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RESEARCH

Management of Birth With the Fetus in the Occiput Posterior Position by Midwives in Sweden

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ABSTRACT

Objective: To explore midwives' experiences of managing childbirth with the fetus in the occiput posterior position.

Design: Qualitative study using focus groups with midwives.

Setting: Six clinics in southeast Sweden.

Participants: Twenty-six midwives who took part in six focus groups.

Methods: The study was conducted between May and December 2022. Reflexive thematic analysis was used to analyze the interviews, and each focus group consisted of three to six members.

Results: The overarching theme, *Midwifery in the Face of Uncertainty,* and three themes, *Putting the Clinical Puzzle Together, Navigating an Unpredictable Birth Process,* and *Traveling Together,* represented the experiences of the participants. The participants put together clinical "puzzle pieces" to assess the position of the fetus, but challenges in accurately determining the occiput posterior position through external palpation highlighted the need for improved skills. The participants navigated unpredictable progress of birth and balanced intervention strategies to encourage rotation, but no single approach guaranteed success.

Conclusion: Uncertainty regarding palpation of the fetus, the need for optimal support for women with fetuses in the occiput posterior position, and the need for effective communication emerged as recurring needs throughout the study. Increased understanding of the clinical context of the occiput posterior position and education and training in palpation techniques for midwives and students are essential to promote positive birth experiences.

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During childbirth, the occiput posterior (OP) position of the fetus is associated with an increased risk of complications. In a cohort study from Norway with 112,019 women, Eide et al. (2024) reported that an OP position during birth increased the risk of prolonged labor, use of vacuum extraction, and a greater likelihood of severe perineal tears and cesarean. Prolonged labor has been found to negatively influence the birth experience. Kempe and Vikström Bolin (2020) conducted a study in Sweden in which 1,380 women evaluated their birth experiences using a visual analog scale. They reported that women who had a spontaneous vaginal birth were more likely to report a positive experience compared to those whose labor ended in vacuum extraction or cesarean. These findings are relevant considering the rising global rate of cesareans, which currently occur in more than one in five births. Cesareans carry health-related risks for women, such as increased hemorrhage and infection, and for newborns, such as delayed breastfeeding initiation and disrupted skin-to-skin contact (World Health Organization [WHO], 2021). Despite these challenges, evidence-based strategies to manage birth when the fetus is in the OP position are still lacking. As a result, approaches to support optimal outcomes for women and newborns remain limited.

Literature Review

The OP position is a common malposition during childbirth. In a prospective evaluation of 129 women, it occurred in approximately 33% of labors at onset (Dall'Asta et al., 2021). Among a prospective cohort of 495 women with fetuses in a persistent OP position, Parsy et al. (2023) reported

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The occiput posterior position of the fetus can affect childbirth experiences and obstetric outcomes, and accurate identification remains challenging.

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that the fetuses of 410 participants (84%) did not perform spontaneous rotations before birth. This resulted in birth in the OP position, manual or instrumental rotation, cesarean, or instrumental birth. Sawai et al. (2025) investigated the maternal and neonatal outcomes of OP birth in Japan and reported that OP vaginal birth required more time, and the increased number of assisted vaginal births resulted in more maternal lacerations and hemorrhage than when the fetus was in the occiput anterior (OA) position. When assessing a head-first presentation, it is essential to distinguish OP, occiput transverse (OT), and OA positions of the fetus's head and back, each of which can be oriented left sided or right sided (Bertholdt et al., 2019). In a study on manual rotation from Iran, midwives and gynecologists were asked how often they could accurately determine fetal position. Of 258 participants, 149 (57.7%) stated that they usually or always identified the OP position correctly (Allahbakhshi Nasab et al., 2023).

Spontaneous rotation from OP to OA is more likely when the first stage of labor lasts less than 7 hours (Parsy et al., 2023). If rotation does not occur, manual rotation may be attempted. In a Cochrane Review, Phipps et al. (2025) analyzed six randomized controlled trials (RCTs) including 1,002 participants and concluded that the effectiveness of manual rotation in preventing vacuum extraction, cesarean, hemorrhage, and sphincter injuries remained uncertain. When studying fetal positions, researchers have focused largely on the fetal head, and the role of the fetal spine remains poorly understood. In an RCT conducted in Italy with 58 nulliparous women, Masturzo et al. (2017) reported that knowing the fetal spine position increased the success of manual rotation and resulted in more spontaneous vaginal births.

