Joy, guilt and disappointment: An interpretative phenomenological analysis of the experiences of women transferred from midwifery led to consultant led care

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A R T I C L E   I N F O

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Transfer
Interpretative phenomenological analysis
Birth Experience

A B S T R A C T

Background: Irish maternity services are predominantly medicalised and consultant led, therefore women who choose midwifery led care (MLC) do so in the context of limited birth choices. Transfers to consultant led unit (CLU) for consultant led care (CLC) can be unpredictable and can affect women’s birth experiences. This study provides an in-depth exploration of women’s experiences of transfer from MLC to CLC during late pregnancy or labour.

Methods: Transfer experiences are explored through qualitative explorative in-depth interviews using interpretative phenomenological analysis (IPA).

Sample: Mothers who had experienced transfer from MLC to CLC during late pregnancy or labour were invited to participate. A purposive sample of eleven women following birth (five to 16 months post partum) provided their views.

Findings: Women described choosing MLC as a means of avoiding interventions and hoping for a fulfilling natural birth experience. However, participants describe feelings of ambivalence about their experiences, leading to conflicting emotions of joy with their new baby offset with disappointment about needing to transfer to CLC.

Conclusions: Choosing MLC in a risk averse culture can affect how women experience the transfer process. The impact of the transfer can involve a multilayered psychological and emotional adjustment to a different birth experience for women. The findings provide important insights into issues of policy, preparation, and communication prior to and after transfer to CLC, which should be useful for policy makers, health care professionals and educators.

Introduction

Midwifery Led Care (MLC) is a specific women centered model of maternity care where the midwife is the lead autonomous professional for ‘low risk’ women. The ethos of MLC is a belief in the normality of childbirth, and the provision of women-centered care by a known and trusted midwife (Hatem et al., 2007). Benefits for mothers include retaining a sense of identity, feeling more in control, minimising interventions (Sandall et al., 2013), and subsequent positive birth experiences (McLachlan et al., 2016).

Autonomous MLC in the Republic of Ireland is limited to two midwifery led units (MLUs) located alongside hospital consultant led units (CLU). Although the benefits of MLC are recognised and accompanied by an exponential increase in the number of units elsewhere (Rowe, 2010), the number of MLUs in Ireland has remained static. Policy recommendations (KPMG, 2008) and affirmative evaluations of MLUs (Begley et al., 2011; McNelis, 2013) have mirrored international positive outcomes. Despite consumer requests for maternity care choices in Ireland (AIMS Ireland, 2014), this remains an unmet demand, with hostility towards birth choices offering alternatives to hospital based models of care (OBoyle, 2013). Against this backdrop and threats to the existing MLUs (Murphy-Lawless, 2011), MLC remains disappointingly peripheral to mainstream maternity services.

In Ireland the antenatal transfer rate from MLUs to CLUs is 37.4% and 14.6% during labour and birth (Dencker et al., 2017) similar to UK transfer rates of 50% (Rowe et al., 2013). In the UK where ‘stand-alone’ birth centres are well established, Walker (2000) found that women experienced a sense of loss, with reduced continuity of care, when transferred from MLC to CLC. There were mixed responses to the transfer to CLU from birth centres in the UK, ranging from relief to access epidural analgesia, to anxiety, perceptions of not being in control, nor feeling safe (Rowe et al., 2013). Women in Australia were relieved to have local expertise when they were transferred from a birth centre located within the hospital grounds, but welcomed returning to the birth centre.
Table 1
Participant’s characteristics.

