict theory with the findings illuminated the ways in which *'us and them'* dynamics emerge and may be ameliorated or prevented. Although intergroup conflict theory has been applied to communication in maternity care, and oxytocin has been shown to increase the effects of group identification and intergroup conflict, this was the first time these two areas have been used in relation to synthesising the interactions in the birthing room of a woman transferred from a planned homebirth.

It is hoped that the human rights perspective embedded in the grounded theory, *'Supporting woman centred care in homebirth transfer',* will strengthen the growing international call for acknowledgement of women's rights in childbearing. The fact that Australian law and healthcare policy underpins the tenets of woman centred care has been revealed in the process. Those who purport the fetus as having a 'voice' separate from its mother may heed that their view is not supported by law, policy or principles of human rights.

Transfer from planned homebirth to hospital is a challenging transition for women to make during labour. Fostering a strong midwife-woman partnership in pregnancy will support a woman through a transfer to hospital, if one eventuates. Reducing her uncertainty during pregnancy, by undergoing mechanisms of preparation, and encouraging her to be open to the possibility that transfer may occur, is of value.

Understanding the dynamics of the interactions between those caring for transferred women in this study enabled the composition of guidelines for handover communication and role negotiation between health professionals that may assist in improving care in the transfer setting. Prioritising the needs of each individual woman by respecting her authority as an informed decision maker, and sharing her goals for the health and well-being of herself and her baby may result in the more frequent celebration of successful homebirth transfers.

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