

*“An exploration of midwives’
experiences and practice in relation to
the assessment of maternal postnatal
genital tract health”*

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experiences and practice in relation to
the assessment of maternal postnatal
genital tract health”*

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Abstract

Over the past 15 years the focus of postnatal care has changed. Contemporary professional guidance no longer directs midwives to undertake specific assessment tasks in relation to women's genital tract, but advocates an holistic and individualised approach. However more recently some concern has been expressed within the professional literature that women's physical needs may be overlooked. It is unclear how midwives decide upon their approach to maternal genital tract assessment, the involvement of women in this process, what assessment methods they use and the factors that influence this clinical reasoning process.

A constructionist grounded theory methodology was employed to guide the research design and processes, including analysis of the data, the use of theoretical sampling to evolve the emerging research categories and the construction of a grounded theory. Ethical approval was gained from the regional research ethics committee and the research and development committee at the data collection site. Sampling was purposeful and data was collected using narrative style in depth interviews involving fourteen midwives and observations of fifteen postnatal assessments involving five midwives and fifteen postnatal women.

Three themes were identified from the data and form the framework of the constructed grounded theory; they are Methods, Motivators and Modifiers. Within each theme are a number of categories and focused codes. The Methods theme summarises a range of assessment methods used by the midwives, including risk assessment, questioning and clinical observations. The Motivators theme incorporates factors which motivated how, when and why the midwives undertook genital tract assessment and includes verification, personal preferences and sensitive care. The Modifiers theme consists of factors and contexts, which facilitated or inhibited the midwives' ability to negotiate an appropriate approach to assessment and includes the categories therapeutic relationship, care in context and evolving midwifery knowledge.

The findings of this study suggest that the midwives are aware of a range of assessment methods, however there was less articulation or demonstration of methods pertaining to assessment of uterine health. The motivating and modifying factors highlight midwife, woman and contextual factors, which may enhance and inhibit the midwives clinical reasoning process. The complexity of contemporary midwifery practice is illuminated as these factors conflict and create practice tensions and contradictions for the midwives. There was limited evidence that the midwives involved women in deciding the approach to genital tract assessment. Implications include the need to ensure midwives have the knowledge regarding uterine health and the skills and affective abilities to engage women in health assessments and practice effectively within the complexity of contemporary practice.

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Author's Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by Northumbria University Health, Community and Education Studies School Research Ethics Committee, Regional Research Ethics Committee and the local Research and Development committee.

Name: Valerie Larkin

Signature:

Date: 1.6.12

Chapter 1

1. Chapter 1 - The Introduction

1.1 Introduction

My thesis presents the culmination of a five-year period of intensive study and research activity as part of a professional doctorate programme. This chapter orientates the reader to the background of and foundation for the research project. It includes the rationale for my interest in the area and professional credibility for research within the field of midwifery. The chapter concludes with an overview of how the thesis is structured and sequenced.

I am a registered midwife currently working within higher education as a senior lecturer contributing to the educational provision for pre-registration and post-registration midwifery students. I therefore have a range of roles and responsibilities, as both a midwife and academic, many of which are enshrined in national and international law. Midwives have a professional commitment to “caring for and monitoring the progress of the mother in the post-natal period” (NMC 2010 p.45). This includes ensuring the student midwives I guide develop the skills, knowledge and abilities they require to assess, plan, implement and evaluate effective postnatal care including maternal postnatal genital tract assessment (NMC 2008; NMC 2009). My interest in the research area was stimulated by national debates concerning postnatal genital tract assessment, which I discuss in chapter 2, but also my involvement in a local action research project, in which student midwives identified ‘practice dilemmas’ in which they had difficulty identifying the most appropriate practice response (Larkin & Sookhoo 2002). The student midwives frequently cited assessment of postnatal genital tract health as a dilemma area and during workshop discussions the students demonstrated that their knowledge and practice experiences regarding approaches to maternal genital tract assessment were widely divergent. Some students experienced midwives regularly undertaking clinical observations of the maternal genital tract postnatally, whilst others students gained very limited experience or insight. This research intends to develop a grounded theory of contemporary midwifery experiences and practice in relation to the

assessment of maternal postnatal genital tract health. From this research, both strengths and limitations of midwifery practice in relation to assessment of maternal genital tract health will be identified and recommendations made to enhance midwifery practice, the guidance provided to student midwives, service organisation and ultimately the care provided to postnatal women and their families.

1.2 Background to the research - Debates concerning postnatal care

Following childbirth women experience a diverse range of physical, emotional and social changes and challenges. One of the fundamental aims of midwifery postnatal care is to support women and families through these changes and challenges by promoting and maintaining maternal health (NMC 2010; WHO 2010). Maternal physical morbidity following childbirth is a principal midwifery public health issue, which Biro (2011) suggests is in need of much greater priority. Increasing the midwifery professions' focus upon public health initiatives is advocated within national strategy documents such as Midwifery 2020 (2010) and the Prime Ministers commission on the Future of Nursing and Midwifery in England (2010).

Maternal health has improved over the preceding years in correlation with general public health improvements such as sanitation, reduction in overcrowding and poverty, improved diet and the recognition and development of specific interventions such as infection control strategies, antibiotics and availability of safe blood transfusion (De Costa 2002; Marchant 2006; Bick 2010). These improvements in health have had a more profound impact over the last century upon maternal mortality rates, which have seen significant reductions in developed countries such as the United Kingdom (WHO 2010; CMACE 2011). McIntosh (2011) highlights how many health care professionals within the United Kingdom had assumed that deaths from sepsis were no longer a concern. However, national findings from the recent triennial report into maternal deaths have highlighted a significant rise in maternal deaths due to genital tract sepsis (CMACE 2011). Genital tract sepsis is now the major cause of direct

maternal deaths in the United Kingdom, for the first time since the enquiry commenced in 1952, with 26 women dying as a result of genital tract sepsis, over the three years of 2006 -2008 as compared to 9 women in the period 1985-1987. The CMACE (2011) report considers for 12 of the women who died, substandard care contributed, specifically in relation to prompt diagnosis and treatment of infection. McIntosh (2011) considers the increasing resistance of bacteria to antibiotics may place the management of genital tract sepsis in a similar position to the time prior to the introduction of antibiotics. Therefore prevention of and prompt identification and treatment of postnatal maternal genital tract sepsis are a contemporary maternal health care priority.

In contrast to the relatively low rates of maternal mortality, postnatal maternal morbidity has consistently remained high. A range of research and literature identifies the extent and enduring nature of maternal health needs and their limited identification and management following childbirth (MacArthur, Lewis and Knox 1991; Glazener *et al* 1995; Brown and Lumley 1998; MacArthur *et al* 2002; Marchant 2006; Williams, Herron-Marx and Knibb 2007; Webb *et al* 2008). A large American study involving 1323 women in structured interviews identified 69% experiencing at least one new health problem following childbirth (Webb *et al* 2008). This includes morbidity associated with the genital tract, with up to 87% of women reporting perineal morbidity in a UK study (Williams, Herron-Marx and Hicks 2007; Bastos and McCourt 2010; East *et al* 2011). Incidence of morbidity related to postnatal blood loss is difficult to establish as it goes unreported or is treated in the community setting by a GP. In a study by Marchant, Alexander and Garcia (2002) 20% of the 324 women surveyed reported they had been worried about their vaginal loss following childbirth. Rates of re-admission to hospital for women with complications of abnormal bleeding or uterine infection are considered to be approximately 2%, with the present live birth rate at 706,248 births, this could equate to 14,124 women admitted to hospital per year (Bick, MacArthur and Winter 2009; ONS 2010). Early identification of postnatal morbidity via accurate assessment processes may facilitate early intervention, potentially reducing the severity, duration and

long-term impact of such health issues (Bick 2008a; Bastos & McCourt 2010; CMACE 2011).

Many health needs are interrelated in nature, with postnatal physical health impacting upon other areas of the woman's well being, such as psychological health and her ability to fulfil social roles and responsibilities (Brown & Lumley 2000). The study by Webb *et al* (2008) highlighted a correlation between physical morbidity, emotional health and functional limitations related to the women's roles and responsibilities, such as employment and childcare. Findings from the study by Herron-Marx, Williams & Higgs (2007) highlight the continued high incidence of maternal perineal morbidity and its potential impact upon the woman's physical, social, psychological and sexual health; one woman discussed how she had spoken to her GP and midwife about feeling low and had been prescribed anti-depressants but she had not discussed her enduring perineal morbidity with anyone. She stated that this problem was probably the main cause of her depression. However, the health care professionals involved with this woman had not appreciated or investigated the potential of an association between the woman's emotional and physical health.

Rolfe (1998) suggests as health disciplines, such as midwifery, have become an academic discipline there is an increased focus upon research, theory and technical rationality. This can fracture and reduce perceptions of health needs to their individual components, exacerbating the separation and marginalisation of the body or physical needs and care from other client needs, such as emotional and social needs, rather than maintaining an integrated holistic perspective (Philips 1993; Parrott and Fahy 2008; Davis & Walker 2010). Bryar & Sinclair (2011b) suggest a traditional medical model of care imposed upon midwifery practice can perpetuate the fragmentation of women, including the separation of their mind, body and environment. This can create dichotomous thinking in which a focus is given, by health care practitioners, to the mind or the body or the social components of health, leading to a limited representation of a client's needs during a health care assessment (Cameron & McDermott 2007). As highlighted by

Cameron & McDermott (2007 p.195) as they discuss the need to bring back the body to health related social work, “it is the dominance of mind, body or social factors that is problematic” and suggests rather than dichotomous thinking, the focus of health and social care practitioners must remain open and focused upon all factors that impact upon health.

This changing focus upon different components of health need can be seen within the varying amounts of interest given, in the professional literature and advocated in midwifery practice, to different aspects of maternal postnatal health over recent years. Over the previous decade there has been a proliferation of much needed interest, critique and research exploring means of assessing emotional and social needs and well-being of women following childbirth (Marchant 2006; Bick, MacArthur & Winter 2009; Marmot Review 2010). This has included recommendations to incorporate such assessment processes within midwifery practice (NICE 2007a), despite some authors identifying concerns about the predictive value of some of the screening tools (Bick, MacArthur & Winter 2009). In contrast to emotional and social needs, whose assessment has become more prescribed over the past decade, the assessment of maternal postnatal physical morbidity has become less prescribed.

Up to the early 1990s the midwife was directed by professional and educational guidance to complete set tasks to assess maternal postnatal physical well-being, particularly of the genital tract, including the assessment of the uterus, lochia (blood-loss) and perineum (Garcia and Marchant 1996; Marchant 2006). This was completed utilising traditional “hands-on” midwifery assessment skills including palpation of the uterus and visualisation and smell of the women’s perineum and blood loss (lochia) (Marchant *et al* 1999; Bick, MacArthur and Winter 2009). Such clinical observations were common practice, reinforced by professional and educational guides up to and including the 1990s. However, during the last decade or so concern has been expressed within the midwifery literature that these clinical observations were applied indiscriminately to postnatal women regardless of individual need or circumstance (Robinson, Golden &

Bradley 1983; Garcia and Marchant 1996; Marchant 2006). Indiscriminate use of clinical observations was felt to focus postnatal assessments upon physical health, particularly in relation to the maternal genital tract, at the expense of social and emotional health.

Contemporary professional guidance does not direct midwives to undertake specific observational tasks but instead advocates a holistic approach to the assessment of maternal needs (Marchant 2006; NICE 2006; NMC 2010). This necessitates the midwife deciding when assessing maternal postnatal well being, if and what form of assessment and observation methods of the maternal genital tract she will employ. However, there has been concern expressed in the professional literature; from the women who access postnatal care, the midwives providing the care and those researching aspects of postnatal health, about the content and provision of contemporary postnatal care. Women within a Swedish study by Rudman and Waldenstrom (2007 p. 189) believe insufficient attention was paid postnatally to their physical health and recovery with the authors suggesting “postpartum care in the old days was driven by rigid routines and medical check-ups, today’s care may have gone too far in the opposite direction.” Deborah Bick, a midwife who has spent most of the past 2 decades researching postnatal midwifery care has voiced concerns that United Kingdom midwives may not be utilising or acting upon observations and examinations of maternal well-being and that service provision may not facilitate effective postnatal care (Bick 2008a; Bick 2008b). These concerns are also reflected within national reports reviewing maternal deaths and the national press, focusing upon high profile cases involving maternal death following puerperal sepsis (Guardian 2008; CMACE 2011).

The impact of this changing philosophy upon the practice of assessment maternal genital tract health by midwives is ripe for evaluation. As highlighted by Bick (2008b), there is limited data concerning the impact contemporary guidelines have upon the practice of midwives in relation to postnatal care and there is a gap in the evidence base concerning how and why contemporary midwives negotiate particular assessment approaches of

maternal genital tract health. In addition the small local action research study I was involved in suggests there is variation in practice regarding maternal genital tract assessment and novice midwives appear to be unsure how, when and why to undertake such assessments (Larkin & Sookhoo 2002). By considering these questions of how, when and why within this thesis, fresh insights in relation to postnatal midwifery assessments will emerge which will be useful to midwives, service and educational providers and contribute to enhancing postnatal care for women and their families.

My joint professional and academic credentials will help to ensure that the relevant professional insights and skills to critique midwifery practice and undertake ethically sound and trustworthy research are in place. The professional doctorate programme has provided access to guidance, facilitation and support. My thesis is presented in the first person. This position can be justified where the research topic is an inextricable part of the researchers practice (Hunter 2011).

1.3 Outline of thesis

In this chapter I have provided an introduction to the thesis and research area. Chapter 2, 'Literature Review', provides insights into the topic of study, highlighting limitations in the existing knowledge base. Research, literature and theory are reviewed to highlight underpinning theoretical and conceptual frameworks pertinent to the thesis including genital tract assessment methods and clinical reasoning processes involved in decision making. This analysis sets the foundations for the research aims and objectives. Chapter 3, 'Research Paradigm and Design', evaluates the research philosophy and methodology, together with constructionist grounded theory, in relation to the intentions of the research. The analysis includes quality principles integrated within this study, research methods including narrative style semi-structured interviews and observation data collection and the applications of principles of constructionist grounded theory in the coding, and data analysis. At the end of this chapter the grounded theory structure constructed from the data analysis will be

introduced, in preparation for the subsequent chapters in which themes from this grounded theory are presented. Chapter 4, 'Encounters in the Field', critiques issues concerning gaining access to the field and ethical and sampling processes to provide a detailed discussion of the researcher's activity to demonstrate effective and appropriate application of ethical processes and principles. The discussion includes strengths and limitations and areas of challenge encountered during the process of collecting and analysing the data and the potential impact these may have upon the quality of the research process and outcomes.

The data from this research study is presented over the following three chapters, chapters 5,6, and 7, each chapter reflecting the three principal themes to emerge from this research, 'Methods', 'Motivators' and 'Modifiers'. Within each data chapter key categories deriving from the data will be presented and analysed sequentially substantiated by providing data extracts. Each chapter will commence with a diagrammatic presentation of how the data categories relate to the particular research theme for discussion within that chapter. Each category will be defined and their properties and dimensions explored, highlighting the focused codes and codes within the category. At the beginning of the discussion for each category a diagram will provide a visual summary guide for the reader of the focused codes and codes within the category. The presentation in the data chapters will demonstrate and illuminate contemporary postnatal maternal genital tract assessment.

Chapter 8, 'Discussion', contains discussion and evaluation of the research findings. This includes assimilating the findings with other work in the field and synthesising the potential implications the new insights generated from the research may have for midwifery practice, education and service provision. The thesis will conclude with chapter 9, 'Conclusions', containing a summary of my developmental journey, including the principal strengths and limitations of the research. Suggestions are made in light of the insights and abilities attained during the process of undertaking this study. These will include outlining new ideas and questions, which have arisen

concerning potential research areas for further investigation and the development of methodology and methods within future research activity.

The attached appendices provide clarity regarding the research resources, including, research timetable, sample data collection guides, participant information leaflets, information presentation and consent forms.

Chapter 2

2. Chapter 2 - Literature Review

2.1 Introduction

In this chapter I present a critique of research, literature and theory pertinent to the thesis focus. As suggested by Parahoo (2006) the aim of a literature review is to increase understanding of the subject area and place the intended research activity within the context of existing work. The review will identify limitations in the existing knowledge base and thereby justify the intentions of this research.

To facilitate this aim a number of health related databases were electronically searched (appendix 1). In addition a number of influential midwifery journals (appendix 1) were hand searched to ensure relevant literature had not been overlooked by the electronic searches and to ensure inclusion of those journals and books not available electronically. Search terms initially focused upon aspects of postnatal care and assessment (appendix 1). However as exploration of the subject evolved it became evident that the search terms and inclusion criteria needed to be developed to include a broader conceptualisation of midwifery postnatal assessment and to access transferable information involving other health care professionals (appendix 1). Walsh and Downe (2006) acknowledge the reality of accessing data is complex and incremental with each new encounter revealing new potential areas for exploration. Appendix 1 provides detail and clarification of the literature search strategy, which supports this thesis.

Literature not in English was excluded and precedence was given to evidence from more economically developed countries with patterns of midwifery care, health care and social systems comparable to the United Kingdom. Literature reflecting contemporary midwifery practice evolving after the Expert Maternity Group recommendations DH (1993) was prioritised. Critical consideration was given to the rigour of the evidence reviewed. Aspects for qualitative methods such as credibility, dependability,

and transferability were considered (Koch & Harrington 1998) and assessment tools for quantitative and qualitative data such as the Critical Appraisal Skills Programme (CASP) (2010) were consulted. This literature review has incorporated a diverse range of practice evidence including quantitative and qualitative research, discussion and debate emanating from known experts in the field and evidence reflecting postnatal women's perspectives of their care. This will enable a range of methodological approaches to be included which will help form an eclectic and holistic view of the subject for analysis (Walsh & Downe 2006) and acknowledge the complementary nature of a diverse range of evidence (McCourt 2005).

The literature review commences by defining assessment and considering potential approaches to genital tract assessment, which have been identified during the literature review process. This will include risk factors, clinical observations and maternal questioning. The evaluation will highlight strengths and limitations of assessment approaches within the evidence base regarding postnatal genital tract health. The critique will then focus upon how midwives determine their approach to maternal genital tract assessment. The literature reflecting present understanding of processes employed by health care practitioners to enable them to make practice decisions using clinical reasoning is then explored. The discussion culminates in the formulation of the intentions of this research, presented as a statement of purpose.

2.2 Assessment

The Cambridge Dictionary (2011a) defines assessment as,

“When you judge or decide the amount, value, quality or importance of something, or the judgment or decision that is made.”

Assessments employed in health care contexts reflect aspects of this definition as health care practitioners make judgments about what is important to identify, how it is identified and judged; and what decisions regarding health care will be made as a result of the assessment (WHO 2011). Dillion (2007) suggests health care assessments integrate and

process a range of data including clinical observational findings, client reports, history and contextual factors to inform practitioners' clinical reasoning processes and subsequent identification of health needs, care planning and implementation. Midwives must undertake assessments of women's health related needs to inform the care that they provide including, "*preventative measures . . . the detection of complications in the mother*" (NMC 2010 p.43). In the postnatal period this includes assessing women's genital tract well being in the postnatal period (Marchant 2009). The genital tract consists of the organs of reproduction, the uterus, ovaries, fallopian tubes, vagina and vulva (Stables & Rankin 2010). The uterus and vaginal loss (lochia) and the vulva, particularly the perineum, are aspects of the genital tract, which midwives frequently assess during postnatal care interactions (NICE 2006; Marchant 2009; Baston & Hall 2009). For the purpose of this research when I identify the activity of maternal genital tract assessment it is these commonly assessed areas to which I refer. Assessments of the maternal genital tract contribute to assessing involution of the genital tract, a physiological process in which a return to pre-pregnant status is approximated and to identifying genital tract morbidity including infection, haemorrhage, perineal healing and function (Garcia and Marchant 1996; Marchant, Alexander and Garcia 2003; Stables & Rankin 2010).

2.3 The potential approaches to genital tract assessment

The literature identifies a range of potential approaches to assessing maternal genital tract well being postnatally. This includes recognition of risk factors for genital tract morbidity, clinical observations and maternal questioning (NICE 2006; Bick, MacArthur & Winter 2009; Marchant 2009). Each potential approach to maternal genital tract assessment will be critiqued sequentially, presenting a summary of the available evidence regarding the effectiveness of the approach.

2.3.1 Risk factors

The literature identifies a recognised link between genital tract morbidity such as trauma, pain, infection and haemorrhage and particular events

effecting the genital tract during childbirth. Identification of risk factors can alert the midwife to the need for extra vigilance and a more intensive approach to genital tract assessment (Marchant 2009).

Trauma to the external genital tract, the vulva and perineum, increases the woman's risk of postnatal morbidity including perineal pain, dyspareunia and urinary and faecal incontinence (Boyle 2006; Bick, MacArthur & Winter 2009). In addition breaches to the integrity of the skin, place the woman at increased risk of infection (Boyle 2006; Chang, Daly and Elliott 2006).

Trauma to the external genital tract as a result of childbirth may take the form of unintentional wounds such as a perineal tear or an intentional wound such as a surgical incision into the perineum called an episiotomy, which involves the skin and muscle layers (Steen 2007). Perineal tears and labial grazes and lacerations may occur during any birth including spontaneous vaginal deliveries. The most recent national statistic suggests 57% of women who gave birth spontaneously suffered some degree of perineal laceration (The NHS Information Centre for Health and Social Care 2011). However the extent of the trauma with such spontaneous lacerations may vary considerable, from a small graze, involving only the superficial layer of skin to those which involve deeper structures such as muscle layers (second degree) and in the most severe cases the anal sphincter. The majority of perineal lacerations fall within the second-degree category (Steen 2007).

Instrumental delivery is associated with higher levels of perineal morbidity (Williams, Herron-Marx and Knibb 2007). The NHS Information Centre for Health and Social Care (2011) highlight a ten-fold increase of episiotomy, with forceps and ventouse birth as compared to spontaneous vertex vaginal birth. Nulliparous women and those with larger babies or multiple births have an increased incidence of obstetric intervention, including assisted birth and perineal lacerations occurring during spontaneous vaginal birth (Kettel and Tohill 2008; Bick, MacArthur and Winter 2009; Hamilton 2009). In addition the greater the degree of trauma sustained is predictive of women reporting higher levels of perineal pain post birth (East, *et al* 2011). Therefore trauma, being nulliparous, instrumental birth, large baby and

multiple births may indicate an increased risk to genital tract morbidity associated with the perineum and vulva. However Williams, Herron-Marx and Hicks (2007) reported that women with an intact perineum also reported new onset perineal morbidity, including dyspareunia suggesting that perineal morbidity can still occur in the absence of perineal trauma.

The existing published evidence also demonstrates an association between postpartum haemorrhage and risk factors such as previous antepartum or postpartum haemorrhage, grandmultiparity, multiple pregnancies, pregnancy induced-hypertension, prolonged labour and instrumental and caesarean birth (Selo-Ojeme *et al* 2005; Marchant *et al* 2006; NICE 2007b; Said and Geary 2007; Roberts *et al* 2009).

Risk factors have also been identified for genital tract sepsis including caesarean birth, prolonged rupture of the fetal membranes, multiple vaginal examinations, internal fetal monitoring, anal sphincter tears, manual removal of the placenta and perineal infection (Maharaj 2007; Norwitz *et al* 2010; CMACE 2011). The commonest cause of direct maternal mortality in the UK is genital tract sepsis, with most cases occurring as a result of beta-haemolytic streptococcus Lancefield Group A (*Streptococcus pyogenes*) (GAS). GAS is very common in childhood and therefore those women at greater risk would be those who have or work with young children.

“All of the mothers who died from Group A streptococcal sepsis either worked with, or had, young children. Several mothers had a history of recent sore throat or respiratory infection and some of these women also had family members, especially children, with sore throats suggesting that spread from family members is a further risk factor for developing life-threatening sepsis.” (CMACE 2010 pg.2)

2.3.2 Clinical observations

Clinical observations involve the use of the practitioner’s senses to gather pertinent clinical information (Mosby’s medical dictionary 2009). Potential

clinical observations to inform assessments of genital tract well being following childbirth include general parameters, such as vital signs and pain; and specific clinical observations such as palpation of the uterus and inspection of the perineum and lochia (Marchant *et al* 1999; Bick, MacArthur and Winter 2009; Marchant 2009).

There are a range of general signs and symptoms identified in the professional literature as potential indicators of genital tract morbidity. These include pyrexia (a raised temperature higher than 38 degrees centigrade); hypothermia (temperature lower than 36 degrees centigrade); tachycardia (pulse rate higher than 100 beats per minute); tachypnoea (respiratory rate higher than 20 respirations per minute); general malaise; fatigue; aches and diarrhoea (NICE 2006; Bick, MacArthur and Winter 2009; Baston and Hall 2009; Byrom, Edwards and Bick 2010; CMACE 2011). General signs and symptoms of GAS infection include sore throat or upper respiratory tract infection and generally occurs over the winter months (CMACE 2011). As highlighted by the CMACE report (2011), infection can present with a normal, raised or low temperature and analgesics commonly used following childbirth, such as paracetamol, are anti-pyretic and therefore can mask pyrexia. This makes it difficult to identify a particular temperature as being indicative, or not, of sepsis. Takahashi (1998) suggests routine temperature taking may not be a sensitive tool for identifying puerperal pyrexia.

Maternal genital tract pain may be indicative of genital tract trauma and morbidity and its presence should be assessed. The severity of postnatal perineal pain has been identified in several studies to correlate with the degree of trauma and morbidity (MacArthur & MacArthur 2004; Bastos and McCourt 2010; East *et al* 2011). In turn, the trauma and associated perineal pain is associated with increased ongoing and longer-term maternal morbidity (Williams, Herron-Marx & Knibb 2007). Uterine pain, tenderness and abdominal pain may be indicative of uterine morbidity such as genital tract sepsis and necessitates urgent further investigation by the midwife (NICE 2006; Bick, MacArthur and Winter 2009; CMACE 2011).

2.3.2.1 Perineal observations

During childbirth, women may sustain trauma to the perineum or surrounding tissue resulting in a perineal wound. The most common method of assessing any wound is visual clinical observation (Kennedy and Arundel 1998). As wounds heal they undergo sequential changes that may be seen in the wounds appearance, including haemostasis, inflammation, proliferation and remodelling (Boyle 2006; Steen 2007). Benbow (2007) suggests accurate wound assessment via clinical observation is vital for providing initial base line information regarding the wound for subsequent comparison. Subsequent clinical observations can identify any arrest in wound healing; its potential causes and therefore guides corresponding management. Symptoms such as tissue colour, appearance, exudate, odour and pain aid the identification of the stage of wound healing and any impairment in the process or morbidity including infection and haematoma formation (Benbow 2007; Steen 2007; Bick 2009; Bick, MacArthur & Winter 2009; Steen 2010). Steen (2010) highlights there are a number of perineal trauma scales that have been produced, usually as part of a research project, which integrate aspects of perineal observation such as oedema, bruising and other aspects of the wound appearance. However several of the scales remain unevaluated, several have practical difficulties of use, making them not feasible for everyday use and have not been adopted into midwifery practice (Tohill & Metcalf 2005; Steen 2010).

Contemporary guidelines do not advocate routine clinical observations of the woman's perineum unless the woman articulates a concern or requests for her perineum to be clinically observed (NICE 2006). Marchant (2009 p. 658) suggests, *"it is not essential for the midwife to examine this area and arguably it is an intrusion into the woman's privacy to do so."*

2.3.2.2 Uterine observations

The content of uterine palpation includes the height of the uterus, its tone, position and if it was painful when palpating (Johnson and Taylor 2006;

Bick, MacArthur and Winter 2009). It reflects the physiological process of uterine involution, in which the uterus reduces its mass and approximates to its pre pregnancy size and shape (Coad and Dunstall 2005). Within two weeks of birth the uterus is again a pelvic organ and usually not palpable abdominally, however complete involution takes approximately six weeks (Stables and Rankin 2010). Sub involution is a slow rate of uterine involution and has been associated with retained products of conception, post partum haemorrhage and uterine infection (Coad and Dunstall 2005; Stables and Rankin 2010). Marchant (2009 p.668) also highlights other potential indicators of genital tract infection being if the uterus palpates less well contracted or “boggy”. Due to the variability of normal uterine involution, these observations need to be recorded in a consistent manner to enhance continuity of care between care givers (Cluett, Alexander & Pickering 1997; Marchant, Alexander and Garcia 2003).

The significance of uterine palpation as a predictive tool of uterine morbidity is not clear and has a limited evidence base. Cluett, Alexander and Pickering (1995) conducted a small study involving a total of 28 midwives who were assessed measuring the uterine fundal height using a tape measure. The data suggested that there were inconsistency in findings when the assessment was undertaken by different midwives on the same woman (inter-observer), with a range of 5cm and also when the assessment was undertaken repeatedly with the same midwife and woman (intra-observer), with a range of 2 to 3 cm. Cluett, Alexander and Pickering (1997) then undertook a study of 28 postnatal women to evaluate the normal pattern of uterine involution. The findings identified a considerable variation in the pattern of uterine involution in these women, which led the authors to conclude assessment of uterine height and anticipated involution rate was *“too variable to provide a basis of a clinically useful screening tool”* (Cluett, Alexander and Pickering 1997 p. 15). These sentiments are reflected in the NICE (2006 p.12) Postnatal care guidelines, which state that “assessment of the uterus by abdominal palpation or measurement as a routine observation is unnecessary“ but suggest if other signs of uterine morbidity are present,

such as excessive or offensive lochia, abdominal tenderness or fever then the uterus should be palpated to determine its size, tone and position.

A later study by Marchant, Alexander and Garcia (2000), the Blood Loss in the Postnatal Period (BliPP study), included a case control study, of the records of women who were admitted to hospital postnatally for excessive or prolonged vaginal bleeding or uterine infection. Each case record, involving admission, was compared to two control records, of women not admitted, with a total of 729 records reviewed. Following review of the records, the authors suggest that routine palpation of the woman's uterus by the midwife was useful in predicting abnormal vaginal bleeding and uterine infection in the first three months postnatally. Following this publication Alexander (2001) acknowledged the disparity between the recommendations from the earlier study (Cluett, Alexander and Pickering 1997) and the more recent BliPP study (Marchant, Alexander and Garcia 2000), and suggested that on manual palpation the midwives probably observe the uterus for more factors than its height, that is also its tone, position, if painful and simultaneously integrating these findings with observations of the women's lochia. It is the integration of these findings that Alexander (2001) suggests may give uterine palpation some predictive value of genital tract morbidity. Technical diagnostic methods to predict uterine morbidity are less successful, a prospective observational study of 94 women utilising ultrasound did not identify a correlation between ultrasound findings and postnatal morbidity (Deans and Dietz 2006). Technical methods generally focus upon information from one source, however practitioner assessments may integrate a range of information to reach a conclusion (Alexander 2001; Dietland *et al* 2006).

2.3.2.3 Lochia observations

Following the separation of the placenta women experience vaginal blood loss called lochia. As the uterus involutes the upper layers of the decidua are sloughed off, the placental site heals and the endometrium regenerates (Stables and Rankin 2010). The amount, colour and constituents of the

lochia alter over the postnatal period reflecting these physiological processes, with more blood in the lochia initially, termed lochia rubra, followed by lochia serosa, pink in colour, which contains some blood but also degenerating decidua cells and exudate from the healing placental site and finally lochia alba which is cream / brown tinged containing serous fluid and mucous (Coad, Dunstall 2005; Stables & Rankin 2010).

Midwives need to assess the amount and colour of the lochia, which should approximate with the anticipated physiological changes occurring in the woman's genital tract. Initial blood loss may be "*heavy during the first few days,*" and bright red, but should then become lighter in amount and colour (Bick, MacArthur & Winter 2009 p.12). Any profuse vaginal blood loss, sudden return to fresh red loss after the first postpartum week, passing of large blood clots or offensive smelling lochia should be investigated (NICE 2006; Baston & Hall 2009; Bick, MacArthur & Winter 2009; Marchant 2009).

The survey of women's experiences of vaginal loss from 24 hours to three months after childbirth, the Blood Loss in the Postnatal Period (BliPP) study involved 524 women who were asked to complete diaries and questionnaires on two occasions up to 16 weeks post birth (Marchant *et al* 1999). The findings identified that women's vaginal loss was more varied in the amount colour and duration than had been previously reported within traditional midwifery texts, with the authors recommending that this information could be used to provide women with information about expectations regarding vaginal blood loss following birth (Marchant *et al* 1999).

2.3.3 Questioning as an assessment method

When undertaking assessments in health care, questioning is recognised as a legitimate and valuable tool to access relevant data to inform subsequent client care planning and interactions (Lloyd 2010). A range of midwifery professional texts advocates the use of maternal questioning concerning general well being, pain and vaginal blood loss to identify maternal genital

health and potential morbidity. This includes national guidelines pertaining to postnatal care and key texts providing principals of midwifery postnatal assessment and care (NICE 2006; Baston and Hall 2009; Bick, MacArthur and Winter 2009; Marchant 2009).

The findings from the survey of women's experiences of vaginal loss from 24 hours to three months after childbirth, the Blood Loss in the postnatal period (BliPP) study identified the need to carefully question women to ascertain information regarding blood loss (Marchant *et al* 1999). Utilising timing of changing of sanitary towels was not a reliable indicator of vaginal blood loss, as women appeared to change their pads at different rates, not always indicative of the amount of soiling and therefore not a reliable indicator of amount of blood loss, unless other parameters were also employed such as degree of staining. Marchant *et al* (1999) suggest when utilising questioning as an assessment technique to utilise the amount of staining of lochia on a sanitary pad, or comparison with a recognised object, such as the size of a pea or a small orange as a means to more effectively and reliably identify blood loss and clot size.

The text by Bick, MacArthur and Winter (2009) has evolved from an earlier, large randomised controlled trial study in which specific questioning of women using symptom checklists were implemented to identify maternal health problems, the IMPaCT study, MacArthur *et al* (2002). The use of symptom checklists in the IMPaCT research was driven by various research finding suggesting "women did not volunteer information about their health problems, but would provide information if they were asked" (Bick, MacArthur and Winter 2009 p. ix). The study involved 36 general practices in the West Midlands, the midwives working in that location and the 2064 women in receipt of postnatal care, being randomly allocated to either the intervention or control group receiving traditional midwifery care. This resulted in 1087 women allocated to the intervention group consisting of midwifery led care extended to three months postnatally, in which midwives used symptom checklists on four occasions, at the first postnatal visit, day ten, day twenty-eight following birth and at the final interaction

approximately ten to twelve weeks following birth. Outcomes measured included women's physical and mental health and women's satisfaction with the care they received.

The research did not demonstrate any difference in physical health outcomes between the two groups, however as discussed earlier in this literature review much postnatal morbidity is a consequence of factors and events occurring prior to the postnatal period, such as genital tract trauma. As suggested by MacArthur *et al* (2002) such postnatal morbidity takes time to resolve, therefore the culmination of the trial data at 4 months post birth may not have been of sufficient length to demonstrate any difference in length of morbidity, or sensitive enough to demonstrate any reduction in the severity of the morbidity. However the intervention group did demonstrate a significant improvement in mental health measures, which may have been indicative of the increased intervention either reducing the severity or impact of the physical morbidity or enhancing the management of the woman's health problems and providing the women with more effective support. This is supported by significantly better evaluations by women in the intervention group of "*being able to talk to midwives about most or all symptoms, and having no difficulties in this*" (MacArthur *et al* 2002 p.383). Therefore an explicit approach to and content of maternal questioning may help in the assessment of maternal well being which would include assessment of the genital tract. This is supported by Herron-Marx, Williams & Hicks (2007) who suggest from their research that interaction with health care professionals had become more generalised with very little in the way of specific questioning relating to cues associated with physical morbidity and suggest in order to give women "permission" to discuss their health needs, explicit assessment should be made. However the recommendations and model of care suggested from the IMPaCT study have not been recommended nationally or adopted universally in midwifery practice (Bastos & McCourt 2010).

2.4 Women's knowledge and access to information

Underpinning the use of questioning as an assessment method, is the prior activity of the women having sufficient knowledge and information to be able to undertake, identify and articulate their experiences and perceptions of their genital tract well being. Leap (2010) considers midwives need to have faith in women and enable them to take greater control over their postnatal bodies, including self-determination of their physical health. As part of this midwives need to help women develop the knowledge, skills and confidence to monitor their own health (Goering 2009).

An earlier qualitative study involving 33 postnatal women, utilising focus group discussions, identified a major theme for women was their lack of knowledge regarding their postnatal health with women stating they wanted more information on their health (Kline, Martin & Deyo 1998). The literature suggests some women have limited insight regarding their postnatal physiological processes of their genital tract, with 4% of the primiparous women in the BliPP study not aware that they would have blood loss following childbirth (Marchant *et al* 1999). Women interviewed by Persson *et al* (2011) in a Swedish qualitative study of 14 recently delivered women, also identified a need for information regarding postnatal changes. In addition findings in a large (1240 women) Swedish survey of women's postnatal experiences indicated women who were "very satisfied" with their care were more likely to consider they had received sufficient information regarding their own health and physical changes following childbirth (Hildingsson & Sandin-Bojo 2010).

Women in the United Kingdom are less likely to report they receive the information and explanations they require postnatally than at any other time during their maternity experience. In response to the question, "Were you given enough information about your own recovery after birth?" in the 2010 National Care Quality survey of UK women's experiences of the Maternity Services, of the 24,393 respondents, 18% replied "no" and 40% responded, "yes, to some extent" (Care Quality Commission 2010 p.33). Another recent

national survey involved a self selected group of women, 95% of which were NCT members, who responded to the National Childbirth Trust (NCT) survey of women's postnatal care experiences was telling entitled "Left to your own devices" (Bhavnani & Newburn 2010). Of the 1260 women who responded to the NCT survey, only 35% of women by the end of the first month following childbirth felt they had received all the information they needed regarding their own health (Bhavnani & Newburn 2010). This finding is supported by the detailed qualitative study involving semi-structured interviews of 20 recently delivered women, which identified women had unmet informational needs, including aspects of their physical health (Beake *et al* 2010).

Limited insight into events and their potential implications may affect the ability of some women to identify what to report in relation to postnatal vaginal blood loss. The NICE guidelines recommend midwives inform women of life threatening conditions to report including "*sudden and profuse blood loss or persistent increased blood loss, fever, abdominal pain and or offensive vaginal loss*" (NICE 2006 p.11). In addition midwives are advised to provide women with "*the physiological process of recovery after birth*" (NICE 2006 p.11). Some written information regarding expectations of blood loss in the postnatal period can be found at the National Childbirth Trust website (NCT 2011), however this information may not be highlighted to or readily accessed by all postnatal women. The Department of Health document, Birth to Five (DH 2009), is available to women following childbirth, with 65% of the 5333 women surveyed by the National Perinatal Epidemiology Unit (NPEU 2010) reporting they had received a copy. However the majority of the content is directed at providing information upon infant care. There is only one chapter titled "Your own life" which tends to focus upon general health promotion advice, such as diet, exercise and rest and does not mention genital tract physiological processes following childbirth such as blood loss or perineal trauma and healing or what would be classed as abnormal and in need of reporting to their midwife. Within the paragraph, which discusses sexual health, it states if intercourse is still painful after two months the woman is to talk to her General Practitioner.

Only one third of the 33 midwives interviewed in an Australian study identified providing information to women about postnatal physiological changes or how to identify postnatal morbidity (Rayner *et al* 2008). In the research by Beake, McCourt & Bick (2005) some midwives were found to underestimate how unfamiliar some women were in relation to postnatal physiological processes and needs.

2.5 Midwives' views upon postnatal genital tract assessment

There is very limited research explicitly focusing upon midwives' views and experiences of maternal postnatal genital tract assessment. A small focus group study exploring 26 midwives views regarding postnatal care identified that most midwives were supportive of regular clinical observations in terms of assessing physical health and as an introduction to discussion of the physiological changes following childbirth (Cattrell *et al* 2005). The study quotes one midwife as stating "*If you go into a room to examine a woman she will often ask you questions as you go along, but if you just say do you have any problems she is likely to say no*" (Cattrell *et al* 2005 p.208). One third of the 33 Australian midwives who participated in semi-structured interviews exploring their perceptions of postnatal care, suggested an aim of postnatal care was "*aiding women's physical recovery*" for which they discuss providing education and information to women but do not discuss specific genital tract assessment methods (Rayner *et al* 2008 p.314). An Australian action research study involving a total of 31 midwives, engaged in group discussions and interviews in which their perceptions of postnatal care were explored (Schmied *et al* 2008). The midwives suggested an intention of postnatal care was to monitor the woman's physical health postnatally and suggested that daily "strip search" assessments were not necessary, however further detail of assessment approaches are not discussed (Schmied *et al* 2008 p.4).