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<tr>
<th>Parity</th>
<th>Age of baby</th>
<th>Reason for transfer</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>1. Becky</td>
<td>Para 0 + 2</td>
<td>Seven months, ‘heart rate dipping’</td>
<td>Ventouse Birth Post partum haemorrhage (PPH)</td>
</tr>
<tr>
<td>2. Helen</td>
<td>Primigravida</td>
<td>Six months, Meconium stained liquor, induction of labour</td>
<td>Ventouse birth Epidural analgesia Epidiotomy</td>
</tr>
<tr>
<td>3. Sheila</td>
<td>Para 1</td>
<td>Six months, ‘heart rate dropping’</td>
<td>Spontaneous vaginal birth Entonox 2nd degree tear</td>
</tr>
<tr>
<td>4. Ruth</td>
<td>Primigravida</td>
<td>16 months, 42 Term + 13 Induction of labour</td>
<td>Spontaneous vaginal birth Epidural 2nd degree tear</td>
</tr>
<tr>
<td>5. Brid</td>
<td>Primigravida</td>
<td>One year, in labour SROM, op position, Syntocinon</td>
<td>Forceps birth PPH epidural analgesia 3rd degree tear</td>
</tr>
<tr>
<td>6. Mary</td>
<td>Primigravida</td>
<td>One year, in labour SROM, EFM</td>
<td>Spontaneous vaginal birth Pethidine Entonox</td>
</tr>
<tr>
<td>7. Zadie</td>
<td>Para 3</td>
<td>Seven months, premature rupture of membranes</td>
<td>Spontaneous vaginal birth given antibiotics</td>
</tr>
<tr>
<td>8. Jean</td>
<td>Para 1</td>
<td>Eight months, Breech/oblique presentation</td>
<td>Spontaneous vaginal birth Episiotomy</td>
</tr>
<tr>
<td>9. Pauline</td>
<td>Primigravida</td>
<td>Eleven months, Reduced movements. ARM, ARM</td>
<td>TENS Entonox Epidural analgesia Spontaneous vaginal birth</td>
</tr>
<tr>
<td>10. Noeleen</td>
<td>Primigravida</td>
<td>Five months, In labour No progress</td>
<td>Epidural analgesia Forceps birth</td>
</tr>
<tr>
<td>11. Sandra</td>
<td>Primigravida</td>
<td>Eleven months, Slow labour ARM syntocinon</td>
<td>Epidural analgesia Spontaneous vaginal birth</td>
</tr>
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later (Kulikulas et al., 2016). Furthermore Dutch studies also highlighted the feelings of loss around continuity of care among women transferred from primary care to hospital (De Jonge et al., 2014; Wiegers, 2009).

To date there is no research focussing specifically on women’s experiences of transfer from MLU to CLU in an Irish context. Due to current strict criteria surrounding eligibility to enter MLU, once a woman has experienced difficulties during pregnancy and or labour they remain within CLU either temporarily or permanently (Dencker et al., 2017). Women are, therefore, very aware of possible complications necessitating transfer such as hypertension and unforeseen emergencies.

Gaining greater understanding of the unique perspectives of women transferring from MLU to CLU can help generate specific, context-related, knowledge which has the potential to enhance care for women and their families. This exploration could potentially reinforce positive practice in relation to care and highlight areas which may be of concern to women, health professionals and policy makers.

Method

A qualitative hermeneutic design using Interpretative phenomenological analysis (IPA) was used. IPA is a distinctive in-depth idiographic approach suited to healthcare research (Biggerstaff and Thompson, 2008). Using IPA principles helps to reveal how individuals construct personal meanings of particular events, enriching existing knowledge with the addition of both their own and researchers analysis and interpretation (Piekiewicz and Smith, 2014). Data were collected from in-depth individual interviews by the author (PL) with women who had been transferred from MLU to CLU.

Reflexivity

Acknowledging the researcher’s ‘fore structures’ or prior experiences and assumptions are an important element of the interpretive approach (Smith et al., 2009). The researcher (PL) employed critical self-reflection by being sensitive to any preconceptions and biases which might impact on the research process. In addition to the reflexive nature of the analysis and audit trail, possible personal and theoretical preconceptions and their potential to shape the conclusions reached were discussed with an academic colleague (DB).