Researchers have investigated potential interventions that could influence OP rotation. Lee et al. (2021) conducted a systematic review of seven studies including 1,422 women across multiple countries. They reported that positions involving flexed thighs did not show statistically significant effects on OP rotation. They suggested that this position might shorten the first stage of labor. Similarly, Le Ray et al. (2016) conducted a multicenter RCT in France with 322 primiparous and multiparous women with ruptured membranes. They reported that adopting a lateral position opposite the fetal spine had no significant effect on facilitating rotation from the OP position. Finally, in an RCT conducted in Switzerland with 439 women with fetuses in the OP position, Guittier et al. (2016) found that the hands-and-knees position also did not promote rotation.

Beyond physical interventions, continuous support and informed decision-making during labor are also important aspects of the childbirth experience. In an RCT with 59 women conducted in Sweden, Stjernholm et al. (2021) reported that continuous support by a midwife increased the likelihood of spontaneous vaginal birth and shortened the active phase of labor. In a systematic review, Kloesterx et al. (2022) analyzed 13 studies involving 253 midwives from countries across Australia, Europe, and North America. They identified that active involvement in informed decision-making was central to midwifery practice, empowered women to make well-considered choices, and helped women feel secure during childbirth. However, midwives reported time constraints and differing professional perspectives on shared decision-making, which highlighted the need for further education and research. The WHO emphasized effective communication and information to women during childbirth, including explanations about fetal position (WHO, 2018). We previously conducted a qualitative study involving 12 women who gave birth when the fetus was in a persistent OP position. After birth, the women sought explanations for labor progression, contraction patterns, and birth outcomes, and whether these could be related to the OP position (Lindgren et al., 2024).

Research on the experiences of midwives with the OP position remains limited. However, in one study conducted in Australia, Lee et al. (2015) interviewed 9 women regarding their experiences of back pain in labor and 11 midwives regarding their experiences with providing care for women with back pain in labor. Lee et al. (2015) identified two main themes: *Back pain in labor: Accounts, rationalizations, and coping strategies* and *Fetal position: Destabilizing the OP back pain discourse.*

Qualitative research on the perspectives and clinical experiences of midwives is needed to better understand births in the OP position. Therefore, it is necessary to first establish a baseline understanding of how the OP position is

currently managed in clinical practice and which interventions are applied. Such knowledge may help reduce complications and promote positive birth experiences. To deepen the understanding of the clinical context in which an OP position arises and the related challenges midwives face, the researchers aimed to explore the experiences of midwives in managing childbirth in the presence of a fetus in the OP position.

Methods

Design

We conducted this study according to the methods of Krueger and Casey (2015), who identified five characteristics of focus groups: (a) small group of persons, (b) who possess specific characteristics, (c) provide qualitative data, (d) in a focused discussion, (e) to increase understanding of the topic being studied. This design provides a structured team and group dynamics to maximize the quality of qualitative data (Krueger & Casey, 2015). We chose this method because interaction among participants is believed to enrich the content and contribute to the development of knowledge and understanding (Krueger & Casey, 2015). We also followed the Reflexive Thematic Analysis Reporting Guidelines to ensure comprehensive reporting (Braun & Clarke, 2024). The study was approved by the Swedish Ethical Review Authority.

Setting

We conducted the study at six hospitals in southeastern Sweden, each with approximately 900 to 2,400 births annually.

Participants

Participants were midwives who managed births in which fetuses were in the OP position. In Sweden, midwives are nurses who complete a 3-year bachelor's degree followed by 1.5 years of midwifery training. They work independently to manage normal labor, monitor uncomplicated births, and consult obstetricians when complications arise (Socialstyrelsen, 2025). We used a purposeful sampling strategy and included participants with at least 2 years of experience in managing childbirth who worked in a birth unit at the time of the study. We conducted six focus groups with a total of 26 participants, and each group consisted of three to six individuals.