2.6 Women's views upon postnatal genital tract assessment

Women within a Swedish study believed insufficient attention was paid postnatally to their physical health and recovery with 24% reporting they were dissatisfied with physical examinations (Rudman, El-Khoury and Waldenstrom 2008). Of the 294 women who responded to a Swedish survey of new mothers, 34% reported they were dissatisfied with postnatal care, including the postnatal checks of their own health (Hildingsson 2007). An Australian survey of postnatal women found women rated less well or had not received information and support pertinent to their own postnatal health needs (Fenwick *et al* 2010). In the British NCT survey over 1 in 5 women reported they received little or none of the physical care they needed and that those women who had perineal trauma “needed their midwives to check their wound was healing normally” (Bhavnani & Newburn 2010 p.27). Women in the Rudman & Waldenstrom study (2007 pp.187) suggested their concerns were not taken seriously and care was based upon the ability to self assess a “*help yourself model.*”

Fostering a health service, which is service user led is a recognised driver of contemporary health care. Policy changes are frequently offered as a means of creating “*a patient-centred NHS, where patients and their carers are in charge of making decisions about their health and wellbeing*” (DH 2011 p.3). Within midwifery there is increased recognition of the need to move to a partnership approach to care (Marchant 2009; Leap & Pairman 2010; Nylander & Shea 2010). The use of maternal self-assessment and information from other family members is recommended within many of the established texts concerning assessment of maternal postnatal well being. The NICE (2006) postnatal care guidelines state women and family members should be encouraged to report concerns regarding postnatal maternal health. There is some evidence that women value, and more favourably rate their postnatal care when they are involved in identifying and planning that care. The intervention group of women within the IMPaCT study, who had greater involvement in determining the content and timing of

postnatal visits, rated their experience of postnatal care more highly (MacArthur *et al* 2002).

The extent of the interaction and involvement of women in care decisions fluctuates along a continuum of involving and non-involving, influenced by midwives and women behaviour, the characteristics of their interactions and factors associated with the practice context (Bryans & McIntosh 2000; Millard *et al* 2006; Porter *et al* 2007; Trede and Higgs 2008). However Porter *et al* (2007) identified the most common approach to client involvement in midwifery as bureaucratic decision-making in which adherence to contextual drivers, such as written protocols is prioritised by the midwives. As suggested by Hindley & Thomson (2005) midwives may exert control over women's choices because women often view the midwives knowledge as legitimate. Therefore if the midwife chooses to use a particular form of postnatal genital tract assessment this may be perceived by women to be the most pertinent and she may lack the confidence or ability to request an alternative approach to the one offered. In the recent National Childbirth Trust survey of 1260 postnatal women, a third of women felt midwives "never" or "only sometimes" took into account their personal needs and preferences (Bhavnani and Newburn 2010).

This critique of the literature suggests there is limited and on occasions conflicting evidence concerning the effectiveness of various methods of maternal genital tract assessment. There appears to be no clear indication of which is the most effective assessment method that the midwife should employ as all methods have strengths and limitations. However this critique has identified a range of potential methods of maternal genital tract assessment discussed within contemporary literature.

2.7 Determining the assessment approach

The guidance offered to midwives regarding which approach to maternal genital tract assessment should be employed is not consistent. The guidelines developed as a result of the IMPaCT study encourage midwives

to complete baseline clinical observations of the lochia, perineum and palpation of the uterus in the initial postnatal period; this includes *“encouraging the woman to also palpate her uterus to increase awareness of body changes during the puerperium”* (Bick, MacArthur and Winter 2009 p.12). Subsequent assessments are to be based upon questioning unless potential genital tract morbidity is suspected and then again clinical observations are recommended (Bick, MacArthur and Winter 2009). The WHO (2010 p.25) suggests, *“all postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height and temperature measured routinely.”* In contrast the national guidelines (NICE 2006) do not advocate any postnatal baseline or routine clinical observations with the exception of maternal blood pressure within 6 hours of birth to evaluate for pre-eclampsia, despite this being relatively rare postnatally (Tan & De Swiet 2002). Marchant (2009 p.659) recommends assessing the woman’s pulse considering it is *“probably one of the least invasive and most cost-effective observations a midwife can undertake.”* In addition CMACE (2011 p.17) advocate if significant perineal trauma has occurred *“then the perineum should be inspected daily until satisfactory healing has taken place.”* Daily clinical observations may be difficult for midwives to achieve with the increased early transfer of care to the community setting and the reduction in the number of postnatal visits (Gale 2008; Bick 2010; NPEU 2010)

When undertaking subsequent maternal genital tract assessments, the midwife is advised to utilise questioning of the woman regarding her genital tract well being (NICE 2006; Bick, MacArthur and Winter 2009). The need for subsequent clinical observations is to be determined upon individual maternal need, as interpreted by the midwife (NICE 2006; Bick, MacArthur and Winter 2009;). Whilst CMACE (2011) acknowledges clinical observations are no longer routinely carried out, they urge if potential symptoms of morbidity, particularly genital tract sepsis, are noted clinical observations should be undertaken. However, the CMACE Report (2011) acknowledges there were situations involving women who died of postnatal genital tract sepsis, in which midwives failed to undertake basic clinical

observations, despite the woman presenting with symptoms indicating that clinical observations were required. The national occupational standards concerning maternal postnatal assessment, suggest assessment methods should be selected that are “*safe for the woman, appropriate to her needs, and take account of all available information and other relevant factors*” (Skills for Health 2010 p.4). How contemporary midwives assimilate these factors when determining the maternal genital assessment approach they adopt is not evident in the literature. Consequently it will be valuable to explore how midwives determine individual maternal need in relation to maternal genital tract assessment and the potential range of assessment methods they employ.

2.8 Clinical reasoning

Within the literature there are a range of terms utilised to define the thinking processes that inform practice actions. These include clinical reasoning, critical thinking, theoretical reasoning, reflective reasoning, diagnostic reasoning and decision making (Cioffi and Markham 1997; Rashotte and Carnevale 2004; Spendlove 2005; Funkesson, Anbacken and Ek 2007; Simmons 2010; Jefford, Fahy & Sundin 2011). There are similarities and overlap in the definitions of these terms but also subtle differences which relate to the sources of knowledge and knowing informing the reasoning and or the goal of the reasoning process (Fowler 1997; Hunter 2008; Bonis 2009). For example theoretical reasoning utilises different sources of knowledge but similar reasoning process as clinical reasoning. Theoretical reasoning produces general insights about the area of interest, whilst clinical reasoning produces knowledge in and for practice, which influences practice actions (Mattingly and Fleming 1994).

Within my thesis the term and focus is clinical reasoning as this equates most effectively with midwifery practice and the intentions of the study. Clinical reasoning involves thinking about issues, decision-making processes and forming conclusions (Simmons 2010). It results from the integration of knowledge and insights concerning the practice, client, context

and practitioner to inform the most appropriate selection of practice decisions and actions for that particular client on that particular day (Fowler 1997; Funkesson, Anbacken and Ek 2007; Higgs and Jones 2008; Simmons 2010; Jefford, Fahy & Sundin 2011). Levett-Jones et al (2010) consider the ability of a health care professional to recognise and respond appropriately to a deteriorating patient is related to effective use of clinical reasoning skills. Mattingly and Fleming (1994) within their research involving occupational therapists, express the range and integration of knowledge and insights as four forms of clinical reasoning; procedural, interactive, conditional and narrative reasoning, which are influenced by the knowledge source and decision making approach employed by the health care professional.

2.8.1 Procedural reasoning

Procedural reasoning helps midwives identify practice problems and potentially useful practice procedures, techniques and effective practice responses (Mattingly and Fleming 1994). The knowledge that informs procedural reasoning is predominately technical knowledge, involving the application of existing technical or procedural knowledge. Aristotle is attributed as being one of the first to make a distinction between forms of knowledge, suggesting two types, technical knowledge and practical knowledge (Eraut 1994). Technical knowledge is public “espoused theory” which is applied to practice situations in a logical deductive manner (Argyris and Schon 1974; Schon 1987; Eraut 1994; Hunter 2008). It shares a similar philosophy as the information-processing model of decision making (Mattingly and Fleming 1994). Information processing uses a hypothetico – deductive approach and has 4 stages;- cue recognition, hypotheses generation, cue interpretation and hypotheses evaluation (Banning 2008; Simmons 2010; Jefford, Fahy & Sundin 2011). Cues related to maternal genital tract well-being could include visual cues of maternal well-being, such as appearing in pain; client’s health and obstetric history which may indicate particular risk factors; and maternal responses to midwifery questioning regarding specific physiological signs and symptoms, such as

colour, amount and smell of lochia, raised temperature, general malaise and abdominal or perineal pain (NICE 2006; Bick, MacArthur and Winter 2009; CMACE 2011).

Within the study presented I intend to highlight which cues and technical knowledge inform the midwives procedural reasoning in relation to determining and the potential range of approaches to assessment of postnatal maternal genital tract well being.

2.8.2 Interactive and conditional reasoning

Interactive reasoning involves the face-to-face interactions between midwife and client that helps the midwife to better understand the woman's individual needs whilst conditional reasoning helps the midwife identify impacting contextual factors (Mattingly and Fleming 1994). Interactive and conditional reasoning is informed by the midwives' practical knowledge. This is "theory in use", the reality of how practitioners respond in practice contexts and is learnt and demonstrated through practice (Argyris and Schon 1974; Eraut 1994; Higgs *et al* 2008). There are two subsets of practical knowledge, firstly "craft knowledge" which is gained from repeated practice of processes with differing contexts and clients developing a range of insights and practice experiences. The second is "personal knowledge" regarding ones self, including abilities and limitations, and relationships and interaction with others (Higgs and Titchen 2001; Hunter 2008). Practical knowledge aligns with the intuitive model of decision-making. This uses intuition and knowledge gained from professional experience, involves reflection in action and is characterised by a range of factors including recognising the uniqueness of each case, use of experience and maintaining an "open" attitude (Rashotte and Carnevale 2004; Higgs *et al* 2008). Higgs and Jones (2008) highlight the significance of effective practitioner interaction and communication with clients to facilitate the reasoning process.

Effective communication and relationship development may enable a more individual and accurate assessment of the woman's individual postnatal

health needs and the most pertinent assessment approach within her social context (Millard, Hallett & Lucker 2006; Yelland, Krastev & Brown 2009; Frei & Mander 2010). However the 5333 women who responded to the NPEU (2010) survey were more critical of their interaction with staff postnatally than at other times in their maternity care, with 20% of women stating 1 or more members of staff did not treat them with respect or kindness. An Australian survey of women's postnatal experiences identified similar issues. The largest impact upon women's ratings of their postnatal care included midwives who did not "always" demonstrate a sensitive and understanding approach to their interactions with women (Brown, Davey & Bruinsma 2005).

Midwives in two Australian qualitative research studies involving a total of 64 midwives, also emphasised the importance of developing a relationship with the woman to enhance information sharing and being able to respond to the woman's needs (Raynar *et al* 2008; Schmied *et al* 2008). Woodward (1998) suggests a mutual relationship between the midwife and woman helps to promote sensitive beneficent guidance by the midwife, which is respectful of the woman's autonomy. However the midwives in the study by Catrell *et al* (2005 p.211) suggested they were "too busy" to be able to spend time talking with women and assessing their needs.

Research has identified a breadth of contextual factors that may also influence conditional reasoning including practice traditions, values, organisational and resource considerations (Hunter 2004; Lavender & Chapple 2004; Beake, McCourt & Bick 2005; Martin and Bull 2005; Cheyne, Dowding and Hundley 2006; Mclachlan *et al* 2008; Symon *et al* 2008; McKellar, Pincombe & Henderson 2009). The midwives interviewed in several small qualitative studies suggested lack of time, staff and other organisational pressures directly affected their ability to provide postnatal care (Catrell *et al* 2005; Rayner *et al* 2008; Schmied *et al* 2008). The observational study by Wray (2006a) of UK midwives working on a postnatal ward also highlighted similar concerns including administrative duties and staff being relocated to the labour ward.

Interactive and conditional reasoning may enable the midwife to comprehend and integrate the woman's individual needs and contextual factors and facilitate the involvement of the woman in the decision making process. In addition this discussion highlights the potential impact a range of contextual factors may have upon the reasoning process of the midwife and the woman. If and how midwives attempt to reflect interactive and conditional reasoning aspects when deciding upon their approach to postnatal genital tract assessment is not known. In addition there is limited evidence, which specifically explores the contextual factors, which impact upon their reasoning process in relation to maternal postnatal genital tract assessment.

Within this study the approach to information gathering regarding maternal genital tract well being will be explored. This will include how midwives attempt to identify individual client needs and contexts and the practice knowledge that informs their actions; and what contextual factors influence their approach to postnatal maternal genital tract assessment.

2.8.3 Narrative reasoning

The final form of clinical reasoning, narrative reasoning, can help the midwife and client integrate and make sense of all the influences and select and rationalise the most pertinent practice action for that particular client and her circumstances (Mattingly and Fleming 1994). This reasoning process transcends the factual knowledge about particular practice issues and needs and gives preference to the meaning of the experience for the client (Bonis 2009; Fleming & Mattingly 2008). Narrative reasoning shares similarities with the integrative approach of decision-making in which aspects of the initial 2 models, hypothetico – deductive and intuitive model, are integrated (Banning 2008). Rolfe (1996) suggests this way of thinking involves abductive reasoning in which both technical and practical forms of knowledge are accessed and integrated. Abductive reasoning constructs an informal theory applicable for that client and day, which Rolfe (1996) proposes as a module of nursing praxis (action). Praxis can help integrate

and balance diverse needs and demands involving the client, context and practitioner (Kilpatrick 2008). Such complex integration of insights is indicative of the realities of contemporary practice and a necessity for ensuring appropriate assessment and judgments are made (Rolfe 1996; Fish 1998; Henry 2006). Such sentiments as these can be seen within the findings of the research by Downe, Simpson & Trafford (2007) exploring midwifery expertise. They suggest it encapsulates wisdom, integrating formal knowledge and expertise; skilled practice including competence, confidence and abilities to make judgments and enacted vocation. The latter they suggest,

“As the practitioners in our review became more expert, they appeared to (re)value and to express qualities such as trust, belief and courage, to be more willing to act on intuitive gestalt insights, and to prioritize connected relationships over displays of technical brilliance”

(Downe, Simpson & Trafford 2007 p.136).

Within this study I explore if, how and why midwives use different forms of clinical reasoning, when negotiating observations of maternal genital tract well being. My study includes how midwives employ narrative reasoning to engage their clients in a therapeutic dialogue, as a means of ensuring the practice action resultant from the clinical reasoning is client focused and sensitive, resulting in a unique therapeutic journey for their clients.

2.9 Conclusion

The evidence base regarding genital tract assessment discussed in this literature search has its limitations. In some areas, such as the effectiveness of methods of clinical observations, there is insufficient robust evidence to draw firm and generalisable conclusions for midwifery practice (CASP 2010). Other areas, particularly women’s views of the maternity services, tend to be identified via survey data. Surveys have several limitations, many are conducted some time after the event and therefore

recall of information and detail may be reduced. For example the Brown, Davey and Bruinsma's (2005) survey was distributed to women 6 months after the birth, although its intention was to capture the views of women within the first week of birth, whilst receiving care in the hospital postnatal ward. In addition the women who respond to surveys may be self-selected and may not be representative of the views and experiences of the general maternity population. This may be the case for The NCT survey, of which 95% were NCT members (Bhavnani & Newburn 2010).

Several qualitative studies are cited in this literature search, most using interview methods and a qualitative approach to data analysis identifying key themes. Most of these studies had small numbers, which is to be anticipated with qualitative data, most were clearly explained with sufficient detail regarding research processes such as data collection methods and analysis to present a clear audit trail of the research design and process (Silverman and Marvasti 2008). Although the qualitative work critiqued in this literature review is not generalisable, its credibility means aspects may be transferable and have some significance for developing understanding of the field (Koch & Harrington 1998). In addition the qualitative data bring detail, illumination and differing perspectives and insights to the topic area including psychosocial factors, preferences and individual perceptions (Tracy 2010). These reflect the recommendations of the Midwifery 2020 (2010 p.29) Report, stating that the quality of the maternity services should also take into account "women's experiences and satisfaction with care, person centeredness in addition to safety, effectiveness, efficiency, equity and timeliness."

Despite some of these limitations to the evidence base, there appears to be some consistent issues raised from several sources of evidence concerning genital tract assessment approaches and the content and process of clinical reasoning, as applied to maternal genital tract assessment. These include mixed messages concerning the assessment approach to employ, unmet informational needs impacting upon the use of questioning as an assessment approach, unmet maternal postnatal physical health care

needs, the significance of interaction upon postnatal assessment and the potential impact of contextual factors upon the clinical reasoning of both women and midwives.

To summarise, the changing philosophy and approach to assessment of maternal genital tract assessment and the impact this has had upon the practice of contemporary midwives is pertinent for investigation. This is particularly relevant for those assessment and clinical observations that have been identified as having potential value, in relation to maternal genital tract assessment such as inspection, palpation and smell of the uterus, perineum and lochia. Available theory identifies a range of issues and concepts that are integral or contribute to the conceptual frameworks applicable to this research. What is not evident from the work to date is if and how these concepts and theories apply within the context of maternal postnatal genital tract assessment, or how all of the facets of the reasoning process interact when midwives decide upon a particular approach to maternal genital tract assessment and the significance this may have upon client need, care and midwifery practice. It is clear that postnatal women have concerns and anxieties regarding their postnatal physical health and suffer from significant physical morbidity. However there is a dearth of research exploring how contemporary midwives assess maternal genital tract well-being, what methods they use and the factors that influence and impact upon their decision regarding assessment methods. Holistic midwifery does not separate emotional, social and physical health as they are all inextricably bound together. However to enable a focus for my research which is realistic and achievable within the resource parameters, my focus is the physical aspect of postnatal genital tract health.

Therefore the intentions of my research are as follows.

2.10 Statement of purpose

Aim

To explore the experiences and practice of midwives' in relation to the assessment of maternal postnatal genital tract health.

Objectives

1. To explore how midwives determine, and the potential range of approaches to, assessment of postnatal maternal genital tract health.
2. To consider why midwives decide upon and negotiate a particular approach to assessing maternal genital tract health, highlighting the plurality and range of influencing factors including the woman, midwife and practice context.
3. To discern how midwives involve women in determining the approach adopted for assessment of genital tract health.

Chapter 3

3. Chapter 3 - Research Paradigm and Design

3.1 Introduction

This is the first of two chapters where I discuss the principles and processes of my research philosophy and technique. This chapter sets the scene, with an analysis of the research theory, principles and formal processes, which have guided the development of my study, providing evidence of my appreciation and integration of theory. The discussion includes research philosophy, methodology, data collection methods, sampling, data analysis and quality principles. The following chapter focuses upon my encounters in the research field, with an emphasis upon ethical principles, recruitment and issues emerging within the research field in relation to data collection. The chapter includes critiquing the reality of assimilating research principles, discussed in this chapter, within the practice context and demonstrates the maintenance of research quality via reflexive activity.

The methodology employed within this research emerges from constructionist grounded theory. Methodology is defined by Corbin and Strauss (2008 pg.1) as *“a way of thinking about and studying social phenomena.”* It integrates the philosophical beliefs and assumptions underpinning the research intentions and those of the researcher with processes designed to facilitate insights reflecting that philosophical perspective (Crotty 1998). As the researcher, it is my responsibility to make explicit these philosophical beliefs and provide a coherent rationale as to why a particular methodology provides the “best fit” for a particular research study. This I intend to do within this chapter of the thesis (Silverman and Marvasti 2008 pg.33).

I will commence the discussion by clarifying potential research philosophical frameworks, focusing upon those that provide the most suitable match with the research intentions and my own philosophical beliefs. I will briefly summarise alternative research designs considered, before focusing upon

the chosen methodology, grounded theory. This will include identifying the origins of grounded theory methodology, acknowledging the differing approaches that have developed since its inception. Consequently the original design and approach to grounded theory as proposed by Glaser and Strauss (1967) and the more recent constructionist interpretations particularly those proposed by Charmaz (2006) will be compared and contrasted. This comparative analysis will enable the differing perspectives to be highlighted, discussed and debated in light of the philosophical assumptions that underpin the differing approaches and how they align with my study. The analysis will flow systematically guided by salient aspects of the methodology, including methods of data collection and data analysis, researcher perspectives and quality issues in qualitative research. This evaluation will provide a rationale for my chosen methodology of constructionist grounded theory. The chapter will close with a summary of the chapter discussion and key conclusions

3.2 Paradigmatic influences

Philosophical and theoretical research frameworks known as paradigms reflect interrelated beliefs about the world and how it may be perceived and interpreted. They consist of:-

- The ontology, what is the nature of reality;
- Epistemology, what is the nature of knowledge and the relationship between the knowledge and the researcher;
- And methodology, the design, processes and outcomes associated with the research.

(Crotty 1998; Guba 1990; Denzin and Lincoln 2003).

These beliefs about reality, knowledge and how it may be perceived should unite to form a coherent philosophical framework, a research paradigm, to form the foundation that provides shape and focus for my research intentions, processes and outcomes (Crotty 1998). In addition the focus of my research should influence the philosophical framework, as particular research intentions are more effectively responded to by particular

paradigmatic perspectives (Cheek 2008). There is no hierarchy to research paradigms, one is not intrinsically better than another, however one may be more appropriate for a particular inquiry than another (Jaccard and Jacoby 2010). Ensuring that both the research paradigm and the research intentions form a complimentary fit will help to confirm the inquiry is integrated and methodologically “sound” (Appleton and King 2002; Crotty 1998; Weaver and Olson 2006).

As highlighted by Weaver and Olson (2006) research paradigms are constructed by researchers with shared values and beliefs concerning inquiry and are therefore not fixed or absolute. Different authors suggest different terms for classifying these paradigms, such as Crotty's use of theoretical approaches; and they suggest varying numbers of paradigms (Crotty 1998; Blaikie 2007). However, Denzin and Lincoln (2008 pp.31) suggest paradigms can be distilled to 4 principal philosophical and theoretical research frameworks (paradigms) reflecting the underpinning ontology, epistemology and methodology of methods of inquiry. These are positivist and postpositivist; constructionist and interpretive; critical theory and emancipatory and finally poststructural and feminist.

As highlighted by Cluett and Bluff (2006) midwifery research is perceived as less valuable and therefore not as influential upon practice as medical research, which tends to focus upon positivist approaches and practice outcomes. However, there is an increasing focus upon midwifery led research, which frequently originates from differing research paradigms and includes developing theory for midwifery practice (Bryar and Sinclair 2011a).

My philosophical beliefs and intentions are incorporated within the constructionist/ interpretative paradigm. As suggested by Guba & Lincoln (1994 p. 109) “*the term constructionism denotes an alternative paradigm whose break away assumption is the move from ontological realism to ontological relativism.*” Ontological realism denotes a belief that reality exists independently of human perceptions and experiences of it. It aligns with the positivist paradigm and modernist thought, which developed from

the enlightenment period during which traditional scientific techniques were born (Lincoln and Guba 2000). These assert there exists ultimate truths, which can provide generalisable theory and provide a direct representation of reality (Blaikie 2007; Jaccard and Jacoby 2010). My study does not intend to fulfil these assertions and therefore the study does not sit within the positivist paradigm. In contrast the relativist position fundamental to constructionism asserts, "*reality exists only in the context of a mental framework for thinking about it*" (Guba 1990 pp 25). At the heart of which lies the concept of perception (Denzin & Lincoln 2003). Two slightly differing terms are evident in the literature, constructivism and constructionism. Constructivism focuses upon the perceptions and associated cognitive processes undertaken by the individual mind when constructing meaning. In contrast constructionism focuses upon shared generation and transmission of perceptions, processes and meaning (Crotty 1998; Blaikie 2007). In light of these subtle differences, Blaikie (2007) highlights that social constructionism tends to be the focus of social inquiry and therefore will be the focus and term used within this work as it more accurately reflects my study's intentions and processes, to focus upon shared generation of meaning.

Constructionism became prominent during the 1960s following the publication of the *Social Construction of Reality* by Berger and Luckmann (1966). More recently, throughout the 1990s to the present day, Kenneth Gergen has continued to defend and develop the ideas of social constructionism, most notably in his generative theory in which he suggests constructionism may help to generate new and alternative insights (Gergen 1978; Gergen, Cisneros-Puebla and Faux 2008). Within their work Berger and Luckmann (1966 p. 26 & p. 27) set out to explore the sociology of knowledge, which they considered must include "*everything that passes for knowledge in society*" including "*the social construction of reality*". They highlighted how individuals share their experiences of reality with others through interactions and "*typifications*" which help to construct that reality (Berger and Luckmann 1966 p. 47). In addition social processes and structures within the social reality help to maintain the construct (Berger and

Luckmann 1966 p. 175). This is particularly evident within the means of interacting, in which the authors identify the impact of a “*common language*” (Berger and Luckmann 1966 p.173).

The constructionist / interpretative paradigm considers that the meaning of social reality is constructed and interpreted by people through transactional interactions between thought processes, the external world and other people (Blaikie 2007; Crotty 1998; Jaccard and Jacoby 2010; Lincoln and Guba 2000; Schwandt 2000). Crotty (1998 p.3) highlights the epistemology of constructionism is related to the theoretical perspective “symbolic interactionism”, as it involves the use of symbols such as language and writing to transmit ideas. It reflects a multitude of perceptions of reality with the potential to facilitate the evolution of new insights via the fusion of these transactional engagements (Crotty 1998; Schwandt 2000). Such constructed meaning is specific and time and context bound, therefore constructionism does not claim to unearth the truth or generalisable theory but ‘invent’ a truth concerning the focus of the inquiry. It intends to develop a mid range theory which is grounded in the data but may have some transferability (Jaccard and Jacoby 2010 pp.7). This mirrors the philosophy and intentions of my study. Which is to explore how midwives make sense of complex social interactions and for me to construct with these midwives a representation of their experiences. It is acknowledged that such representation is bound in the time and context. For example if I had interviewed a particular midwife on a different day she may have shared different narratives of her practice, sourcing differing perceptions and leading me to construct different concepts. Contextual and temporal relevance reflects the nature of constructionism in which reality is complex, dynamic, unique and obscure and in turn it also mirrors the dynamic nature of midwifery practice in which many potential truths co exist (Jaccard and Jacob 2010).

Social constructionism has come to the forefront at the same time as postmodern theory, a group of perspectives that rejects the concept of ultimate truths and grand scale theories replacing them with small-scale

theories arising from and conceptualising specific issues, situations and times (Blaikie 2007; Crotty 1998; Denzin and Lincoln 2000). A number of the processes, which are part of the postmodern armoury have similarities with constructionist principles, such as the significance of symbols as ways of constructing meaning and the potential of liberating new insights through the exploration of multiple perspectives (Crotty 1998; Rolfe 2000). These themes I have attempted to reflect within this research process, engaging with multiple perspectives, supported by multiple data collection methods and simultaneous analysis of the emerging data concepts and contemporary literature, research and theory. Within the analysis of the data and the concepts and themes constructed from it, I have analysed the claims made to enable an exploration of the tensions and contradictions within and surrounding them, to facilitate a more critical postmodern analysis.

The epistemology of the constructionist paradigm is subjectivist embracing the intimacy of those involved in the construction of knowledge, including that of the researcher (Denzin & Lincoln 2003). This acknowledges that inquiry cannot be independent of values as not only is reality constructed by people who have belief systems and values, but in turn the collection and interpretation of the data will be influenced by the values and beliefs of those involved in the process (Guba 1990). This includes the contribution of myself as researcher who participates in the creation of the experiences of the participants when creating a means of expressing that experience, "*such experience, it is argued, is created in the social text written by the researcher*" (Denzin and Lincoln 2008 pp.26). I have in the study presented, assimilated and constructed theory from multiple perspectives, capturing the values and beliefs of those involved.

Despite the embracement of subjectivity this research can be perceived as having rigour as it explores and reports the perspective of reality as constructed by the midwifery practitioners and myself with recognition of the contextual factors that influence our thoughts and actions (Blaikie 2007). In addition quality processes as discussed later in this chapter help to ensure that intimacy does not become bias.

The discussion so far has critiqued and established the philosophical position underpinning this research. The focus will now move to how these principles are integrated and applied within the research design, commencing with the methodology.

3.3 Methodology

Denzin & Lincoln (2000) suggest constructionism is not aligned to one specific methodology but encapsulates a dialectic approach. However as suggested by Rolfe (2000) the post-modern researcher who reflects a relativist / subjectivist stance is still able to make discerning judgments concerning methodology and methods by acknowledging why such decisions appear the most appropriate.

One of the initial choices I had to make was whether the research should be quantitative or qualitative. Quantitative philosophical positions are more adapt at responding to research that aims to provide numerical data and therefore describe events and outcomes. In contrast qualitative philosophical positions provide detail, elaboration and exploration of individual perspectives and contextual consideration (Silverman 2005; Silverman and Marvasti 2008). This research is qualitative in nature as it explores not only what midwives do but also the rationale underpinning these actions, highlighting the subtleties and range of midwifery perceptions and meanings, to provide a deeper understanding. The literature review has not identified established theory regarding midwives' approaches to maternal genital tract assessment, therefore it is more appropriate to focus upon theory construction (Layder 1993). Strauss & Corbin (1998) suggest the use of grounded theory methodology helps to illuminate and interpret the details of individual perception and develop theory. This statement appears to fit comfortably with the intentions of my study. As suggested by Bryar & Sinclair (2011b) much of the theory development in midwifery intends to identify principal concepts and the relationships between these concepts to

evolve a mid range theory. My thesis intends to contribute to this theory development.

3.4 Other potential methodologies

I did consider other potential methodologies, however I felt that they did not have such a comfortable philosophical fit with my research intentions or had more practical issues that would be difficult for myself as a novice researcher to overcome. As suggested by Silverman (2005) I needed to push knowledge boundaries, however also be sensitive to my strengths and limitations to ensure the research is ethical and of sound quality. I explored conversational analysis, which offered potential illumination as to the interaction between midwife and woman. However my research intentions also included the reasoning and experiences of the midwives, including the factors, which may influence and impact upon these processes, such as context and culture, which is not a strength of conversational analysis (Barbour 2008). In addition conversational analysis would necessitate intensive recording preferably using video and audio taping which would not be ethically or feasibly practical in the open ward setting or clients home where other family members and friends could be present, causing consent issues (Silverman 2005).

I also considered using a think aloud approach (verbal protocol procedure and analysis) involving the midwives either recounting from a provided scenario a step-by-step breakdown of their thoughts and potential actions, or asking midwives to articulate their thoughts whilst they provide maternal postnatal assessment (Ericsson and Simon 1980; Fonteyn, Kuipers and Grobe 1993; and Fowler 1997). However think aloud processes tend to be mainly descriptive of the content of clinical reasoning but do not illuminate why the midwife uses a particular approach, what it means for them and what has influenced the process, which are all aspirations of my research (Arocha & Patel 2008; Loftus & Smith 2008).

3.5 Grounded theory

After these deliberations I decided the research methodology would be within grounded theory. However since the original inception of grounded theory by Glaser and Strauss (1967), the detail of this methodological approach and design has changed to such an extent that the differing perspectives may be perceived as different research approaches, based upon differing paradigmatic assumptions (Duschcher & Morgan 2004). There needs to be clarity regarding which approach to grounded theory is to be employed so I can expose the intentions and features of the methodology and enhance the rigour of the study (Chiovitti & Piran 2003). Therefore I will critique the two differing approaches and provide analysis and justification of the application of constructionist grounded theory methodology for my study.

The research context at the time of the original inception of grounded theory by Glaser and Strauss (1967) was one in which positivism was the most prevailing doctrine (Charmaz 2003). This was based on the use of scientific empiricism, the use of the senses to verify or falsify “facts” which represented an objective reality that was generalisable and replicable (Hughes & Sharrock 1997). Glaser and Strauss (1967) suggest their contemporaries had concentrated upon verification of existing theory at the expense of theory generation, a focus upon causality over explanation. At this time qualitative research was perceived to be only descriptive in nature, unsystematic and biased (Charmaz 2006). The grounded theory work of Glaser and Strauss (1967) aimed to redefine qualitative research as a credible means of developing explanatory theoretical frameworks and a design for social inquiry.

The union of the differing research backgrounds of the authors was pivotal in the evolution of this new methodology (Cutcliffe 2005). Glaser came from Columbia University, providing him with insights and skills in quantitative methodology, whilst Strauss inherited the more qualitative and interpretative

philosophy from the Chicago School including traditional social inquiry methods such as open interview techniques (Strauss & Corbin 1998; Duschscher & Morgan 2004; Mills *et al* 2007). As suggested by Crotty (1998) most researchers unwittingly follow in the paradigm footsteps into which they are initiated and engage in research approaches and designs that reinforce or at most refine the paradigm. However, the methodological processes of the traditional grounded theory are more heavily influenced by the positivist inclination of Glaser (Denzin & Lincoln 1994; Guba 1990) to the extent that it is also known as Glaserian grounded theory (Cutcliffe 2005).

Following the publication of their combined work in 1967, the paths of Glaser and Strauss diverged, with Glaser continuing with the original approach to grounded theory, whilst Strauss developed a more interpretative and relativist approach to his work independently and with Corbin (Strauss and Corbin 1998; Glaser 1999; Glaser 2004; Walker and Myrick 2006; Bryant and Charmaz 2007; Mills *et al* 2007; Corbin and Strauss 2008). Mills *et al* (2007) suggests constructionist grounded theory has its roots in the work undertaken by Strauss & Corbin (1998) in which they introduce a number of processes such as axial coding, diagramming and accessing literature to construct the truth rather than waiting for the truth to emerge. These are all processes I have employed within my study. Kathy Charmaz, a former student of both Glaser and Strauss, was the first to identify her research methodology as constructionist grounded theory and has written extensively on the subject and influenced my developing research philosophy and the design of this study (Charmaz, 2003; Charmaz 2006; Bryant & Charmaz 2007; Mills *et al* 2007). Other researchers have also evolved grounded theory, most notably Adele Clarke, who adopts an explicit post-modern approach utilising situational analysis to explore the discourses within the inquiry (Clarke 2005). Although interesting, I decided not to utilise a situational approach for two reasons. Firstly I felt the focus upon situations, context and discourse only partially fulfilled the intentions of my research. I also wanted to capture detail, experiences, the potential intimacy of the midwife and woman interaction, which is part of postnatal midwifery care. In addition I felt constructionist grounded theory offered

some structure regarding methodological processes which provided the guidance I felt I needed at this stage of my development as a researcher.

Charmaz (2006) suggests all approaches to grounded theory research commence with the intentions of identifying what is occurring, the social and psychological process involved and producing middle range theories, which emerge from the collected research data. The principal features of grounded theory remain relatively constant in both traditional (Glaserian) and constructionist approach and consist of the following elements (Charmaz 2006). Data are collected utilising a variety of qualitative methods. In my research this involved interviews, and observations. The data are sorted, shortened and summarised into codes. These are initially descriptive and abundant but through further coding, categorising and data collection they become fewer and increasingly conceptual until groups of concepts described as categories are developed. Possible relationships between the categories are identified using theoretical coding, which moves the data from analytical to theoretical. Additional features include memo writing by the researcher in which developing thoughts and analysis are recorded and theoretical sampling during which the researcher returns to the field for further data. All of these processes are undertaken simultaneously using the constant comparative method, comparing codes, incidents and categories to themselves and other sources of data leading to theory generation (Glaser & Strauss 1967; Charmaz 2006; Bryant and Charmaz 2007).

Although these principles remain relatively constant in both traditional and constructionist approach; it is how they are applied which reflects the paradigm shift and the appropriateness of constructionist grounded theory as the methodology for this research.

3.6 Questions of objectivity, subjectivity and mutuality

An emphasis upon objectivity dominates the original grounded theory work. The researcher should “*study an area without any preconceived theory that*

dictates prior to the research relevancies in concepts and hypotheses.”

Glaser & Strauss (1967 p. 33). This includes on commencement not defining a specific research question and delaying the literature review until after the researcher has developed independent analysis (Cutcliffe 2005).

Glaser and Strauss attempt to distance the researcher believing this will enable the participants' true meanings and concerns to emerge and prevent “forcing” the data by introducing ideas originating from other sources (Glaser & Strauss 1967; Layder 1993; Cutcliffe 2000; Duchscher & Morgan 2004). Questions used as part of the research methods, must be dictated by the emerging concepts from the data, as emersion in the data is considered the only means to achieve theoretical sensitivity (Glaser & Strauss 1967; Walker & Myrick 2006). This range of strategies aims to maintain objectivity of the researcher, prevent threats to the validity of the research and therefore to enable a predictable and generalisable truth to be uncovered. This objectivity reflects a positivist epistemology, which is not compatible with the philosophical intentions and values underpinning this research study (Guba & Lincoln 1994).

The ability to achieve this objective detachment of traditional grounded theory approach is questionable, as the decisions we make in any situation are informed by a myriad of past and present insights, knowledge and experiences (Jaccard and Jacoby 2010). These will be exacerbated when the researcher, such as myself, originates from the profession at the centre of the process of inquiry and has a developed body of profession specific knowledge (Cutcliffe 2000). Subjectivity impacts upon what I have chosen to research, why and how and necessitate I make these processes explicit. In addition I needed ethical approval prior to commencing the research, as part of which I needed to articulate specific research intentions and detail of methods, making it impossible for me not to give the intended research area some thought and review prior to commencement (Cutcliffe 2005; Charmaz 2006).

In contrast, constructionist grounded theory advocates a more flexible adaptation of grounded theory processes in which the researcher and participants develop and mutually construct a version of reality as is the intentions of this research. Mutuality has implications for several aspects of the research design. Firstly co-construction helps to place the research within the social, political and historical context in which the perceptions of all the participants, both practice midwives and myself, are embedded. Therefore constructionist grounded theory helps to build a version of how and why participants create meanings and actions in individual situations, which is more relevant to my research intentions and ontological position, rather than defining an ultimate predictable truth (Charmaz 2006). There may be potential for transferability, rather than generalisation.

My engagement in a participatory research process helped to demonstrate to the midwife participants' reciprocity and a sense of trust and mutuality to help equalise the relative power in the participant and researcher relationship (Hall & Callery 2001). This aim is reminiscent of participatory / emancipatory research intentions, with its notions of empowerment and engagement with research being a mutual venture rather than an activity undertaken by the researcher upon the participants (Crotty 1998; Tetley 2000). Empowerment and engagement are very salient issues for this study in which midwives have exposed their values, beliefs and practice actions for external scrutiny. They needed to feel that this was a mutual venture to enable them to speak and act honestly. During data collection my engagement and mutuality provided a form of intimacy that facilitated and permitted the midwife participants to express personal thoughts and experiences, and enabled me to connect with the emotional content of the message (Charmaz 2003). In addition to facilitating participants' expressions, engagement prompted my thoughts and creativity. Midwife participants articulated or demonstrated issues I had not considered or viewed in a particular way, examples of which are discussed in the following chapter. Cutcliffe (2000) suggests that engagement accesses the researcher's tacit knowledge, promotes creativity and enhances theory development. However the success of this mutuality during data collection

was not as straightforward as I had hoped and is explored further in the following chapter, 'Encounters in the field'.

The fostering of subjectivity and mutuality in the design of my research does not mean that my bias, assumptions or opinions should be allowed to dominate the research processes and outcomes. As with all research, issues of quality and rigour must be addressed, in traditional grounded theory quality originates from objectivity and distancing of the researcher. In contrast within the constructionist grounded theory approach by making transparent the procedures I have used to ensure methods are reliable and conclusions trustworthy, quality and rigour are achieved (Koch & Harrington 1998; Silverman 2005).

3.7 Quality issues

As highlighted by Graneheim and Lundman (2004) trustworthiness consists of credibility, dependability and transferability and is deemed to be a more appropriate assessment tool for determining the quality of qualitative research. I must ensure the work I present is transparent so that credibility and dependability can be established and the potential for some of the findings to be transferable clear to those who may seek to make such application. An integral aspect of such trustworthiness and therefore ensuring quality research is reflexivity, an in-depth self-awareness of one's strengths, limitations and perspectives (Cowley and Billings 1999; Lincoln and Guba 2000; Patton 2002). This reflexivity ensures bias and assumptions are explored and made explicit to enable them to be challenged and help safeguard against my pre conceptions entering the analysis unless they are evident in the data (Robson 2002). To fulfil these quality expectations throughout this thesis, I have ensured I have made explicit how data have been constructed and acknowledged and questioned my values and pre conceptions throughout the process (Hall and Callery 2001).