Inclusion and exclusion criteria

A small homogenous sample is consistent with the theoretical orientation of IPA, to both carefully explore a specific experience in-depth, and to understand the contextual applicability of such findings (Smith et al., 2009). A purposeful sample included women > 18 years of age who shared the experience of transfer from MLU to CLU in late pregnancy (> 36 weeks) or during their actual labour. Both primiparous and multiparous women were included to obtain a diversity of experiences. Mothers who had given birth in the past year were included in order to capture recent experiences and the context of contemporary transfer policies. Exclusion criteria included women whose baby had been stillborn or unwell. Non English speaking women were excluded.

Recruitment and access

Designated midwives acting as gatekeepers in both MLUs, invited eligible women to participate in the study. Invitations were also advertised on the MLU Ireland Facebook page. Women provided contact details, either directly to the researcher (PL) or through the gatekeepers. Fifty five potential participants were sent information packs and consent forms. Twenty eight women responded and consented to be interviewed. All respondents were contacted to arrange an interview. However, 16 women did not respond further or were unable to contribute due to time constraints, thus a final group of 12 women were interviewed. The interview schedule was piloted by a volunteer mother in order to test the interview process. The ‘pilot interview’ enabled the researcher to refine, reflect, and improve the interview process. This data was not used in the final analysis.

Sample

Purposeful sampling was utilised thus enabling the researcher to access participant’s unique perspectives of a shared phenomenon (Smith et al., 2009). The sample consisted of 11 participants who had given birth between five and eleven months prior to the interview. The parity of the sample, birth outcomes and the rationale for their transfer are outlined in Table 1.

Data collection

In-depth, one to one interviews were conducted at a venue of the participant’s choosing. Most women opted to be interviewed in their own homes, whilst four women selected a quiet area of a coffee shop, where they were not overlooked. The interviews lasted between 50–90 minutes, all interviews were transcribed verbatim. In keeping with the tradition of IPA, interviews were constructed to encourage the provision of contextually rich extensive data. An interview guide was formulated to facilitate a synergy which provided ‘comfortable interactions with participants’ (Smith et al., 2009:59). The opening question introduced the topic of women’s choice of MLC, which provided participants with an opportunity to think about and explain the rationale for their choice. The researcher (PL) could then identify the elements of MLC that were importantly different to CLC for women. The interview’s opening also provided a foundation for further probes and prompts about the individual impact and meaning of the transfer experience. A reflective summary was discussed with each participant, to establish the accuracy of the synopsis of their experiences. All participants were later thanked, via email or text, to reiterate the availability of the researcher, should any further input or further discussions be requested by participants. A reflective
account of the interview was recorded by the researcher (PL) to provide an audit trail and demonstrate transparency (Yardley, 2000).

Ethical issues

The study was approved by the local Health Services Executive (HSE) and Dundalk Institute of Technology (DkIT) ethics committees. Interview location and timing was at the convenience of participants. Eligible participants were provided with an information pack including a consent form at least a week prior to the interview. The ongoing nature of consent during the interview was reiterated verbally, prior to and throughout the interview. Midwifery managers from both units agreed to facilitate a ‘debriefing’ meeting between participants and MLU staff in case any women experienced distress from their experience, or wanted to discuss their care. None of the participants availed of this facility. Confidentiality was maintained by assigning a pseudonym to the participant data, no personal details were recorded.

Rigour and quality

The rigour of IPA research consists of a fusion of four broad principles; sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance (Yardley 2000) (Table 2). Briefly, Smith et al. (2009), suggest that sensitivity is indicated by an awareness of the context of the sociocultural milieu of the study. As a midwifery practitioner, lecturer, and author (Larkin et al., 2012, Larkin et al., 2017) the lecturer is attuned to the context- sensitivity of such research. Commitment relates to the individual participant experiences and an appreciation of the skills and thoroughness of an IPA study (Smith et al., 2009). Combining standpoints, honouring the contextual and divergent nature of individuals and collected experiences, is apparent in the interview transcripts. Transparency and coherence are demonstrated by a consistently detailed description of the data collection, analysis, and individual experiences. The ‘impact and importance’ of the study is related to the utility of the research and the application of the findings to the community for which it is intended (Yardley, 2000). The study addresses women’s experiences highlighting their meaning to women’s lives. The study has a practical impact in raising awareness of the significance of the transfer experience. It draws attention to the interpersonal, environmental and cultural contexts of individual experiences, enabling them to be better understood.