Procedures

In accordance with the focus group method of Krueger and Casey (2015), we referred to the interview guide as the "questioning route," which outlined the structure of questions used during the sessions (see Table 1). We developed the interview guide in collaboration with two midwives who had experience in childbirth involving the OP position of the fetus. We asked one midwife at each clinic to serve as a contact person. This contact person distributed an information letter to potential participants that outlined the study's purpose, assured confidentiality of data, and emphasized voluntary participation. The contact person organized the focus groups when there was interest in participation. Once they agreed to participate, the participants received verbal and written information about the study's purpose, along with forms to provide signed consent to participate.

Data Collection

One focus group was conducted at each clinic between May and December 2022. The first focus group was a pilot interview and was included in the study because we made no changes to the

Table 1: Questioning Route: Topics/ Questions Addressed During the Focus Groups

Question
1. What are your thoughts, reflections, and experiences when you think about an OP position of the fetus during childbirth?
2. How do you identify an OP position when palpating?
3. What is your experience on the management of labor when you have identified an OP position?
4. How do you perceive that these women handle labor, contractions, and pain? Are there any symptoms you associate with OP positions, and if so, which ones?
5. What is your experience on risks/complications in relation to an OP position?
6. What kind of support do you provide to women giving birth with the baby in the OP position?
7. We previously interviewed women who gave birth with the baby in the persistent OP position. Many of them had not been informed that their baby was in this position, and sometimes the midwives were also unaware until the moment of birth. What are your thoughts on that?
8. Our clinical experience is that many fetuses rotate from the OP position late in labor; what are your thoughts on that?

Note. OP = occiput posterior.

The occiput posterior position increases the risk of prolonged labor, severe perineal tears, and cesarean.

study design. The first author (A.L.) led the discussions, accompanied by an observer who took notes and ensured that all participants were involved. We included four observers: two attended one session each, and the other two attended two sessions each. We began each interview by showing the participants images of fetuses in OP, OT, and OA positions, and we encouraged open sharing of their experiences with births with the fetus in OP position. We asked follow-up questions to deepen the narratives. Topics included managing childbirth, providing support, identifying fetal position, and symptoms or complications related to the OP position. We asked the participants to reflect on when to inform women about the OP position. Each focus group lasted 45 to 68 min (median = 50 min). We concluded data collection once we reached information power (Malterud et al., 2016). We recorded and transcribed the focus group discussions verbatim and checked the transcripts against the recordings before analysis.

Reflexivity

The research team comprised five authors with complementary professional backgrounds. The first author (A.L.) is a midwife with clinical experience in obstetrics who has worked in settings that emphasize awareness of fetal position and palpation. The second author (H.G.) is a midwife with experience in obstetrics and gynecology, and the third author (M.O.) is a midwife and university professor. The fourth author (K.K.) is a medical doctor specialized in obstetrics, and the fifth (P.T.) is a nurse and associate professor.

Table 2: Overview of Each Author's Clinical and Research Experience

Author	Year of Graduation	Years of Research Experience	No. of Qualitative Publications
First author	2004	5	1
Second author	2010	14	15
Third author	1982	23	25
Fourth author	2006	17	1
Fifth author	1984	29	12

Author details, such as years since graduation and number of qualitative publications, are presented in Table 2. Our understanding of the clinical context enriched our interpretation of participant narratives. Continuous reflection and discussion helped us avoid overanalyzing and ensured the development of accurate themes. The diverse expertise in midwifery, obstetrics, and nursing of the research team contributed valuable perspectives. The interviewer (A.L.) had no professional ties with the participants.

Analysis

We analyzed data using the six-phase reflexive thematic analysis of Braun and Clarke (2022) and applied subjective interpretation. The inductive analysis incorporated semantic perspectives (explicit content) and latent perspectives (underlying meanings; Braun & Clarke, 2022). For example, participants described uncertainty about whether changing the position of the woman would promote rotation of the fetus, which we interpreted as an illustration of the unpredictability of birth. The first author (A.L.) reviewed transcripts to become familiar with the material and noted findings relevant to the study's purpose.