I have used a reflexive journal acknowledging issues and concerns as they arise, which are an accepted method of enhancing the rigour of qualitative research (Graneheim & Lundman 2004; Silverman and Marvasti 2008). Koch & Harrington (1998) clarify that the reflexive account must be detailed and contextual and reflect the engagement of the researcher within the research process involving self-critique and self-appraisal. This I have undertaken and found to be a powerful reflexive tool. My examples within the thesis during the following chapters including encounters in the field, data and discussion chapters, help substantiate my reflexive stance. Such explicit recordings of my decisions and thoughts throughout the research process have provided an audit trail illuminating how the research has been constructed and what has informed and influenced this process, so the reader can examine the degree of trustworthiness of the inquiry by establishing issues such as credibility, dependability and transferability (Koch & Harrington 1998; Chiovitti & Piran 2003; Graneheim & Lundman 2004).

Quality issues and constructionist grounded theory principles such as mutuality have influenced other important aspects of the research design, the methods of data collection, which I will now focus upon.

3.8 Methods

I needed to identify methods that would mutually establish how the midwife participants constructed meaning and actions to clarify why these may be so and how their experiences are embedded within broader contextual influences (Charmaz 2006). The methods needed to provide sufficient detail and complexity, provide access to the diversity of beliefs and insights of the midwives, to fulfil the intentions of both my research and constructionism approach of emic, within, methods (Appleton and King 2002; Jaccard and Jacob 2010). As my study had a range of research questions I intended to explore, I considered a mixed method approach could be useful as it is a common way to capture a range of differing perspectives a “bricolage,” in qualitative research (Denzin and Lincoln 2000

pp. 4; Silverman and Marvasti 2008). This use of multiple methods and triangulation of the data aims to provide greater detail and complexity to the data I constructed. It does not attempt to validate findings by finding an objective reality as in quantitative approaches but add depth and credibility (Denzin and Lincoln 2008; Silverman and Marvasti 2008).

To access not only what midwives did, but why, how and what influenced their approach to maternal genital tract assessment, data collection methods included interview and observation. The interviews were in-depth, semi-structured and narrative focused with midwives whose current practice includes facilitating postnatal care for women and families and non-participant observation of midwives providing postnatal care. I have completed 14 interviews and observed 5 midwives interacting with 15 postnatal women.

The following discussion will substantiate the appropriateness of these methods of data collection for this study and constructionist grounded theory.

3.8.1 Interview data collection

I wished to enable the midwife participants to express their own meanings and interpretations of events, processes and action; therefore I decided to use interviews (Ritchie and Lewis 2003). Wimpenny and Gass (2000) summarise the process and content of grounded theory interviews as accessing the narrative including feelings and reflections. Czarniawska (2004) suggests narratives are used by people as a way of capturing and making sense of their experiences. I intended to encourage the midwife participants to share narratives of their practice experiences, asking them to initially talk about a recent postnatal assessment they had undertaken. Wimpenny & Gass (2000) suggests an initial interviewee narrative enables the interviewee to facilitate the direction of the interview and issues for discussion. The narrative involves perceptions of what has happened but through midwives giving preference to certain aspects of their stories, it also

provides insights as to how experiences have evolved within particular contexts as “cultural stories” (Silverman 2006 p.137). In turn these narratives influence practitioners’ future clinical reasoning, practice knowledge and actions, therefore utilising narrative style interviews provided access to these thoughts and processes (Fleming and Mattingly 2008; Higgs and Loftus 2008). Cioffi, Swain & Arundell (2010) used a similar strategy, in their recent qualitative study, encouraging midwives to focus upon cases from their experience to “mine” aspects of the decision making process.

In keeping with the principles of constructionist grounded theory, I identified potential key concepts and ideas to explore from the literature review. Traditional grounded theory considers such an activity can limit and bias the data however Charmaz (2003) suggests this approach is useful to initiate the inquiry process and to develop interview questions facilitating participant disclosure and emerging themes, particularly for novice researchers such as myself, who may otherwise inadvertently direct participants responses. These sensitising concepts were extremely relevant for this study, contributing to the research proposal for ethical approval and helping this novice and anxious researcher with initial data collection by forming the basis of an interview guide (appendix 2).

Although the focus was to encourage the midwives to recount narratives, the interview guide prompted me as it identified areas for initial exploration during the interviews including the midwives identifying key decision points, cues, dilemmas, surprises, rationales for actions and factors influencing decisions and actions (Mattingly and Fleming 1994). Developing this guide helped me to consider areas for inclusion and how to phrase questions, enhancing my confidence and competence. I felt it was a little like writing a shopping list, I needed to do it, but once it was done I didn’t necessarily need to refer to it all the time during the process, its development had been the thinking time and confidence boost I had needed. I did not adhere to the interview guide in a prescriptive manner as each midwives’ narrative was unique, as was the interview process, with particular interactions between

the midwife participant and myself provoking a unique response, which in turn evoked a particular follow up question. Therefore both the midwife participant and I mutually constructed the interview and mutually constructed an account of her experience, rather than an attempt to create a direct representation of her experience (Charmaz 2006; Silverman 2006). Therefore each interview within this study involved a unique process and produced a unique outcome. Charmaz (2006) considers that intensive qualitative interviewing fits particularly well with grounded theory methodology as both have a sense of direction, but enable emergent themes to develop, as sensitising concepts are starting points only, as elaborated later in this chapter. Facilitating narrative focused interviews necessitated a range of qualities and skills and at times this proved to be more challenging than I had anticipated. This is discussed in the following chapter. The interviews were recorded and transcribed for ease of data analysis. However, I did re-listen to the recordings to help identify nuances in articulation, when the midwives gave particular emphasis to a phrase or content area.

Interview data can help uncover procedural reasoning underpinned by procedural knowledge such as theory, physiology and guidelines (Loftus & Smith 2008). By encouraging individual midwifery interviewees to recount narratives from their practice experiences, including their thoughts, feelings and actions, some access to other forms of clinical reasoning did emerge, including interactive and narrative reasoning (Mattingly and Fleming 1994). This provided some access to the midwives' personal practice knowledge and is evident within the data analysis presented in the subsequent chapters. However as suggested by Eraut (2000) such tacit knowledge remains elusive to capture as it involves the midwives being sensitive to subtle differences in the practice context and is grounded in practice action (Eraut 2000; Fleming and Mattingley 2008). This is confirmed by Loftus and Smith (2008) in a review of clinical reasoning research they conclude that using experiences in narrative style interviews in conjunction with practice observation is more likely to reveal clinical reasoning as used in practice. The midwives in this study, rather than just relying on their memory of

espoused theory were also observed in practice, therefore enhancing the trustworthiness of the data collected (Corbin & Strauss 2008).

3.8.2 Observational data collection

Kawulich (2005) defines observation as a method that involves a rich description of events, behaviours and activities within a particular time and place decided by the research intentions. In the instance of my research I wished to access the content and process of the clinical reasoning of the midwife and influencing factors, in relation to maternal genital tract assessment. Therefore I negotiated access to postnatal interactions between the midwife and postnatal women in which maternal postnatal genital tract assessment would be considered. This focused observation occurred interspersed with interview data collection and analysis of all the data collected to date, with all processes interacting to evolve the focus of the interviews and observations.

This action is compatible with constructionist grounded theory principles in which data collection and analysis must be simultaneous and mutually informative (Kawulich 2005; Charmaz 2006). Observational data involved five midwives who were each observed interacting with several different postnatal women. This helped to illuminate any differences in assessment method employed by the midwife depending upon individual client need, circumstance or context, which may not be expressed during interview and therefore provided a more holistic and trustworthy interpretation. The observation included non-verbal communication, difficult to articulate practice actions and interactions and insights into the contextual factors relating to the research focus, including unscheduled events, which have added to the richness of the data I collected, and the subsequent data analysis. Bryans and McIntosh (2000 p. 1249), who researched health visitors' assessment decisions, suggest such observation of practitioner and client interaction is vital to access practice knowledge and theory in use, which the practitioner may be unaware of using or unable or unwilling to articulate. They suggest alternatives such as vignettes make the

practitioner the passive recipient of knowledge, to explore the assessment process the midwife needed to be “an active producer of information”. Gibb and Hundley (2007) in their research exploring midwives’ assessment of maternal psychological well-being also highlighted that midwives found it difficult at times to articulate what or how their practice judgements and action were formed, suggesting the value of complementing interview data with observational data. For example, during observational data collection I could identify how particular responses from a postnatal woman lead to a particular content and approach to questioning, as the midwife sought to produce relevant information concerning the woman’s genital tract health. Although midwives had mentioned something similar during interview data collection, observing the phenomena in practice was fundamental to my being able to conceptualise the practice and the identification of a “sliding scale” approach as discussed in the data chapter.

Undertaking observations also provided me with access to the reality of contemporary practice contexts. I am and have been within higher education as a midwife teacher, for the past seventeen years. Observations helped illuminate the contextual factors influencing midwives clinical reasoning and practice actions. Silverman (2005) clarifies how observational data can provide insight into how social experiences are created and given meaning and the influencing contextual factors. Examples of this are presented within the data chapters, one of the most salient being the high noise and activity levels in the postnatal ward (Chapter 7). Combining observational with interview data also enabled me to explore not only midwives’ practice aspirations but also “*illuminate discrepancies between intent and outcome*” and why such discrepancies manifest (Barbour 2008 p. 17). This particularly helped to provide detail and complexity regarding interaction processes between the midwife and woman and is discussed in the data chapters. As Kawulich (2005) suggested I looked for regular and irregular activities and variations including examples, which confirmed and disconfirmed the grounded theory I was developing. These are discussed in the data analysis section.

Kawulich (2005) describes three roles with associated continuums of stances when the researcher is an observer.

Complete participant ----- Complete observer
Complete participation ----- Non participation
Full membership -----Peripheral membership

I feel my research intentions, professional insights, and acceptance by the group placed me as an “observer as participant”. I was not a direct member of the group, as I did not work in practice but in education in a different location with a different employer. I was interested in being part of the group as a means to collect research data. The main role of my presence was to collect data and this was made explicit to all involved. However I could participate in some aspects of the groups’ activities. Therefore I made explicit I would engage in the social aspects of the midwife and mother interaction, help carry equipment and chat to toddlers, but not participate in the care interaction which was the focus of my observation and data collection. Therefore I had passive participation and membership to the group and activity under research scrutiny. The reality of applying these principles during observational interactions will be explored in greater depth within the following chapter.

When considering means of observational data collection, I needed to consider the practical and ethical considerations. Barbour (2008) suggests this is particularly salient as ethical processes can make observational data difficult to access and record. Within my study this was the case. I needed to develop quite complex processes to enable women to have decision making time to consent to their care being observed whilst being mindful of the limited number of interactions between women and midwives, as discussed in the following chapter (National Research Ethics Service 2010). The means of recording the observations was also driven by the fundamental principal of research participation being based upon Informed consent (National Research Ethics Service 2009). Postnatal interaction between midwives and women frequently occur in the presence of others. On postnatal wards the voices and actions of others can be heard or

viewed. Therefore I felt unable to use recording or photographic equipment within the postnatal context and instead made notes of only those observations I had been given access and consent to do so.

Accurate field notes form the basis of reliable observational data (Silverman 2005). I developed a field guide for making notes of my observations (appendix 3). Kawulich (2005) suggests such guides can be useful when a relatively short amount of time will be spent observing, which is salient for this study as I would spend hours rather than weeks or indeed the years that some anthropologists spend observing in the field. As with the interview guide, the field note guide was based upon a critique of the literature concerning data relevant to capture during observation to facilitate an integrative record of the event, and included conversation, actions, non-verbal behaviour and contextual factors (Silverman 2005; Charmaz 2006). Content areas to capture were also identified and these were based around the differing types of clinical reasoning that I may encounter during observation of midwives including procedural, interactive and narrative reasoning (Mattingly and Fleming 1994).

In addition elements of the medical interview aural rating scale (MIARS) observational instrument were integrated into the field notes observation sheet. The MIARS identifies levels of clients' verbal and non-verbal cues and disclosures regarding their health concerns, ranging from a hint of concern to explicit emotional response such as crying. The observational instrument also classifies the potential form of practitioner cue responding behaviours and the function of the response, such as to explore the cue or distance the cue by switching focus and has been validated as a useful addition to observational data collection (Caris-Verhallen, Timmermans and Van Dulmen 2004; Uitterhoeve et al 2008). The intention was to use the MIARS as a form of qualitative short hand, a form of magnitude coding, rather than numerical data (Saldana 2009). This did prove to be useful as I did at times struggle to note sufficient detail during observations. The reality and challenges of maintaining field notes will be explored within the following chapter, encounters in the field.

3.9 Sampling principles

As the research and data collection methods for this study were qualitative, which provides a wealth of detailed data; the sampling could be relatively small (Silverman 2005). I had anticipated that approximately 10 midwives would be interviewed and 10 midwife / client postnatal interactions observed, however this was to be dependent upon the data generated, as sampling could continue until no new concepts are evident (Glaser and Strauss 1967). The final tally on completion of data collection was 14 interviews and 15 midwife / client postnatal interactions. Appendix 4 provides an overview of the biographical details of the midwife participants, appendix 5 of the biographical details of the women participants and appendix 6 a summary of the sequence of data collection.

Initial sampling was purposeful and self selected, as I needed to identify those midwives in a position willing to share their thoughts and actions in relation to postnatal practice (Appleton and King 2002; Silverman & Marvasti 2008). Therefore the sample was of midwives whose current practice included postnatal care in hospital or community settings. The self-selected nature of the initial sample in this study is a necessity, as only those willing to participate, can and did. Though I do recognise that self-selection may limit data to potentially only those with the loudest voices or particular perspectives to express. However the intention of constructionist grounded theory is to capture the diversity of the potential data, not to identify a representative or random sample (Turkett 2004; Silverman & Marvasti 2008). To uphold the principles of grounded theory rigid inclusion and exclusion criteria were avoided, as this may limit the authenticity of the evolving theory (Punch 2006).

In addition, as the research process developed, theoretical sampling was employed to allow the principles of grounded theory methodology to emerge, in which the data determine the direction of the inquiry (Cutcliffe 2000; Silverman & Marvasti 2008). Initial participants identified other midwives who had particular perspectives and experiences and most of

those I approached did subsequently agree to participate, enhancing the diversity of the recruitment and resulting data, for example midwives with specialist caseloads such as very young mothers. Confirmation and elaboration of the evolving theory was made possible and disconfirming cases, enabled exceptions to be highlighted and inform the theory construction, as discussed in the data chapters. A flow chart, illustrating the use of theoretical sampling in this thesis is presented in appendix 7. Further detail and discussion of recruitment to the study is provided in the following chapter.

3.10 Data analysis

The discussion will now focus upon how the data collected during this research study were analysed, in line with the principles of the research methodology and constructionist grounded theory. The analytical processes must ensure trustworthiness and fulfil the expectations for qualitative research quality.

I repeatedly reviewed the data from the interviews and practice observations to ensure I had recognised the detail, subtleties and differences in the data. Transcribing was completed soon after each interview and observation. I commenced the first cycle coding by individually analysing each interview and observation, by sorting, shortening and summarising the data into descriptive and abundant initial codes. Such initial coding helped to section and divide the data into smaller actions and events, a process of data reduction (Charmaz 2006; Silverman and Marvasti 2008; Saldana 2009). I summarised what had been said, or the activity or context, in small sections of the text, sometimes line by line, sometimes I summarised every few lines. I did attempt initially to always code the transcripts line by line as suggested by Charmaz (2006). However this detracted from the narratives within the interviews and the contextual factors and events within the observational data and made the evolving codes not as meaningful or an accurate reflection of the content. As suggested by Czarniawska (2004 p. 23) in narrative interview analysis it is not only what has been said but also how it

is expressed and constructed and the “emplotment” which indicate how connections are made and used to give coherence. Saldana (2009) agrees that data do not necessarily need to be coded at a pre-determined frequency, but as indicated by the data. I also tried when possible to use “in vivo” codes reflecting actual words, phrases and activities from the data to maintain the emerging codes close to the data and the reality of what the midwives had expressed, the common phrases that they used and activities and events encountered. Charmaz (2006 p.51) advocates such an approach “*build your analysis step by step from the ground up without taking off on theoretical flights of fancy*” as a means to facilitate the creation of a “grounded” theory, reflecting the content of the data.

The first interview transcript I attempted to code I initially felt I was only describing what had been said but as I re-listened and re-read the transcript I did start to identify what I considered to be potential codes. A number of which I had anticipated, such as potential cues re genital tract well being; others I had not such as the impact of obesity or the significance of relationships and communication to the process. At my supervisors’ suggestion I brought the first interview transcript and my initial codes to a supervision meeting, which was very useful to develop my confidence and insights regarding interview analysis and coding. Silverman and Marvasti (2008 p. 192) suggest such engagement with the supervision process helps to develop the researcher’s skills and prevent her from “drowning in data”, a sentiment I fully endorse.

In addition to identifying initial codes in the data, I commenced simultaneous memo writing, following the principles of grounded theory (Glaser and Holton 2004). I captured my initial ideas and potential links between the data by making notes, which I kept as an evolving catalogue of my thought processes. In addition, and in contrast to traditional grounded theory methodology, I continued to read widely to continually maintain and develop my knowledge base generally, but also I would undertake focused reading as I related some of the emerging issues from the research data to other work in the field (Charmaz 2003; Lempert 2007; Silverman and Marvasti

2008). This I captured within my memos and research journal, which I used to enhance my analytical engagement with the data and refining of concepts, and also used as a platform to share my developing ideas with my supervision team during supervision meetings (Chiovitti & Piran 2003).

After initial coding I commenced focused coding, a form of second cycle coding in which the most significant codes were grouped, and distilled (Charmaz 2006; Saldana 2009). This involved revisiting initial coding to refine, amalgamate and enhance or remove codes to provide a more accurate representation of the data. It included stepping back from the detail of an individual piece of data and viewing it both more holistically and also from a distance, considering what the codes described but also how, why and what assumptions they reflected (Corbin and Strauss 2008; Saldana 2009; Jaccard and Jacoby 2010). This enabled me to construct focused codes which were more representative and inclusive of the data but also develop fresh insights into how the codes formed a focused code, what it involved and why (Silverman and Marvasti 2008). In addition I compared one piece of data to another to help identify and refine the focused codes, comparing interview with interview, observations with observation and interview with observation (Corbin and Strauss 2008).

Initially I attempted to relate the emerging focused codes to the areas within the initial interview and fieldwork guides, based upon the theoretical analysis I had undertaken when developing the research proposal. These guides were constructed around the forms of clinical reasoning, procedural, interactive, conditional and narrative reasoning. Whilst undertaking this assimilation it became obvious that using the reasoning framework from the data collection guides was not going to be an appropriate theoretical framework for the emerging focused codes and potential grounded theory. It made the focused codes repetitive and it was difficult to align the data from the focused codes to the areas of the data collection guide. This tended to move the analysis and focused codes away from what was emerging from the data. Charmaz (2006 p.46) advises the grounded theory researcher not to apply preconceived codes “ *we create our codes by*

defining what we see in the data". In addition to not fully representing the emerging data, I considered the reasoning framework did not respond fully to the breadth of the research intentions, as these needed to include not only what forms of reasoning midwives used, but also how and why, including contextual factors. Therefore the focused codes reflected groups of codes, which in turn reflected the data I had collected, rather than my data collection guide and so began to initiate emergent theory.

Within my study there was simultaneous collection and analysis of data to facilitate a constant comparison of data, which enhanced the refining, and verification of the concepts generated (Charmaz 2003; Chiovitti and Piran 2003). As issues emerged from the data, I incorporated them into future data collection, in the form of new questions or observations within the data collection guides, and via theoretical sampling seeking those participants who may provide these insights (Glaser and Strauss 1967; Charmaz 2006). This enabled me to confirm or disconfirm aspects of the emerging theory and provided conceptual detail, including deviant cases. As suggested by Silverman and Marvasti (2008) what is important about deviant cases is to analyse what, how and why they are different and how this information can enhance the emerging theory. For example the data identified that many midwives used information from others, such as family members when assessing maternal well-being. However, further data collection exploring and elaborating this finding also provided examples of occasion when such information sources may be unreliable (chapter 6).

The simultaneous refinement of codes with further data collection helped to maintain the analysis close to the data, which is the grounded aspect, ensuring the evolving insights are contextually situated, which facilitates greater theoretical complexity (Charmaz 2006). It also helped to ensure the quality of the subsequent theory development through testing and ensuring it was trustworthy. Saldana (2009) highlights that all researchers bring with them and may apply their philosophical and theoretical assumptions which then act as a coding filter when analysing data and constructing codes and categories. However engaging in constant comparative analysis and

discussing my thoughts with my supervision team, has helped me to minimise the impact of my personal coding filters and prevented my analysis and subsequent theory development being based upon a biased selection and analysis of data (Silverman and Marvasti 2008). Within the data chapters of the thesis I have presented data quotes to make explicit how codes have formed and to make this process open to external scrutiny, a responsibility of a qualitative researcher (Saldana 2009). Appendix 8 and 9 provide examples of my initial coding process and appendix 10 an example interview transcript.

Through constant and comparative focused coding and data collection the focused codes became fewer and increasingly conceptual. This enabled me to identify and construct groups of focused codes, which shared characteristics and connections, described as categories (Charmaz 2006; Saldana 2009). Simultaneously, how these categories related to each other and connected was developed through further data analysis, enabling me to not only fragment the data but also to re construct it in a meaningful way (Corbin and Strauss 2008). This Strauss and Corbin (1998) and Corbin and Strauss (2008) describe as axial coding in which analysis involves “*crosscutting or relating concepts to each other*” (Corbin and Strauss 2008 p.195). This enabled the properties and dimensions of the categories to be defined, explored and related developing the theoretical sensitivity of the developing grounded theory (Charmaz 2006; Corbin and Strauss 2008; Saldana 2009). Possible relationships between the categories and existing theory and research were identified during the analysis, as presented within the data and discussion chapters in this thesis, moving the data from analytical to theoretical and therefore the formation of a grounded theory (Glaser and Strauss 1967; Strauss and Corbin 1998; Cutcliffe 2000; Charmaz 2003).

Some categories constructed with relative ease with focused codes forming obvious groupings with overt connections, for example those in the category ‘Clinical Observations’ within the Methods of Assessment theme chapter. However not all categories were so easily defined or the most appropriate

placing of a focused code evident. This is exemplified by my initial difficulty encountered in refining and placing the initial code 'Embarrassment'. It appeared to be relevant to two categories, 'Sensitive Care' and 'Rapport'. Attempting to place all the detail of the findings related to "embarrassment" in only one of the categories was unsuccessful as it altered the category and did not provide a coherent account of the data. By continually analysing and comparing the data and also pertinent existing research and theory in the area, the researcher was able to progress her thoughts. This insight developed the use of the term 'Embarrassment' from a descriptive term to a more conceptual understanding of how embarrassment was applied in differing ways to the midwives' practice and why. The strategy, of conceptualising the various potential meanings of a word or phrase, is advocated by Corbin and Strauss (2008) as a means to aid developing analysis. Therefore although the term embarrassment is present in both categories it reflects differing aspects and affects each category differently. These feelings relate well to the conclusions drawn by Glaser (1999 p. 838) of the requisite qualities of the grounded theorist researcher. These include skills in developing concepts from data and the ability to tolerate the inherent confusion and at times regression that such in depth analysis evokes. This includes recognising when refocusing is needed as codes become refined, sharpened and occasionally redundant (Saldana 2009). Walker and Myrick (2006 p. 549) suggest grounded theory is both a "*inductive, yet reductive process*", i.e. moving the conceptual analysis on but refining it and comparing it to existing theory in the constant comparative method.

Grounded theory methodology suggests data collection continues until no new concepts are being identified from the data and the theory is saturated with the properties and dimension of categories defined (Corbin and Strauss 2008). This is a difficult concept to operationalise when undertaking research as part of a course, which is time limited and in a practice area to which I have time limited access, as data gathering cannot continue in perpetuity. In addition as each interview and observation with a midwife participant was unique, there was always something new. However the

data collection and analysis did reach a point in which no significant new concepts were identified.

3.11 The Grounded theory

The codes, focused codes, categories and themes I identified within my data analysis have been refined and grouped to present the closest approximation to the co-constructed account of the midwives' experiences and practice in relation to the assessment of maternal postnatal genital tract health; a grounded theory. Theory is a symbolic construct clarifying the content and relationship between concepts related to a particular phenomenon (Jaccard and Jacoby 2010). A grounded theory emerges from analysis of qualitative data, reflecting individual experiences, it is not necessarily a generalisable theory (Corbin and Strauss 2008).

The theory constructed from the data in this research reflects the construction of a grounded theory of midwives' assessment of postnatal maternal genital tract health. It is a middle range theory that examines an aspect of midwifery practice and intends to explain some of the principal concepts, which may then be tested, if desired, subsequently (Bryar & Sinclair 2011). As such this middle range theory is a thread from the tapestry that is midwifery, and as any thread does not capture the whole tapestry, it is not a grand theory, which attempts to represent all of midwifery practice; but a thread that contributes, connects and relates to the larger tapestry of midwifery practice.

A theory should provide transparent data concerning its principal ingredients, both concrete and abstract phenomena, which are known as concepts (Bryar & Sinclair 2011). In this study the concepts are represented in the categories that have formed from the analysis of the research data. In addition a theory must make explicit what these concepts consist of, its properties and attributes including observable aspects, its empirical referents (Walker & Avant 2005). These conceptual qualities are articulated and discussed within this grounded theory under each category and consist

of a range of coded research data. They are listed below in table 1, but discussed in detail within the following data chapters.

3.11.1 - Table 1 - Concepts that form the Grounded theory

Themes <i>How the concepts relate</i>	Categories <i>Principal concepts</i>	Focused Codes <i>What the concepts consist of</i>
MODIFIERS Of genital tract assessment	A Therapeutic Relationship	Rapport Meaning Making
	Care in Context	Location Competing Priorities
	Evolving Midwifery Practice	Personal Theory Generativity
MOTIVATORS Of genital tract assessment	Verification	Sufficient Information Accurate Information
	Personal Preference	Maternal Preference Midwife Preference
	Sensitive Care	Recognising Individual needs Providing appropriate genital tract care Care with Dignity
METHODS Of genital tract assessment	Risk Assessment	Childbirth Events Women's Lifestyle
	Questioning	General Symptoms Specific Symptoms Self Assessment
	Clinical Observation	General Observations Specific Observations

In addition a theory may suggest how the concepts relate to each other, illuminating potential constructed “meanings and actions” (Charmaz 2006 p.130). In this grounded theory the relationship between the categories are expressed as three themes; Methods, Motivators and Modifiers. The Methods represent the potential range and use of maternal genital tract assessment methods midwives may action. However the Methods of assessment are influenced by the other two themes, the Motivators and Modifiers. The Motivators theme reflects categories from the research data, which indicated how midwives’ actions, and assessment methods, were prompted by their particular beliefs, knowledge and experiences. The final theme, Modifiers, consists of factors and contexts that facilitated or inhibited

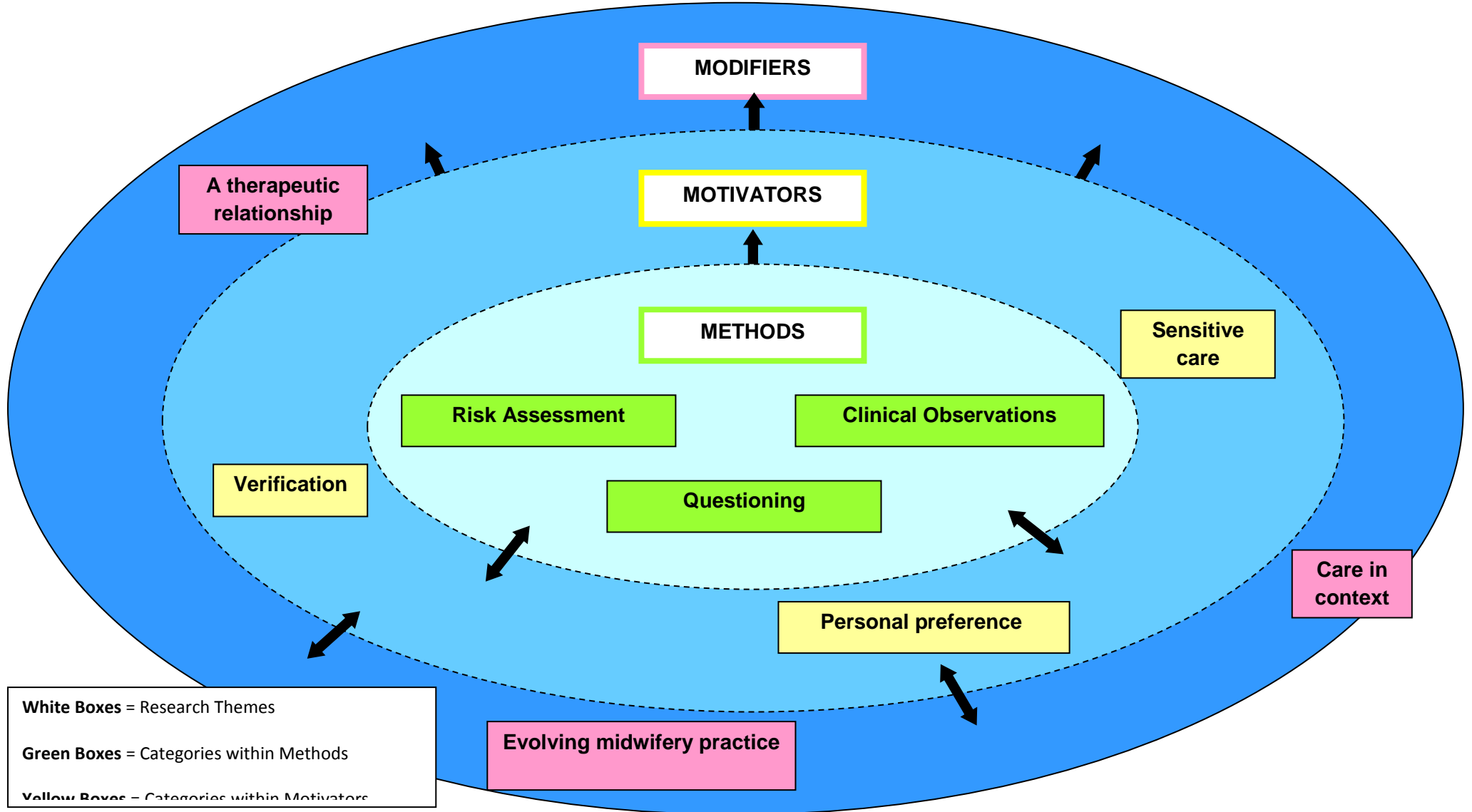
the midwives' ability to negotiate an appropriate approach to genital tract assessment and impacted upon both the motivators and methods categories.

However, the concepts within the constructed theory are dynamic. They interact, relate and simultaneously apply to the midwives' reasoning as they undertake postnatal genital tract assessment. For each midwife, woman and context there are different connections, resulting in differing midwifery practice responses and actions.

Such complexity is difficult to express within a two-dimensional written account, where sequencing and order are expected to follow a traditional academic writing style. I had initially developed a linear model of the emerging theory (appendix 20). However I felt this did not represent the potential connections, interaction and dynamic nature of the midwives' clinical reasoning processes. As my work and thinking progressed I revised and developed the model, included revisiting and refining the focused codes and theoretical concepts, until the final version was constructed (appendix 11). The diagrammatic representation of the theory reflects a system model as it attempts to express the dynamic, interconnections between the layers (Jaccard & Jacoby 2010). McCourt (2005) suggests systems theory is particularly relevant for conceptualising midwifery practice as it helps prevent aspects being fragmented and isolated and acknowledges that the integrated model, as a whole, has more properties than the individual components.

As suggested by Corbin and Strauss (2008) integrated diagrams can be a useful way of expressing the emergent theory. This I have undertaken in this thesis, with a diagrammatic overview of the grounded theory on the next page (and appendix 11). In addition during each data chapter I have included diagrammatic representation of the themes, categories and focused codes preceding the discussion.

3.11.2 - Diagram of the grounded theory of midwives' experiences and practice in relation to the assessment of maternal genital tract health



3.12 Conclusion

This chapter has presented an analysis of the research theory and formal processes, which guided the development and implementation of the research. I have discussed research paradigms with a focus upon constructionism, substantiating its appropriateness for this study. The chosen methodology of constructionist grounded theory has been critiqued in depth and its appropriateness and significance for the research evaluated. Traditional grounded theory (Glaser and Strauss 1967) aims to explain the “truth” of the research area and through its objectivity and the realisation of formal theory enable future predictions (Denzin & Lincoln 2003). In contrast the work of Charmaz (2006) suggests a constructionist interpretation of grounded theory in which the participants and researcher develop and construct a version of reality. This highlights how and why participants create meanings and actions in individual situations rather than defining an ultimate predictable truth and mirrors the intentions of my research (Charmaz 2006).

The various facets of the research design have been presented and critiqued in relation to their methodological fit and appropriateness to this study’s intentions. The discussion has included data methods, data analysis and how I have ensured the quality of these processes within the study. A number of these issues will be further explored within the following chapter, detailing my encounters in the research field and the reality of assimilating research principles within the practice context.

Chapter 4

4. Chapter 4 - Encounters in the field

4.1 Introduction

This chapter of my thesis builds upon the analysis of research philosophy, methodology, data methods and data analysis of the previous chapter. It provides an evaluation of my encounters in the research field, highlighting strengths, challenges and limitations encountered as I attempted to assimilate my theoretical understanding of research principles to the reality of planning and implementing research within a “real” research and practice context. The chapter presents and discusses several key aspects of the research process including gaining access to the research field for data collection and methods of data collection.

The presentation style is reflexive, utilising a mix of accounts from my research journal and analysis of relevant research literature and theory. Such an approach enables me to provide an account of not only events but also my developmental journey. The quality of the research is thereby enhanced, by establishing the trustworthiness of all aspects of the research process (Koch & Harrington 1998; Graneheim & Lundman 2004). The reader is provided with an audit trail of decisions, highlighting strengths and limitations, which may have impacted upon the research process, data and research conclusions.

The discussion commences with an outline of the formal ethical processes I completed prior to commencing data collection. This is followed by an appraisal of the ethical considerations integral to the study, including issues of consent, confidentiality and security of data. These ethical principles are demonstrated in the provided account of the recruitment and sampling technique employed. My experiences in relation to gaining access to research participants and using interviews and observation are analysed in depth and the success of their implementation evaluated. Strengths and

limitations in technique and other factors that may have impacted upon data collection are identified.

4.2 Ethical issues

As the research involves using data from human NHS participants it required and received favourable approval by the Northumbria University School Research Ethics Committee, Regional Research Ethics Committee and local research and development committee (appendix 12). The latter were accessed via the NHS National Research Ethics Service (2011) and the Integrated Research Application System. Due cognisance of ethical principles and processes, such as confidentiality, consent, protecting the participants and acting with good faith and integrity were reflected within all areas of the intended research including appropriate research intentions, methodology and methods (Department of Health 2005; Northumbria University 2009).

I developed and provided verbal and written information to potential research participants in which I had ensured the text and layout enhanced comprehension, maintained objectivity and was free from any coercion (National Research Ethics Service 2009), (appendix 13 and 14). I also ensured consent was gained and reaffirmed throughout the research process as discussed in more detail within the recruitment discussion (appendix 15, 16 and 17). All of the processes, products and data used during the study, reflected the Data protection Act (Great Britain. Data Protection Act 1998) and Freedom of Information Act (Great Britain. Freedom of Information Act 2000). Data were anonymised and stored securely, with hard copies of information within a locked storage area and electronic information password protected (Northumbria University 2009). Coding data sources, at interviews and observations, such as midwife A client 1, adheres to the confidentiality rules. I used pseudonyms for the women participants. Research records will be retained, to meet ethical requirements. Records to demonstrate good research practice will be retained for 10 years following completion of the project and then destroyed

via shredding or electronic re formatting (Northumbria University 2009). When gaining consent, I made research participants aware of the legal and professional exceptions to my maintaining confidentiality. These included an event in which legal or professional parameters had been breached, for example incidents reported or witnessed by myself in which the safety, well-being or ethical and professional treatment of individuals was a concern. Participants were informed of this prior to consenting to their inclusion. If these or any other adverse event affecting the research participants, researcher or others had occurred they would have been reported in line with University procedure, however none occurred (Northumbria University 2009). A honorary research contract (research passport) was arranged to fulfil the contractual requirements to facilitate research activity within the NHS.

4.3 Recruitment

Recruitment to the study involved midwives and postnatal women from one North East NHS Trust. The trust has a maternity unit, with just over 1,500 deliveries per annum, which has obstetric involvement and provides postnatal care in both the hospital setting and the client's home. It was chosen as its size and function is representative of many maternity units within England and it provides midwifery led postnatal care, the focus of this study. The location for the research is a teaching hospital in which the midwives frequently have student midwives who work with them observing and participating in the care they provide to women. Many postnatal women routinely experience a second person present during postnatal care provision. Therefore the observational aspect of the study did not involve any changes to usual care experiences or practices. I had previous connections with the unit, but none at the time of the research. I hoped that this mix of being known but not active in the area would facilitate access without the confusion of other concurrent roles. The success of this approach will be evaluated a little later in this chapter.

When planning the research I approached the head of midwifery services for the locality and discussed the principles of the study. The head of midwifery was supportive of the study's intentions and the potential for the data collection to involve midwives employed in the locality and provided a letter of support, which I attached to ethics and research and development applications.

Recruitment must be handled ethically and sensitively and as a registered midwife with over 20 years experience I ensured sampling would exclude any individuals who had personal, contextual or maternity issues which may indicate it was inappropriate to approach the individual for inclusion.

The inclusion criteria for midwife participants were midwives who currently provided postnatal care in either community or hospital setting. Midwives had entered midwifery via either 3 year or shortened (post nursing) entry routes and had a range of practice experiences, including the length of practice experience and location of practice. These factors were identified in the biographical details at the beginning of interviews and observations and a summary is provided in (appendix 4). Exclusion criteria included any practitioner undertaking a period of supervised practice, or phased return to work following a period of sickness / absence, in which any additional pressure of interview or observation may be deemed inappropriate.

The inclusion requirements relating to the postnatal women whose midwifery care was observed included;-

- Both first time and mothers with previous births
- Postnatal assessment interaction occurring in the postnatal ward and woman's home.

The exclusion requirements relating to the postnatal women whose midwifery care was observed included any complications of the intranatal or postnatal period which would make such observations insensitive or inappropriate. This included;-

- Stillbirth, neonatal morbidity or neonatal death.
- As part of the focus of the observation is to observe how the midwife interacts with the client, it would be unhelpful to data collection to observe an interaction in which an interpreter was required.

The midwife participants were made aware of potential inclusion and exclusion criteria and asked to identify potential women who could be approached for consent for one of their care interactions with their midwife to be observed. This did have the potential for gate keeping or selection bias from the midwife participants, however their professional expertise and accountability for their clients must be acknowledged and respected and therefore they were the gatekeepers to accessing their clients.

It was hoped that up to 5 midwives and several of their postnatal women would agree to their initial postnatal interactions being observed, the minimum number of women involved in the observations was to be 10, the final number achieved was five midwives involving 15 women. This sample included 4 midwives who had also participated in the interview data collection.

Midwife participants were accessed via information provided about the study in leaflets and also by information provided by myself at midwifery team meetings (Appendix 13; Appendix 18). Those midwives who were interested in participating in the study were asked to contact the researcher, who then discussed the requirements of the study with the individual and gained consent. Arrangements were made for data collection (interview and / or observation) at a later mutually agreed date. Prior to the data collection, I again discussed the research and ensured written informed consent. This ensured decision-making time for the midwife participants (National Research Ethics Service 2010).

Accessing and recruiting postnatal women to the observational aspect of the study involved 2 similar approaches, dependent upon the location of the anticipated observation, hospital postnatal ward or the woman's home. When a community midwife had agreed to participate in the observational aspect of the study, she was asked to identify women who she anticipated to require postnatal care within the data collection period. In the first instance the midwife was asked to provide these women with the information sheet regarding the research and proposed observation. If the woman was amenable to allowing me to enter her home with her midwife and observe the midwife providing care on one occasion, she was provided with my contact details and study information leaflet to enable her to access further information and clarify any queries.