Analysis

The researcher (PL) conducted the data analysis and a second academic (DB) reviewed and agreed the superordinate and subordinate themes. The analysis process was conducted using a blend of iteration and induction drawing on the six step approach by Smith et al. (2009). Although the steps appear linear, the process involved complex dynamic, cyclical, reflexive, careful, thoughtful interpretation. Using detailed field notes following each interview identified individual contexts, providing an audit trail which later helped with the analytical process. The initial step involving verbatim transcription, and close reading through each interview repeatedly promoted engagement with, and immersion in the transcript data. Comprehensive descriptive, linguistic, and conceptual notes relevant to the emerging patterns were recorded in the text to understand the context of each participant’s experience (Smith et al., 2009). ‘Stepping up’ the analysis from descriptive to conceptual themes encouraged the more abstract interpretative nature of IPA. Emergent themes were identified by linking individual experiences without losing the complex connections between the detailed notes and the original transcript. These steps were used for each ‘case’ taking care to detail the connection between the participant’s words and the researcher’s interpretation, then moving on to the next case and repeating the process. The final step connected the part to the whole identifying thematic patterns, across ‘cases’ or participants. The completion of the ‘hermeneutic circle’ involves looking at the relationship between the part and the whole (Pietkiewicz and Smith, 2014). The circulatory nature of the analysis encompasses reviewing individual accounts to ensure the analysis was ‘grounded’ in participants’ accounts, which evolved into interpretation. The subsequent themes were clustered into groups sharing basic ideas and concepts thus synthesising themes. A consensus was reached about the subordinate and two higher order themes with a second academic (DB). The higher order themes that emerged from the data were ‘Disconnection’ and ‘Joy Guilt and Disappointment’ (Table 3).

Findings

This section reports on one of the two higher order themes resulting from the analysis. The research attempts to grasp what it feels like for the individual in the context of their lifeworld to experience the transfer from MLU to CLU. The frequency of themes derived from the analysis is illustrated in Table 4. The superordinate theme of ‘joy guilt and disappointment’ reflects the ambiguity of women’s feelings in relation to

<table>
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<tr>
<th>Table 2</th>
<th>Characteristics of good quality research (Yardley 2000).</th>
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<tbody>
<tr>
<td>1. Sensitivity to context</td>
<td>Theoretical: relevant literature; empirical data; sociocultural setting; participants’ perspectives; ethical issues.</td>
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<tr>
<td>2. Commitment and Rigour</td>
<td>In-depth engagement with topic; methodological competence/skill; thorough data collection; depth/breadth of analysis.</td>
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<tr>
<td>3. Transparency and coherence</td>
<td>Clarity and power of description/argument; transparent methods and data presentation; fit between theory and method: reflexivity.</td>
</tr>
<tr>
<td>4. Impact and importance</td>
<td>Theoretical (enriching understanding); socio-cultural; practical (for community, policy makers, health workers).</td>
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<th>Table 3</th>
<th>Superordinate themes with subordinate themes for ‘Joy Guilt and Disappointment’.</th>
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<th>Table 4</th>
<th>Subordinate themes identified within interviews.</th>
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<td></td>
<td>Going against the grain</td>
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<td>Interview 1</td>
<td>✓</td>
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<td>Interview 2</td>
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<td>Interview 3</td>
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<td>Interview 10</td>
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<td>Interview 11</td>
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their experiences. Although delighted that their baby was alive and well, mothers struggled with a sometimes confusing feeling that they had, in some way, missed out on their expected experience and needed to adjust to a different one. A critical theme was one of disappointment. The rationale for their disappointment ranged from having to leave an environment of psychological and physical safety and support, to women’s doubts about their ability to give birth without interventions. The subordinate theme interpreted women’s emotional response of relief on the one hand in addition to regret for an intangible loss. Three subordinate themes comprised firstly of ‘going against the grain’ which described the contexts within which women framed their decision to birth in the MLU. A second subordinate theme ‘trade off’ reflected what women had to forego to guarantee a physically safe birth. The third subordinate theme ‘questioning and reclaiming’ explains an evolving process of women’s initial reflections about the transfer, then relinquishing and needing to come to terms with the altered experience before integrating it into their subsequent lives.