We organized the data in NVivo 20 software and generated initial codes that closely reflected the text, which resulted in 25 codes and potential patterned meanings. Co-authors P.T. and H.G. reviewed the material to deepen their understanding and refine the thematic structure. We iteratively refined the code names as needed and then grouped the codes into potential themes and created a thematic map (see Figure 1). The first author (A.L.) then reviewed the material again, and all authors completed a joint analysis. Throughout, we moved between the data set and specific data extracts. Although the first author (A.L.) led the analytical work, we collaboratively and reflectively shaped the final themes as a research team.

Results

The participants were female midwives ages 31 to 67 years (median = 48 years). They had worked as midwives for 2.5 to 40 years (median = 14 years) and in a birth unit for 2.5 to 40 years (median = 13 years).

We identified one overarching theme, *Midwifery in the Face of Uncertainty,* that represented the experiences of the participants. Overall, these experiences could be understood as a process of uncertainty that included factors represented by

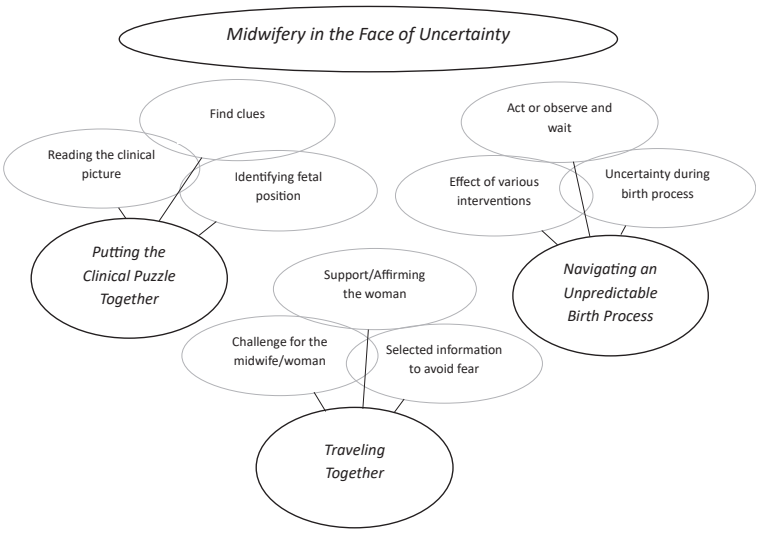

Figure 1. Map of themes.

three themes: *Putting the Clinical Puzzle Together, Navigating an Unpredictable Birth Process,* and *Traveling Together.* These themes illustrated the complexity of managing births in which the fetus was in the OP position and the clinical, emotional, and relational dimensions of midwifery care. The quotes provided herein revealed the experiences of the participants.

Putting the Clinical Puzzle Together

The first theme represented assessment of fetal position as a process of piecing together puzzle pieces that included external palpation, vaginal examination, listening to the fetal heartbeat, and considering the woman's own perception of fetal movements. The pieces were often difficult to interpret, and combining them into a complete picture required skill and experience. Solving the puzzle began when participants noticed prolonged or stalled labor. In these situations, they turned their attention to the fetal position and performed a more thorough assessment using external palpation. When the fetus was in the OP position, participants reported that they felt movements and the extremities of the fetus centrally or bilaterally in the uterus. They struggled to identify the back of the fetus because it was not distinctly palpable. Listening to the fetal heartbeat offered a clue for locating the back, but external palpation was still considered challenging.

Participants in several focus groups expressed the opinion that the prevalence of the OP position was far more common than the 30% reported in the literature. They noted that this position may have become more prevalent during the past 2 decades. The participants also noted that most fetuses rotated the "long way" rather than the more favorable "short way" down.

Another puzzle piece was internal palpation by means of vaginal examination. Participants noted that differentiating the fontanelles and sagittal suture could be difficult because of anatomical factors and because vaginal examinations were intrusive. It had to be balanced with respect for the integrity of the woman. They emphasized that combining results from external and internal palpation was essential to accurately assess the position of the fetus: "How they feel the baby kicking. You ask the woman how she experiences the movements, and she says it's here or there. You have to puzzle together many things and connect the pieces" (participant 2, focus group 3). Another noted, "It's really about forming a complete picture with the external palpation and then the vaginal examination" (participant 5, focus group 3).