After the woman had given birth and returned home, her midwife again confirmed with the women that she was happy to allow me to observe the midwife providing one of her care interactions and that the inclusion / exclusion criteria were considered. The midwife completed this prior to my arrival at the woman's home, either during a previous postnatal visit, or via a pre-visit telephone call. Following this confirmation I arrived at the woman's home with the midwife then discussed with the woman the research and gained written informed consent to the observation. However the woman was assured that at any point she could change her mind and rescind consent to participation. These steps occurred in a sequential fashion facilitating decision-making time for the women (National Research Ethics Service 2010).

When a hospital-based midwife agreed to participate in the observational aspects of the study, a date was negotiated for the researcher to attend the postnatal ward when the midwife was on duty. Prior to my meeting the women the midwife would identify women who fulfilled the inclusion / exclusion criteria and provide them with verbal and the written information sheet regarding the research and proposed observation. Those women amenable to allowing me to observe her postnatal assessment would be identified to me when I attended the postnatal ward. I then discussed with

the woman the research and gained informed consent to the observation. However the woman was assured that at any point she could change her mind and rescind her consent to participation. These steps occurred in a sequential fashion during the woman's hospital postnatal stay. Therefore facilitating decision-making time for the woman.

The impact of time for decision making, particularly in light of the limited interaction midwives and women now have postnatally, was a part of the research design I had not considered prior to planning this research and did initially find quite challenging. However the ethical processes I designed pertaining to participant selection and recruitment were effective during the data collection. I feel participants had time to make informed decisions regarding their participation without placing undue expectations on the participants, particularly the women who in the immediate postnatal period have many new challenges to negotiate. I will be able to apply and build upon these insights I have developed in any subsequent research studies.

The discussion now turns to the challenges I encountered when gaining access to the research field, potential participants and research data.

4.4 Gaining access

After I had successfully completed the research proposal and ethical scrutiny stage, and following interview and scrutiny of all paperwork by the local Research and Development Office and their personnel department I was provided with an identify badge and letter of access. My six-month approval for access to the research site was initiated from the date the personnel department completed their processes. My initial timeframe had assumed I could move from this stage to undertaking some initial data collection in just over a month. This would involve initial meetings with midwifery department leads and then attending meetings with midwives so I could provide them with information about the research and hopefully start generating some interest and potential participant recruitment. This did not

happen at all as I had planned. Staff failed to respond to my e-mails and cancelled meetings. As an excerpt from my research diary notes;-

“Received e-mail from community midwifery lead who suggested none of the dates / time were convenient and reminding me that for community midwives lunchtime rarely exists (in my e-mail I had suggested might lunch time be a good time to catch people). I responded by saying perhaps it was best if we approached this the other way and if she could suggest a date and time, possibly when she was having a community midwifery team meeting, I would try and attend. Since I have had no communication.

This has been a surprise I had hoped my past relationships with the staff (which I thought) had been very positive would help allay potential anxieties / resistance regarding the research. I do appreciate staff are busy and my research will be fairly low on their list of priorities, however I’m wondering how it’s been articulated to the lead midwives. Perhaps they feel their time is being devalued, perhaps they feel anxious regarding what the implications could mean for them, i.e. am I “spying” on their practice. It could of course just be simple work overload, or perhaps community lead is on holiday and therefore not responding. It has left me feeling very anxious, as I know my research clock is ticking, particularly access to the trust.”

4.5 Outsider - insider continuum

I had assumed my previous connections with the staff and the area would have helped provide access as I would be known to them and perceived as one of them, what several authors call an insider (Reed & Procter 1995; Labaree 2002). I initially had assumed insiderness as I was a midwife but insiderness is transformed by the situation and decided by the research participants, not the researcher as I had assumed (Labaree 2002 p.101). In some respects I am an insider, I am a midwife and I do know, from past professional or personal interactions, many of the midwives at the research area. Labaree (2002) suggests for many researchers it is not an insider / outsider dichotomy, but rather a continuum along which most researchers sit.

However I have not worked in practice for some time. I am an educationalist making me in some ways an outsider with differing insights, perspectives and values. Therefore, perhaps I am an outside - insider or what Reed & Procter (1995) term a hybrid model, a practitioner but researching the practice of others.

Labaree (2002) highlights how being along the insider continuum does not automatically give advantages to gaining access which I had assumed when planning this study, as I needed to negotiate new relationships when there have been previous professional relationships or friendships. This was evident when I attempted to gain access to the community midwives. I had to re-negotiate my roles and relationships and have them accepted and legitimised by the research participants (midwives). I attended the practice area prior to the commencement of their working day, which involved getting to the practice area by 7.30 several times over a 2-week period. I almost felt the midwives took this as a sign of my commitment, particularly the lead community midwife.

However there are also advantages to being an outside - insider. Kawulich (2005) highlights the potential ethical dilemmas of being treated as an insider but needing to share findings externally. Some information is traditionally maintained amongst a cultural group, therefore my position needed to be explicit to ensure an appropriate ethical stance, with the midwife participants aware of my intentions to construct from the data a theory which would be shared with others including publication in professional literature. I had particularly chosen the research site as I did have some previous professional connections with the staff. Therefore I hoped that some familiarity would facilitate trust but some distance would enable a new researcher identity to be negotiated and accepted by the research participants and avoid the staff feeling coerced to participate because of other roles I had in the practice area. Morse *et al* (2008) highlight the potential of participants feeling coerced to participate when the researcher is involved in the area, via employment or other roles and responsibilities. I feel the strategy I employed was useful and effective,

once I had negotiated my new identify as a researcher with the potential participants including, the “gatekeepers” (Reed & Procter 1995; Labaree 2002).

4.6 Gatekeepers

“Gatekeepers” are key informants who may provide access to other informants, information and access to the research field generally (Silverman 2006). In my research these would equate with the head of midwifery service and the senior midwives for the postnatal ward and postnatal community care. Kawulich (2005) warns researchers to be vigilant when using gatekeepers to gain access as they may misdirect the researcher to those who may not be key informants or the researcher may be perceived by staff as being a “spy”. However if the gatekeeper is perceived by others to be respected then this may facilitate access. I felt there had been initially some distrust as I tried gaining access at the senior midwife level, following initial discussions with the head of service. However once I had gained the acceptance of the senior midwives I did feel the staff then accepted me, this was particularly evident with the senior midwives and rest of the staff in the community setting where once I gained access, I had several midwives immediately willing and able to be participants for both interview and observational data.

I had to develop my information for the potential participants in a variety of means. I had a PowerPoint presentation (appendix 18), a handout of the presentation, participant information sheets (appendix 18 & 13), consent forms (appendix 15, 16, &17), all of which I supported by verbal discussion. This had to occur in a range of ways and means to mirror the demands of the opportunities and locations I was given to provide staff with information. Hunter (2007) highlights such challenges in real world research, and the need to be flexible to gain access. Once I did gain access to them, the midwifery staff gave me a very warm reception and were very interested in the research, stating they felt it would be a relevant area for investigation and they were aware that midwives approached genital tract assessment

and observation differently. They identified particular colleagues who may have particularly approaches (many of whom were present and agreed they may have something different to offer). For example, midwives who have a particular focus to their caseload, such as teenage pregnancy, drug and alcohol and local Bangladeshi community, those who have been qualified a long time and midwives recently qualified. Many midwives informally, verbally agreed that they would be willing to participate in the research and from this point access to data collection was quite smooth, with many midwives giving generously of their time and experiences. This generosity I felt needed to be acknowledged so I formulated thank-you letters, which I gave to all participants (Hunter 2007) (appendix 19).

4.7 Interview data collection - being flexible

Now that I had willing participants I needed to commence data collection. The intention had been these interviews would be undertaken within a quiet office within the practice location, with the resulting dialogue tape-recorded for later transcription and field notes made of non-verbal responses. Again I had to be flexible and negotiate with the practicalities of real world research in the practice context, such as interruptions. However these were kept to a minimum as the midwifery participants carefully choose the most convenient time and location for the interview. By offering some flexibility and following the midwife participant's lead regarding time and venue, the midwives reciprocated by being sensitive to my requirements whilst collecting the data and found somewhere suitable for the interview. The success of the data collection methods, are fundamental to the trustworthiness of the research conclusions (Roulston 2010).

The initial opening questions during the interviews regarding biographical facts were useful to relax both interviewee and myself and quite quickly we slipped into a comfortable conversational style. When I moved on to provoke narrative telling, asking for a typical event, the first midwife interviewee responded with "*what sticks out is the ones where you pick out a problem*". I didn't attempt to pull her back by insisting she remember a

“typical” practice example as per my interview schedule for two reasons. I felt she had instantly highlighted a potential chink in my interview schedule; as she was quite correct people do tend to be able to recollect the unusual more readily than the mundane. Hunter (2007) in her PhD study found similar issues and highlights that the focus on the dramatic can sometimes obscure the detail of every day practice. In subsequent interviews I emphasised the desire for an everyday example, by reinforcing the idea of describing a recent practice event, as suggested by Hunter (2007). However when midwives did veer towards a critical example I recalled one of the principles of narrative style interviews is to let the stories flow. This I did and just attended to areas in my interview schedule in a different order, in the order that I suppose made more sense to the midwife being interviewed. Silverman (2006) states the interviewer must use a flexible style whilst remaining mindful of the research intentions to ensure the content is applicable. Using a more responsive interview style, rather than adhering to a rigid interview pattern is suggested to be more likely to facilitate “*the genuine views and feelings of respondents*” (Wimpenny & Gass 2000 p.1488).

4.8 Interview technique

I recognised I needed to develop a rapport with the interviewee to facilitate open discussion. I tried to maintain appropriate non - verbal communication, such as eye contact, nodding, smiling and an open posture, to demonstrate attentive listening and interest and therefore hopefully to maintain the flow of narratives (Silverman 2006). With verbal responses I tried to keep to general utterance to demonstrate I was listening but to try not to interrupt the flow of the narrative or direct the narrative by indicating a preference to a particular response. Shah (2006) highlights how difficult this can be, to both demonstrate empathy but not assume insight into the interviewee’s perspective and at times I did find this challenging, particularly with less responsive interviewees, as discussed below.

Charmaz (2006) suggests that the semi-structured interview has some conversational aspects, however differences include the use of particular linguistic techniques to facilitate the depth of exploration of the topic area. In this research these included probing, such as “that’s interesting can you tell me more” summarising and positive listening. I would on occasions ask a specific question, sometimes closed or open to probe when I felt I needed more information or clarification to illuminate detail, intentions and significance of the comment (Silverman 2006). Hunter (2007), in her experiences of qualitative interviews with midwives highlights how midwives use “embodied knowledge” by talking with gestures or using set phrases to articulate assumed common knowledge. In this instance probing and also confirmation strategies such as paraphrasing and summarising helped ensure I fully comprehended what was intended by the midwife rather than making assumptions from my interpretation (Silverman 2006; Roulston 2010).

Some midwives appeared to automatically give lots of examples, using a range of narratives from their practice. There was some repetition of issues, however when people tell stories this is common, sometimes repetition can indicate areas that people think are particularly important. In addition, to interrupt might prevent the development of the narrative flow of the interview and I was anxious not to do this. With a small number of midwives they appeared to have a less natural narrative flow. Reflecting upon when this first occurred I felt I could have developed the narrative flow a little more, when the midwife was providing a general response, by asking if she could provide practice examples. This technique I used successfully in later interview interactions.

4.9 Overcoming perceptions of hierarchy to access mutuality

However interviews are co-constructed and therefore issues can arise from the perceptions of the interviewee as the following excerpt from my research diary illuminates; -

“The second interview, I was much less nervous. However my interviewee was more nervous on this occasion. The midwife had been a previous student of mine and I had not particularly seen or interacted with her since that time. During the interview process I felt she was a little anxious that she might somehow give the “wrong” answers during the interview and perhaps was not as confident in her midwifery practice as the previous interviewee, a midwife with over 20 years experience. I tried to reassure her re the intention was not to seek a right or wrong answer, but the diversity of practice. When reminding her re the exception to the confidentiality clause would be if I heard anything ethically, legally or professionally which I felt I needed to inform someone else, I felt the need to balance the statement and reminded her that this was reciprocal, if she had any concerns with my conduct I reminded her who to contact. I felt this went a little way in attempting to stabilise the balance of power between us. Perhaps an overhang from the student / teacher days. Which was fascinating for me, as I have never considered myself a particularly threatening or a power focused teacher. However these concepts can be inherent within the role, particularly when summative assessment is involved and as such it wasn’t my perceptions that were important, it was those of my previous student who I was interviewing.”

As suggested by Mills *et al* (2006 p. 8) constructionist grounded theory must be based upon “a position of mutuality between researcher and participant in the research process”. This is required to facilitate the mutual co-construction of meaning and achieved through a reciprocal approach, ensuring a balance of power by avoidance of perceived hierarchy. Nairn, Munro and Smith (2005) highlight how themes such as perceived power may impact upon recruitment and contribution to qualitative interviews. Where hierarchy is perceived, the ability to refuse inclusion may be difficult for the interviewee and they may feel compelled to express a particular perspective to win favour with the interviewer. I didn’t feel I had coerced midwife B to participate, as she had volunteered to participate during a presentation I made regarding the research to a small group of midwives, I was not consciously aware of seeking her out. However during the interview I was aware of a small number of responses, which I felt, were expressed for my benefit, such as the source of knowledge being “a good university education”, but she was laughing as she said it, so perhaps I am reading too much into this. However Silverman (2006 p.137) warns the

researcher against “identity work” in which the interviewee presents a particular persona. This may be in response to the identity I presented, or the perception the interviewee had of me, or the intentions of the interview. This is particularly relevant for my work, in which I was conscious that as I am an educationalist the midwife participants might perceive I wanted a particular rhetoric regurgitated, perhaps involving their procedural, theoretical knowledge and may feel compelled to present that identity during the interview. In an attempt to overcome such pre conceptions I attempted to develop a rapport to form trust with the interviewees, acknowledging their anxieties regarding being interviewed and contributing to the research (Charmaz 2006; Hunter 2007).

However in my attempts to relax this interviewee I feel I initially responded more attempting to be friendly and didn't leave the gaps I would usually leave to invite the interviewee to provide detail. This problem was also encountered by Nairn, Munro and Smith (2005) who found they used an increasingly wordy questioning style when encountering difficulties in the interview interaction. This made the initial part of the second interview I undertook a little more interviewer lead and focused.

Traditional interview approaches, based upon hierarchy and distance between the interviewer and interviewee have been perceived as promoting a power imbalance, which mutuality could overcome (Sinding and Aronson 2003). However Shah (2006 p.211) warns of the dangers of “overrapport” which can lead to the interviewer assuming insights into the interviewee's perceptions and also places the interviewee in a position of vulnerability. In my attempts to be friendly I could have created an exaggerated intimacy, which can manipulate the Interviewee into wishing to please and mirror the interviewer. This may occur during the interview or around the interview and involve re affirming valued ideals and identities, in this instance regarding a “good” midwife and “good” midwifery practice (Sinding and Aronson 2003). McCabe and Holmes (2009) liken the interview to the confessional, in which ideas of good and bad may be perpetuated, which is exacerbated by a society in which interview culture dominates and can objectify the

interviewee (Denzin 2001). I needed to ensure a balance between being the distant and enmeshed interviewer, to ensure I constructed narratives with interviewees and not about them. McCabe and Holmes (2009) suggest reciprocal reflexivity can help the researcher help the participant to explore their actions from new perspectives and therefore both the researcher and research participants may develop new insights into self and the research phenomena, a more emancipatory approach. I attempted this within the second interview, but am not sure how successful I was. However if used reflexively, even these less effective interactions may be enlightening, by highlighting strengths and limitations not only in our researcher skills, but the tools, processes and contexts in use (Nairn, Munro and Smith 2005). As I undertook more interviews and critiqued my interview skills, my technique progressed and reciprocal reflexivity was evident in several of the interactions. For example during the third interview, as the midwife discussed her practice she began to also question her actions, she commented,

“Oh yeah, Gawd! You’re making me think! I’m sitting here thinking, ‘How do I assess that?’” Midwife C (Line 574).

Although I did encounter some challenges during interview data collection, which I have discussed, I did feel I had some foundation skills, which I fairly quickly developed throughout the experience of interview data collection. I assumed that I would have similar transferable skills from my professional practice I could apply to observational data collection, however I found this much more challenging than I had anticipated.

4.10 Observational data collection - skills and techniques

The first few observations I had arranged were to be with community midwives in the woman’s home. In preparation for observing the midwives undertaken maternal postnatal assessment in the hospital postnatal ward or woman’s home, I had my prepared field notes guide, as discussed in the previous chapter. I now gave some attention to how I should look and act. I felt the need to be conscious of what clothes I wore. I went for a “smart /

casual“ look in an attempt to look as if I had made an effort (for the woman and midwife) but without appearing too smart as if I felt the situation was formal and potentially reinforcing any perceptions of hierarchy or monitoring the process. I was conscious I needed to quickly develop a rapport, to try and minimise the potential impact of my presence upon the midwife and woman’s interactions and therefore the data collection (Lambert, Jomeen & McSherry 2010). This included my presence impacting on the midwife who may assume what my intentions were and tailor the assessment with the women to provide the data she perceived I wanted (Labaree 2002).

Hunter (2007) suggested developing relationships and rapport is fundamental to accessing authentic data. Rapport takes time to develop and involves a range of interpersonal skills including active listening, respect and empathy (Kawulich 2005). Hunter (2007 p. 79) identified how she “chatted to the women and her family, held the baby, played with other children, carried the midwives bag and generally tried to seem warm and friendly and unthreatening”. These are activities and qualities that I attempted to emulate, carrying equipment trying to be a little useful and engaging in the social interactions. One of the advantages of my having profession insider knowledge is having access to the shared understanding regarding cultural norms (Labaree 2002). Therefore I was aware as a woman and midwife of the usual social pleasantries used during initial meetings with women following childbirth which helped me to fit in and created a more trusting environment.

The first observation I undertook of a midwife undertaking postnatal assessments was in the community, in the woman’s home. I had a great day, but was almost so enthralled just to be back in the practice domain I was seeing the mother and baby and at times losing focus on what I was trying to particularly observe. My lack of focus during this observation did reduce my receptiveness to the subtleties of the interaction, such as non-verbal cues and inferences and subsequently impacted upon the quality of the data I produced from this observation (Kawulich 2005). I had assumed my insider position would be an advantage, however it also had

disadvantages. Labaree (2002) warns that insider insights may equate with false assumptions if a reflexive approach is not adopted. Hunter (2007 p.78) suggests the midwife researcher must guard against drawing conclusions about what she observes or hears based upon insider knowledge of midwifery practice and “treat the familiar as strange.” With my first observation I failed to achieve this intention. I was so nervous, excited and then quite overwhelmed by being back in the practice domain I thought and observed like a midwife rather than a researcher with midwifery insight. That is I assumed understanding and tended to focus more on what action I would undertake next if I were to provide the assessment and care, rather than be sensitive to those cues and responses of the midwife and woman I was observing. I also found it very difficult to be social (I was a guest in some one’s home), but non-participant and to make meaningful notes without appearing to be monitoring the process.

With the second round of observations I undertook in the community setting, I responded to the difficulties by maintaining focus upon the intentions of the observations, from the prompts from my interview guide and considering where I positioned myself within the room. Initially I placed myself close to the woman when gaining consent and make some pleasantries and then deliberately sitting slightly further away from the woman than the midwife, to try and keep (if possible) out of eye line. I also took a small note pad and this made it more comfortable to make some brief notes. This helped to ensure subsequent observational data collection was more focused and productive.

4.11 Writing and maintaining field notes

I found making and writing up field notes more challenging than I had anticipated. I attempted to make chronologically sequenced, detailed notes however I did not note every occurrence. Wolfinger (2002) suggests there are 2 principal approaches to writing field notes, the “salience hierarchy” in which those issues deemed relevant to the research focus are noted or “comprehensive note taking” in which systematic and comprehensive notes

are made of everything that occurred. I believe my strategy incorporated some elements of both approaches. From a very practical perspective I could not physically note everything that was occurring within any given context and interaction and so inevitable some selection utilising my prior professional knowledge of what may be associated with assessment of maternal genital tract well being was inevitable and did occur. Tjora (2006 p.433) agrees that researchers must use their tacit professional knowledge to provide a “significance filter” regarding what to particularly focus upon during observations and note taking. Such subjectivity is an integral aspect of qualitative research such as mine, which derives from the constructionist paradigm. However selectivity is subjective and if I wielded it indiscriminately, it would introduce bias and effect the quality of the data I collected and the conclusions I drew from the data, highlighting the need for a reflexive approach to try and minimise such an occurrence (Corbin and Strauss 2008; Marshall, Fraser and Baker 2010). I initially made brief notes on a small note pad during the observational process so as not to detract the research participants and make them feel under scrutiny or miss any of the interaction whilst looking down making notes. Then I developed and expanded them on my interview schedule as soon as feasible after the event, adding detail from memory (Charmaz 2006; Silverman and Marvasti 2008). This at times proved challenging as I occasionally questioned whether an observation was factual or queried my interpretation of events. Kawulich (2005) suggests what the researcher recalls will reflect what is documented, what is noted and interpretations may be influenced by limited recall and the values, assumptions and biases of the researcher. To help reduce this interpretative bias I provided copies of my typed notes to the midwifery participants for them to check and confirm the accuracy.

4.12 The impact of location

I found accessing observational data in the community setting relatively easy with several midwives and their clients amenable to participating in the study. However I experienced some difficulties accessing observation in the postnatal ward, which I had initially assumed would be much easier to

access than the community setting, as there is invariably the required experience occurring, i.e. postnatal assessments. Within his health research, Silverman also found some difference in accessing observation of the same experience in different locations (Silverman and Marvasti 2008). He found it easier to undertake observation in the NHS setting rather than the private health care consultation rooms. He suggests that those settings in which the client has greater territorial control may be more difficult to predict and the researcher feels more uncomfortable and conspicuous. Interestingly, I have found the converse to be true.

Several of the midwives working in the hospital postnatal ward quickly agreed to being interviewed, but there seemed to be more reluctance to participate in observational data collection. However one midwife did agree and the first observational data collection took place in the postnatal ward setting. The women being assessed by the midwife I was observing were in bays of 4 women and babies. Curtains were closed around the cubicle to try and provide some privacy for the assessment. The space behind the curtains was very limited and my presence was difficult to minimise. There was only 1 area in the enclosed space for me to place myself during the observation. In addition there was no other simultaneous roles I could fulfil such as carrying equipment, talking to other children, it was very evident I was there and watching. Therefore I considered my ability to negotiate my identity, ensure the participants were clear of the research intentions but also to some extent also fade when undertaking observation was limited on this occasion. This fading is an attempt to minimise the practitioner being unduly conscious of being observed and potentially performing for the observer. Silverman (2006) discusses how research participants can 'frame' the data they provide depending upon their perceptions of what the researchers will find useful and the researcher's perceived identity. I felt the researcher's presence did have some impact upon this initial observation, the woman appeared a little unsure whom to look at and talk to, the midwife or researcher, and some of the conversation was stilted and hesitant.

Following this observation on the postnatal ward, I had 3 subsequent observations cancelled. All for a variety of reasons, none of which were articulated by the midwives as no longer wishing to be observed, with promises of re-arranging the observations. However I did consider if the slightly claustrophobic atmosphere of the first postnatal ward observation had been discussed amongst the midwives and had an impact upon staff wishing to be observed. I did manage to negotiate other observations in the postnatal ward, involving two midwives and six postnatal women. On these occasions I discussed my positioning with the midwife prior to commencing the observations and was able to negotiate a little more space behind the curtains and sit out of eye line of the participants, placed at the opposite side to the midwife, a little more distant. I also considered asking the midwife and woman to use a cubicle with more space, if required, but this did not prove to be necessary. Subsequent observations did appear to be more comfortable for the participants, with the researcher less conspicuous and facilitated more naturalistic observations.

4.13 The impact of episodic observation

The observations I undertook of the midwives assessing postnatal women were episodic in nature. That is I would observe perhaps a 15 to 30 minute interaction between the midwife and woman. Hunter (2004) suggests episodic observation cannot be considered an ethnographic study as limited time is spent engaged in the practitioners and clients lives. Traditional ethnographic observation has been used for well over a century particularly in the field of anthropology, in which researchers would involve themselves in local culturally rich activity over a period of time and then report upon their experiences (Kawulich 2005). Instead Hunter (2004) suggests episodic observation should be termed as an ethnographic approach and its potential limitations acknowledged. The limited view episodic observation provides must be kept in mind when considering the data collected, to avoid assumptions being made regarding what has been observed (Corbin and Strauss 2008). For example whilst observing midwife C, as the interaction between midwife and woman progressed, I noted more closed questions

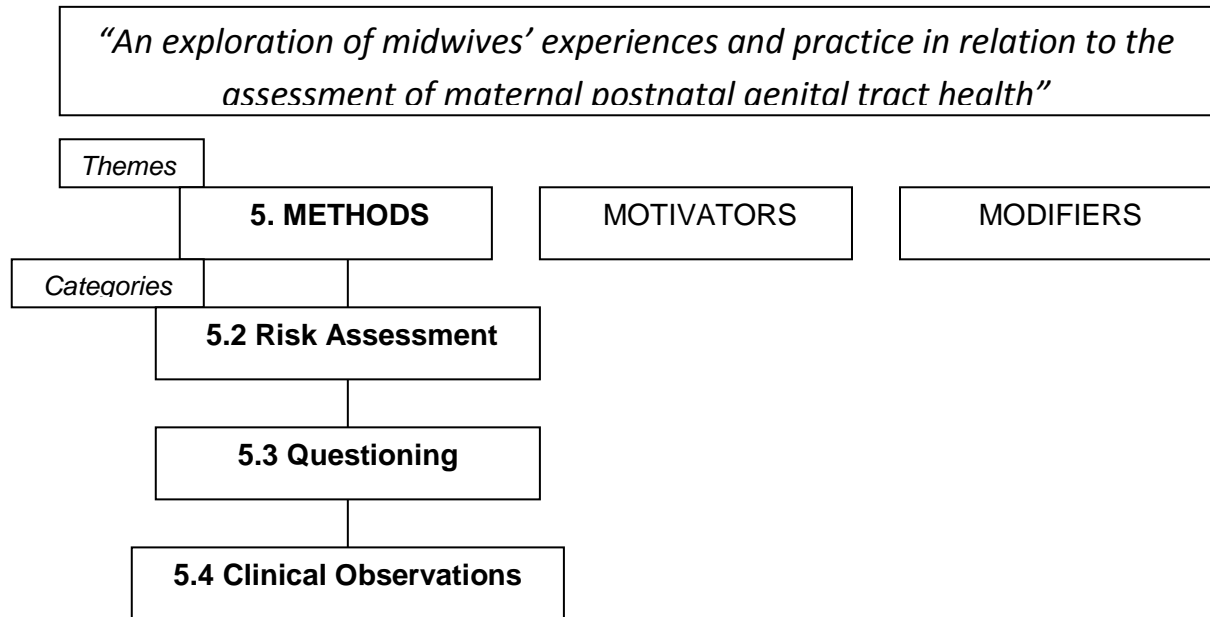
were used. I wondered if the midwife was becoming conscious of time pressures, as she had another appointment. However when I discussed this with the midwife after the observation, whilst clarifying what I had seen, she informed me this was not the case. She had seen the woman the previous day, so felt some of the questions were a continuation of a conversation she had commenced with the woman then. This highlighted to me the need to be mindful of the episodic nature of my observations; particularly in the community setting where frequently community midwives have built up relationships with their clients over a period of time (Gibb and Hundley 2007).

4.14 Conclusion

This chapter has demonstrated how I have ensured this study has complied with ethical principles, including consent, confidentiality, security of data and recruitment and selection. In addition it has presented an in depth evaluation of my application of research principles and processes within the research field. This has included gaining access to research participants and the data collection methods I employed. I have highlighted, analysed and substantiated these activities utilising a reflexive approach integrating accounts from my research journal and pertinent theory and research of the issues raised. Therefore demonstrating my developing appreciation and skills, within the context of real world research. Challenges encountered during the research process have been acknowledged and their potential impact upon the research process and outcomes critiqued. This transparency or research processes contributes to the achievement of quality parameters for qualitative research by establishing the trustworthiness of this research. This transparency will be continued during the subsequent chapters of this thesis, commencing with the following chapter presenting data findings.

Chapter 5

5. Chapter 5 - Methods of Assessment



5.1 Introduction

This is the first of three chapters, which presents findings from the analysis of the interviews and observations, which formed the research data for this study. From the data analysis three key themes have emerged in relation to midwives’ experiences and practice of assessing maternal genital tract health postnatally, these are Methods, Motivators and Modifiers.

This chapter focuses upon the first key theme, ‘Methods’. As defined by the Oxford dictionary (2011a) a method is “*a particular procedure for accomplishing or approaching something, especially a systematic or established one.*” Within this study the term method is used to denote the range of procedures and approaches to postnatal assessment of maternal genital tract health discussed or demonstrated by the midwives. There was abundant data, from both interviews and observations, relating to this theme, with all of the midwife participants contributing to all of the categories. How these categories relate to the theme of methods and the other themes within this study is presented visually in the diagram above. The categories, which I have grouped within the Methods theme, are;-

- Risk assessment
- Questioning
- Clinical observations

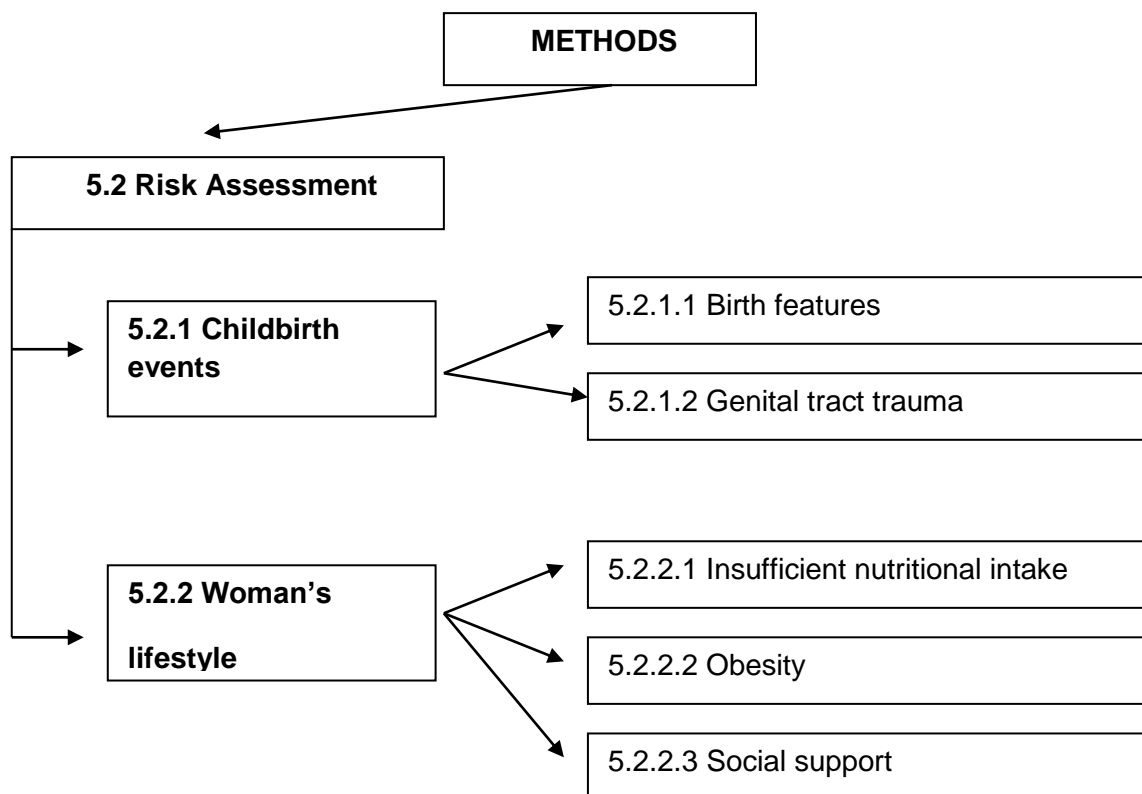
The first category is risk assessment and this pertains to the midwife identifying any factors associated with childbirth events or maternal lifestyle that the midwives considered placed the woman at greater potential risk of postnatal genital tract morbidity. Identifying the presence or absence of such factors and events was commonly an initial method of maternal genital tract assessment used by the midwives in this study. The second category is questioning and provides elaboration upon the content of various questions the midwives used to elicit information regarding maternal genital tract health. This includes questions, which probe the use of self-assessment, predominately by the woman, but may also include the contribution of other family members. The final method of assessment is clinical observations. This category presents a range of clinical observations discussed and demonstrated by the midwives during data collection for this study.

The data within the theme of methods contributes to the intentions of this research study as it helps to illuminate the potential range of approaches to assessment of maternal genital tract health adopted by the midwife participants. In addition it provides some illumination upon the procedural reasoning and knowledge, which may influence the assessment approach.

Each category will be presented and analysed sequentially. A diagrammatic representation of each category will precede the discussion, to provide a visual explanation of the content and relationships of the category, focused codes and codes, discussed within the text. Each category will be defined and its core properties and dimensions explored and analysed, providing connection between the codes within the category (axial coding), substantiated by providing data extracts to demonstrate and affirm my conclusions. This explicit movement from data, to concepts, categories and

themes facilitates the development of grounded theory (Corbin and Strauss 2008). Any limitations of the data and resulting concept development will be highlighted. This transparency, of data processes and conclusions, is an explicit intention of the researcher as a means of conveying in detail the research findings to the reader and also to uphold the quality of the research by providing an audit trail for the reader to judge the credibility, dependability and transferability of the research findings (Koch & Harrington 1998; Graneheim & Lundman 2004). The chapter concludes with a summary of the chapter discussion and key conclusions.

5.2 Risk assessment



Risk is defined by the World Health Organisation as “an evaluation of the probability of occurrence”, including identifying those who may be vulnerable to the focus of the risk assessment (WHO 2010; WHO 2011). All of the midwives within this study identified factors they felt might place a particular woman at greater risk of having or getting genital tract morbidity.

“You kind of know if it’s been fairly straightforward or if it’s been complicated.” Midwife F (line 97).

In contrast establishing the absence of these factors was perceived to be a reassuring factor. As highlighted by midwife E if there are no risk factors the midwife is less likely to consider an intensive approach to genital tract assessment or the use of clinical observations.

“If it’s (*the perineum*) been observed and there’s documentation to say that it’s clean, there’s no problems and the woman’s happy . . . I’ll not look at it.” Midwife E (line 171).

Therefore identifying and recognising the presence or absence of risk factors was a method of maternal genital tract assessment commonly used by the midwives in this study.

Identifying and responding to risk is recognised as a key component in all aspects of midwifery practice, to enhance the quality, safety and effectiveness of midwifery care (Aslam and Brydon 2009). When assessing client needs, identification of pertinent risk factors is recognised as a necessary component, to facilitate an appropriate practice response to individual client needs (Lloyd 2010). Within midwifery this includes recognition of risk factors associated with the postnatal period (WHO 2010)

The risk factors clustered around two areas, which formed the two focused codes for the risk assessment category; these are childbirth events and the woman's lifestyle. Within the first focused code, childbirth events, the midwives identified particular occurrences, which they considered might have a direct impact upon the health of the woman's genital tract and therefore place the woman at greater risk. The midwives also provided narratives of their experiences, in which they highlighted general maternal lifestyle issues, particularly diet and social support, which they believed placed the woman at increased risk of genital tract morbidity. These form the second focused code constructed from the data, titled the woman's lifestyle.

The process of risk assessment usually involved the midwives critiquing the woman's personal and childbirth history.

“A lot of the women come through here with some degree of trauma and I wouldn't necessarily go in and insist on looking at it. It would sort of depend on the type of trauma, the feedback that I've had from staff prior to coming in and it would depend on the woman herself.” Midwife G (line 111).

The history sources identified by the midwives included midwifery documentation, medical notes and verbal information from other midwifery staff. The midwives also questioned women to access appropriate history, however this will be discussed in the following category, maternal questioning. Midwives used documentation to identify risk assessment factors. This information was used by the midwives to guide if and what other methods of genital tract assessment they would use.

“She had a tear of her perineum and then it extended to a third degree tear so with her, I really felt that I needed to have a look at her perineum . . . the other lady I went to after her, it was her third baby and she didn’t have any stitches . . . so with her I just basically spoke to her.” Midwife H (line 94)

The majority of midwives would commence the interaction by reading the woman’s midwifery notes, to highlight any potential areas of risk and provide a basis for discussion and focused assessment.

“I’ll read the delivery summary, I’ll read all of any postnatal checks that have been done, I’ll always read everything so it might be five minutes that I’m sat reading.” Midwife C (line 309).

During observed interactions this was most evident with the observations in the community setting. As the midwives did not have other forms of professional information such as verbal “hand-over” which occur in the postnatal ward, they appeared to give more attention to critiquing the woman’s childbirth history for risk factors.

5.2.1 Childbirth events

The midwives identified particular occurrences, throughout the childbirth continuum, which they considered might have a direct impact upon the health of the woman’s genital tract and therefore place the woman at greater risk of present and future morbidity.

“What sort of delivery she’s had. Whether she’s had any trauma to the genital tract, what her blood loss was like, the size of the baby, whether

she's had an instrumental delivery, whatever or a section." Midwife M line 127.

This connection between event and potential morbidity was sometimes implicit to a statement made by the midwife, implying that knowing a particular issue was potentially relevant by including it within their practice narrative, usually within the opening text. More commonly, particularly in the midwifery interviews, the midwives articulated a more explicit linking of risk factors and genital tract morbidity. For example Midwife C made explicit association between type of birth and potential genital tract morbidity, trauma.

"What sort of birth they've had so I'm picking up what sort of trauma they've got in any way." Midwife C line (317).

The midwife participants in this study identified two principal childbirth events that they considered placed the woman at risk and therefore contributed to risk assessment as a method of the woman's genital tract health; birth features and existing genital tract trauma. Several of the risk factors associated with childbirth events were connected, for example a primiparous (first birth) woman has a greater risk of operative birth and therefore perineal trauma. For ease of reporting they are identified in separate codes, but they frequently occurred and were articulated by the midwives in an associated manner, as the following quote from midwife D demonstrates.

"It was her first baby, quite recently, and had had what you would class not as a particularly tough time for us, one that I would expect. It was a big size baby, Neville-Barnes forceps, episiotomy and obviously you know the woman's going to be uncomfortable, she's going to be sore." Midwife D line (126).

5.2.1.1 Birth features

Several features associated with the birth were considered to place the woman at a greater risk of genital tract morbidity. These included if it were the woman's first birth, a large blood loss at birth and birth features

associated with the baby including a higher birth weight or a multiple birth, such as a twin birth.

“Was it a normal delivery, was it an instrumental delivery, have you got stitches, yes or no, did you have to have a blood transfusion, did you have a big blood loss? . . . if they’ve had a particularly big baby, was it a multiple birth, because obviously then you’re thinking about a uterus that’s been extra large so it’s going to take longer to involute” Midwife E (line 273).

The majority of the midwives highlighted the mode of birth as a salient birth feature, with forceps, vacuum or caesarean section modes of birth considered by the midwives as conferring a greater risk of genital tract morbidity. This was usually articulated by the midwives in association with wishing to establish if genital tract trauma had been sustained during the birth.

5.2.1.2 Genital tract trauma

The types of trauma the midwives referred to related to the woman’s vulva and perineum and included bruising, oedema, lacerations, tears, episiotomies and sutures. The severity of the trauma was identified as a significant risk factor by half of the midwives. These midwives perceived the more severe the trauma, particularly if it involved third degree tears of the perineum or complex labial lacerations, the greater actual morbidity and need for increased surveillance to assess for additional morbidity, such as wound infection.

“Obviously anyone with a third degree tear I’m extra cautious with”
Midwife L (line 120).

The more severe the trauma and therefore greater perceived risk the more likely the midwife was to also use clinical observations as the means of assessment.

“If it was someone who’d had significant trauma such as a third and fourth degree tears or nasty labial tears then I would possibly look anyway (examine the woman’s perineum)” Midwife J (line 121).

A couple of the midwives made a comparison between severe perineal trauma and an abdominal wound as a result of caesarean birth.