Going against the grain

Women in the study spoke about how they grappled with the paradoxical emotions they felt. Both mothers and babies were physically well, yet some women expressed sadness for what could have been. Within each narrative women’s feelings were related to both personal and societal expectations of what they thought they should feel following the birth of the baby. Each story provided a rich contextual backdrop about women’s choices to attend the MLU rather than CLU. Adopting this unusual position demonstrated a belief in their own abilities, doubting the necessity for interventions and in particular managing their labour pain, since opting not to have an epidural was considered ‘not the norm’. Having to transfer to CLU represented an altered experience on several levels. For example Becky suggested her choice of attending MLU was a concern about risks of medicalised birth imposing interventions:

‘not like consultant care …I would always… been more open and more comfortable to…. midwifery care….more natural pain relief like…..and not being forced into being induced…or having epidurals or ….unnecessary …caesarean sections etc.’(Becky)

Helen explained her inherent belief in herself having a certain ‘mind set’. Her family particularly her sister was worried about her attending the MLU and warned her:

‘Well I certainly have a mind-set ….like my sister will tell you because she had two babies in the CLU and she was all the time saying…you don’t know how it is going to go and I was like no, no …..I am going in the MLU, there is going to be limited pain relief and that is the way we are going to do it,’ (Helen)

Mary, having her first baby instinctively knew she did not want an epidural. Although she had not heard about MLU as most of her friends had their babies in the CLU ‘the normal way’. Avoiding an epidural would she felt be made easier in the MLU:

‘Well I compared it (attending MLU) talking to friends who had done it the ‘normal’ way, (CLU they offered it to me and I was like I have heard nothing but good stories so I said yeah…. I’d like to try and I think from the minute I had got pregnant that I didn’t want an epidural because the amount of people I heard ah it left me ….on one side and blah blah so I didn’t want it so the MLU suited me’. (Mary)

Zadie had experienced births twice in the MLU, and felt it was more ‘womanly’ to birth naturally. She had strong views compared with some of her friends about ‘natural childbirth’ A supportive group of her friends had similar views but they were in the minority:

‘I suppose I just feel like women were made to do this …obviously if you have to have intervention I certainly wouldn’t be going you know…..it’s less of an experience if you have had a section or an epidural or anything….. some of my friends would not think of not having a section they had one and they are going to have another one…(laughs) but there are a few of us say three out of nine of us would be …like .a natural way.’ (Zadie)

Similarly, Helen’s belief in a less medicalised natural birth and the idea of managing without pain relief was not supported by her friends or family. Helen was having her second baby and had successfully given birth to her baby previously n the MLU:

‘No well when I had my first baby everybody thought I was just being green and very optimistic,……. they were saying you don’t know what you’re in for kind of thing…… you are mad (laughs) and I said ……well at the end of the day you were never told you can’t have anything, if you want an epidural you will get one but you will be transferred…..’ (Helen).

Avoiding an epidural and a ‘stubborn’ belief in her own abilities was reiterated by Pauline. . She perceived that Caesarean Sections would mean a less fulfilling experience.

‘I suppose I just wanted to minimise the risk of having like an epidural….people thought I was daft… I think I was a little bit stubborn as well I was trying to do it myself first like……. It was my first option to do it myself…..and some of my friends then had a CS ….. you know and after all it is only something that is going to happen to you a few times in your life so yeah….. they felt very robbed really…..’ (Pauline)

The potential to derive a sense of fulfilment or enjoyment from the experience motivated Noelene who also had a belief in an inner capacity to deal with pain as members of her family had - despite disparagement from others.