Documenting fetal position was considered helpful for clarifying position and rotation but was not widely practiced. Opinions differed on using ultrasound to determine fetal position. Some participants needed it for confidence, while others trusted palpation alone. When necessary, a physician could confirm the position. The participants reflected on more puzzle pieces during birth and noted that rotational patterns during the second stage of labor could have signaled an initial OP position. If the fetus did not complete

the fourth rotation or if the head rotated back to OP after birth while the body remained in the birth canal, a shift from OP to OA could be indicated. Incomplete shoulder rotation was also considered a possible barrier to descent and indicated initial OP position. Participants navigated uncertainty by observing these physical cues that might have suggested an initial OP position. Participants in the focus groups highlighted uncertainty about when OP position might hinder progress, as it did not always prolong labor.

Participants described feeling surprised or uncertain when they discovered the OP position unexpectedly at birth. Successfully identifying fetal position gave participants satisfaction because it helped them visualize the fetus. Participants described how they often suspected an OP position but then the neonate was born OA: “Most of the time, we assume, oh, this is probably in a direct OP position. And then they don’t come out that way" (participant 4, focus group 2). Another noted, “But they might have rotated the long way around” (participant 1, focus group 2). This created confusion and doubt about the accuracy of their assessments. Some participants considered fetal orientation less important because they rarely observed signs that required thorough examination. Others reported that they performed detailed palpation only when labor stalled, and fetal position was relevant in those situations. Overall, this theme highlighted the challenges that participants faced in piecing together different puzzle pieces in the assessment of fetal positions. These challenges potentially influenced how participants understood the clinical picture and approached decision-making.

Navigating an Unpredictable Birth Process

The second theme represented how the OP position made birth unpredictable. Participants noted that it often led to prolonged labor, increased pain, and uncertainty about how to promote rotation. Once identified, participants perceived the OP position as difficult to manage. Labor could become prolonged, require interventions, or proceed without complications. Participants felt that OP positioning placed greater demands on themselves and the women. They also recognized that prolonged labor increased the risk of operative interventions, cesarean, and severe perineal tears. These concerns sometimes led to frustration, which seemed to influence clinical decision-making.

Some participants associated OP position with irregular or ineffective contractions and noted that labor sometimes stalled despite strong contractions that typically supported rotation:

She has such strong contractions, but it still takes time, maybe the fetus remains at the same station. It feels strange because her contractions are so strong. When palpating, you can really feel how strong they are. It’s very clear (participant 2, focus group 4).

Participants speculated that the fetal head might not engage the cervix effectively, which could lead to inefficient contractions.

The participants based many clinical decisions, such as encouraging various birth positions (squatting, side-lying, hands-and-knees, or upright), more on experience than on evidence. However, it was unclear which maternal position promoted rotation. These approaches showed attempts to manage labor and highlighted its inherent unpredictability, a topic raised in several focus groups. The participants expressed frustration over different approaches to manage OP births. Some supported early interventions, such as maternal position changes and oxytocin administration, to address dystocia. Others emphasized risks, such as hypertonic contractions and fetal stress, and favored rest and patience. Amniotomy was also debated, and some participants cautioned that early rupture of the membranes might hinder fetal rotation and recommended position changes first. Participants emphasized assessing birth progress by cervical dilation and fetal rotation and descent: "We focus a lot on dilation, but instead we should be looking at descent and station” (participant 3, focus group 2). Another participant agreed: "Yes, and especially that. I think it’s something we’re missing” (participant 4, focus group 2).

Participants described early urges to push as challenging with few options for relief. They highlighted emotional support, being present, breathing together, and validating the woman’s experience as crucial for coping with intense pain. Overall, the experiences of the participants reflected an unpredictable clinical landscape, diverse practices, and a reliance on clinical experience in the absence of clear evidence.