“There’s a similarity between third degree tears because of the extent of the wound repair, it’s similar really to a section . . . And so just because it is quite a great deal of trauma really, you want to check...” Midwife J (line 218).

However it was also acknowledged that trauma was not only associated with perineal sutures. The midwives also identified bruising and oedema.

“Just because they (women) haven’t got any stitches people will sometimes assume that well if they haven’t got any stitches then they are fine. Sometimes they can still have some bruising and some swelling that’s causing them some discomfort and some apprehension.” Midwife A (line 197).

The midwives in my study identified a range of childbirth events which they considered placed the women at greater risk of experiencing genital tract morbidity, including primiparous women, higher neonatal birth weight, multiple births, mode of birth and genital tract trauma. These factors are comparable to those within the contemporary evidence base as discussed within the literature review (Boyle 2006; Bick, MacArthur & Winter 2009; East, Sherburn, Nagle *et al* 2011; Kettel and Tohill 2008; Steen 2007; Williams, Herron-Marx and Knibb 2007). In addition the response of the midwives in my study, who were more likely to use clinical observational methods, with greater potential risk, is also recognised in the professional literature as a legitimate rationale for such observations (Bick, MacArthur and Winter 2009; Baston and Hall 2009). This may reflect the midwives use of procedural reasoning, involving the application of existing technical and procedural knowledge, regarding risk factors for genital tract morbidity, within their practice (Higgs & Jones 2008; Hunter 2008).

However, the risk factors identified by the midwives tended to focus more upon trauma to the genital tract, resulting from perineal wounds. Some of the factors the midwives identified such as mode of birth, blood loss at birth, multiple births, anal sphincter tears, caesarean birth and manual removal of the placenta do also place the postnatal woman at risk of postnatal genital

tract haemorrhage and genital tract sepsis (Selo-Ojeme *et al* 2005; Marchant *et al* 2006; Maharaj 2007; NICE 2007b; Said and Geary 2007; Roberts *et al* 2009; Norwitz *et al* 2010; CMACE 2011).

In the data collected from the midwives, they rarely made an explicit connection between these risk factors. Midwife E, a very experienced community midwife, is one of the few midwives who did make an explicit association, relating multiple births to longer uterine involution and vaginal blood loss (see section 5.2.1.1). In the interview with midwife L she acknowledges identifying maternal pyrexia during labour as a potential risk factor

“If they’ve had high blood pressure or they’ve had a temperature in labour, you’d be doing that (vital sign observations) anyway.” Midwife L (line 175).

Other potential risk factors associated with postnatal genital tract sepsis were not identified such as prolonged rupture of the fetal membranes, multiple vaginal examinations, internal fetal monitoring and women who work with or have young children as being at greater risk of Group A streptococcal infection (Maharaj 2007; Norwitz *et al* 2010; CMACE 2011).

Perhaps the limited explicit reference by the midwives to childbirth features associated with increased risk of uterine morbidity indicate missed opportunities during data collection where further probing by the researcher may have led the midwives to make an explicit association between these risk factors and uterine infection and haemorrhage. However it is a fairly consistent finding throughout the research data, perhaps indicating that risk factors for genital tract sepsis and postpartum haemorrhage, which are predictive risks, are not as readily recalled and identified by midwives in comparison to risk factors for perineal trauma, which involves recognising existing morbidity, and then the potential risk of secondary morbidity such as wound infection.

5.2.2 Woman's lifestyle

The midwives specified several risk factors associated with the woman's lifestyle that they considered impacted upon postnatal genital tract health.

“The improvement in women's general health and their diet” Midwife A (line 657).

Midwife A considered health improvements she had noted over her 25 years in practice had enhanced maternal health and genital tract well being. However for some women these midwives suggested there remained health risks associated with life style factors. These included insufficient nutritional intake, obesity and those with limited social support. These factors were felt to potentially impact upon the woman's physiological response to trauma and make her vulnerable to morbidity such as infection or delayed healing due to poor nutrition and tissue perfusion. This was thought to be particularly pertinent for those women who had sustained trauma during the birth such as perineal tears or episiotomy.

5.2.2.1 Insufficient nutritional intake

Not eating enough food, or a balanced diet, resulting in dietary deficits such as anaemia was a concern for some midwives.

“A lot of the girls are still quite anaemic after they've had their babies, so that's another risk to the healing.” Midwife G (line 791).

A couple of the midwives made explicit associations between nutritional insufficiency and increased genital tract morbidity, particularly infection and poor wound healing. The midwives articulated their procedural knowledge of dietary requirements for health maintenance and an understanding of the physiological consequences of dietary deficit. Midwife E also suggests identifying a risk of insufficient nutritional intake would increase the methods of genital tract assessment methods she used, including using clinical observations.

“She wasn’t eating or drinking properly, so I needed to check the integrity of the wound to make sure that it wasn’t infected, that it was starting to heal.” Midwife E (line 108).

During the observational data collection midwives were observed asking women about their diet and what they had eaten in the previous 24 hours. A range of factors associated with maternal general health, are recognised as placing an individual at greater risk of morbidity. Poor diet impacts upon wound healing and associated anaemia would place the woman in a vulnerable position with regards to infection and blood loss (Maharaj 2007; NICE 2007; Steen 2007; CMACE 2011).

However, as explained by midwife G later in her interview not eating is sometimes a deliberate act by those who want to lose weight quickly.

“They just expect to be back into their size eight when they leave hospital and if they’re not, they’re going to make sure they’re in a size eight within a few weeks.” Midwife G (line 813).

Midwife G was one of a small number of community midwives who suggested some women attempted to lose weight too quickly after giving birth. This caused concern for the midwives as they felt sudden weight loss placed the woman in an increased state of vulnerability at a time when physiologically her body was still recuperating and repairing from the demands and potential trauma of pregnancy, childbirth and infant feeding. The midwives thought the women’s desire for sudden weight loss was instigated by a need to comply with unrealistic images of postnatal women and societal expectations of the female body.

“The mother and baby magazines make everything sound so wonderful . . . They look fabulous, look at them,” and they haven’t been out of their pyjamas for three days or something. So I think that has a big influence, the media has a big influence, like all these yummy mummies having babies one minute and then the next week they’re in size eight jeans.” Midwife N (line 690).

Several of the midwives made comments about the pressure exerted upon postnatal women concerning their body image and weight loss postnatally, including the impact of celebrity culture, in which some women attempt to

emulate the life style of celebrities, who lose weight gained during pregnancy instantly. Some of the midwives suggested pressure to lose weight was greater for younger women. This, the midwives felt, may reflect an age related increased susceptibility to societal pressure regarding body image and prompt a desire to return to pre-pregnancy tight clothing.

“But some of the girls are desperate to stay in their jeans for as long as they can in the pregnancy and that they get back in them so soon after and on chatting to them, I tend to find that if you go in on day five or six and they’ll say to you, ‘It was getting better and then I went out yesterday and it was killing last night.’ And I’ll usually say, ‘Did you have your jeans on?’ and nine times out of ten, they’ll say, ‘Yeah, but I’m not going out in joggers.’ You know, that kind of thing and that’s why I tend to now say, ‘Try and put something on a little bit more comfortable because that’s tight, it’s friction, it’s rubbing, you’re going to be sore.’” Midwife D (line 330).

A couple of the midwives suggested tight clothing may further impact upon wound healing and perineal pain due to friction caused by restrictive clothing.

The midwives recognised the impact of diet and perceived it to be a risk factor worthy of note when considering maternal genital tract assessment. The midwives suggested the cause of some insufficient dietary intake was due to women, particularly younger women, feeling pressured to lose weight very quickly placing them at postnatal risk of morbidity. Postnatal body image is a common theme in the literature, Swedish research by Olsson, Mundqvist, Faxelid and Nissen (2005 pp. 385) identified that postnatal women were concerned about their body image and felt that “*childbirth and breast feeding should not leave visible traces*”. Younger women may have the added pressure of wishing to distance themselves physically from a pregnancy that is deemed by society as not acceptable due to the age of the mother (Smith 2010).

5.2.2.2 Obesity

The midwives perceived the incidence of maternal obesity was increasing, as articulated by midwife A.

“When I first came out onto the community you use to get the odd obese woman . . . and now its dramatically increased to me from when I first came out onto the community and that was highlighted to me . . . at my antenatal clinic on the number of times I had to use my large cuff to take a BP.” Midwife A (line 657).

These midwives identified a range of potential factors associated with obesity, which they considered placed the woman at greater risk of genital tract morbidity. These included poor nutritional status and tissue perfusion, impacting upon tissue viability and folds of excess adipose tissue providing moist warm areas in which bacteria could colonise and making it difficult for the woman to ensure effective cleansing of wounds

“She’s a very large lady, I really felt that I needed to have a look at her perineum . . . because of her size, I was thinking maybe her hygiene might not be as easy for her. Midwife H (line 96).

“wound problems . . . these have all been larger ladies with bigger BMIs. . . . I think the main thing with the abdominal wound is the overhang. That’s what’s causing that, it’s the lovely environment that the bugs have got to grow in and therefore the skin is always moist.” Midwife K (line 281).

Midwife A suggests obese women sometimes have difficulty discerning sensations such as perineal discomfort which would normally alert the woman and midwife to potential morbidity. Therefore midwife A, as do several other midwives, acknowledges her approach to maternal genital tract assessment will be different for obese women, with other assessment methods such as clinical observations more likely.

“They tend to be uncomfortable anyway in their groin because of the amount of weight they are carrying. I would probably check that perineum a little bit more frequently, than I would check any other woman’s perineum. Its difficult to palpate the fundus.” Midwife A (line 676).

Obesity has become an escalating concern in maternity care, increasing maternal morbidity and mortality rates considerably. It increases the woman’s likelihood of requiring obstetric interventions including caesarean section, of having postpartum haemorrhage, wound infection and conditions such as diabetes, which compound the risk of morbidity (CMACE 2010; Kerrigan and Kingdon 2010; Nobbs & Crozier 2011).

The midwives in my study suggested maternal obesity made clinical observations of the genital tract difficult, particularly palpating the uterus. The midwives' clinical reasoning was influenced in the instance of abdominal examination. If the woman was obese the midwives were less likely to use clinical observations. These findings confirm the suggestions in the discussion paper by Veerareddy, Khalil and O'brien (2009) that the use of clinical observations such as abdominal palpation to assess uterine size and tone may be difficult if a woman is obese. However, in contrast some of the midwives in my study were more likely to use clinical observations involving wound inspection of the perineum or abdomen due to obesity placing the woman at greater risk of wound infection. The evidence acknowledges obesity places the postnatal woman at higher risk of morbidity and mortality. However assessment must be undertaken sensitively. The qualitative study by Nyman et al (2010) involving ten obese women, suggests the women feel a sense of shame about their obesity making them very sensitive about others viewing or touching their body.

5.2.2.3 Limited social support

One of the midwives who had a particular case load remit involving younger mothers, made reference to younger mothers having limited social support, which she perceived increased their risk for genital tract morbidity by impacting upon their ability to fulfil their dietary needs. This included funds for food and when living independently, difficulty with accessing shops to buy food when they are recently delivered.

“A lot of the girls are still quite anaemic after they've had their babies, so that's another risk to the healing . . . you know, tell them all the reasons why they need to eat. And they're not going to have a proper dinner, especially if they're living independently . . . Quite often, they'll just say, 'No, I'm not bothered, I'm not hungry.'” Midwife G line (787).

In addition to effecting their dietary requirements this midwife suggested limited social support and the necessity to quickly resume activities impacted upon the ability of the mothers to have appropriate rest and

recuperation following the birth. This she suggested had a cyclic effect upon their health as they were too tired, to prepare food.

“They’ve got nobody to look after them, so they have to go out and get their shopping or whatever, when they’re two days postnatal, out with the baby and up and down stairs with their prams and things. So I just think the physical effort that they have to go through sometimes puts them at risk.”
Midwife G (line 743).

Midwife N also suggested some women out of necessity had to quickly resume household activities. She considered this was influenced by different levels of social support and cultural norms around childbirth.

“A lot of the Asian ladies don’t leave the house until they’ve stopped bleeding . . . And I often think they’ve got it sussed really because they have everybody running around after them, whereas other women . . . have a six hour discharge and then go and do the shopping.” Midwife N (line 710).

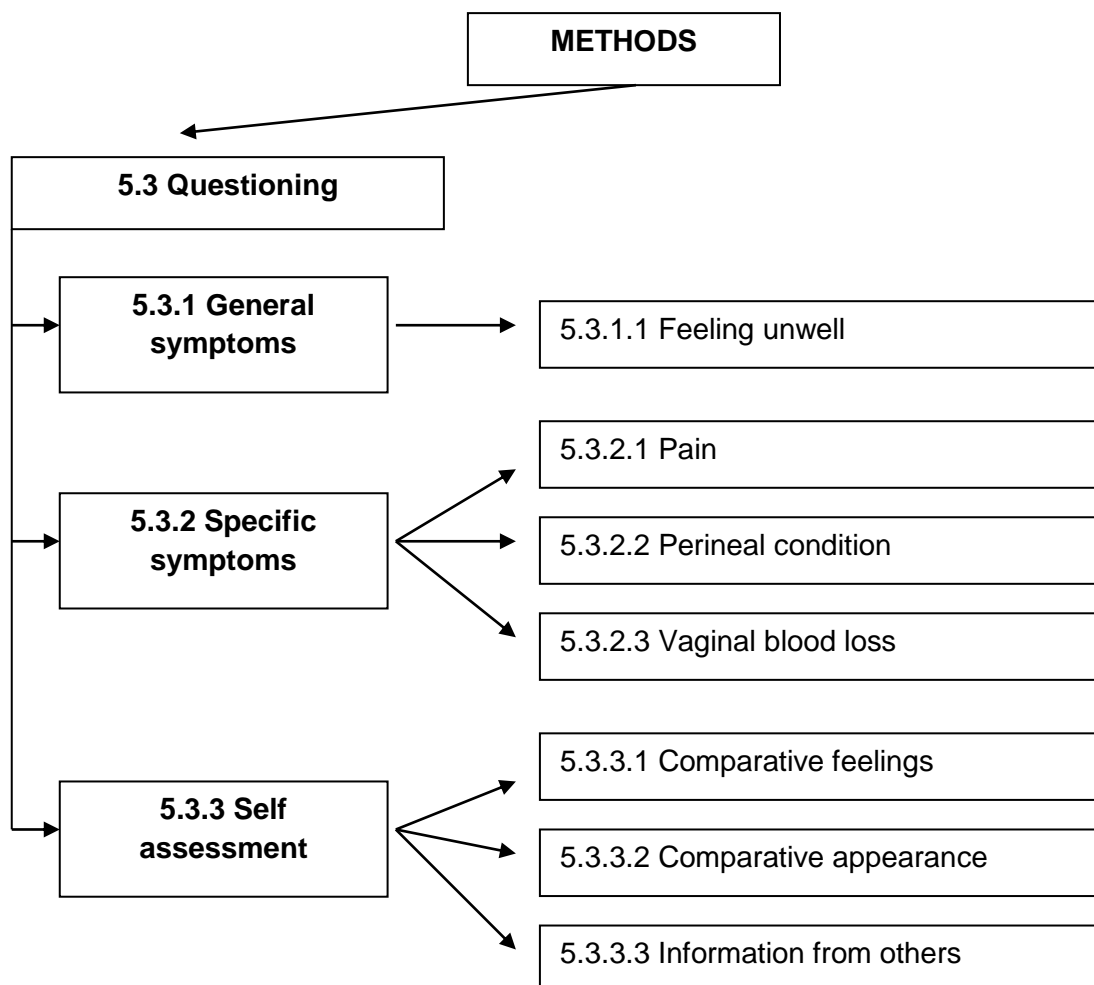
Disparity in health associated with socio-economic status is well established (Department of Health 2010). The maternal mortality rate for those women whose partners were unemployed (or did not have a partners) is up to six times higher than those women who did have a partner (CEMACE 2011). Some of the women identified by midwife G live in localities of high deprivation. Those women who live in localities of the highest deprivation have a mortality rate nearly double that of those who live in areas with the least deprivation (CEMACE 2011). The incidence of postnatal maternal genital tract morbidity is also higher for those in greater social and economic difficulties (Norwitz, Belfort, Saade and Miller 2010; Steen 2007).

Bick (2009) acknowledges the potential reciprocal connection between social support and physical health, such as limiting access to tangible support, which may enable the mother to rest and recuperate following childbirth. The Australian research by Yelland, McLachlan, Forster et al (2007) highlights for postnatal assessment of maternal well being to be effective it needs to be holistic, integrating physical, social and emotional well-being. However their findings suggest postnatal psychosocial assessments are based upon antenatal information. Within this study the midwives provided examples of the impact of limited social support,

particularly for young women, which resulted in them being tired and finding it difficult to ensure they had a healthy diet. The data suggests that some of the participant community midwives did attempt to integrate social factors within their postnatal risk assessment, all be it in an informal manner as no evidence of particular social assessment tools specific to the postnatal period were evident.

During interview and observational data collection, the midwives in this study, articulated and demonstrated undertaking risk assessment as a method of genital tract assessment. Therefore identifying and recognising the presence or absence of risk factors was a method of maternal genital tract assessment commonly used by the midwives in this study.

5.3 Questioning



Questioning of the woman by the midwife and the corresponding maternal verbal responses were utilised consistently by all of the midwives within this study as a method of maternal genital tract assessment.

“Going through the questions of how they feel” Midwife J (line 66).

The midwives articulated details of the content and approach to maternal questioning during interviews. In addition the application of questioning was evident within the observations made by the researcher of midwife and mother postnatal interactions. This section will focus upon the content of the questions, however aspects of the conversational style of questioning which overlap with this section, are discussed later in chapter 7 within the category ‘A Therapeutic Relationship’.

Several of the midwives identified a pattern to guide their questioning, usually reflecting an anatomical linear approach commencing at the woman's top or head and moving down her body. The content of the questions would relate to specific aspects of postnatal maternal anatomy or physiology.

“First of all ask, I'd generally ask how you're feeling and get a feel for that, and then I would say, right, we'll start from the top and work down, maybe start with breasts.” Midwife I (line 151).

Quite often this pattern of questioning articulated or demonstrated by the midwives corresponded to the information requested on the midwifery documentation, commonly referred to as the postnatal checklist. Some of the midwives made this connection between their need to complete the postnatal midwifery documentation and the content of their questioning. However these midwives suggested they did not feel the need to complete the documentation dominated the questions they asked the woman but more facilitated a pattern of assessment to help them consider and remember all potential areas for questioning.

“But you don't literally just sit down and, you know ask the questions and tick the boxes, or I personally don't. I tend to have a conversation around that checklist.” Midwife B (line 131).

This response, as with others, suggests the documentation does not automatically make the questioning linear or midwife focused and led. Patterns of information, reflected in documentation may be a useful 'safety net' of potential questions to ask.

The data from this study identified that the midwives questioned postnatal women in relation to 3 content areas, the first being general symptoms which were not specific to a particular aspects of the genital tract, but may be relevant to assessment of genital tract well-being. The second was specific symptoms, which were focused questions, which midwives frequently used to seek clarification from women upon potential signs and symptoms of postnatal genital tract physiology and potential pathophysiology. The third category, self-assessment, related to questions

and maternal responses, which were based upon the woman making self-assessments of her health following childbirth.

5.3.1 General symptoms

The majority of the midwives in this study suggested they questioned postnatal women upon general physiological symptoms as part of their assessment of maternal genital tract health. A symptom is defined as being “a subjective indication of a disease or a change in condition as perceived by the patient” Mosbys Medical Dictionary (2009). A general symptom could pertain to several causes and is therefore non-specific.

“First of all ask, I’d generally ask how you’re feeling and get a feel for that.”
Midwife I (line 150).

When questioning the woman regarding general symptoms the midwives usually asked the woman if she felt generally “well.” The notion of “wellness” was implicit to the statement, but not necessarily explained to the postnatal women or me during observations. It tended to be defined by the absence of its opposite, feeling unwell as this appeared to be easier to articulate than the concept of feeling well.

5.3.1.1 Feeling unwell

“If they felt really unwell” Midwife F (line 483).

When I asked “what do you mean by unwell”, midwife F identified raised temperature and other specific symptoms related to the genital tract, which will be discussed later. Midwife C and Midwife M also articulated symptoms of unwell as being a raised temperature and flu like symptoms.

“Cold-like symptoms, flu-like symptoms . . . Temperature, shakes, shivering, feeling unwell. ’ Midwife C (line 210).

During observations two midwives did question women upon general symptoms utilising more explicit terms. Midwife C, asked Vanessa if she “felt well, not fluey”. It was not clarified with the woman what flu like

symptoms in particular to report however Vanessa did respond “no” and otherwise appeared well, so this line of questioning was left by the midwife who then focused upon other issues raised by the woman.

On the second occasion Midwife G was observed undertaking a postnatal visit to Harriet. The midwife initially asked Harriet if she had been well since the previous visit. Harriet stated she had been well until the previous evening, when she felt very uncomfortable, her abdomen feeling tenderer than it had been. The midwife then sought clarification, by asking Harriet did she feel feverish or generally unwell, to which Harriet responded “no”.

It would seem that some midwives are aware that general symptoms may have some relevance to genital tract assessment and on occasion do question women about such symptoms. This appears to be particularly around having a raised temperature (pyrexia), general malaise, fatigue and flu like symptoms.

5.3.2 Specific symptoms

All of the midwives made some reference to questions they would ask the woman in relation to specific symptoms of genital tract condition and function in an attempt to assess genital tract health or morbidity. Specific symptoms are those, which relate to a particular disease or part of the body. These involved the presence or absence of pain, condition of the woman’s perineum and amount and smell of the woman’s lochia.

5.3.2.1 Pain

All the interviewed and observed midwives, questioned the women regarding perceived pain. Sometimes this was acknowledged generally and not related to a specific part of the woman’s genital tract.

“If she’s got any pain” Midwife M (line 141).

However on most occasions when the midwives questioned the women regarding pain the question was associated with a particular aspect of the

genital tract. This was most commonly in relation to perineal pain. The midwives frequently articulated this in general terms; by suggesting they asked the women how her perineum felt, rather than using the word pain.

“Did you have to have stitches, how’s it feeling?” Midwife E (line 491).

This was consistent with the observational data of midwives interacting with postnatal women. The observed midwives tended to ask generally how the woman’s perineum felt, occasionally using terms such as discomfort or sore.

“I would normally ask if its her first visit how its been since they delivered and whether the discomfort they’re feeling is more or less then they’ve experienced in the previous days.” Midwife A (line 165).

The majority of the interviewed midwives also identified they would question the woman to determine if her perineal pain was reducing or increasing over time and the impact posture and mobility had upon the woman’s perception of pain. The midwives acknowledged that some degree of pain associated with perineal wounds was to be expected.

“I can tell them that it’s quite normal to have perineal pain following an episiotomy, with a tear, with any kind of suture, it’s quite normal. “
Midwife K (line 249).

But the midwives also suggested that the amount of pain was significant, as a potential indicator of the severity of genital tract trauma.

“I think everyone’s different with pain anyway, but I think you just get a feel of...when you go to a woman and you think, oh my goodness, she looks terrible, you can see she can’t move hardly and that’s not normal, we don’t want people...so either she’s had her pain mismanaged or the trauma’s much worse than we anticipate, or the swelling or whatever.” Midwife I (line 225).

However several midwives highlighted that identifying the degree of pain may be difficult due to the subjective nature of pain.

“I usually say to them, “How painful? Like, tell me is it bearable, can you not sit down, describe it to me how painful it actually is?” Midwife N (line 492).

A number of midwives also commented during interviews or were observed by the researcher asking women about their use of analgesics, the types of analgesic and frequency of administration. This appeared to be in an attempt to clarify the severity of pain the woman had.

“If they’ve been having regular pain relief and they’re asking for it all the time, it’s an indicator that they’re uncomfortable” Midwife J (line 187).

However several midwives suggested the amount of pain did not always correspond to the underpinning morbidity.

“I’ve seen some girls who’ve had forceps delivery but they get up and they’re pottering and they’re getting on with it.” Midwife D (line 372).

The midwives provided examples of some women appearing comfortably despite severe trauma, whilst other women appeared very uncomfortable despite little evidence of trauma or morbidity.

The midwives used maternal questioning regarding pain as a determinant of potential genital tract condition. A review of the literature by Bastos and McCourt (2010) concludes that the severity of postnatal perineal pain correlates with the degree of trauma and morbidity, supporting the actions of the midwives. However some of the midwives in my study also highlighted that there could be difficulty in identifying the degree of pain perceived by the woman. The perception of pain is intrinsically subjective and individual; therefore any attempt to assess the pain of another brings inherent difficulties (Steen 2008). Bick (2009) highlights that no studies have evaluated the use of a pain assessment tool specific to postnatal perineal pain. When women’s perceptions of their postnatal pain have been identified within a research study, the authors use general pain rating tools such as visual analogue and numerical rating scales (Bick 2009). In this study there was no evidence that midwives used any particular tool to identify women’s perceptions of pain, but relied on the women’s qualitative comments and comparative assessment of symptoms over time. Steen (2008 p. 386), as part of an evaluation of the analgesic effect of a perineal cooling system involving 317 women, identified women’s perceptions of their

perineal pain from birth to the fifth postnatal day. On day one and two, women used words associated with acute wounds such as “*sore, throbbing, aching tender and stinging*” and thereafter the women’s descriptions of their pain appeared to reflect that the pain severity diminished over the five-day period. These views appear to support the actions and expectations of the midwives in this study, who encouraged the women to use descriptive terms to describe their pain. They anticipated that women’s descriptive responses should normally reflect a reduction in pain and corresponding changes in descriptive words, over time and that midwives would suspect perineal morbidity if this was not the case.

All of the fifteen midwives participating in this study articulated or demonstrated questioning the woman about postnatal perineal pain, in contrast only five midwives made explicit reference to questioning the mother regarding uterine pain. Uterine pain, particularly tenderness and diarrhoea may be indicative of uterine morbidity such as genital tract sepsis (NICE 2006; Bick, MacArthur and Winter 2009; CMACE 2011). Three of the interviewed midwives; midwife A, midwife E and midwife M identified asking the woman about uterine pain.

“Whether she’s experiencing any cramps any after pains.” Midwife A (line 302).

In addition during observational data collection two midwives; midwife C and midwife G explicitly asked women about uterine pain, discomfort and cramps. All of these midwives are very experienced community midwives.

5.3.2.2 Perineal condition

The midwives also identified asking the postnatal woman about the condition of her perineum, particularly bruising and swelling.

“The possibility of bruising and things like that. If I knew somebody that had had more than one or two stitches. Um, you know like more than a... a small tear, something like that, I would be asking them quite a lot of questions about how things were feeling downstairs.” Midwife B (line 600).

This finding was also noted in the observational data, whilst observing midwife H with Lesley, midwife H asked Lesley if her perineum was bruised or swollen. This is further discussed in section 5.3.3, titled self-assessment.

Some of the midwives in this study also associated the woman's ability to void urine comfortably and in adequate volumes as a potential indicator of perineal condition.

“Ask her whether she's passing urine. I would ask her whether she's passing good volumes of urine, whether she's comfortable passing urine, if she's got any pain.” Midwife M (line 142).

Therefore the midwives questioned the women about their ability to pass urine including the amount, frequency and any discomfort upon micturition.

5.3.2.3 Vaginal blood loss

During both interview and observational data collection the midwives articulated a range of questions they would ask a postnatal woman concerning her vaginal blood loss, lochia. The questions included determining details such as the amount, colour, smell, the presence of clots and sequential changes of the lochia.

“I ask what colour the lochia is, how heavy it is, if they've passed any clots, is it heavier at particular times of the day, just tell them so they know that the more you do, the higher chance is of having a heavier blood loss. Is it smelly?” Midwife G (line 506).

Whilst observing the midwives some of them made a general enquiry regarding the lochia.

“How is your blood loss?” Midwife N (line 475).

This quite often instigated a detailed response from the women, who provided a description of the amount and colour of her lochia. However if the information provided was not sufficiently detailed, the midwife usually undertook further questioning of the women. When Wendy responded to midwife Cs question, “what's your blood loss like?” with “Not very much”, midwife C asked Wendy to clarify “what do you mean by that?”

The majority of the midwives articulated a range of questions they used to attempt to clarify the amount of maternal lochia. These usually involved comparisons with menstrual blood such as heavier or lighter.

“ I’ll always say, ‘Well, compare it with a period. How does it look?’ ‘Oh, it’s nothing like that,’ or ‘It’s much heavier than that.’” Midwife I (line 158).

In addition, comparisons were made with blood loss colour, “*reds, pinks and browns*” Midwife C (Line 400) and amount on previous days, and the frequency of needing to change sanitary pads.

“What colour it [*lochia*] is, does it have an offensive smell, is it particularly heavy, how many pads do they use, are they changing their pads regularly . . . any clots?” Midwife E (line 241).

Several of the midwives highlighted that not only was it important to ask how many sanitary pads the women was using, but how soaked with blood they were, as they suggested the frequency of sanitary pad changing was individual to different women.

“Asked her how often she was changing her pads and, you know, asking her how much lochia there was there, was there less than the day before.” Midwife H (line 143).

Midwife C suggested some women would change their pad when only slightly marked as they felt uncomfortable and are not used to the feel and smell of sanitary towels as many women normally use tampons during menstruation. Midwife C then provided a narrative of a woman who on questioning regarding blood loss identified that she had soaked 10 sanitary pads in less than 3 hours. The woman was admitted and treated in hospital for secondary post partum haemorrhage.

“If someone’s saying to me that they’re bleeding heavily, I would say to them . . . you try to work out pads, how many times they’re changing sanitary pads. Is it soaked through, the sanitary pad? For example, I had a woman the other day who . . . I got there at nine o’clock and she said, ‘I’ve been bleeding quite heavily,’ right, well, ‘What’s heavily mean?’ ‘I’ve gone through a packet of pads.’ ‘Okay. How long is it since . . . how many was in the packet?’ ‘Ten.’ ‘Since when?’ ‘Since half past six this morning.’

‘How soaked were they?’ because some women will change a pad when there’s a little bit of blood on it because they just don’t like...when women are used to using tampons or Tampax, they’re not used to that blood smell and they find it unusual to have that smell about them, but this woman said, ‘No, they’re soaked through.’ And then she said, ‘I’ve kept them in a plastic bag for you,’ so it was like, ‘Okay, let’s have a look at them.’” Midwife C (line 375).

The midwives also discussed techniques they employed for identifying the size of clots passed. Usually this involved making comparisons with a variety of everyday objects.

“If they say, “I’ve lost a clot,” I would say, “How big? Was it clear, was it a fifty pence piece, was it a golf ball?”” Midwife N (line 832).

These included coins, five pence or fifty pence coins, asking the woman to describe the size or use her hands to indicate the size and using fruit for comparison to clot size. Some midwives identified several potential comparisons they could make.

“Well, was it the size of a golf ball or was it the size of a grape?’ because obviously you’re trying to relate to them. Or you’ll say, ‘Was it the size of my thumbnail?’” Midwife E (line 241).

5.3.3 Self assessment

A significant proportion of the questions midwives asked women regarding their postnatal genital tract condition and the corresponding maternal responses to midwifery questioning, involved to some extent, the women making some form of self assessment. Maternal self-assessment tended to involve women reporting how they felt generally, or specifically how their genital tract felt. In some instances self-assessment also included the women looking at their genital tract or lochia and reporting on what they had seen.

Under the category of self-assessment I clustered the data relating to assessment of maternal well being by a non-professional. In most instances this is the postnatal woman, however midwives discussed and I observed, significant others to the postnatal woman, being involved in non professional

assessment of maternal well being. This was usually the woman's partner or mother. The information from others tended to provide additional information to the woman's, sometimes similar but often providing more or different detail.

5.3.3.1 Comparative feelings

Maternal self-assessment usually involved the postnatal woman making comparative assessments of her health status, comparing present or expected and previous postnatal health status. This comparative feelings assessment was usually articulated as questioning the woman in relation to if she felt generally "well," "right" or "comfortable", as discussed in section 5.3.1. Several of the midwives engaged the women in general self-assessment by asking if they had any concerns or questions.

"I'll say, 'Have you got any problems? Have you got any real concerns? Is there anything you want to ask me about?'" Midwife D (line 467).

In addition all the midwives used maternal self-assessment of comparative feelings to determine the sequential changes of their genital tract during the postnatal period. This included maternal perceptions of improvements of their perineum, with women self-assessing if the perineum was feeling and therefore getting better.

"They'll generally say, 'Oh, it's (*the perineum*) much better than a few days ago,' or, 'It still hasn't got any better.'" Midwife F (line 437).

Some of the midwives explicitly suggested that maternal self assessment is a pertinent and potentially more accurate assessment tool, as the postnatal woman may be the best individual to make such comparative assessments.

"They know their own body" Midwife C (line 434).

5.3.3.2 Comparative appearance

The midwives in this study used maternal self-assessment of sequential changes affecting the appearance of the woman's lochia and perineum. This was identified consistently during interview data collection but also

observed by the researcher during observation of midwifery practice. Community and hospital based midwives would ask women if their lochia was diminishing and they were asked to compare it to its previous colour and amount.

“Then obviously as the days go by, we’re saying, ‘Is it (blood loss) the same as yesterday,’ and they’ll say, ‘Oh no,’ like usually, it’s a little bit less.” Midwife J (line 469).

Several midwives in this study suggested they encouraged women to use a mirror, to look at their perineum’s to self assess changes in the appearance of the perineum.

“I do encourage women to look, I say, “Have a look.” “Ooh no, what? Down below, you mean, down there?” I say, “Well yeah, have a look.”” Midwife N (line 558).

This is a recommendation made by both hospital and community based midwives, suggesting that women may look at their perineums on several occasions over the postnatal period, enabling them to see sequential changes in the perineum’s appearance. During the observation of Midwife G with Erica, Erica stated the bruising had nearly gone. To which the midwife asked Erica if she had looked at her perineum with a mirror and Erica responded “yes”. The midwives in hospital had told her to look at it and she had a few times and could see that the bruising was going and it was “looking better”. Several of the midwives suggested that most women were quite open to the idea of looking at their perineums.

“A lot of women will look at their perineum’s or look at their stitches or their bruising and they’ll say, ‘Oh yeah, I’ve had the mirror and it’s getting better,’ so you take what they’re saying as well.” Midwife C (line 432).

In addition, midwife G suggests self-assessment of the perineum may enable the woman to identify concerns regarding perineal condition and encourage the woman to seek professional assessment and help.

“Always encourage them to have a look themselves because then, if they have a look and they go, ‘God, that looks awful,’ they’ll let you have a look the next time you go in. So if they look themselves, it’s better than nobody having a look.” Midwife G (line 548).

Maternal self-assessment of the perineum may potentially offer a more consistent approach to assessment of maternal genital tract well being, with one person, the woman, observing and noting changes. This may be particularly useful if the woman is reluctant to allow professional inspection of the perineum and when there is limited continuity of a particular midwife providing postnatal genital tract assessment.

The midwives questioned the women upon a range of symptoms including a raised temperature (pyrexia), general malaise, fatigue and aches, the condition of her perineum and lochia including the amount, colour, smell, sequential changes and presence of clots, all factors which are also identified within the professional literature (Marchant *et al* 1999; NICE 2006; Bick, MacArthur and Winter 2009; Baston and Hall 2010; Byrom, Edwards and Bick 2010).

5.3.3.3 Information from others

Some of the community based midwives provided narrative examples of other family member providing information to substantiate or negate the woman's self-assessment. The other family members, most commonly cited were the woman's partner or mother. The partner may have been asked by the woman to look at her perineum and he subsequently provides feedback to the midwife.

“Some of them do get their partners to have a look.” Midwife G (line 228).

Sometimes the other information source would prompt more detail of an event or explanation the women was providing to the midwife.

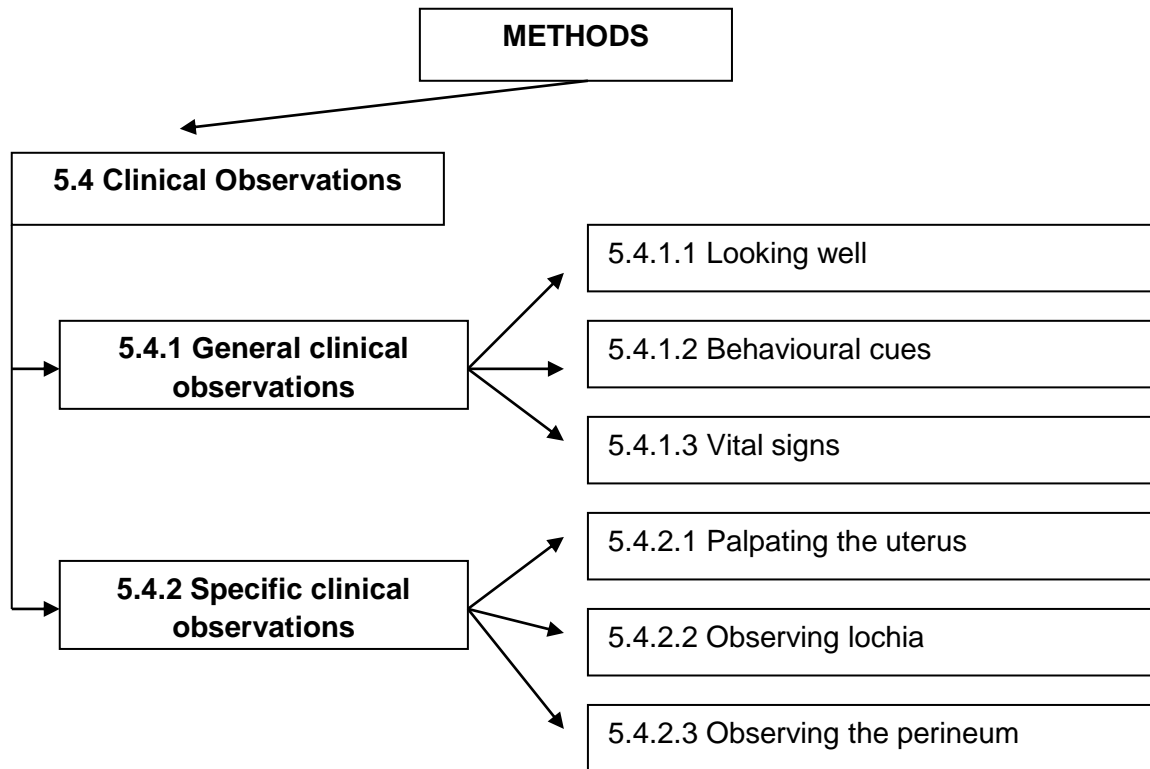
“I've had that where a woman is saying, ‘Yes, yes, I'm absolutely fine,’ and her husband or her partner or her mother has said, ‘Well, no, you've been up all night or you've been sitting crying,’” Midwife F (line 507).

On several community-based observations of postnatal assessment, I observed the involvement of partners in the assessment process. The partner of Harriet observed with Midwife G, was encouraged to contribute,

as he provided his observations of Harriet's behaviour and activities. When the midwife asked Harriet if she had been taking her analgesia regularly, Harriet responded she had, however her partner contradicted her stating she hadn't until last night.

All of the midwives within this study consistently discussed and demonstrated using maternal questioning and appeared to recognise it was a significant method of assessing maternal genital tract well-being. When making assessments of maternal genital tract well being, all of the midwives in this study identified using information from maternal self-assessment and some of the midwives explicitly acknowledged an additional source of information arising from partners and the woman's mother. This suggests the midwives do involve women and their families in the assessment of their postnatal genital tract well being and indicates that midwives value the contribution of interactive reasoning as they attempt to identify the woman's individual needs. Some of the midwives also identified women visually inspecting their genital tract, which may provide a more consistent assessment approach. However none of the midwives in this study articulated or demonstrated the potential of women self-assessing the condition of their uterus, by self-palpating.

5.4 Clinical observations



The final category within the theme of ‘methods’ is clinical observations. Clinical observations are defined as concerning the “direct observation” of clients, utilising the practitioner’s senses whilst in direct contact with the client or patient (Medline 2011). All of the midwives in this study identified a range of clinical observations that they may use as a method of assessing maternal postnatal genital tract well being. They consisted of a range of midwifery activities undertaken to gain primary, or first hand, information about the woman’s genital tract. The range of clinical observations, articulated and demonstrated by the participating midwives, are clustered into 2 particular types, which have formed the 2 focused codes or this category, general clinical observations and specific clinical observations.