‘so it was about making it kind of as enjoyable as I could, again, because it was my first child, because a lot of people were laughing at me reading my books….they said to me well you’re mad, you’re going to get an epidural, you need to get that, you know!! …..I kind of thought not that was my idea, I’m going to have this baby one way or the other………my grandmothers had 18 between them without pain relief.’ (Noelene))

Sandra likewise validated her decision as she felt that her priority was a feeling of confidence and safety…rather than the availability of pain relief:

‘I always felt we will talk about the pain relief……what was more important to me was to have the confidence in where I was, I feel like I could manage it that you know …the priority wasn’t …an epidural, the priority was feeling very safe and when we went in, the atmosphere that was there for us was so ………nice, you know’ (Sandra)

Participants had an innate belief in their own capabilities and had chosen MLU as a means of avoiding interventions such as epidural analgesia, despite the prevailing belief of most friends and families that it was either foolhardy or ‘daft’ to make such a choice.

The trade-off

Participants had time to reflect on their experiences of transfer and had thought about them at some length. Trying to make sense of what happened, there appeared to be a trade-off for each mother between their much wanted experience in MLU which had to be surrendered in order to deliver her baby safely. Participants attempted to balance their less positive feelings with their positive physical outcomes. The findings suggest that women were loath to complain as their baby was healthy.

Becky typically felt that it was counterintuitive to express any negativity as she and her baby were both physically well. Becky also experienced some recrimination from a family member who said she should not have had her baby in the MLU:

‘then….yeah, like you know you are in two minds over it…. kind of like in one hand you have a healthy baby and you can’t really say anything
on the other hand, yeah it is, it's very disappointing......but she was like (sister who recommended CLU) I told you!... (Becky)

Brid expressed another example of bargaining. As with other participants she found that there was a 'price worth paying' for the transfer... what she had planned did not come to pass as she required syntocinon induction and although not planned, she availed of the epidural:

‘But I think you could look at it another way and say the way things went I was glad to have the epidural as well do you know for pain relief...... I think you have to take the bad with the good sometimes you know that way it is a price worth paying’ (Brid)

Zadie, was disappointed that she had to transfer for her third baby, and expressed a different experience although her disappointment was ameliorated by the happiness at the birth of her baby,

I was just so happy that she was here and I had a girl so yeah I was delighted. I didn't feel low or anything like that I felt you know ...good ..but I did feel.....(hesitates) like it is just such a different experience and I wouldn't like to have it again if I was having more and I probably won't have anymore because I have enough (Zadie)

Ruth felt her transfer was understandable; she was to be induced as she was two weeks past her due date. Nevertheless, she was disappointed that her plans for natural pain relief were not realised. While she would not have chosen an epidural, due to needing a syntocinon induction she felt she had no alternative. Although Ruth was unhappy about some aspects, the necessity for the epidural and active management of the third stage appeared a small concession as she pushed her baby out herself:

‘I cried at first because I was disappointed I did not want it (epidural) ....Once I had it I was delighted ....I felt in control again and I could have the craic with the midwives ....I was able to push her out myself I didn't care after that ....I put her on my breast and I forgot everything else ....delivering the placenta myself went out the window too’ (rolls her eyes) (Ruth).

Questioning and reconciliation

The subordinate theme related to participants questioning whether they could have avoided the transfer in any way. Participants sometimes expressed a sense of failure, and had reluctantly reconciled themselves to a compromised experience. Most participants were satisfied that the transfer was required and the subsequent interventions were warranted and had come to terms with the transfer. Some mothers worried or even felt guilty wondering if they had intervened or questioned decisions more forcefully then such interventions could have been avoided. Others were resigned to the fact that everything had been done for them and they had done everything to help themselves. Helen blamed herself for not being more assertive however she felt that she was not strong enough to say no and the threat of damage to her baby was foremost in her mind:

‘You know but all along (Monitoring) was something that I really didn’t want to have so I just felt maybe... if I had been a stronger person and said you know listen okay, I appreciate that need to do the continuous monitoring but can we come to an arrangement where you do it every five minutes but I can stand up during it, like when I think back on it at the time.. I never thought to question...anything and neither did David (partner). I suppose like this is a first baby and we didn’t really know what was going on’ (Helen)