Traveling Together

The third theme represented how caring for women with fetuses in the OP position was challenging and

required patience. The uncertain nature of OP labor made it important to find ways of traveling together with the woman throughout the birth process. This included providing explanations, reassurance, and affirmation. Participants described the OP position as demanding and exhausting for many women. Women often asked why labor was prolonged, why they felt an early urge to push, and whether complications were increasing. Participants had to address these questions while keeping the situation under control.

The prolonged process affected the women and the participants, and everyone became increasingly tired as labor slowed. In these situations, patience was crucial, as was working together toward a shared goal. Once participants recognized an OP position, explaining the situation to the woman often became a relational challenge. Participants described how providing information without causing anxiety or fear was a delicate balancing act. Participants were concerned that providing too much information, such as potential risks or that birth might end with vacuum extraction or cesarean, could frighten women: "Because sometimes we say too much, and they get scared and shaken, you know, they can't relax because we've said too much" (participant 4, focus group 5).

To support women, participants explained that many fetuses did rotate, although it could take longer from the OP position. Although participants agreed that women should be informed, they sometimes delayed sharing information due to its emotional effect, and despite their efforts to avoid negative framing, many women later perceived the fetus to be in the "wrong" position. Participants emphasized the need for clear communication about events and interventions and noted that women with fetuses in the OP position often required more attention and information than those with fetuses in the OA position, especially when fatigue limited position changes. They highlighted the importance of affirming and empowering women, especially when labor was prolonged or ended with vacuum extraction or cesarean birth. Participants observed that some women blamed themselves for these outcomes and emphasized the importance of reassuring women that they had done everything possible: "They've been struggling because it's been a prolonged process, eh, but you've done everything you could, and this baby even chose to rotate the long way around, that gives us an explanation. In a way, it strengthens the woman" (participant 3, focus group 2).

Findings highlight the need for improved understanding of labor patterns associated with the occiput posterior position and emphasize the need for enhanced skill with palpation.

When the OP position contributed to prolonged labor, participants found that providing explanations helped. These explanations enabled women to understand the situation and maintain confidence, even when the process deviated from their expectations. This theme highlighted the importance of empowerment and affirmation in shaping women's understanding of birth.

Discussion

The participants in this study described managing birth with the fetus in the OP position as midwifery in the face of uncertainty shaped by the dynamic interactions among the woman, the fetus, and the midwife. A central source of this uncertainty was difficulty in determining fetal position. In particular, participants described external palpation as more challenging than internal palpation. In a prospective cohort study, Yashaswi et al. (2024) reported that when assessing the position of the head of the fetus, agreement between digital vaginal examination and ultrasound was 66.67%. We suggest that this finding and ours highlight the need to improve the safety and accuracy of fetal position assessment. Targeted educational initiatives may strengthen the confidence of midwives in assessing fetal position.

Participants in this study speculated whether there are really more OP positions at labor onset than the estimated 33% prevalence reported by Dall'Asta et al. (2021). Hjartardóttir et al. (2021) examined fetal head rotation in a single-center study with 99 women conducted in Iceland. The frequency of OP positions in early labor was 52%. Similarly, Svelato et al. (2017) reported that 52% of fetuses were in the OP position at the onset of labor in a multicenter observational study from Italy including 86 women. We suspect that this reflects increased OP prevalence or better identification.

Participants in this study rarely recorded fetal position on the partograph, which may have reflected uncertainty and difficulty in distinguishing between the OP, OT, and OA positions. This pattern aligns with previous research. For example, Bahizi et al. (2023) conducted a retrospective study in Uganda to examine 365

partographs, but fetal head position was not included as a documented variable. Similarly, in an Australian RCT to compare two partograph models among 228 women, Lee et al. (2023) reported that although labor progress was assessed, fetal position was not recorded. In the present study, participants emphasized that assessing fetal head descent and rotation was essential for clinical decision-making. On this basis, we suggest that adding fetal position to the partograph is relevant and desirable. Participants described how the OP position during labor was associated with prolonged labor and increased pain. They emphasized the importance of understanding which maternal positions best promoted OP to OA rotation. In a study from Iran involving 180 nulliparous women with intact membranes, Bahmaei et al. (2023) reported that adoption of knee-chest or semiprone positions for 15 to 30 min per hour during the active phase increased spontaneous OP-to-OA rotation. Participants in our study observed that frequent position changes may cause maternal fatigue. Bjelke et al. (2024) conducted a qualitative study and interviewed 15 primiparous women about their experiences of a prolonged second stage of labor. Women could experience frustration when positional changes did not result in labor progress, and these movements were challenging to perform.