5.4.1 General clinical observations

The midwife participants in this study identified or demonstrated a number of general clinical observations they considered as a potential method of assessing maternal genital tract condition. These clinical observations are grouped under this focused code acknowledging they are “general” as they are not directly aligned to a specific symptom of a particular cause of genital tract health or morbidity, but were used by the midwives as a general indicator of maternal and genital tract condition.

“I don’t necessarily do temperatures or anything like that but obviously if they looked unwell, then I would be doing the temperature which I have done and found people to be pyrexial, tachycardic, tender fundus, you need antibiotics.” Midwife E (line 300).

They tended to use general clinical observations before or with more specific clinical observations, or as a means to indicate if more specific assessment methods were required. There were 3 particular types of general clinical observations discussed by the midwives, if the woman looked well, the woman’s behaviour and her vital signs.

5.4.1.1 Looking well

Most of the midwives made reference to observing the woman’s general appearance, if she “looked well.”

“Does she look well?” Midwife M (line 119).

The midwives suggested in their comments, if they observed that the woman looked well, they concluded that she was probably physiologically well. This was substantiated in the observational data. For example whilst observing midwife I with Barbara, the midwife commented how she could see she was up, showered and dressed and “I don’t think you are anaemic, you look very well and are not pale.”

In contrast CMACE (2011 p.92) identify that women tend to appear well and very suddenly become extremely ill with generalised symptoms of morbidity,

at which time “*it may be too late for effective treatments.*” Therefore a woman appearing to look well cannot be interpreted as a confirmation that she and her genital tract is healthy.

“Looking unwell” was associated with the woman appearing pale, tired or in pain. This was summarised in the view expressed by midwife H, as she articulated observations which would make her concerned about a woman’s well being.

“Didn’t want to get out of bed, was asking for lots of pain relief and just looking unwell and pale and lethargic.” Midwife H (line 377).

5.4.1.2 Behavioural cues

The midwives in this study identified during interview or demonstrated when observed, a range of behavioural cues they used as a method to inform their assessment of maternal postnatal genital tract well being. Many of the midwives suggested they commenced observing the mother from the very beginning of the postnatal assessment and that this observation of the mother’s appearance and behaviour continues for the duration of the postnatal interaction.

“I observe the mother as soon as I come in the door.” Midwife B (line 155).

This observation involves noting the woman’s ability to mobilise. The majority of the midwives commented upon wishing to see the woman walk. This was usually associated with movement around the woman’s immediate environment.

“They’ll come to the door, you can usually tell as they turn away from you and how they’re walking, that they’re quite comfortable or they’re not.” Midwife D (line 448).

A few of the community midwives suggested and were observed asking the woman if she left the home. For example, Midwife G and Tracy, where the midwife was visiting following a previous visit in which Tracy had stated her perineum had felt uncomfortable. Midwife G asked Tracy if she had been

out walking with the baby, which Tracy responded she had. The midwife appeared to conclude from Tracy's ability to mobilise comfortably, and other aspects of the interaction, her perineum was now more comfortable. The ability to mobilise appeared to be perceived by the midwives as indicative of lessening of symptoms such as pain and swelling.

Some of the midwives also mentioned observing the woman climbing up and down stairs or getting on and off of her bed as being a useful observation potentially indicative of maternal genital tract well being.

“How they climb up the stairs because you very often find if their perineum isn't healing as it should walking up and down the stairs . . . you'll see them struggling.” Midwife A (line 598).

In addition to mobility, the midwives in this study identified maternal posture as a behavioural cue they would observe when making assessments of genital tract well being. Some of the midwives suggested if the woman had genital tract morbidity she might hold her self in a “stiff” position, influencing all of her movements and posture. The maternal posture most frequently articulated by the midwives was the ability of the woman to sit, comfortably and squarely.

“If a woman's got a sore perineum she'll sit to one side and you can always tell.” Midwife M (line 152).

Conversely the midwives articulated if they observed the woman was sitting very comfortably this would indicate to them that her genital tract was comfortable.

“If I go in and someone's sat cross-legged on the bed or sat on a hard chair, that kind of thing.” Midwife H (line 238).

After several of the observed postnatal assessments, the midwife would either spontaneously or in response to my questions make comments about how the women was mobilising or sitting comfortably.

Some of the midwives articulated maternal facial expressions as potentially being indicative of maternal well-being and as such factors they observed

during postnatal assessments. Midwife B suggested she would observe for a “strained” facial expression as being indicative of potential genital tract morbidity. The other midwives tended to use the term facial expression simultaneously with other behaviour and that such general clinical observations made them aware of potential genital tract morbidity.

“Her body language sort of indicated that, ‘I think this girl’s in pain . . . the facial expressions and just sort of the way she walked and easing herself down to sit or lying on the bed, you think, Oh there’s something . . . this girls uncomfortable.” Midwife J (line 101).

5.4.1.3 Vital signs

Some of the midwives in this study identified taking the woman’s vital signs, as general clinical observations, particularly the woman’s temperature and pulse.

“I was getting her in a chair, I was just feeling her pulse and it was quite high.” Midwife K (line 817).

None mentioned taking the woman’s respiratory rate. As highlighted by CMACE (2011 p.92) “*tachypnoea (respiratory rate higher than 20 breaths per minute) is sepsis until proven otherwise.*”

However because the midwives failed to mention taking vital signs, does not necessarily indicate they did not use them. For example three of the midwives, who did not mention taking maternal vital signs during interview, were observed by me to measure a woman’s vital signs.

From observations of postnatal assessments, there was a distinct difference between the frequencies of vital signs clinical observations. Of the seven postnatal assessments observed in the community involving two midwives, only one incident of obtaining maternal temperature was observed. This involved midwife G and Harriet, who had complained of abdominal pain, a potential indication of uterine infection and therefore an indicator that signs of infection such as pyrexia should be observed for. In contrast, during the

observation of three hospital-based midwives involving eight different postnatal women, seven of the eight women had their vital signs obtained and recorded. Only one of these women had a history of previous raised temperature and infection. The other six women did not appear to the researcher to have risk factors that might indicate taking the woman's temperature. However hospital based midwife L provided a potential rationale for this disparity, suggesting the need to complete maternity records instigated the obtaining of maternal vital signs.

“I always do blood pressure, pulse and temp because a lot of the girls sometimes want to go home on the same day and when you do your postnatal documentation, you've got to put the temp, BP and pulse into the discharge . . . So it's just easier to do them at the time.” Midwife L (line 163).

5.4.2 Specific clinical observations

During interview, all of the midwife participants identified a range of specific clinical observations they might use as a method to assess maternal genital tract condition. These involved midwives clinically observing, using sight, smell and touch, the woman's genital tract by observing the lochia, perineum and palpating the woman's uterus. The midwives in this study, used these specific clinical observations selectively, dependent upon a range of motivating and modifying factors.

“The three (postnatal genital tract assessments) that I have done are all very different, so . . .my assessment was different for each woman.” Midwife H (line 92).

Within this category, the content of the specific clinical observations will be explored. Within the following chapters the issues motivating and modifying the midwives to employ a particular approach to genital tract assessment will be explored.

5.4.2.1 Palpating the uterus

During interview, all of the midwives mentioned potentially palpating the woman's uterus. In addition I observed midwives, undertaking uterine

palpation on several occasions in both the hospital and community setting. The midwives identified they were particularly observing for the height of the uterus, if the woman's uterus was central and not deviated, its tone and if it was painful when palpating.

“Feel for where the uterus is. And I tend to feel... feel quite widely. I ask if there's any pain. If I'm hurting them where I'm touching them, but I'm also feeling for the height of the fundus and how firm it is as well . . . so you're feeling to see if the uterus... infection, you know retained pieces of placenta. Midwife B (line 500).

When the midwives were asked why they undertook these specific clinical observations they suggested signs such as poor uterine tone, commonly referred to by the midwives as a “boggy” uterus, uterine pain or tenderness and the uterus higher than anticipated, sub involution, may be indicative of retained products of conception or uterine infection or potential secondary post-partum haemorrhage. This articulation of their rationale for their actions demonstrated their procedural reasoning and technical knowledge in action. In addition the midwives suggested findings regarding the woman's blood loss, would influence their desire to palpate the woman's uterus.

“Whether or not I was having some concerns about her lochia and depending on the results of what she said, then I would maybe automatically put your hand on her fundus and feel her fundus. But if a woman's sitting and discussing things quite coolly and calmly with me and saying, ‘Oh, no, the bleeding's fine, there's hardly any and everything's fine,’ I wouldn't necessarily go to be fiddling with her uterus either. So it would depend on what she was saying.” Midwife I (line 162).

The midwives identified the use of uterine palpation and integrated a range of parameters including the height of the uterus, tone, position and if tender (Johnson and Taylor 2006; Bick, MacArthur and Winter 2009). The midwives also tended to associate uterine palpation with describing findings about the woman's lochia demonstrating a tendency to integrate these findings, which may enhance the predictive value of uterine palpation to genital tract health and morbidity (Alexander 2001; Dietland *et al* 2006).

Several of the midwives, suggested they tended not to palpate the uterus of a woman following a caesarean section birth.

“I never ever palpate a section . . . because they’re usually bruised, they’re tender, you know you’re going to have delayed involution anyway and I just think . . . well, I don’t know really, because I can’t say a hundred per cent that they haven’t got retained products of conception, or they haven’t got any placental tissue there from the section. But you’re not as concerned that there’s been any . . . because obviously, being scrubbed for sections, I’ve seen how thorough they are. They’re checking the uterus before they close . . . I would if they had problems.” Midwife D (line 677).

The rationale provided for this included it would be painful for the woman, sub involution was to be anticipated due to the post surgery inflammatory response and a couple of the midwives suggested retained products of conception were unlikely as the uterine cavity had been directly visualised following removal of the placenta during the surgery (midwives A, D & E). However during observational data collection, midwife G was observed palpating the uterus of Harriet who was several days post caesarean section birth. This was as a result of Harriet reporting she had some abdominal tenderness, suggesting some midwives; on some occasions do palpate the uterus of a woman post caesarean section.

All of the midwives appeared to be aware of uterine palpation as a specific clinical observation they could use as a method of maternal genital tract assessment. However none of the midwives articulated during interviews, or demonstrated during observations, that whilst palpating the woman’s abdomen as part of uterine palpation they would seek other findings, such as divarication of the rectus abdominis muscles. Towards the end of data collection three of the midwives were specifically asked if they considered the tone of the abdominal muscles and assessed them when palpating the woman’s uterus. All of the midwives said no, stating they had not encountered a woman with divarication of the rectus abdominis muscles.

5.4.2.2 Observing lochia

During interview data collection all of the midwives made reference to observing the woman’s lochia as a potential clinical observation of genital tract well being. This included observing the amount of blood loss, its colour, clots and the smell of the lochia.

“Over the next few days or the next couple of visits, they should be saying it’s getting less or it’s changing colour . . . I’ll often say to them, ‘What colour is it?’ We’ll go through the reds, the pinks to the browns. Midwife C (line 394).

The midwives acknowledged they infrequently directly observed the woman’s lochia, tending instead to use maternal questioning and only using clinical observations if they perceived a particular need, due to other indicators.

“I would look at the lochia if I felt like the uterus was a little bit high or if the woman was showing concerns, thinking that her lochia was a bit excessive.” Midwife J (line 506).

Or if the blood loss was so great it was in open sight.

“When she stood up, it was soaking on the floor.” Midwife D (line 726).

In addition the midwives frequently associated observing the woman’s lochia with palpating her uterus.

“If she said her blood loss was a little bit heavy or offensive, obviously I would lie her down. I would check whether she had any pyrexia, if her pulse was elevated, just looking for signs of infection perhaps. Feel her fundus, palpate her fundus, see if there’s any tenderness there, see if her lochia appears to be heavy, check her pad, see whether it’s offensive or whether that’s normal.” Midwife M (line 167).

Differences in the incidence of observing the woman’s lochia were noted in the observational data of the midwives. None of the community midwives were observed looking at a woman’s lochia on a sanitary pad. In the hospital setting, on two occasions a woman’s lochia was observed. Such a small difference in practice may be purely coincidental, however as suggested by midwife H, ease of access to the woman’s lochia and associated soiled sanitary pads may make observing the woman’s lochia more likely in the postnatal ward.

“When she’d come up from delivery suite . . . I’d give her a hand and took her to the toilet and things, so I actually saw the pads and how soaked they were.” Midwife H (line 156).

Several of the community midwives identified that women occasionally kept sanitary pads, particularly if they had passed a clot for the midwife to observe when she next visited.

“She said, ‘I’ve kept them in a plastic bag for you,’ so it was like, ‘Okay, let’s have a look at them.’” Midwife C (line 384).

5.4.2.3 Observing the perineum

The midwives in this study identified observing the perineum as a potential specific clinical observational method of assessing the genital tract.

“Bruising and a little bit of oedema but it’s inflammation as well, you don’t want...redness.” Midwife J (line 145).

The midwives suggested they observed for trauma, including spontaneous tears or an episiotomy, grazes, bruising, haematoma and oedema. The midwives observed for the presence of such trauma, but also factors that would facilitate and indicate wound healing such as close approximation of wound edges and anticipated sequential changes over time including the reduction of bruising and oedema. As suggested by midwife H, a hospital based midwife, the content of perineal observations may be dependent upon where the midwife worked, as different physiological changes of the perineum and symptoms of particular pathophysiology would usually occur within a particular timeframe after birth. The majority of the postnatal women within this study remain on the postnatal ward for under twenty-four hours, therefore the changes and potential symptoms a hospital midwife may observe for and anticipate would be different to a community-based midwife.

“So I think that I’m probably more looking for swelling, haematoma, (*rather*) than infection in the first couple of days.” Midwife H (line 417).

A number of the midwives, predominately community midwives, identified observing for potential signs of perineal wound infection, which included the wounds visual appearance, limited signs of healing, discharge and offensive smell. Midwife C, a community based midwife, provides a narrative of a

woman she had recently visited ten days after her birth in which an infected perineal wound was identified.

“I looked at the perineum, it was absolutely infected. It was really sloughy and horrible . . . the perineum had gone completely . . . it was completely gaping and there were no signs of any kind of granulation of the wound. It was just open and pussing.” Midwife C (line 113).

The data in this study indicate that the midwives are aware of a range of clinical observations that they may use as a method of maternal genital tract assessment. There appears to be some variety depending upon location, of their use. Hospital midwives were more likely to measure maternal vital signs to complete discharge documentation and to visually inspect the woman’s lochia whilst helping her to attend to her personal needs. In addition the midwives articulated differing expectations regarding the content of specific observations dependent upon where the midwife worked, as different physiological changes of the perineum and symptoms of particular pathophysiology would usually occur within a particular timeframe after birth.

5.5 Conclusion

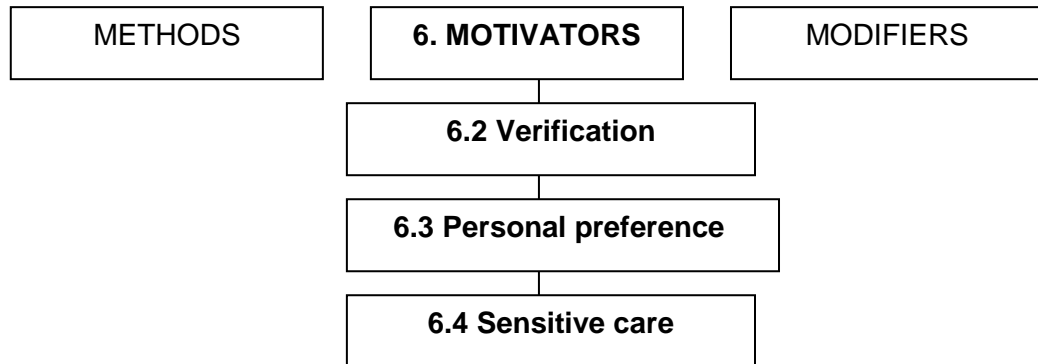
Within this chapter a range of potential methods of assessment of maternal genital tract condition have been identified as employed by the midwives in this study. These have been grouped and presented within 3 categories entitled risk assessment, questioning and clinical observations. It is acknowledged the grouping of the data within these categories is not without contention. Many of the issues within this theme of methods when expressed within the reality of midwifery practice happen simultaneously. The written format dictates I must attempt to fracture this cohesiveness to enable a sensible, articulate and understandable written account. However some areas do overlap, for example, the questioning category in which the content of the questions asked by the midwives in relation to general or specific symptoms and the resulting verbal responses were frequently based upon the woman making a self-assessment. In these instances I have attempted to minimize repetition, but provided enough information so

the reader can make sense of the data and follow my reasoning process, to ensure research credibility.

Chapter 6

6. Chapter 6 - Motivators

“An exploration of midwives’ experiences and practice in relation to the assessment of maternal postnatal aenital tract health”



6.1 Introduction

To motivate is “to cause someone to behave in a particular way” (Cambridge Advanced Dictionary 2008). This chapter focuses upon the second theme to be constructed from the data ‘Motivators’. The motivators described or demonstrated by the midwives in this study impact upon their reasoning process and resulting practice actions to employ a particular assessment method. The data are grouped into 3 categories. However, the midwives frequently identified several motivators influencing their methods of maternal genital tract assessment simultaneously. Therefore these 3 categories must be perceived as occurring and influencing the midwives clinical reasoning processes simultaneously. The categories within the motivators’ themes are;-

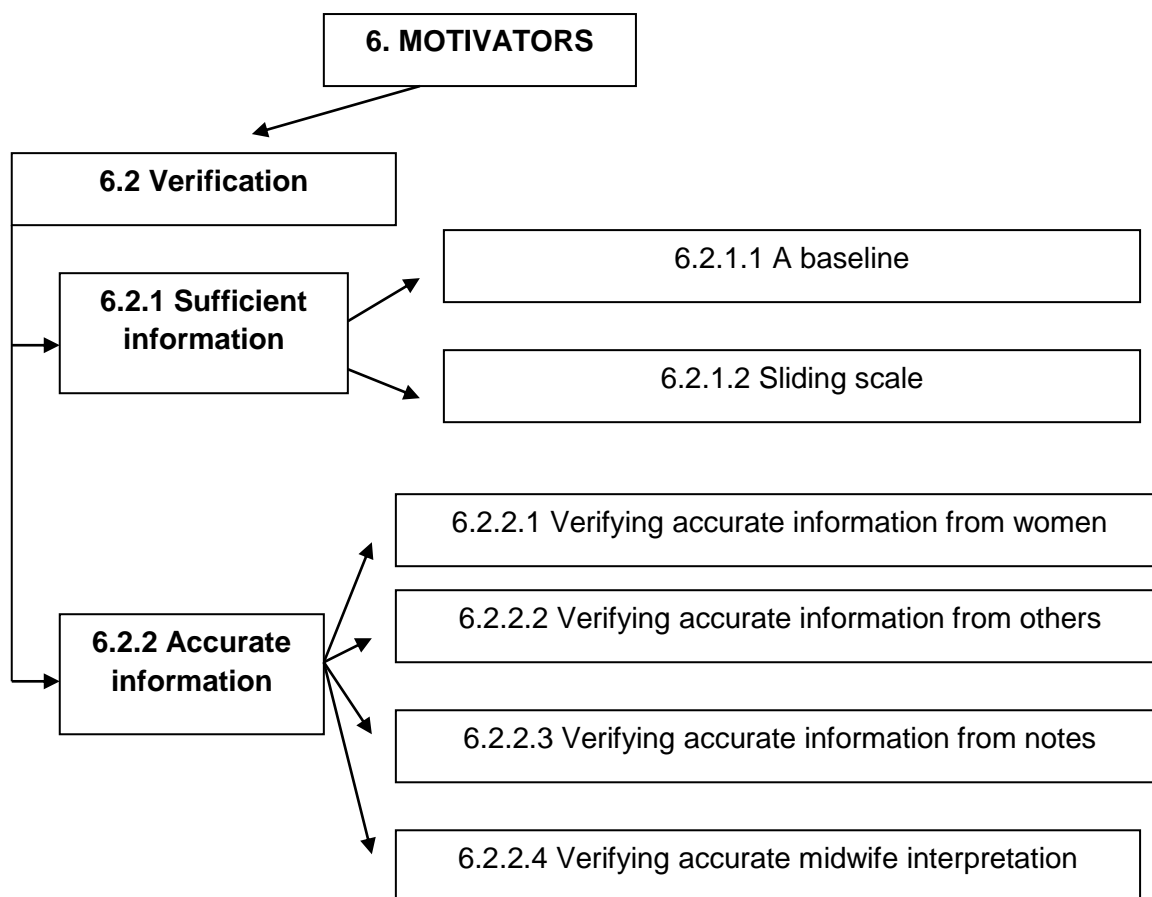
- Verification
- Personal preference
- Sensitive care

The first category I explore is verification in which the midwives articulated a desire to verify they had sufficient and accurate information to justify their

approach to maternal genital tract assessment and therefore support their conclusions of maternal genital tract health. The midwives also considered their approach was motivated by both maternal and midwife preferences regarding genital tract assessment and these form the second category. The final category is sensitive care in which the midwives discussed and demonstrated being motivated by a desire to provide an approach to maternal genital tract assessment which was sensitive to individual maternal needs, providing focused information, advice and appropriate midwifery action.

The issues raised within the theme of motivators responds to all three of the research objectives, as the analysis illuminates how and why midwives determine their approach to maternal genital tract assessment and discerns how midwives involve women in determining the approach adopted for assessment. In addition the presentation facilitates an appreciation of the forms of clinical reasoning and knowledge sources accessed by the midwives, which motivate their approach to maternal genital tract assessment. In this chapter there is particular emphasis upon interactive reasoning and how midwives practical or craft knowledge informs their practice.

6.2 Verification



Verification is defined as “*evidence that provides proof of an assertion*” (Collins English Dictionary 2009a). All the midwives discussed or demonstrated practice actions in which they attempted to collate information to use as evidence to support their assertions concerning the condition of the woman’s genital tract. The assertions that the midwives attempted to verify, related to the genital tract progressing through anticipated ‘normal’ sequential stages, reflecting physiological processes such as genital tract involution and perineal healing if trauma had occurred during the birthing process.

“That’s why we’re there, to advise and ensure that what they’re experiencing is normal and reassure them, and obviously to detect abnormality and make decisions.” Midwife M (line 665).

In addition the midwives suggested they attempted to verify, or not, their suspicions concerning potential genital tract morbidity. Being able to verify

genital tract condition motivated the midwives' practice actions in relation to which assessment methods they would employ.

The midwives verified 2 aspects of the information that they used to evidence their assertions regarding maternal genital tract condition. These were that they had sufficient information and that the information was accurate.

6.2.1 Verification of sufficient information

All of the midwives in this study identified or demonstrated means of verifying if the information they had was sufficient to support their assertions of the condition woman's genital tract. By sufficient information the midwives considered they needed enough information to "assume the truth" regarding the woman's genital tract condition (Collins Dictionary 2009b).

"Because I want to ensure that the woman is healing, is moving forward the way she should do, is not in discomfort, not in pain, is feeling as good as she can and I guess I just want to make sure things are progressing normally for her." Midwife I (line 855).

How much information was enough information to verify the midwives' conclusions appeared to vary dependent upon factors associated with the individual woman and midwife, which are reflected within the 2 other categories in this theme, personal preference and sensitive care. My research data suggested the midwives employed two particular techniques to verify if they had sufficient information to determine maternal genital tract condition. These were determining a baseline of sufficient information and applying the range of assessment methods in a sliding scale approach until sufficient information was gained.

6.2.1.1 A baseline

The midwives suggested if the postnatal interaction with the woman was her first postnatal assessment, on the postnatal ward or within the community, they would seek to routinely identify a baseline of the woman's genital tract condition. A baseline is defined as being "a starting point for comparison"

(Oxford Dictionary 2011b). The majority of the midwives stated or demonstrated during practice observations they preferred to use clinical observation of the genital tract to identify a baseline of information. This involved palpating the woman's uterus to identify the condition of the uterus.

“On my first visit, I would always palpate the uterus . . . so I can assess where the uterus is at that stage, and if then they would say to me in subsequent visits, if the lochia was normal, if they have no pain or problem passing urine, then I wouldn't necessarily touch the woman again, it would all be done verbally but I always think you need a starting point for me.” Midwife N (line 81).

If the woman had genital tract trauma, the midwives tended to prefer to visually inspect the perineum at least once, to form a baseline of information concerning the condition of the perineum.

“I always like to have a look at the perineum on anybody who's had any trauma, on the first visit. I always like to see it for myself and the reason I do that is because I say to the women, 'I could suggest some treatment or I can observe to make sure there's no signs of infection this early.' And if it does become more problematic, I've got something to go by in a few days down the line, rather than you seeing that it's really, really bad now but it may be better, than, say the first day. And if I haven't looked at it, I've got nothing to compare it with.” Midwife D (line 140).

The midwives identified a need to verify a baseline of maternal genital tract condition to not only determine the present condition of the woman's genital tract but then if required to make comparative assessments during the postnatal period. Bick, MacArthur and Winter (2009), following critique of the evidence base, also recommend as appropriate practice undertaking a baseline of clinical observations.

“You've got no base to start where you think actually, one day, that perineum looked really nice and healthy, the episiotomy looked healthy and pink, no sign of infection so the next day it's broken down, you don't know when that's actually happened. Midwife N (line 318).

The comments made by some of the midwives suggested they felt that clinical observations of the maternal genital tract, were the pinnacle of the range of approaches to maternal genital tract assessment and that postnatal

midwifery care was not based upon sufficient information unless at some point clinical observation were considered.

“You’ve done what I would class as a full postnatal examination on the first visit as a midwife to me . . . that gives you a basis . . . we wouldn’t necessarily be visiting everyday . . . by doing a full examination on your first visit will give you an indicator as to when it will be appropriate to do the next visit.” Midwife A (line 275).

In addition midwife A, suggests a detailed baseline of maternal well-being enables subsequent workload planning and enables the midwife to determine a selective visiting pattern, to reflect maternal needs. Midwife D highlighted if she identified discomfort or morbidity regarding perineal health, she would ensure the women was revisited the next day to ensure advice was successful and discomfort and symptoms were reducing. Several of the midwives did acknowledge the approach to undertaking a baseline assessment of maternal genital tract condition might differ dependent upon maternal risk factors associated with genital tract morbidity, as discussed in chapter 5.

Not all of the midwives suggested they routinely used clinical observations to verify a baseline of sufficient information regarding maternal genital tract condition. These midwives stated they used other approaches to genital tract assessment, such as identification of risk factors, maternal questioning and self-assessment and would selectively use clinical observations.

“If everything’s normal, they’re comfortable, it wouldn’t give me . . . I don’t feel I’d have the need to check, if it was an episiotomy or first degree tear” Midwife J (line 196).

“I don’t palpate the uterus with everyone. You know, it just depends how much lochia there is.” Midwife H (line 130).

These comments are more congruous with the recommendations within the national guidelines (NICE 2006), which do not advocate any routine clinical observations unless the woman articulates a concern, or requests the midwife to examine her. These midwives, as was midwife J who also didn’t use a baseline of perineal condition, were based upon the postnatal ward.

There appears to be differing practice between community and some hospital-based midwives in relation to undertaking clinical observations to provide a baseline of maternal genital tract condition. The community-based midwives suggest baseline clinical observations are useful to inform subsequent comparative assessments, which may be required during the several days or weeks when they provide postnatal care for the women. In contrast the hospital-based midwives usually provide only immediate postnatal care, with the majority of women leaving the postnatal ward within 24 hours of birth. The hospital based midwives are less likely to make comparative assessments of the woman's genital tract over a period of time and therefore potentially have fewer grounds for routinely establishing a baseline involving clinical observations of the woman's genital tract.

6.2.1.2 Sliding scale

Following the initial baseline assessment the midwives in this study discussed and demonstrated verifying if they had sufficient information concerning maternal genital tract condition in subsequent postnatal assessments through a sliding scale technique. The Collins English Dictionary (2009c) defines a sliding scale as “a variable scale . . . in response to changes in some other factor, standard, or conditions.” Within this research the term sliding scale is used to indicate the process undertaken by midwives as they determine if they have sufficient information to be satisfied that maternal genital tract is progressing as anticipated or until an issue is raised which suggests and motivates the midwife to a particular method of genital tract assessment.

The data indicted the midwives would commence with the least intrusive method of maternal genital tract assessment, identifying risk factors, questioning and maternal self assessment.

“Sometimes you can come out of a visit and then think I didn’t actually put my hands on that women. But you’ve got the information you need from the woman her self.” Midwife A (line 897).

The midwives described proceeding along the scale incrementally until they had sufficient information to consider genital tract health was confirmed. However at any time along the sliding scale the midwives suggested they might reach a pivotal point, a concern, necessitating her to “jump” along the sliding scale, usually to request clinical observation.

“Depending on her answers obviously, that would lead me on to further investigation really.” Midwife M (line 162).

“By asking those questions, you’ll be able to elicit any abnormalities in the postnatal recovery, which you might say, ‘Well, now that you’ve told me that, I’m going to have to do this, if you don’t mind. But now that you’ve told me you’ve got a pain, and now that you’ve told me you’ve passed a clot as big as a grapefruit, now I need to have a little examination just to make sure that there’s no other problems going on.’” Midwife E (line 504).

Many of the midwives suggested a history of significant trauma during the birthing process would spring their sliding scale assessment to a preference to use clinical observations.

“I think, without a shadow of a doubt, if it was someone who’d had significant trauma such as third and fourth degree tears or someone with nasty labial tears, then I would possibly look anyway, it didn’t matter what the woman was saying.” Midwife I (line121).

All of the midwives indicated that maternal responses to questions might instigate the midwife to undertake clinical observations. For example responses concerning unexpected or severe perineal pain would indicate to the midwife she might need to clinically observe the woman’s perineum in order to ensure she had sufficient information.

“This one in particular complained that the area was sore so I was inclined to...I just asked her if it was all right to check, and it was actually very inflamed and bruised.” Midwife J (line 68).

If the woman reported heavy or offensive lochia or abdominal pain the midwives perceived this would be a pivotal point necessitating clinical observations, including palpating the woman’s uterus.

“If she said her blood loss was a little bit heavy or offensive, obviously I would lie her down. I would check whether she had any pyrexia, if her pulse was elevated, just looking for signs of infection perhaps. Feel her fundus, palpate her fundus, see if there’s any tenderness there, see if her lochia appears to be heavy, check her pad, see whether it’s offensive or whether that’s normal.” Midwife M (line167).

In addition, general clinical observations such as the woman appearing unwell would instigate a sliding scale response involving specific clinical observations such as temperature, pulse, palpating the uterus and inspecting lochia and perineum. The contemporary literature and guidelines support the responses of the midwives in this study, suggesting findings such as those discussed would warrant clinical observations (Macarthur & Macarthur 2004; Bick, MacArthur and Winter 2009; Marchant 2009; Bastos and McCourt 2010; Steen 2010; CMACE 2011; East *et al* 2011).

6.2.2 Accurate information

All of the midwives discussed how they made attempts to verify that the information they used to base their assessment of maternal genital tract well-being upon was accurate. This was particularly the case for non-clinical observation assessment approaches; that is use of risk factors, maternal questioning and self-assessment.

“I looked after her all day yesterday so I knew how much lochia she had yesterday, and just talking to her and her telling me there was less today, you know, I accepted that.” Midwife H (line 149).

If the midwife felt unable to verify the accuracy of the information from these approaches, then she may wish to undertake clinical observations to verify maternal genital tract condition. The midwives suggested they verified the accuracy of the information they received from postnatal women, the woman’s family, from documentation and they also questioned the accuracy of their own interpretation of information and practice events. Ensuring they had an accurate representation of factors and events, the midwives felt, was fundamental to them being able to make practice decisions regarding maternal genital tract well being. Therefore their ability to verify they had

accurate information motivated the approach to maternal genital tract assessment the midwives employed.

6.2.2.1 Verifying information from women

A large proportion of the questions midwives asked women regarding their postnatal genital tract well being and the corresponding maternal responses to midwifery questioning, were based on the premise that women will, or be able to make an accurate self assessment and articulate this information to the midwife.

“Women know when something’s not right. You say to them, ‘Does it have an offensive smell?’ and they’ll say, ‘No, it just smells like it’s always smelt,’ or they might say, ‘Oh, yeah, it does.’ I’ll say, ‘Well in that case, I might need to do a swab, so let’s have a look,’ that kind of thing.” Midwife E (line 296).

All of the midwives considered most women could provide them with accurate information on which to base their decisions regarding maternal genital tract well being. The midwives suggested most women had some insight of the physiological changes during the postnatal period. They indicated this was particularly the case for older women, who some of the midwives felt invested time in accessing information regarding the potential childbirth events and physiological changes.

“A lot of the older ladies have deliberately waited till they’re older to have a family, do lots and lots of reading.” Midwife D (line 398).

The midwives also recognised women needed the verbal articulation skills and confidence in their verbal skills and self-assessment to be able to effectively and accurately provide information to the midwife.

“When your talking to a woman in the home you’re very often we’ll get more from the conversation than you’ll sometimes get from the physical examination.” Midwife A (line 267).

This recognition of the significance of maternal communication skills for women providing sufficiently detailed and accurate information was also noted during observational data collection. For example, Midwife I with

postnatal woman Jenny did not inspect Jenny's lochia or palpate her uterus (no perineal wound). On discussion with midwife I after the postnatal assessment, she suggested her rationale for choice of genital tract assessment approach was influenced by Jenny being multiparous and familiar with the physiological changes of the postnatal period. She was communicative and articulate and therefore use of questioning and self-assessment was deemed by the midwife as an appropriate approach to assessment of genital tract well being.

However all of the midwives in this study identified a small but significant number of women in which they had concerns about the women's ability to provide accurate information regarding their genital tract condition. Some of the midwives suggested following childbirth, women thought midwifery care was for the baby and not to meet their needs.

“You know, they think because they've had the baby, everything's finished with them. We're not interested in them any more, we're just there to see the baby . . . I just think it's important that women know they are as important as the baby after the event.” Midwife E (line 198).

The midwives identified that not all women had an accurate understanding of genital tract anatomy and physiology or knew what to expect in relation to their genital tract, following childbirth and the physiological changes during the postnatal period. This proved challenging for the midwives, who then had to verify the accuracy of the information provided by these women.

“You tend to assume that women will now be much more informed than they've ever been. And the majority of women are but you will still get women who will not have any knowledge of how their own body functions and you know how you can expect to be after you've had the baby.” Midwife A (line 492).

Some of the midwives suggested with the information explosions of recent years, including internet access, there is an assumption that women will be better informed regarding their genital tract and postnatal events, and therefore able to independently identify and meet their genital tract needs. However the midwives suggested this was not always the case, with some

women not particularly better informed, resulting in the women being “shocked” by the reality of their genital tract condition following childbirth.

“I don’t think sometimes they expect to have a blood loss, especially when they’ve been a section. I think they get quite a shock. They think, “Where’s that coming from?” . . . Obviously, the older women are a bit more savvy but the young girls . . . and I think some of them get a shock at how heavy the loss is at first when they’ve first delivered. So their perception’s slightly different to ours.” Midwife L (line 289).

Some of the midwives identified women who they felt were more likely to be unprepared and not sure what to expect postnatally. This tended to be younger women and those from less affluent backgrounds. However several of the midwives also highlighted all women had different insights regarding their genital tract, regardless of age and socio-economic group.

“I think even women who are really highly educated are just as daft! In fact, they probably have less commonsense.” Midwife E (line 411).

Two midwives related this limited insight into postnatal health and events to their own experiences. Despite being well-educated women, in nursing careers at the time, before entering midwifery they had limited knowledge of postnatal genital tract expectations.

“Before I went into midwifery, I wasn’t really aware of this (blood loss following childbirth) either so unless you know about it, the questions are only easy if you know the answers to them.” Midwife J (line 451).

Some of the midwives commented that the lack of awareness of genital tract physiology might be exacerbated by women not usually using sanitary towels when they menstruate.

“Some women will change a pad when there’s a little bit of blood on it because they just don’t like . . . when women are used to using tampons or Tampax, they’re not used to that blood smell and they find it unusual to have that smell about them.” Midwife C (line 379).

This would mean they had little experience of seeing amounts of blood on a sanitary towel. When observing Midwife Z with Jill, Jill identified that she thought she was losing quite a lot of blood. The midwife asked for clarification, regarding amount, how soaked her sanitary pads were and

how frequently Jill was changing them. Jill, had changed her sanitary pad once that morning, it was now nearly lunchtime, indicative of vaginal blood loss within normal limits.

The midwives suggested as women have no reference points to relate their self-assessment to, this can make use of maternal self-assessment of the genital tract inaccurate.

Several of the midwives expressed concerns that if a woman did not know what to expect in relation to her genital tract postnatally then she would not know what to report to the midwife.

“They’re not going to have any perception of what is heavy, what is normal, if they didn’t even know they were going to bleed.” Midwife K (line 355).

Lack of knowledge would undermine the accuracy of the information she provided when responding to questions and self-assessing and potentially the accuracy of the assessment of maternal genital tract well-being. Some of the midwives provided detailed narratives of practice experiences in which the woman’s limited understanding of what is normal and acceptable physiology postnatally, led to her not reporting symptoms of morbidity promptly. Midwife C, discussed a woman who had failed to report offensive lochia, a sign of genital tract sepsis.

“I then commented to her and said, ‘You know, your blood loss has got a smell. Have you noticed that?’ and she said, ‘Yeah, I just thought that was because of my pregnancy. I’ve got to get rid of the bad blood out of my body. And I thought that was just the smell of bad blood when you’ve had a baby.’ I had to say to her, ‘Well actually, it doesn’t smell right.’” Midwife C (line 115).

Some of the midwives suggested some women might not have the confidence to admit to the midwife they are unsure about what to expect postnatally.

“Sometimes women feel like, ‘Well, is this normal? I don’t feel like I want to ask,’ so it’s important just to highlight, especially the first baby, just highlighting what is normal and what isn’t.” Midwife J (line 454).

Midwife A suggested even when a woman has a concern about her health she may not feel comfortable taking the initiative to contact the midwife.

“Anything you’re worried about just give us a ring . . . And invariably I’ll go in on a Monday and they’ll say well you know Friday night this happened and you know I’ve been like this all weekend and you think why didn’t you pick up the phone?” Midwife A (line 543).

A similar situation was encountered during observations involving midwife G and Harriet. On the previous visit, three days earlier, Harriet had been advised by the midwife to contact the midwifery team if her symptoms of abdominal tenderness persisted or became worse. Harriet’s symptoms had persisted and the day before had become more severe, however she had not contacted the midwifery team. Instead, the previous night, she had searched the internet about her symptoms. Harriet was now very anxious as the website she had accessed suggested she might need a hysterectomy. The midwife was visiting on the date pre arranged three days earlier. She reassured Harriet that if she had an infection of her uterus, the most common action was a course of antibiotics. I asked Harriet if she had limited her search to recognised health sites such as NHS Direct, but Harriet responded she had not. She had undertaken a search using a general search engine and was not sure of the source of her information.

My observational data support the claims of some midwives that some women are reluctant to initiate contact with the midwifery team, despite having concerns. It also highlights that not all women are selective in the information sources they access.

Similar issues to these identified by the midwives in this study have been highlighted within the professional literature. Authors have suggested reporting of morbidity is problematic, as some women may not know what constitutes “normal” physiological parameters following childbirth or lack the confidence or motivation if they feel unwell, to articulate their concerns (Marchant *et al* 1999; Cattrell *et al* 2005; Herron-Marx, Williams & Hicks 2007; Gale 2008; Bhavnani & Newburn 2010; Beake *et al* 2010).

The midwives in the qualitative study by Porter et al (2007) considered some women had limited knowledge of childbirth and unrealistic expectations influenced by media portrayals, which they stated impacted upon the woman's ability to engage in decision making processes concerning care. Marchant (2009 p. 653) suggests midwives need to make individual assessments of a woman's communication skills and "self knowledge" to determine when a proactive approach to undertaking clinical observations is needed, which some of the midwives in this study appeared to do.

All of the midwives provided examples during both interview and observational data of how they attempted to provide information to postnatal women. The midwives discussed giving this information predominately verbally as they felt women were too busy to read all the written information they were provided with.

"I think we give so many leaflets out, you know. I mean, there's information in the pregnancy book about postnatal care and what to expect and what not to expect, but sometimes women don't always have time to read every leaflet that you give them. So I think it's a personal approach is more reassuring probably than a leaflet." Midwife M (line 672).

The impact of information giving is developed in chapter 7. The information provided by the midwives to the women included explaining the normal sequential physiological changes to maternal genital tract postnatally and what signs and symptoms would be a concern and need early reporting to the midwife.