Brid quickly recognised that she had to compromise due to her inexperience. She particularly wanted to avoid some interventions such as an episiotomy but wished she had been ‘stronger’ about maintaining mobility:

‘When there is a lot of people and they are kind of telling you that your baby is in danger, or whatever you kind of think.......oh right...... I trust whatever you say, I know I did at one point when they mentioned the episiotomy, I said absolutely no way because I have a very vivid memory of them saying well if she says no we can’t do it......now looking back and I have read a couple of things that you can be monitored while standing up you know and other things but they were adamant I get into the bed.....I should have said no! If I was a stronger, if I was maybe more experienced at having a baby......but that’s the way it is......now I can’t say anything I have a lovely baby’(Brid).

Sheila on the other hand felt that the right decision had been made, nobody could be blamed. Her own (‘me myself’) shock about the transfer related to the fact that she had her first baby normally without intervention. She felt the ‘unpredictability’ of childbirth was to blame.

‘I had no misgivings ....no it was the way it had to be at the time, it was just because me myself a (points to herself) I wasn’t prepared for it, okay I was thinking if I could do the same as the last time, unfortunately childbirth doesn’t go like that ....once she was there safe and healthy...... No it was the way it had to be at the time, but I just never thought of it. you just think it’s going to be the same as number one, even though you tell everybody childbirth is the only thing you can’t plan’ (Sheila).

Ruth was also resigned to the fact that childbirth was beyond her control. She accepted that there was a need to transfer and was happy every thing had been done to avoid it. She was ambivalent about the epidural. She did reflect about the possibility that the epidural contributed to the fact that she had a forceps birth and a post-partum haemorrhage and the possibility of having ‘lasting damage’ only dawned on her afterwards:

I did wonder.. I mean looking back I know it (epidural) was probably a contributing factor in some ways...but I think you could look at it another way and say the way things went I was glad to have the epidural as well do you know .....for pain relief’. (Ruth)

Jean had already given birth in the MLI and described how upset she was as her transfer was unexpected...but just ‘got on with it’.

.... I suppose I was trying to be optimistic that everything would be the same....(as last time), but when I was transferred out they were so good to me, they could see I was so upset.... I suppose like I said you don’t know how strong you are until you are faced with these things......and you just have to swallow the pill and get on with it (Jean)

Discussion

The findings of the study provide a nuanced account of the emotional turmoil women experience when a transfer to CLU is required. Women's experiences of transfer from MLI to CLU were contextually and practically determined. The decision to attend the MLI was made within a culture in Ireland where birth settings other than hospital are a choice 'outside the norm' (OBoyle, 2013). Participants elective to attend MLC valued the possibility of a positive birth experience, whilst avoiding the imposition of interventions. Although there was a disjunction between their expectations and their experiences women reflected on and adapted to their new experience. Transfer to CLC was disappointing, similar UK and Australian findings (Rowe et al., 2012; Kuliukas et al., 2016). Participants were however, reluctant to articulate their disappointment. Difficulty in expressing negative emotions about childbirth is understandable as a sociocultural obligation prevails where mothers are obliged to appear happy (Nicolson, 2001). Some participants went through a process of cognitive processing of weighing up the pros and cons to rationalise their experiences.

Choosing MLI as a means of avoiding epidural analgesia was met with incredulity by some friends and family. The empowering productive pain model encompassing a working ‘with pain’ paradigm (Leap and Anderson, 2008), resonates with MLI philosophy which was outside so-
cietal norms. Participants resisted the dominant discourse where women doubt their own childbirth capacities relying on interventions particularly epidural analgesia (Larkin et al., 2017). Participants reported decision or skepticism, from friends and family particularly in relation to declining epidural analgesia. Once transferred to CLU over half the sample availed of epidural analgesia (Table 1). Although a variety of contextual factors doubtless contributed to this decision a perceived lack of continuous support has been shown to be the most important influence on women’s ability to cope with labour (Van der Gucht and Lewis, 2015).