Participants in this study reflected on interventions such as amniotomy and oxytocin. They acknowledged potential benefits but also expressed reservations and noted that the effects varied. In an RCT conducted in Thailand that included 248 nulliparous and multiparous women with low-risk pregnancies, amniotomy at 5 cm of dilation shortened the duration of labor (Khunpradit et al., 2025). These findings suggest potential benefits of amniotomy. However, a qualitative study presents a more nuanced view. In an interview study about amniotomy involving 16 midwives conducted in Sweden, the participating midwives expressed uncertainty about whether amniotomy truly accelerates labor or leads to complications (Ingvarsson et al., 2020). We suggest that previous studies highlight the tension between clinical trial evidence and the experiential knowledge of midwives, a perspective also observed in the present study.

Supporting women with the fetus in the OP position required presence and encouragement to facilitate vaginal birth, according to the participants. In a Cochrane Review including 26 studies and 15,858 women from 17 countries, the authors found that continuous support was associated with improved labor progress and more positive birth experiences. They also noted that such support should include information on birth progress (Bohren et al., 2017). Participants in the present study found it challenging to inform women about the OP position without causing concern. However, in another qualitative interview study including 12 women, we found that women with persistent OP births wanted more information about the birth progress (Lindgren et al., 2024), and we suggest that midwives may not need to be as cautious. Participants in the present study noted that women sometimes blamed themselves for prolonged or stalled births. A similar pattern was reported by Bjelke et al. (2024). Some women felt that their efforts were insufficient during labor and that a woman should be able to give birth without the use of a vacuum extractor (Bjelke et al., 2024). We suggest that early identification of the OP position is essential, as it enables tailored communication and support and allows midwives to make active clinical decisions, even in the face of uncertainty, that may in turn increase the chances of a positive birth experience.

Limitations

The regional focus of this study may limit the transferability of findings to other national or international contexts given that maternity care systems and practices vary across regions and countries. Using focus groups may have attracted participants already interested in the topic, introducing selection bias. Variation in years of experience among participants may have created power imbalances that could have influenced openness. The group format may further have constrained individual expression, as some might have felt less comfortable sharing dissenting views.

Implications

Educational initiatives that foster collaborative learning are essential for improving palpation skills. This applies to midwives and labor and delivery nurses, whose roles and levels of clinical autonomy vary across maternity care systems. Strengthening these skills is crucial for understanding the clinical puzzle of fetal position, rotation, and labor progress. Clear documentation of fetal position on the partograph helps visualize the clinical picture. Further evidence is needed to guide management of births complicated by the OP position. This malposition is a known risk factor for adverse outcomes.

Improved strategies may reduce maternal complications and improve quality of care. Developing such strategies can increase confidence in navigating which interventions are appropriate for the clinical situation. Ensuring women's safety during childbirth requires shared professional terminology. It also requires interprofessional collaboration, particularly regarding the identification and management of the OP position. A more comprehensive understanding of the OP position may improve communication with women about their labor process. It may also promote individualized, evidence-based care as midwives and birthing women travel together.

Conclusion

The OP position of the fetus often rendered the birth process unpredictable and required midwives and other maternity care providers to practice in the face of uncertainty. These births demanded clinical reasoning and relational sensitivity, and participants in this study balanced limited evidence with the need to travel together with women through a challenging process. Although participants described early identification of the OP position of the fetus as difficult, this identification is crucial because it enables support, tailored communication, reassurance, and active clinical choices that may increase the potential for a positive birth experience.

CONFLICT OF INTEREST

The authors report no conflicts of interest or relevant financial relationships.

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DECLARATION OF AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work the authors used Copilot to improve readability and language of the work. After using this service, the authors reviewed and edited the content as needed and took full responsibility for the content of the publication.

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