"This is what it's expected to be – it's going to be red, it's going to be heavy for a couple of days. It should settle down," and I normally say that first thing in the morning, it's usually heavier and as you go through the day, it tails off a little bit. And then I normally mention, "When you go home, it might increase a little bit just with extra activity which you're not doing in hospital, and going up and down stairs and stuff like that, so don't get worried. Any clots are not normal. If you do have clots, we need to see them or if you're at home, keep them for the community midwife to have a look at." So that's it." Midwife L (line 225).

Only midwives B and G identified discussing postnatal physiological changes antenatally with women if they attend 'antenatal classes', both midwives had a shared remit regarding teenage pregnancies.

6.2.2.2 Information from others

When information about maternal postnatal well being was provided by other family members, such as the woman's mothers or her partner, some of the midwives also indicated they needed to verify the accuracy of the information the 'others' provided.

“So you've got to probe a bit more on your questioning.” Midwife C (line 274).

The midwife participants suggested the partner or mother of the postnatal woman sometimes provided information that conflicted with the maternal self-assessment. Sometimes the partner or mother provided the conflicting information in an unconcealed manner in front of the woman and midwife, which was also noted in 2 of the community based observational data collections. During interviews, the midwives provided examples of occasions when the partner or mother provided information, which contradicted with maternal self-assessment of well-being, but was provided in a covert manner. This usually involved the partner or mother using gestures such as head shaking when the woman made a comment, ensuring that the midwife could see the gesture, but that the woman could not.

“You'll have people that'll tell you everything's absolutely fine and their mam will go, shake of her head in the background.” Midwife B (line 709).

Midwife F considered this could make the interaction a little difficult, as the midwife would need to verify whose perception was the most accurate. As with maternal information these midwives suggested other family members may not understand the normal physiological changes to the genital tract postnatally or the sequential changes as a perineal wound heals. Midwife F provided a narrative in which a woman's partner had assessed the woman's perineum and reported its condition in negative terms.

“I’ve got my husband to check and he says there’s a big gaping hole there,’ and when you look . . . it’s well lined up and there’s no issues. But sometimes they have felt that looks worse than what it is.” Midwife F (line 530).

In this example a partner appears to have pathologised normal physiological response to perineal trauma and wound healing. Midwife C provided a contrasting example involving a woman, following the birth of her first baby who had heavily offensive lochia, indicative of infection. The woman lived with other female family members who had older children, but none of them identified or suggested to the woman that the smell of her lochia was not normal and perhaps she should contact the midwife.

These examples suggest the point of reference in relation to maternal postnatal genital tract condition, for a midwife, woman and also for her partner and family may be quite different. This may impact upon the accuracy of the information and necessitates the midwife verifying the accuracy of the information.

6.2.2.3 Verification of the accuracy of information from documentation

Several of the midwives suggested they verified the accuracy of the written information provided within the woman’s postnatal midwifery records by maternal questioning, such as asking the woman to recount their childbirth history. A number of midwives provided examples from their practice experiences in which documentation was not accurate. This included having the wrong information concerning a woman’s birth history and any resulting perineal trauma. If the information is inaccurate, there is the potential that appropriate assessment methods, advice and management will not be instigated.

“And then she went, ‘Oh, but when they came to me with those forceps,’ and it was mis documentation. She was a forceps with an episiotomy! So I just said to her, ‘I’m really sorry, can we start this visit again?’ and then we just had the questioning differently because she was actually an episiotomy and a forceps delivery.” Midwife D (line 484).

Other midwives provided examples of ambiguous comments within the woman's notes, which made it difficult for them to ascertain an accurate history of maternal genital tract condition and necessitate them undertaking additional assessments to verify the accuracy of the documentation.

“It's a mixture of looking at the past information, because it's very difficult if you've got someone who's written, 'bruising +++' My idea of what 'bruising +++' to a perineum is might be different to that person's, so I'll take what's written, I'll observe and see what I can see in terms of, say, bruising.” Midwife C (line 425).

When observing midwives undertaking maternal postnatal assessments in the postnatal ward, most used a mixture of information from the verbal staff handover and the observation charts and summary sheets left by the woman's bed. On the majority of observed interactions the information sources appeared to provide the midwives with accurate information and midwives were observed verifying the documented information they had. However on one occasion (midwife H and Lesley) the midwife had been informed by the previous staff Lesley was anxious and asking lots of questions. Following the postnatal assessment of Lesley the midwife went to read the woman's medical notes, which were kept in the ward office and then discovered Lesley had a history of depression.

This incident suggested that midwifery documentation did not always provide sufficient detail to form an accurate maternal midwifery history.

6.2.2.4 Verifying interpretations

Over half of the midwives discussed or demonstrated attempting to verify the accuracy of their interpretations of the information they accessed concerning the woman's genital tract condition. If the midwives were unsure if their conclusions were valid they were more likely to seek further information, utilising additional information from other potential sources within the range of assessment methods. The midwives suggested they attempted to identify if the information from the various range of assessment approaches, such as maternal verbal responses to questions or self-

assessment and behavioural cues, provided a consistent impression of maternal genital tract well being. Several of the midwives talked about “putting together the information” (Midwife H line 401) to give them “the whole picture” (Midwife I line 131). Midwife E (line 572) aptly describes this process as “assimilation.”

Several of the midwives provided examples of when they had verified their interpretations and noted inconsistency. Sometimes this suggested not all of the information may be accurate and the midwife may wish to undertake clinical observations to verify the accurate interpretation of genital tract condition. Examples of this tended to relate to the perineum and women suggesting their perineum was comfortable, but their behavioural cues suggesting they were uncomfortable.

“She came in and she was obviously really uncomfortable. She kind of sat perched on the end of the seat and couldn’t sit down properly. . . And she just said, ‘I’m all right, I’m all right, I’m fine, I’m all right . . . So I said, ‘Have you got some stitches?’ ‘Yeah.’ ‘Shall we have a look at them today?’” Midwife G (line 108).

A couple of the midwives suggested verifying interpretations had to be an ongoing process. Several reasons were offered for this, including to verify the occurrence or accuracy of previous assessments and to minimise the potential of the midwife ‘missing something’ by assuming that consistent symptoms indicated no deterioration or assuming a normal birth with no sutures would be indicative of no perineal trauma.

“That (a woman whose perineum was infected) could very easily have been missed you know . . . because the way she was talking by saying . . . oh well they’re a bit uncomfortable but you know they’ve been uncomfortable all the time so its no worse then it has been and making the assumption that the perineum has been checked previously if the women says well its not really very much different you could possibly think, oh well if its feeling alright you know if its not feeling too bad to you then we’ll just leave it.” Midwife A (line 119).

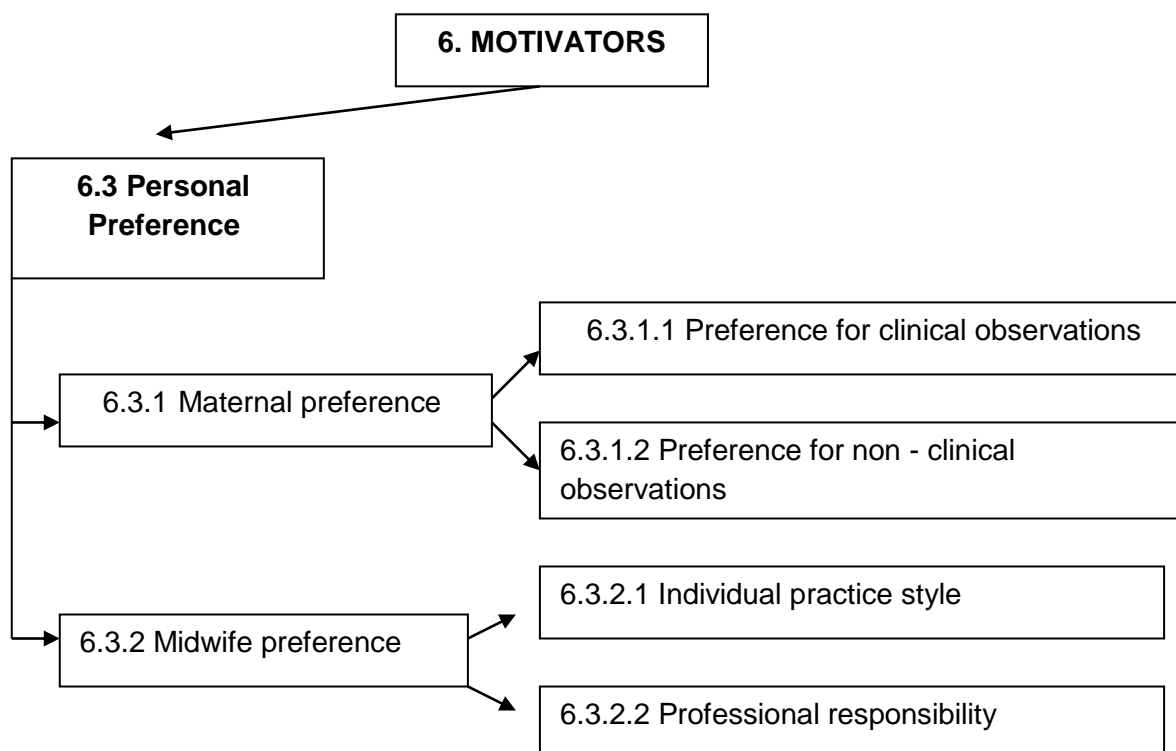
A small number of the midwives suggested they were motivated to verify their interpretations, as on occasions there may be an alternative rationale for a particular symptom. Midwife B suggests she uses maternal

questioning to differentiate between potential rationales, such as pallor and lethargy being indicative of a disturbed night with the baby or potentially as a sign of pain or genital tract infection. Midwife D identified a case of one woman who complained of perineal pain and on inspection the pain was due to a large haemorrhoid and therefore the advice and treatment suggested were different.

“It wasn’t actually her perineum, that was the problem. It was her haemorrhoids.” Midwife D (line 226).

The findings of this study suggest most of the midwife participants do attempt to integrate and use several assessment approaches simultaneously, to enhance and verify the accuracy of their interpretation of the woman’s genital tract health. This integration of cues reflects the use of pattern recognition as midwives access and integrate their procedural and practice knowledge and associated reasoning processes, when providing postnatal care. Similar findings were identified by Cioffi, Swain & Arundell (2010), in their qualitative study critiquing midwives decision-making processes in relation to suturing maternal perineal trauma.

6.3 Personal preference



A preference consists of “*a greater liking for one alternative over an other*” Oxford Dictionary (2011c). The midwives suggested both they and postnatal women had preferences regarding the method employed, which influenced their approach to genital tract assessment. The data in this category are clustered and presented around these two focused codes, maternal preference and midwife preference.

6.3.1 Maternal preference

All of the midwives in this study suggested maternal preference might motivate the midwife to use a particular method of maternal genital tract assessment. On the majority of occasions this involved the women preferring that the midwives used clinical observations particularly in relation to inspecting the perineum and vaginal blood loss. The midwives also suggested the women occasionally expressed a preference for self assessment, declining clinical observations and motivating the midwives to use other approaches to maternal genital tract assessment.

6.3.1.1 Preference for clinical observations

The majority of the midwives provided examples of women asking them to clinically observe their perineum. The midwives frequently suggested the rationale for this request, was maternal need for reassurance and confirmation regarding the condition of their perineum. Several of the midwives suggested this reassurance was needed as women were unsure if their self-assessment findings were accurate and within normal physiological parameters.

““Oh, it doesn’t feel right, will you have a look?” I’ll say, “Yeah, no problem, I’ll have a look at it and you can either say, “Really, there’s not much to see. It looks great, it’s nice and clean, you’re doing everything right,” and that gives them reassurance. If I’ll say look at it and think, “It’s really swollen, I can see where you’re coming from. We really need to get on top of your pain relief. You need to be using the bidet,” and I think obviously that’s going to be reassurance to them, if someone’s looked at them and they think, “Well, I’m not as daft as that,” you know. It does feel as bad as it looks!” Midwife L (line333).

Several of the midwives suggested they would always ask the women if she would prefer the midwife to clinically observe her perineum, irrespective of if the midwife felt she needed to view the perineum. As highlighted earlier in this chapter, some of the midwives suggested not all women had the confidence to articulate their concerns regarding their genital tract well being.

Asking women may enable these less confident women to express their preference.

““Do you want me to look?” it’s giving them the option because some people do, they think if they are a bit worried, you can tell by the body language and just say, ‘I can have a look to see if everything’s ok,’” Midwife J (line 248).

This was evident in one of the observations of midwifery practice involving midwife Z and woman 1, Rachael, a primiparous woman, day one following a normal birth with an intact perineum. Following maternal questioning regarding potential grazes, the midwife stated it (the condition of the

perineum / vulva) sounded Ok, but would Rachael like her to look. Rachael instantly replied “yes” and looked very relieved.

Just under half of the midwives also provided examples of women preferring to use clinical observations to assess their vaginal blood loss. These were particularly in relation to passing blood clots, something many women have not experienced prior to the postnatal period, and may find frightening.

“Clots are a big thing, isn’t it, because women are always frightened. ‘Oh, I passed a clot and it’s massive,’ and you know, it might only be the size of a five pence piece or whatever and obviously, that to us is not big.” Midwife I (line 212).

6.3.1.2 Preference for non-clinical observations

During interview data collection, eleven midwives identified that some women may prefer non-clinical observation approaches to genital tract assessment, such as questioning and maternal self-assessment. This was particularly in relation to assessing the condition of their perineum.

“No-one wants anyone to come along and look at their perineum . . . Often the younger women are a bit more uncomfortable, shall we say, with people looking but it’s all about how you approach them, isn’t it?” Midwife I (line 253).

During observations this was noted in both the hospital and community setting. One of the hospital based observations, involved Midwife H and Debby. It was Debby’s second child and she was day one following a normal birth with a perineal tear that was sutured. Midwife H asked Debby “do you want me to have a look at your stitches?” To which Debby replied, “No, they are feeling comfortable and I’d sharp tell you if they didn’t “ and then Debby laughed. The midwife did not perceive a particular need to request to undertake clinical observations and the woman observed appeared confident and comfortable with making her own assessment of her perineal condition.

Four community midwives highlighted that some women may decline clinical observations if the midwife is not their identified midwife. The midwives suggested these women prefer to wait and be clinically examined by “their” midwife.

“Usually if they do refuse, it’s because I don’t know them, because they’re not my women and they just say, ‘No, it’s all right, I’ll wait till my midwife comes along.’” Midwife E (line 317).

Several of the midwives suggested some women might feel they have experienced enough clinical observations during their antenatal, labour and birth experience, particularly observations involving their genital tract. Some of the midwives implied women might wish to avoid further discomfort associated with clinical observations.

“Sometimes they do think, “I’ve just had enough of being prodded and poked. I’m fine, I’m comfortable.” Midwife M (line 306).

The midwives suggested some women might be reluctant to have clinical observations of their perineum due to embarrassment caused by another person viewing their genitalia. This was felt to be more common with younger women. Midwife A also suggested there might be more profound feelings of embarrassment for women who have had experiences of severe genital tract trauma or sexual abuse. This data also relates to section 6.4.3, care with dignity.

Most of the midwives in this study acknowledge and appeared to attempt to integrate maternal preferences regarding the approach to genital tract assessment into their decision-making. Nicky Leap (Leap 2010 p.18) discusses the concept of “the less we do the more we give,” as including trusting the woman’s perceptions and ensuring control and power rests with the woman. Some of the data in this study suggested some midwives attempted to integrate maternal preference including trusting and facilitating self-assessment of genital tract health. This indicated the midwives using interactive reasoning, involving individual information about the woman, gleaned through face-to-face interaction (Mattingly and Fleming 1994; Cioffi, Arundell & Swain 2009).

However, the midwives in this study also suggested some women may find professional assessments of their genital tract condition reassuring, a finding also of the NCT survey (Bhavnani & Newburn 2010 p.27). This created conflicting tensions for the midwives in this study to negotiate; ensuring care is woman led and encouraging women to be autonomous but recognising and being sensitive to those women who are unable to identify or articulate their genital tract health or needs; or those who prefer more direction from the midwife.

6.3.2 Midwife preference

All of the midwives made comments, which suggested they had preferences that would motivate them to tend to use a particular approach to maternal genital tract assessment.

“Some midwives don’t palpate the fundus, where ...I feel like that’s important that I need to do, or some midwives think it’s the need to check the perineum every single day.” Midwife J (line 763).

The data consisted of factors associated with midwives having a preference for their own individual practice style. In addition the midwives also expressed comments encapsulating their beliefs regarding their professional responsibility towards women postnatally, as motivating a preference to particular assessment methods.

6.3.2.1 Individual practice style

Many of the midwives identified and demonstrated during my observations a preference for an individual practice style, which had evolved during their midwifery career. The midwives individual practice style sometimes involved a particular pattern of working, which they routinely used when undertaking maternal postnatal assessments.

“I mean, a typical postnatal visit to assess a woman’s genital tract I would still start at the very top about her general well-being ... well I would personally go on to check from the top down . . . I usually would palpate their fundus if it’s the first day visit . . . That would be my preference. Midwife M (from line 113).

As part of this pattern of assessment, some of the midwives acknowledged they or other midwifery colleagues had a preference for routinely using a particular approach to assessment of maternal genital tract well being. This may be to use clinical observations, such as to palpate the uterus and inspect a perineum with trauma, as discussed earlier in this chapter.

This framework to postnatal maternal assessments echoes how traditional postnatal midwifery assessments were articulated within textbooks and postnatal midwifery records (Marchant 2009). Midwives within my study are accessing procedural knowledge, learnt during their initial midwifery education informed by midwifery textbooks.

Two of the midwives, midwife B and midwife J, when asked why they undertook routine baseline clinical observation, involving palpating the woman's uterus, stated in part they found undertaking the clinical observation reassuring. Midwife B has been a midwife for six years and midwife J has been a midwife for eighteen months. When I asked midwife J what she meant by reassuring, she stated it reassured her and when I asked whether she considered the need for such reassurance was related to being relatively newly qualified as a midwife, she agreed.

“When you first qualify . . . you're frightened that you're going to miss anything . . . I had to mention every single thing that was written down . . . More because of your lack of confidence because you've just qualified, you feel as though you have to physically do it to know that you've assessed that right.” Midwife F (line 656).

Some midwives suggested their preference to assessment approach could be influenced by “instinct”. These midwives articulated this as a “feeling” which would direct them to specific questions or using clinical observations. Midwife C, suggests she occasionally cannot explain or even understand why she wants on a particular occasion to undertake clinical observations with a particular woman, but it's an instinct she feels she must follow. Midwife C was one of the midwives who was interviewed and also had her practice observed. Midwife C made the comment regarding instinct within

the interview data. During observational data involving her undertaking postnatal assessment with three different women midwife C appeared to vary the assessment approaches she used, with the different women, from questioning the woman to clinical observations.

6.3.2.2 Professional responsibility

Half of the midwives made comments reflecting their beliefs regarding their professional responsibilities towards women. These professional responsibilities suggested a preference for a particular approach to maternal genital tract assessment. As suggested by midwife G (line 824), this professional responsibility involved trying to “do ones best”. The midwives perceived they had a responsibility towards women regarding facilitating optimum genital tract health, through accurate assessment.

“I just wouldn’t want the responsibility of not doing my job correctly because I wouldn’t want to think I’d caused the woman any undue trauma or I’d missed something with her.” Midwife I (line 571).

Interestingly the midwives in this study talked more about the professional responsibility of omission, what they did not do, rather than responsibility about what they did do and say. If a woman refused clinical observation of her genital tract the majority of the midwives identified the need to document the interaction and outcome. However when discussing care actions such as using clinical observations and or providing advice the midwives did not always make an association to relate this action with documentation. Six of the midwives related the association between professional responsibility and the need to document care omission as being driven by a fear of potential litigation.

“Litigation! Accountability, you know, because at the end of the day if someone says no, there’s nothing I can do about that. That’s their right to say no and that’s absolutely fine with me but I don’t want it coming back ten years down the line if they’ve had to have perineal refashioning . . . That’s the only reason I’d document it.” Midwife K (line 384).

This suggests for many midwives fear of litigation also motivated their preference regarding approach to assessment of maternal genital tract.

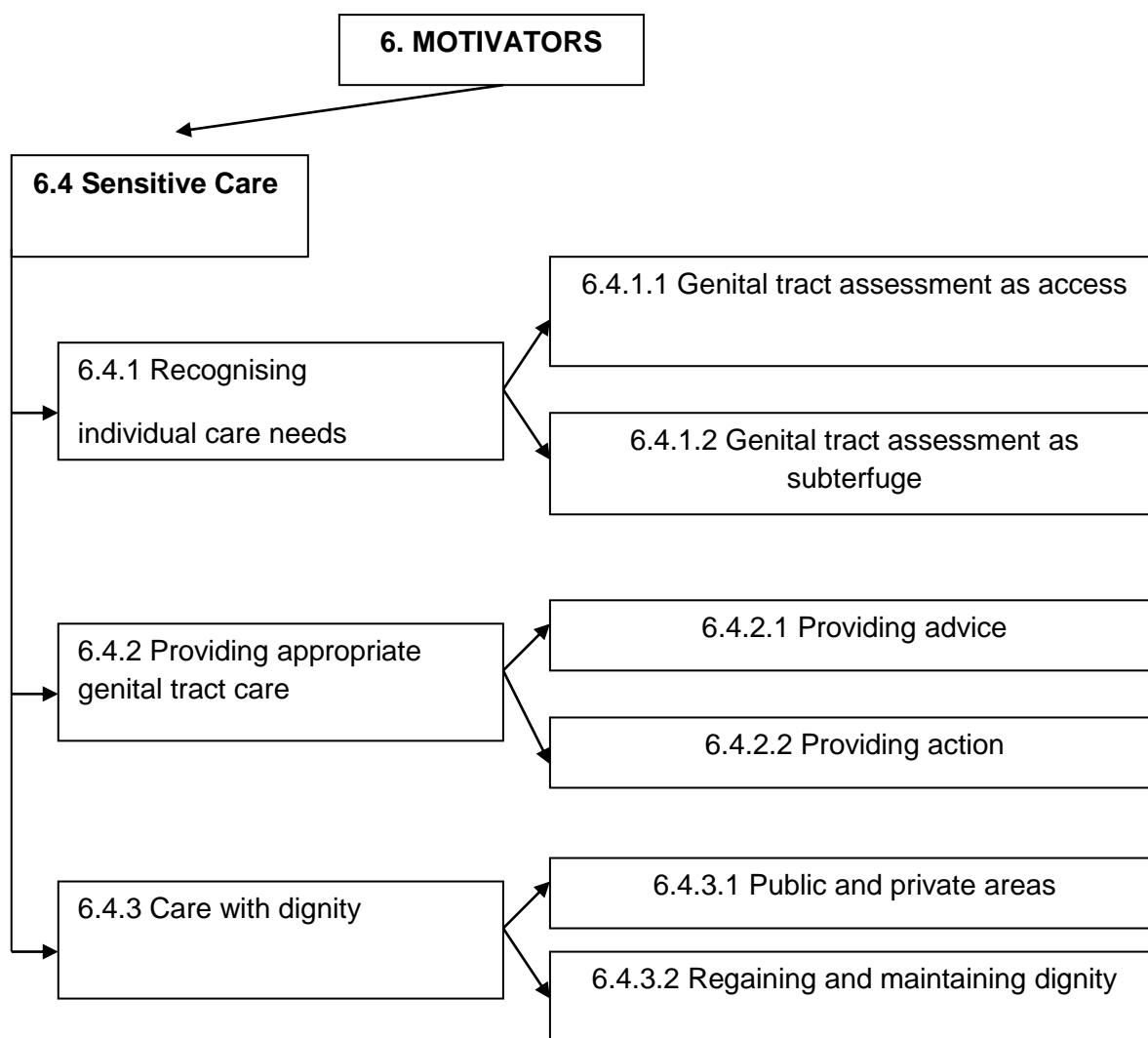
This fear of litigation may reflect the prevailing emphasis upon risk management within practice policies and service drivers. Alternatively or in addition it may be influenced by an increasing culture of litigation within society and therefore service users. Several midwives explicitly acknowledged these contextual considerations influenced their preference to assessment approach and how they recorded their postnatal practice.

“I think in the climate that we’re in, you’d be silly not to do that (*document actions and omissions*).” Midwife F (line 714).

As suggested by Georges & McGuire (2004) deviation from set patterns of working are labelled as variances. Connotations of good quality are aligned to absence of variance and reduction of perceived risk, therefore stigmatising such deviances from the prescribed pattern of practice (Mackenzie Bryers & Van Teijlingen 2010). Research by Kirkham (1999) investigating the culture of midwifery demonstrates how many midwives feel under surveillance and pressured to conform, feelings that Walsh & Steen (2007) suggest are reinforced through a plethora of national and local edicts and dictates. The research by Porter *et al* (2007) exploring midwives decision making strategies also identified that midwives decision making was driven by a fear of litigation and involved adhering rigidly to written policies and procedures. These tensions between standardised responses and the desire to provide individualised care may accentuate the midwives perceived vulnerability to litigation, providing another tensions for the midwives in this study to negotiate when providing postnatal care.

The findings of this study suggest maternal and midwife preferences may motivate the midwife to use a particular approach to maternal genital tract assessment. This reflected the midwife’s individual practice style and her beliefs concerning her professional responsibility to women during the postnatal period. In this study the midwives articulated and demonstrated how their approach to maternal genital tract assessment was also motivated by a desire to integrate and respect maternal preferences regarding assessment method.

6.4 Sensitive care



The final category in the theme of motivators is titled sensitive care. The Oxford Dictionary (2011d) defines sensitive as being “quick to detect or respond to slight changes, signals, or influences”. The midwives in this study suggested their approach to maternal genital tract assessment was motivated by them recognising and responding to subtle changes and signals reflecting the woman’s individual postnatal needs. Sensitive care, therefore encapsulates aspects of midwifery practice in which the midwives discussed or demonstrated recognising and responding to these subtle changes and signals. The data within the category of sensitive care have

been grouped into three focused codes, recognising individual needs, providing appropriate genital tract care and care with dignity.

6.4.1 Recognising individual needs

During interview data collection most midwives suggested their practice was motivated by the need to recognise and meet individual maternal needs when determining the focus and approach to postnatal assessments. Several of the midwives acknowledged the change in midwifery practice over the last decade or so from routine use of clinical observations of all women postnatally to selective use, had enabled a more sensitive approach to identifying individual needs by reducing time spent on routines not necessarily applicable to the individual woman.

“We’ve gone from task delivery of care to perhaps now individualised care . . . which I think is better for the woman and it means you can spend more time talking about or discussing the areas that are more of an issue to her.” Midwife M (line 562).

This more sensitive approach to meeting individual needs reflects a more holistic approach by the midwife to maternal postnatal assessment in which not only physical but emotional and social needs are also integrated, reflecting contemporary professional guidance (Marchant; NICE 2006; NMC 2010). Midwife L suggests there are many new experiences and challenges for postnatal women which means they will have a diverse range of individual needs. These needs will include their own physical needs, caring for a new baby and negotiating a new environment within a postnatal ward.

“I think they’re just really unsure. I like to go and make sure that they’ve eaten, they’ve been out of bed, they’ve had a wee, all that kind of stuff because I think some of the young girls, they’re just absolutely terrified of the baby, never mind being in hospital.” Midwife L (line 407).

Some midwives highlighted that other maternal needs may take precedence over genital tract assessments because that need was greater or more immediate. To access individual maternal needs most of the midwives suggested they used open questions to enable the woman to take the lead in identifying her needs as illustrated in the quote from midwife F.

“I suppose by saying, ‘How are you?’ or ‘How did it go?’ you then get what’s the most important thing to them.” Midwife F (line 580).

Several of the midwives, asked the woman if they had any questions, usually towards the end of the postnatal assessment. This appeared to also be an attempt to access individual needs and therefore provide sensitive care. However when opportunity for maternal questions was placed at the end of the interaction it sometimes appeared to me that the term ‘any questions’ was a little too vague and general and did not give the women a focus of what she may wish to ask questions about. Two midwives did acknowledge not all needs were given equal weighting when assessing individual needs. Midwife K provided a narrative involving a woman in the postnatal ward whose baby was in the special care baby unit receiving treatment. The midwife suggested as the woman did not have a medical need pertaining to her own health her stay in the maternity unit needed to come to an end.

“I’d said to her, “Have you thought about going home?” and I know that the midwife the previous day had already kind of put this in, and she said, “Oh right, well I haven’t really,” and I thought well, you did have this conversation yesterday but I never said that. I just said, “Well, you could be going home but I’m not pushing you out. Later on today will do great . . . but there was no medical need for her to be here any more and, like I say, we didn’t know how long baby would be in SCBU.” Midwife K (line 466).

The articulation of the narrative by midwife K does appear to suggest the woman’s emotional need to be close to her baby was not perceived as being as significant as a medical need. Another hospital midwife (I) suggested some multiparous women asked to stay in the postnatal ward longer so they could get some rest before returning home to household chores and the childcare of several other children. However this she considers is no longer possible.

“But we don’t keep people in hospital for rests any more, you know, those days are gone.” Midwife I (line 500).

The reality of contemporary health care does mean that decisions need to be made about the use of resources, including beds on the maternity unit. This may create contradictions and tensions within midwifery care and

impact upon the midwives ability to respond sensitively to other maternal individual needs. This theme will be developed in chapter 7.

The midwives identified two key aspects of meeting individual needs. The first involved women and midwives using genital tract assessment as a means to access other individual maternal needs to enable sensitive care to be provided by the midwife. This included genital tract assessment used to access sexual health advice and support and legitimise individual needs for emotional support from the midwife. The second aspect involved women and midwives using genital tract assessment as subterfuge.

6.4.1.1 Genital tract assessment as access

Some of the midwives suggested they and postnatal women used genital tract assessment as a means to access other individual maternal needs. Several midwives provided examples of women utilising genital tract assessment as a means of accessing advice and support regarding their sexual health. This included how the genitalia felt, looked and if and when sex could be resumed.

“Women do say will you have a look, especially with intact perineums because I think a lot of, especially primips, worry about getting back to normal. Is it all going to be normal how it was?” Midwife N (line 556).

The majority of these midwives made comments in which they identified and appeared to recognise that women are concerned about the condition of their genital tract postnatally. The midwives recognised the women’s perceptions of her genital tract condition was different to the midwives due to differing reference points and range of experiences.

“It’s about what’s important to that individual person and knowing that they have not seen all of the things that you’ve seen in the past so to them, that’s really bad because that’s never looked like that before.” Midwife F (line 340).

Several of the midwives acknowledged that postnatal women were concerned about how their genital tract now looked following childbirth. This related to the abdomen, when palpating the uterus and the appearance of

stretch marks (midwife F), but more frequently the genitalia as a result of bruising, swelling, tears, episiotomies and sutures.

“Some women don’t appreciate how dilated and swollen the areas going to be in the days immediately following birth and they are a little bit of . . . will it ever look the same again.” Midwife A (line 217).

Midwife M suggested the rise in the field of cosmetic surgery and its increased prevalence in the media may increasingly heighten women’s awareness of the appearance of their genital tract.

“There’s a lot of issues around cosmetic surgery . . . it may be something in the future perhaps that women will be very concerned about.” Midwife M (line 687).

Perceptions of genital tract health and sexuality are occurring in a social context in which cosmetic surgery is becoming increasingly popular; it is presented in prime time television shows reinforcing stereotypes of female body image (Derenne & Beresin 2006). As highlighted by Fitzpatrick (2008) recent trends include women having the genitalia “re fashioned” and “bleached” to comply with notions of how genitalia should appear with web sites advocating associated products (<http://vaginalbleaching.org/>).

The midwives suggested sometimes women asked them directly how their perineum looked or when they inspected the woman’s perineum they would provide reassurance regarding its appearance. A few of the midwives comments suggested they used flattery when describing the genital tract in what appeared to be an attempt to bolster women’s perception of their genital tract condition and provide sensitive care.

“Lovely, sixteen she was and she’d said, “What does it look like?” and I said, “Oh, beautiful, good as new.” Midwife K (line 868).

“I tend to you know like give compliments as well and say, you know like, “You can’t half feel your stomach muscles. You’re gonna be back in your size ten jeans in no time.”” Midwife B (line 568).

Midwife C (line 729) described drawing pictures of the genitalia for women to provide them with information regarding the location and appearance of

tears, sutures and bruising. Other midwives suggested they would reassure women that the immediate postnatal visual changes to their genitalia would “settle down.”

“But to them, that looks terrible and it’s hard because I’m saying, ‘That’ll all settle down and that won’t look as bad and it will return to normal.’”
Midwife F (line 336).

However Midwife M does acknowledge that genitalia changes may persist postnatally as a result of the impact of childbirth.

“Sometimes their genital tract isn’t always the same as pre pregnancy and that’s sometimes quite hard, I suppose, for them to come to terms with.”
Midwife M (line 691).

Some of the midwives also mentioned reassuring women that their perineum’s would feel better over a period of time as the genital tract involuted and trauma associated with childbirth healed. During observational data collection, the midwives tended to ask women how their perineums felt as an indicator of physical needs relating to perineal comfort and healing. I never observed a midwife provide a woman with the opportunity to discuss how she felt about the appearance or sensation of her genitalia.

A small number of midwives made general comments regarding reassuring women that in time their genital tract would be sufficiently healed and she would be able to resume sexual intercourse. These tended to involve general comments relating to informing the woman her genital tract should return to “normal.” Midwife B (line 1062) provided a narrative of advising a woman whose perineum had broken down and was healing via secondary intention.

“I did talk about wounds that I’d seen granulating before . . . and unless you’re gonna be a page three Playboy model, I don’t think it’s really gonna be that much of an issue. Um, and you know like having sex and things like that it’ll be absolutely fine.” Midwife B (line 1050).

Only 1 midwife highlighted she informed women if intercourse was painful they were to seek medical help.

“When I finish, I always say now, ‘Just because I’m not coming, if you have any problems at all, (with the perineum) you must go and see your GP.’”
Midwife D (line 903).

Five of the community midwives described practice experiences in which the woman or midwife used genital tract assessment to discuss concerns regarding resumption of sexual intercourse following childbirth. This sometimes involved the woman asking the midwife to clinically observe her perineum and then confiding and seeking reassurance as she’d had sexual intercourse within the first few postnatal days. Midwife D (line 542) stated, “we know about the risks of having intercourse” however the midwives did not articulate what they felt these risks to be. It was also not clear if the women these midwives discussed did understand the risk of early resumption of sexual intercourse. Only one of the midwives, in this study, midwife N, identified that women were specifically asked about and were given advice about resuming sex postnatally. She suggested over the last 10 years women appeared to want more information regarding resuming sexual function, potentially reflecting a change in women’s expectations of sexual health following childbirth.

“Women’s expectations have changed a lot over the last ten years and just because they’ve had a baby, they still want to be ... they’re still a woman and they still want to look like a woman and think everything is as it should be in terms of their sex life and things like that. You get more questions now about women’s sex lives and things I think than you did, like ‘When is it all right to have sex again?’” Midwife N (line 578).

Genital tract assessment may also provide both midwife and mother with the opportunity to raise sexual health issues, which may be otherwise seen as difficult to discuss, and thereby contributing to achieving national sexual and public health targets (Olsson et al 2005; Healthcare Commission 2007; DOH 2010). As I began to become aware of a sexual health aspect during initial data analysis, I specifically asked several of the midwives about women’s concerns regarding the appearance and sensation of their genitalia postnatally. However when trying to elicit information about advice I would prompt with a general comment. I was attempting not to force the data, however equally I may have phrased the prompt too vaguely to encourage the midwives to share their experiences. Some midwives do connect the

woman's genital tract with the woman's future sexual functioning, so it still remains a little surprising that only one midwife, midwife N, explicitly discussed providing information and advice specific to sexual function.

Midwife G suggested not all women wish or feel able to resume sexual activity quickly following childbirth and therefore some women may use genital tract assessment as access to the midwife acting as an advocate for the woman's sexual health. Midwife G suggested on several occasions women have asked her to tell partners the woman must refrain from sex until her genital tract has involuted and healing of any trauma is complete. This can occur when the woman and midwife have gone to a different room for genital tract clinical observations and the partner is not present. On other occasions the midwife suggests women make a direct request of the midwife in front of her partner.

“Sometimes, they'll do it quite openly. Sometimes they'll say, ‘Will you tell him? Will you tell him I can't, that he's got to leave off because I can't do this because I've got stitches?’” Midwife G (line 606).

One midwife provided a practice narrative in which a woman used genital tract assessment to access the midwife's support for her emotional needs. Midwife F discussed a woman she had cared for postnatally following a forceps birth with an episiotomy. The woman's perineum healed without problem. However the woman asked the midwife repeatedly to inspect her perineum, stating it was sore and necessitating the midwife to undertake frequent postnatal visits. Midwife F inspected the woman's perineum as requested and each time she visited the woman used the opportunity to ask further questions about and discuss her birthing experience. Midwife F felt that the woman used her perineal wound as a means to access midwifery support to meet her emotional needs following childbirth and her need to debrief.

“At each visit, we discussed the birth again and again. A lot of it was reassurance and it seemed like each visit, there was another question, ‘Why did they do this? Why did they do that?’ because I think it happened in a bit of a rush. And she was planned for a home birth so therefore, I don't really think she'd considered that any of these things might happen . . . so when

things didn't go to that plan, it was a bit traumatic for her.” Midwife F (line 201).

Although some midwives have become more comfortable with the concept that postnatal care encompasses not just physical but also emotional needs, this postnatal woman was not aware of or comfortable with expressing non physical needs to the midwife postnatally. There may possibly remain some stigma around mental health, which makes some postnatal women uncomfortable with using direct forms of disclosure regarding their emotional well-being. Midwife F described this woman as “strong” and “independent” (Line 201), perhaps associating particular characteristics of the woman to her unease at explicitly accessing emotional support. Midwife F appeared to use genital tract assessment as a means to meet this woman's individual needs and provide sensitive care.

6.4.1.2 Genital tract assessment as subterfuge

During interviews two midwives provided narratives of using genital tract assessment as a subterfuge strategy. Subterfuge is defined as being “a stratagem employed to conceal something” (Collins English Dictionary 2009d). The midwives identified that genital tract clinical observations were used as a means to conceal other concerns from a woman's partner. The midwife may wish to have access to the woman without her partner where there was a suspicion that the woman may be a victim of domestic violence. Midwife A suggested this concern may be stimulated if the partner did not leave the woman and appeared overly protective. Midwife A suggested she would use the potential of needing to undertake clinical observations as a means to be able to be able to talk to the woman without her partner. Midwife G provided one such narrative.

“I just felt she'd been very controlled so I used that (clinical examination) to get her away from him and into the bedroom so we could have a chat about, you know, had he been domineering, had he pressured her? She wouldn't tell me anything about it but I very much felt she was in a difficult situation. You know, she had the baby out and he obviously wanted sex again. But that must've been awful for her, and then she was concerned she could be pregnant.” Midwife G (line 570).

When analysing the data I was surprised that only two midwives raised domestic violence as a potential factor that motivated their approach and ability to provide sensitive care in relation to maternal genital tract assessment. I asked another 4 community based midwives about the impact of domestic violence. With two of the midwives in a naive attempt not to overtly influence the responses, I phrased the questions so vaguely, I did not make the question clear and therefore the midwives responded with issues related to visitors and privacy, which will be discussed in the following chapter. I specifically asked two other community midwives I interviewed later in the data collection about the impact of domestic violence. The midwives recognised the potential of domestic violence affecting childbearing women, however neither of the midwives related it to the genital tract assessments as a means to access the women without the partner. One of the midwives considered domestic violence was unlikely with her client group. This midwife has a specific caseload involving all non English-speaking women in the locality.

“But fortunately, in all my caseload, I don’t have anybody” (who is a victim of domestic violence) Midwife D (line 526).

However, recent statistics confirm 1 in 4 women will be affected by domestic violence during their life times, with thirty per cent of cases of domestic violence starting during pregnancy (Taskforce on the health aspects of violence against women and children 2010). A questionnaire based study exploring the experiences of 488 midwives in relation to domestic violence within their practice identified the majority of the midwives underestimated the prevalence of domestic violence. In addition only 27% of community and 15% of hospital base midwives felt confident to discuss domestic violence with their clients, with barriers to discussing domestic violence including the reluctance of the partner to leave the consultation (Lazenbatt, Taylor & Cree 2009).