When the pregnancy and birth was not going as planned, participants felt their beliefs about their natural capacity to give birth without interventions were challenged. The transfer from MLU to CLU therefore, represented an intensification of their disappointment, and appeared to magnify women’s feelings of failure.

The health of the baby predominated women’s thoughts, similar to previous observations (Crossley, 2007), the findings suggested the end justified the means. The sense of disappointment and failure were similar to Walker’s (2000) findings that women who transferred from MLU to a distant CLU expressed a multidimensional sense of loss. Kulikas et al. (2016) found women felt disappointed and diminished when transferred during labour, but were also glad to avail of hospital expertise. Resonances with these findings were apparent in this study. Participants had resisted the dominant discourse about the normality of interventions, and justified their disappointment by explaining they needed to forgo their own beliefs as a trade-off to achieve a physically safe outcome. Doubts about the necessity of the transfer persisted with some participants who felt that these risks may well have been exaggerated. Participants explained that they needed to realign their expectations to engage with a medical model of care which included acquiescing to interventions. Finding the positives was an important element to salvage some part of their experience.

Reflecting on their experiences enabled them to better understand their emotions and to rationalise and reconcile themselves to the transfer experience. The study highlights the need for health professionals to have stronger more open communication channels, specifically about preparation for altered birth experiences. The imperative of physical safety meant that women initially suppressed and were reluctant to express negative feelings. Some women also felt guilty that they did not achieve a ‘natural birth’, or had acquiesced to interventions. Insights from this study can provide health professionals with an in-depth understanding of conflicting emotions experienced by women. Being alert to and acknowledging that women can struggle with negative emotions for some time following the birth could prepare women for this possibility.

Participants in this study initially sought explanations and, in some instances blamed themselves for not being able to give birth to their babies. Women questioned their own ‘performance’ and wondered whether they could have done anything more to prevent the transfer. Snowdon et al. (2011) suggest that in a risk averse culture, women are made to feel responsible for their choices and are bound by their consequences. Women questioned their own abilities and ‘performance’ and wondered whether they could have done anything more to prevent the transfer. The cultural context of women’s birth choices and their consequences were also apparent. Advice from relatives and friends appeared to reflect the medical hegemony of risk, doubting participant’s ability to birth without interventions. One participant was admonished when she was transferred with: ‘I told you’ (Becky). These attitudes may be reflective of the prevailing risk discourse around childbirth in Ireland. The national maternity strategy (DOH 2016) claims to support increasing birth choices whilst emphasising risks which actually impedes such choices (Wood, 2017). Focussing on risk can disempower, undermine, and devalue MLC (Healy et al., 2017), with a consequent effect on women who elect to attend there. Women’s feelings of disappointment and guilt may therefore be compounded, by opting for MLC, ultimately reducing confidence in their own abilities.

Strengths and limitations

The small self-selecting sample is congruent with qualitative research, aiming to increase our understanding of experiences, therefore lacking generalisability to other contexts. Participants generated within a particular geographical location may not reflect the experiences of more diverse populations. This is the first study exploring experiences of transfer from MLU to CLU in the Republic of Ireland. Rich descriptions are provided to help determine the transferability of findings to different birth contexts.

Conclusion

The culture within which women elect to avail of MLC in Ireland is imbued by the prevailing emphasis on risk. Perceptions about the normality of childbirth, and belief in women’s abilities could be enhanced by expanding the provision of maternity care choices for women, signalling support for, and belief in MLC by policy makers.

A complex, subtle, understanding of transfer issues is provided with a view to guiding and further optimising midwifery care. An acknowledgement of the profound significance of the transfer experience for women could be useful to help practitioners prepare women for the possibility of an altered birth experience, and to support them afterwards. Discussions about possible paradoxical feelings identified in the study could enhance empathetic care. Further research may be usefully undertaken to gain a greater understanding of broader contextual issues such as policy influences on societal perceptions of risk, in order to support users and providers of MLC.

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Supplementary materials

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References


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