6.4.2 Providing appropriate genital tract care

The second focused code identified from the research data within the category of sensitive care is providing appropriate genital tract care. The majority of the midwives in this study suggested their method of maternal genital tract assessment is also motivated by their intention to provide women with appropriate genital tract care. The midwives identified several factors in relation to what could be appropriate genital tract care and how methods of genital tract assessment may help them to identify the most appropriate care. These were clustered around 2 forms of midwifery care, providing advice and providing action.

6.4.2.1 Providing advice

The midwives acknowledged that some information and advice was provided routinely to all postnatal women. This included normal sequential changes to maternal genital tract postnatally and what signs and symptoms would be a concern and need prompt reporting to the midwife. The midwives discussed and demonstrated providing women with advice of self care strategies to facilitate healing of any genital tract trauma and minimise the risk of genital tract sepsis. Advice frequently articulated by the midwives included;-

- Perineal hygiene - regular cleansing - shower or jug douche and pat dry to minimise potential infection - All midwives (15)
- Hygiene - changing sanitary towels regularly and frequently - All midwives (15)
- Analgesia - 13 midwives
- Nutrition - avoiding constipation, nutrition to aid wound healing - 11 midwives
- Hydration - drinking adequate amounts of fluid - 9 midwives
- Pelvic floor exercise - 6 midwives
- Rest - 4 midwives

- Homeopathic remedies (arnica) - 2 midwives
- Ice / cold therapy - 2 midwives
- Use clean sanitary towel to support perineum when moving their bowels - 2 midwives
- Avoiding tight clothing which may cause perineal friction - 1 midwife

Several of the midwives recognised and provided examples of how they attempted to make this advice more sensitive to the individual woman's circumstances.

“You have to tailor your advice and how you give that advice to whoever you are giving that advice to.” Midwife A (line 452).

This included ways of eating nutritious food, which is quick and easy to prepare, and inexpensive and accepting offer to have meals provided by others. Midwife B suggested to provide appropriate genital tract care, the advice offered must be tailored to the home conditions and financial circumstances of the woman. Midwife B suggests some women have standards of home and personal hygiene which are limited and necessitate the midwife providing advice which recognises these family norms but ensures principles of postnatal genital tract hygiene are met, for example by preventing cross-infection. In addition the ability to have access to resources, including hot water can dictate the need to provide alternative ways of keeping the perineum clean, such as an inexpensive jug purchased specifically for personal use to cleanse the perineum regularly.

“It's their standards . . . don't keep things as clean and pristine as mine, yet that's their normality. And who am I to say that that's right or wrong . . . It might be a good idea if you had your own towel and don't let anybody else use that towel, because he could have been fixing the motorbike or washing the dog, then he washes his hands on that towel . . . Go to the pound shop. Get a plastic jug and every time you got to the toilet, put a little bit of warm water in it and just have a douche.” Midwife B (line 737).

A small number of the midwives (particularly Midwife B and G) make implicit reference to women's limited financial resources impacting upon the women's ability to respond to appropriate genital tract advice. All of the

midwives in this study emphasise the need to advise women to change their sanitary pads frequently and several identified occasionally needing to prompt women to change their sanitary towels more frequently. Although the connection between sanitary pads and financial circumstances was not explicitly made by the midwives in this study, the potential of limited finances could also have an impact upon the woman's ability to respond to midwifery advice to change sanitary pads frequently.

6.4.2.2 Providing action

The majority of the midwives suggested they would be motivated to undertake clinical observations if they felt a need to give specific advice or instigate action in relation to providing appropriate genital tract care. These comments were usually associated with the woman's perineum and the midwives stated they would prefer to inspect the woman's perineum to ensure the advice and action was specific to the condition of the perineum and therefore providing appropriate care. For example, midwife C identified she may suggest the woman uses ice / cooling treatment if the perineum is observed to be oedematous and bruised.

“If there is a comment that they've been bruised, I'll have a look at them and sort of run through information about that as well, about bits of advice that they can use to try and get their swelling down. And sort of link in to the advice that the physiotherapists at this hospital give them in terms of perineum, so the physiotherapist will often suggest an ice pack.” Midwife C (line 411).

The midwives indicated if women wanted midwifery advice or action in relation to their genital tract care, they were usually amenable to the midwife clinically observing their perineums. Approximately half of the midwives stated they would also use clinical observations to evaluate the effectiveness of advice and action they had provided to the women in relation to her genital tract.

“I had a look (at the woman's perineum), it was still obviously infected but improving, it was more pink than it was. So I reported back to her, she was on the right antibiotics. It looked better.” Midwife N (line 428).

Several of the midwives identified and demonstrated when observed particular actions they may undertake to provide appropriate genital tract care, sensitive to the woman's individual needs, which included;-

- Refer to obstetric physiotherapist for advice / megapulse, a pulsed, short-wave electromagnetic energy device which generates heat within the tissues (EMS Physio 2009) (5 midwives)
- Swabs of perineal wounds or lochia if infection suspected (6 midwives)
- Refer to medical staff, either the hospital obstetric team or community general practitioner, if they identified a genital tract problem (9 midwives)
- Refer to medical staff for prescribing antibiotics for genital tract sepsis (9 midwives)

On two occasions I observed advice being given, which was not appropriate genital tract care or sensitive to individual needs. In both instances this was because the advice given was insufficient. The midwives provided premature advice, in which they did not specify when a symptom which may occur commonly in the immediate time following childbirth, would be considered as indicative of needing medical referral if it persisted. Observing midwife Z with Rachael who was day one following a normal birth, Rachael confided to midwife Z that she felt embarrassed as she couldn't stop her self from passing wind. Midwife Z responded by reassuring Rachael that this was common. During the observation of midwife H with woman 2, Lesley, who was day 2 following a normal birth, Lesley complained to the midwife that she felt a dragging sensation in her vagina as if she still wanted to push down as she had during childbirth. Midwife H explained to Lesley that the pelvic floor would have stretched during childbirth and that pelvic floor exercises were important to regain the tone of the muscles. The midwife indicated a leaflet, amongst the collection she was leaving with the woman, however she did not explain what the

exercises were, how to do them effectively or what to do if the sensation persisted.

Both of these observations were in the postnatal ward, so it is feasible that the midwives may have returned to these women later and given more detail regarding these issues which was after the 20 minute or so observation I had undertaken. However neither of the midwives indicated that they intended to do so.

6.4.3 Care with dignity

The final focused code within the category of sensitive care is care with dignity. All the midwives in this study made comments or demonstrated actions, which have contributed to the development of this focused code. Dignity is defined as being “the state or quality of being worthy of honour or respect” Oxford Dictionary (2011e). Dignity as expressed by the midwives in this study, reflects practice actions which are motivated to provide care which is sensitive to the woman’s dignity needs and respecting her feelings and wishes when negotiating assessment approaches of maternal postnatal genital tract well being. Several of the midwives suggested some women might be reluctant to have clinical observations of their perineum due to embarrassment at another person viewing their genitalia. The midwives suggested they anticipated and responded to these maternal concerns by providing care, which was sensitive to the woman’s dignity.

All of the midwives in this study expressed concern regarding women “losing dignity” during childbirth. Most of the midwives suggested events during labour such as repeated vaginal examinations, exposing the genitalia during the birth process and potentially the witnessing and involvement of several health care professionals, contributed significantly to this maternal loss of dignity.

“All the doctors being there and having loads of VEs and I just think when you get them postnatal that that’s enough, you know . . . I think the last thing you want to be doing is lying legs akimbo and somebody doing that

again . . . I think it's awful, especially postnatally when you're trying to get a little bit of dignity back." Midwife L (line 370).

This quote from midwife L reflects comments made by several midwives and suggests losing dignity occurs prior to the postnatal period. However the repercussions of this lost dignity, may surface and impact upon postnatal care, particularly the approach to maternal genital tract assessment. Midwife E suggests these intrapartum events leave women feeling embarrassed because they feel "exposed". According to several of the midwives this physical exposure appears to erode the woman's dignity. Several of the midwives consider following giving birth women no longer wish to be exposed. Therefore using clinical observations postnatally becomes a sensitive issue.

"Obviously people are embarrassed because yes, they've had a baby and all their bottom half exposed, but once you've had that baby, you want to cover everything up. It's just an automatic reaction. You never want to expose that part of your body again!" Midwife E (line 129).

The comments by the midwives suggested care with dignity involved two particular considerations. The first is public and private areas of the body, having differing associations with dignity needs and motivating differing responses from the midwives in relation to ensuring the care they provide to women meets their dignity needs. The midwives also discussed how they attempted to provide sensitive care to women by practicing in a manner that they felt helped women to regain and maintain their dignity. This included how they approached the woman when seeking to undertake maternal postnatal clinical observations of the genital tract and how they conducted the observation.

6.4.3.1 Public and private areas

The sense of exposure the midwives in this study described appeared to be dependent upon which area of the woman's body is involved. Several of the midwives suggested women remained fairly comfortable postnatally with having their abdomens exposed during clinical observations. The midwives suggest women become accustomed to their abdomens being observed

and touched antenatally. This occurs during antenatal abdominal examinations by health care professionals, particularly midwives and by family and friends. The abdomen becomes a public area.

“I’ve done all the palpations, not a problem. They’ve had that right through the pregnancy so to have a feel of their tummy afterwards isn’t a problem for them. It’s the looking at their down below bits that’s awful, even though they’ve been through delivery . . . but that’s that bit, that’s not their private bit, that’s their bump. And their bumps are quite often out anyway, you know, they wear the belly tops and you often see their abdomen anyway when they’re clothed!” Midwife G (line 307).

Several of the midwives suggested the woman’s genitalia were a private area, which had implications for accessing the area for clinical observations.

“Definitely something that is so, so private. And I think I mentioned it when I said that I wouldn’t want just to look at the perineum routinely.” Midwife H (line 474).

These differing perceptions by the midwives of public and private areas of the maternal body may relate to the difference in assessment approaches routinely employed by the midwives. If a woman had a wound on her perineum or genitalia it was clinically observed only if the midwife considered there was a particular need to undertake the clinical observation, as discussed in the preceding chapter. However all of the midwives in this study articulated they routinely used clinical observations of a wound on a woman’s abdomen, following caesarean section birth. This was reflected in the observational data in which every observation of a midwife providing postnatal assessment, involving a woman who had a caesarean section involved the midwife inspecting the woman’s abdominal wound.

Midwife C visiting Kate (day five following a caesarean section) inspected the abdominal wound, with the woman’s permission. There were no factors in the woman’s history to indicate a concern, other than the history of abdominal surgery resulting in an abdominal wound. Similar responses with a perineal wound tended not to lead to a clinical observation implying the location of a wound is perceived as having a different degree of access.

A couple of the midwives considered women expected abdominal wounds to be examined, and that this too motivated their practice.

“I do tend to assess section wounds more often than I would the perineum. If I see a perineum one day and they’re not reporting anything different the next day, I wouldn’t have a look at it the next day, whereas I would a section wound. And it’s just easy access and they’re quite happy to let you have a look at their section wound. Sometimes they’re quite proud of their scar, whereas with the perineum, they’re not so happy to let you see it.” Midwife G (line 490).

This differing approach to assessment of a wound dependent upon its location appears to be motivated by the midwives wishing to provide care with dignity that acknowledges the notion of public and private areas of the body.

6.4.3.2 *Regaining and maintaining dignity*

The midwives discussed and demonstrated particular approaches to genital tract clinical observation, which they felt helped to maintain the woman’s dignity. Several of the midwives suggested providing the woman with a rationale as to why clinical observations would be useful for the woman and reaffirming it is part of the midwives role to maintain the woman’s dignity. As suggested by midwife E

“I’m not a voyeur, I need to look at it for a reason and usually when I explain why I need to look at it ... they’re normally absolutely fine.” Midwife E (line 128).

Three of the midwives identified sometimes needing to adapt their response to clinical observations findings, particularly facial expressions and careful use of phrasing, in an attempt to respect the woman’s dignity and provide sensitive care. This focuses around trying not to alarm women concerning the condition of their genital tract.

“I went to have a look at the perineum I was trying to keep the look of horror off my face because when I looked it was just gone, gone completely. There was no sutures to be seen at all . . . just completely . . . you know . broken down.” Midwife A (line 99).

Several of the midwives made comments suggesting they attempted to maintain the woman's dignity by ensuring she had privacy during clinical observations. In the hospital postnatal ward setting, this consisted of ensuring curtains were closed and using blankets to minimise maternal exposure by keeping the woman as covered as possible. Midwife B identified palpating the uterus over clothes whilst the mother is sitting in the chair. The community midwives indicated they would seek clarification from the woman as to where they could go in the woman's home to ensure privacy during clinical observations. However attaining a private location did have difficulties for both community and hospital based midwives, which will be discussed in the following chapter, when exploring the impact of context upon approaches to maternal genital tract assessment.

Two midwives considered one of the most "exposing" aspects of intimate clinical observations, such as inspecting the perineum, is the act of undressing and dressing in front of another person. These midwives indicated they provided the woman with time to undress and dress in private, to help maintain her dignity.

"The most exposing thing for a woman is removing her underwear or her removing her own underwear in front of people. I think that is very exposing, as a woman myself, I would say that is so I always move outside the curtain, you know." Midwife K (line 220).

Half of the midwives in this study identified the position they asked the woman to adopt for clinical observations of her perineum. When discussing the rationale for using a particular position, the majority of the midwives related their choice to minimising maternal "exposure" or as being a more dignified position. Four midwives stated they asked the women to adopt a left lateral position, with either the knees and thighs drawn forward as in the simms position, or with the upper leg raised slightly. These midwives indicated this position enabled them to view the perineum, especially perineal tears or episiotomy repairs effectively and they considered it reduced the need to touch the woman to view the area. Midwife L suggested using the lateral position as a more dignified for women, as they didn't need to part their legs.

“I couldn’t have anyone open their legs and look that way, I couldn’t. I just think that’s totally degrading for a woman . . . when you’re trying to get a little bit of dignity back.” Midwife L (line 362).

However one midwife, midwife K felt the lateral position was “not dignified”, as the woman was not able to see the midwife during the examination. She also suggests that viewing trauma to the genitalia other than to the perineum, such as labial and urethral grazes, is difficult in the lateral position. Therefore midwife K advocates the use of a supine position, with the woman lying on her back with her legs slightly drawn up and thighs abducted.

“I would say on your back is where I’m more likely to be able to see more without me even having to touch her, you know. I just don’t know how they see clearly and I don’t know, there’s just something about someone again turning their back to you and someone being behind and looking at them. I don’t think that’s very dignified.” Midwife K (line 309).

Two midwives stated they varied the position they asked the woman to adopt. Midwife M indicates that depending upon what exactly she needed to see in relation to the woman’s genitalia, she would suggest either the left lateral or supine, depending upon which she felt would offer the better view of the area. Midwife N, was the only midwife who proposed to vary the position for clinical observation of the perineum, depending upon which position the woman found comfortable.

Midwife E articulated a unique position which she had read about some years ago in a midwifery journal, which she felt offered her a good view of most of the genitalia, but without the women having to part their legs, this she felt was very exposing for women. The position involves the woman lying on her back and drawing her knees towards her chest, in a curled position. Midwife E suggests the woman appear to prefer this position.

“I always say to them, ‘Now I’m going to ask you to do something that’s probably...you’ve never had to do this before. It’s a little bit different but I’m not going to ask you to open your legs or expose yourself,’ and they’ll go, ‘Oh, thank God for that!’ . . . because they just feel as though they’re not as exposed, even though they haven’t got any lower clothes on, they still feel it’s better.” Midwife E (line 155).

Dignity as expressed by the midwives in this study, reflected their practice actions which were motivated to provide care which was sensitive to the woman's dignity needs, demonstrating respect, when negotiating assessment approaches of maternal postnatal genital tract well being. This included the midwives acknowledging the impact for women of "losing" their dignity and then how the midwives attempted to provide care with dignity in an attempt to help women regain and maintain their dignity.

Care with dignity, alongside recognising individual needs and providing appropriate genital care, formed the category of sensitive care. Within this study, the midwives considered sensitive care to involve recognising and responding to subtle changes and signals reflecting the woman's particular postnatal needs. Therefore providing sensitive care would motivate a particular approach to maternal genital tract assessment.

6.5 Conclusion

This chapter of my thesis has presented and analysed data pertaining to factors motivating midwives practice action when assessing maternal postnatal genital tract health. The findings have involved 3 categories; verification, personal preference and sensitive care. The data forming each core category have been presented, explored and analysed to present the properties and dimensions of each category and to enhance the trustworthiness of the interpretations and conclusions drawn from the data.

Chapter 7

Chapter 7 - Modifiers

“An exploration of midwives’ experiences and practice in relation to the assessment of maternal postnatal aenital tract health”



7.1 Introduction

This final data chapter presents and explores the research data, which forms the third theme ‘Modifiers’. A modifier is a “*person or thing that modifies*” Collins Dictionary (2009e), and to modify involves altering or adapting the action, structure, qualities or intent of that being modified. Within the context of this study the term modifier is used to identify factors, persons and contexts, which facilitate or inhibit the midwives’ ability to negotiate an appropriate approach to assessment of the maternal genital tract during the postnatal period. These modifiers exert their impact by affecting both the methods and motivators of maternal postnatal genital tract assessment. Therefore this theme is the most critical to the midwives practice as the modifiers underpin the other two research themes, facilitating or inhibiting the influence of motivators and the successful implementation of methods of maternal genital tract assessment. The modifiers described or demonstrated by the midwives, I have grouped into three core categories. However the midwives frequently identified several modifiers influencing

their practice simultaneously. The categories within the modifiers themes are;-

- A therapeutic relationship
- Care in context
- Evolving midwifery practice.

The first category, therapeutic relationship discusses the qualities and attributes, which the midwives suggested, were significant for forming a therapeutic relationship with the woman postnatally. The presence or absence of a therapeutic relationship could modify the midwives' ability to negotiate an appropriate approach to maternal postnatal genital tract assessment.

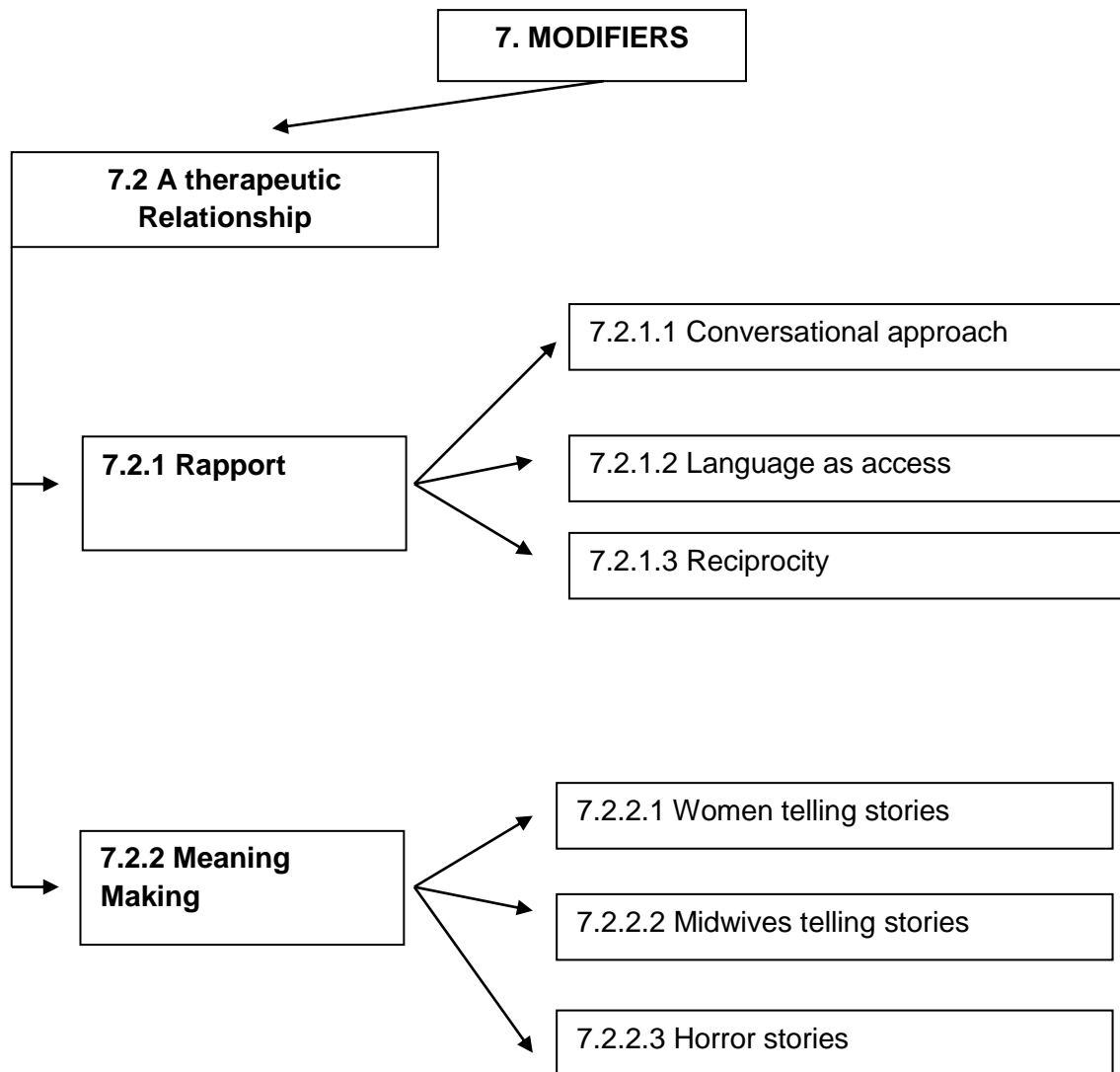
Care in context is my second category and it consists of a range of contextual factors relating to where and when genital tract assessment is undertaken. Aspects of location and competing priorities within postnatal care, which may facilitate or inhibit genital tract assessment, are explored within this category. The final category is evolving midwifery practice. Here I identify and discuss the midwives' accounts of changes to their own practice and the learning experiences for student midwives, which they consider may modify the approach to maternal genital tract assessment adopted.

Many of these modifiers contain or result with tensions or contradictions that must be negotiated when providing postnatal care. Within a particular category there may be contradictory factors or tensions that the midwives recognised or were evident to me. These will be highlighted during the data discussion for each category. In addition contradictions and tensions are evident between categories. The ability of the midwives to negotiate these contradictions and tensions may be influential to the impact the modifiers have upon the approach to maternal genital tract assessment. These

connections will be articulated and explored in more detail within the Discussion chapter.

The issues raised from the research data and explored within this chapter, help to respond to the second and third objectives of the study. The discussion helps to illuminate the factors influencing the midwives' practice approach and how women are involved in this aspect of their postnatal journey. In addition the modifiers and their component categories and codes provide some insight into the forms of clinical reasoning used by midwives to inform their practice actions, particularly interactive, conditional and narrative reasoning. These include the practice and personal knowledge midwives employ within their clinical reasoning process.

7.2 A Therapeutic relationship



The midwives identified or demonstrated actions, qualities or attributes that they felt contributed to the formation and development of a therapeutic relationship between the midwife and the postnatal woman. Definitions of the term 'therapeutic' indicate a factor, in this instance relationship features, which have a positive impact upon the mind or body of an individual, enhancing his/her well being and contributing to the process of health treatments (Oxford Dictionary 2011f). A therapeutic relationship involves a relationship between a health care provider, in this instance the midwife, and the client, initiated and sustained for the duration of a specific client centred purpose (Mosby's Medical Dictionary 2009b). It therefore differs

from a personal relationship. Midwife F reflects several of these aspects in the following quote, when she discusses a recent care interaction with a postnatal woman.

“It’s not like a friendship, it’s like a professional relationship so even though I knew her really well and looked after her antenatally, I suppose they know that your time then ends.” Midwife F (line 266).

The midwives identified relationship features that they considered could modify their ability to negotiate an appropriate and effective assessment of maternal genital tract health, clustered around two key areas, rapport and making meaning. Rapport consisted of interpersonal skills, which the midwives considered could facilitate or inhibit their ability to effectively interact with the woman therefore modifying the development of a therapeutic relationship.

The majority of the midwives in this study also discussed meaning making by story telling, as a means of enabling the postnatal women to make sense of and come to terms with childbirth events and postnatal changes.

7.2.1 Rapport

Rapport is defined as being “A close and harmonious relationship in which those concerned understand others’ feelings and ideas and communicate well.” Oxford Dictionary (2011g). The majority of the midwives in this study identified such qualities and attributes, usually using the term “rapport” to describe the activity. Rapport was felt by most of the midwives to form a connection, which promoted effective woman and midwife communication, enabling the midwife to perceive the woman’s perspective and the woman to perceive the midwives’ perspective. This is significant if the midwife intends to provide genital tract care, which is sensitive, reflecting maternal preferences and if the woman is to accept the midwife’s advice. Through these interactions the modifiers such as rapport may impact upon the motivators identified within the previous data chapter. Effective communication as part of rapport also modifies the methods of assessment, by aiding understanding during information exchange, for example when using maternal questioning as a method of genital tract assessment.

Several of the midwives suggested rapport facilitated the development of trust between the postnatal women and midwife. Trust is recognised as a key attribute of an effective therapeutic relationship. It may enhance the woman's confidence in the midwife thereby modifying the woman's response to midwifery requests or advice, such as suggestions that clinical observations of the genital tract, or particular care would be useful. As suggested by midwife A,

“They'll take it (advice) better from somebody they've built up a rapport with.” Midwife A (line 413).

Trust also facilitates disclosure, which could facilitate open and honest information exchange. Several of the midwives related rapport to developing trust within the therapeutic relationship. As suggested by midwife B,

“If you build up that rapport, you know you have trust. People will tell you things.” Midwife B (line 855).

Several of the midwives also suggested trust was an imperative aspect of developing a rapport due to the intimate nature of postnatal genital tract assessment, involving discussion and possibly clinical observations of the genital tract. Midwife K, (line 166), considers attaining a successful rapport enables the woman “to feel comfortable” in such intimate situations. The intimate nature of the relationship and the need for disclosure contradicts the need for privacy identified within the motivator theme, concerning section 6.4.3.2, regaining and maintaining dignity. The need for disclosure and privacy occur simultaneously and create a tension that must be effectively balanced to maintain the rapport between the midwife and woman and to the developing therapeutic relationship. The midwives recognised there is a tension between the need for the woman to regain her dignity and have privacy, but also that she needs to disclose information and engage in intimate discussion and possibly clinical examinations. Midwife F suggests the midwife must balance her demeanour between being sympathetic and sensitive to the woman's potential embarrassment whilst

maintaining maternal dignity and having a matter of fact approach in which disclosing intimate details including inspecting the woman's perineum is conveyed to the woman as all "part of the job" and not something the midwife feels embarrassed about (Midwife F line 282).

The research data indicate that the midwives discussed three key constituents of developing a rapport with postnatal women, a conversational approach, language for access and reciprocity.

7.2.1.1 Conversational approach

Thirteen out of the fourteen midwives interviewed specified that the sequencing and structuring of the interaction they had with the woman was important when attempting to develop a rapport. They frequently referred to these aspects as employing "chat" or a "conversation." The midwives suggested the opening discussion with the woman needed to be "chat" orientated, as articulated by Midwife B (line 178), this enabled the midwife and woman to "break the ice." The opening conversation involved showing a broad interest in the woman, her family and the new baby, utilising phrases and terminology associated with social interactions. As explained by midwife L, a hospital based midwife, a rapport between the woman and midwife can be initiated.

"I just say . . . "how are you doing," and go a bit through the delivery with her and then have a little look at the baby and a coo over the baby . . . Because you've got to have a rapport." Midwife L (line150).

During interviews the midwives frequently suggested they initially used a general open question, which is non-directional to commence the interaction. This was confirmed by the approach adopted by many of the midwives within the observational data, commencing with a general "how are you" type question. Within conversational patterns it is common to use a general opening questioning. It has the advantage of being expected, the responses within the control of the recipient and therefore not intimidating.

Chat helps form a bridge between general conversations used in most social interactions and more focused questioning which may be more intimate, probing and associated with interactions with a health care professional. Particularly during observational data collection in the community setting, such a general social question appeared to fit the social context of the woman's home. The majority of the interviewed midwives suggested commencing the postnatal interaction with a conversational approach facilitated intimacy and potentially enhanced disclosure of more detailed and personal information from the woman. This is reflected within the quote from midwife B.

“Talking about just general chit chat and it's amazing, you know like people will tell you about boyfriends . . . then people will have a conversation with you generally about anything.” Midwife B (line 859).

The midwives' comments suggested a conversational approach was more informal and less structured than asking a set sequence of questions concerning maternal genital tract well being. As suggested by Midwife F (line 667), using a conversational approach can eliminate the need for specific questions. Women often provide sufficient detail of their experiences to fulfil the information required by the midwife to inform her approach to assessment of maternal genital tract well being. The midwives suggested a conversational approach usually involved using open questions, which had the potential to enable the woman to then take the lead and control of the conversation.

“How are you feeling?” and then they would say . . . usually they say, “I'm all right, but . . .” and then you would get the ‘but’ so from the ‘but’, that is the major part of your assessment really.” Midwife N (line 299).

Many of the midwives suggested following the woman's lead was useful to identify potential issues and develop areas for specific questioning and exploration.

Implicit to the midwives' discussion regarding following the woman's lead, is the need to provide opportunity for and engage in active listening to the woman's response. Within the observational data, the majority of the

interaction between the midwife and woman appeared to involve active listening and open questions. This combination appeared to enable the midwives to identify and then respond to maternal cues. This usually involved the interaction commencing with open questions, listening and then an inter mix of open, closed and probing questions to elicit more detailed information from the woman. Particularly the community midwives were noted to use paraphrasing when eliciting information from the women and summarising when providing information to the women. Summarising is a useful strategy to recap upon significant aspects when a large amount of information is given. It was surprising therefore, that of the eight observations on the postnatal ward, which all involved the midwife providing the women with much information, summarising was only clearly identified on four occasions. During interview data collection the midwives also recognised a conversational approach, which included listening (midwife E line 759), using positive non-verbal communication (midwife B line 870) in an attempt to appear “sympathetic and supportive” (Midwife I line 726).

However on a small number of interactions I observed, the midwives did not consistently use open questions.

During the observation, involving midwife G and Erica, I noted how Erica’s mother tended to dominate the discussion and responded to the midwife’s questions, before Erica had the opportunity to respond. The midwife attempted to and to some extent succeeded in rectifying this by directing her questions at Erica, using non-verbal cues such as eye contact and verbally by stating Erica’s name within the question and specifically asking Erica what she felt.

Within the hospital setting, Midwife I when talking with, Jenny, used some focused questioning following initial open questions, to identify Jenny’s history of postnatal depression and enquire as to her present emotional condition. This use of a focused probing question appeared to help sign post to the woman that her previous experience was recognised and provide an opportunity for discussion.

However, if closed questions were noted to predominate early in the interaction the development of a conversational approach and subsequent rapport appeared less likely. This was noted in one instance, involving midwife H and Lesley, within the postnatal ward. I observed midwife H stating to Lesley, "So you had a normal delivery and no stitches, have you got any grazes?" This closed probing question elicited a monosyllabic response, "yes". As the interaction continued it became increasingly midwife led. This I feel was in part due to how the interaction had commenced. The closed question led to a closed response and quickly midwife and woman became locked in a question and answer cycle, which the midwife found difficult to break. Later in the interaction the midwife asked, "Are you OK" but left no response time and then stated, "You will be pleased to go home?" Lesley responded to this leading question stating "I don't know, I have another one (child) waiting for me there". Her response was not acknowledged or explored, but distanced by the midwife switching focus. In this instance it would appear that the inability to effectively utilise a conversational approach, involving effective interpersonal skills, resulted in a lack of rapport and modified the midwife's ability to respond to the woman's cues. Therefore, where rapport is inhibited, this can modify the midwives' ability to provide sensitive care, reducing responsiveness to individual needs.

I noted that Lesley appeared quiet and did not reciprocate when midwife H initially attempted to engage her in more discussion. A conversation involves two participants. Although both midwife and woman had consented to the observation, I did feel my presence may have impacted upon the situation, as discussed in chapter 4. In addition I witnessed only a twenty-minute or so interaction. One must remember the midwife and woman had some discussion prior to my presence being confirmed as acceptable and had the opportunity to continue the discussion after the observation.

A conversational approach involves sequencing and structure of the midwife interaction with the woman. The data suggest that a conversational

approach contributes to the development of a rapport within the therapeutic relationship.

7.2.1.2 Language as access

The term language is defined as a “body of words . . . common to a people” (Dictionary.com 2011a). As it is a common language, the meaning must be accessible and understood by those sharing the language. The majority of the midwives (12) discussed and demonstrated how they attempted to negotiate an accessible language between themselves and a woman during postnatal assessments of the maternal genital tract.

Language in relation to the maternal genital tract assessment involved midwives negotiating with women words they could both comfortably use to identify aspects of genital tract anatomy and physiology. Many of the midwives (11), considered accessible language was vital to ensure the midwife and woman understood each other. This underpinned and therefore had the potential to modify the effectiveness of methods of genital tract assessment, such as questioning, and the successful implementation of care and advice provided by the midwife to the woman regarding her genital tract. This is reflected in the comment by midwife G.

“Again, you have to pitch it to whoever you’re dealing with because some of the girls, you know, you say, ‘How’s your perineum?’ and they know exactly what you’re talking about. But a lot of girls will say, ‘My what? What do you mean? What’s one of them?’ Even though it’s probably been referred to before during their pregnancy or in delivery. So sometimes, you just have to say, ‘Well, your bottom. How does your bottom feel, when you sit down or when you have a wee?’ You have to make it a bit more understandable for them.” Midwife G (line 322).

The midwives suggested some women were not aware of the anatomical names for their genital tract. Therefore to aid understanding the midwives frequently used lay terms. If the midwife wished to palpate the woman’s uterus, the phrase most commonly used was “feel your tummy” (8), with 2 midwives mentioning using the word womb, in place of uterus. If the woman had sutures in her perineum, the word frequently used by the midwives to

identify the perineum was “stitches”, as in “how do your stitches feel?” midwife L line 184. Other terms for the perineum and vulva mentioned during interview and observational data collection as used by midwives includes, “down below” (7 midwives), “delicate / lady / girl bits” (4), “bottom” (2) and “downstairs (1). During observational data collection the phrases most frequently used were “feel of your tummy”, concerning uterine palpation and enquiring about stitches or grazes when seeking to ask about the condition of the perineum and vulva.

During interviews two of the midwives (B and G) expressed a belief that some postnatal women are embarrassed by genital tract anatomical names and therefore felt “uncomfortable” using those terms (midwife G line 357). Midwives B and G both worked with younger mothers and considered this embarrassment with anatomical words was particularly an issue with this group. As suggested by the following quote, the midwife must use language that the woman is comfortable with because if women feel embarrassed by the terminology used they may limit disclosure and change the focus of the conversation.

“They are more likely to tell you what’s happening, rather than thinking I’m going to get off that subject because it’s embarrassing.” Midwife B (line 236).

Two of the midwives suggested maternal embarrassment could also result if the woman did not understand the word used for the genital tract and needed to ask for clarification. This resulted in the midwives attempting to articulate the genital tract at a level the woman can comprehend, as expressed in the following quote.

“She doesn’t know what a perineum is so me asking her is just going to make her either say, “What?” and feel a little bit even worse. I’m not about doing that so I just won’t let her ... so I’ll say, “How’s your bits? How’s down below?” anything that I think is on her level so that she can answer me comfortably.” Midwife K (line 103).

Although many of the midwives suggested they would follow the woman’s lead concerning accessible terminology for the genital tract, three of the midwives highlighted they had boundaries regarding which words and

phrases they would use with the woman. As articulated by midwife J words deemed to be “crude” were avoided with the intention of “remaining professional” (midwife J line 561). Therefore terms and phrases for the accessible language were negotiated between the midwife and woman.

When negotiating accessible language the midwives articulated several factors that influenced the words and phrases they chose. Several of the midwives considered women who were younger or had limited education may be less likely to understand anatomical terms. The midwives suggested determining the appropriate terminology involved “knowing the person that you are dealing with” (midwife I line 752). The community midwives in this study tended to highlight getting to know the woman, their families and social context throughout the pregnancy. Midwife B (line 343) suggested this helped to negotiate accessible language as it provided an insight into social norms within the family and peer group, which influenced the terminology used for the genital tract. In contrast the hospital midwives who did not have access to the women’s social context, tended to identify age and educational attainment as a guide to accessible language.

“Well, if it’s judgemental, if I’ve got somebody who appears well educated, maybe has a job that would suggest that they’re well educated, I might use the term ‘perineum’ because it might suggest to me that they know what a perineum is.” Midwife K (line 101).

Several of the midwives indicated utilising accessible language and preventing maternal embarrassment was an important factor to help develop a rapport and subsequent therapeutic relationship between midwife and the woman. Midwife B (line 726), suggested she attempts to change the emphasis of the discussion from being “private and professional” to being “normal”, suggesting a more balanced, mutual and partnership approach. Using lay terminology may help facilitate this partnership approach by removing any perceived dominance or power if the midwife uses language not understood by the woman. This is exemplified by comments made by midwife C (line 553) who explained she had previously always used anatomically correct terminology but had recently changed and now tended to follow the woman’s lead and use lay terms. She had questioned why she

felt the need to use anatomical names and considered they might make her “sound so big and high and mighty” and distance women from her. This midwife had a specialist caseload involving women with drug and alcohol problems. The data from this study suggests accessible language may help to equalise the midwife and woman interaction enhancing the therapeutic relationship development.

In addition to accessible language, half of the midwives discussed and demonstrated using language to gain access to the woman’s genital tract. This involved using accessible language, therefore developing a rapport with the woman who may then be more amenable to participating in genital tract assessment. This is expressed by the following quote by midwife G.

“I think if you’re on their level. If you’re on their level, you know, if you’re going in a bit pompous, ‘How’s your vagina? Can I check your perineum?’ you’re closing your door straight away and they’re like, ‘Nah.’ Not a chance. But if you’re more on their level and you’re getting to know them a bit more, then you’ve got more chance.” Midwife G (line 398).

Some of the midwives (7), also articulated during interview data collection, the use of minimising words, particularly when attempting to gain access to the woman’s genital tract to undertake examinations. This involved using words such as “little” (5), “quick” (4) and “peek” (1). Two of the midwives recognised they used such words and acknowledged they used them as part of a deliberate strategy of using language to gain access to the woman’s genital tract. In part these words appear to be used to coax women into agreeing to examinations. However the midwives also appear to be attempting to demonstrate some sensitivity that the woman may have contradictory feelings regarding examinations of her genital tract and may base her understanding of what is involved upon her experiences of vaginal examinations during labour. By using minimising words the midwives appear to be attempting to express they would attempt to minimise the procedure.

“I would cajole them. . . . I would say, “Oh, come on, it’s really important. Honestly, it’ll be dead quick. Just let us have a little look because I think that might be a little bit something wrong that we just need to sort out. You

might need antibiotics.” I’ll dumb it down, that’s what I do, just be quick, minimise stuff, just to try and do what I’ve got to do.” Midwife K (line 767).

Within this quote from midwife K, she also presents a rationale to the woman as a means to gain access, a strategy used by the majority of the midwives and discussed in the previous chapter.

Midwife N (line 311) suggests the phrasing of the request can be significant when attempting to gain maternal consent to genital tract clinical observations. This midwife tends to avoid the word “want”, as in “do you want me to check your stitches?” Instead she prefers to use the phrase “can I”. Using the word want places the responsibility for the request upon the woman. The phrase “can I” places the responsibility for the request upon the midwife who can then legitimise the request by providing a rationale for the need to clinically observe the woman’s genital tract. This appears to be an attempt by this midwife to provide a strategy, which helps the woman overcome the contradictory tensions of privacy and social taboos concerning exposure of her genital tract with the need for others to view the genital tract following childbirth. Other midwives in the study did not articulate this point. Some did not use the term “want” when discussing requesting genital tract clinical observations, however several of the midwives did use the term “want” and “can I”, interchangeably.

The data imply midwives use language as access. This involves using language, which is accessible to both the midwife and woman to aid comprehension and understanding and equalise the midwife and woman relationship. Language as access also involved using language to gain access to consent for genital tract clinical observations. Minimising words were used to coax the woman but also to demonstrate that procedures would be undertaken sensitively. In addition phrasing requests to articulate why the midwife feels clinical observations are legitimate, acknowledges the contradictory tensions experienced by the postnatal woman concerning genital tract assessment. The successful negotiation of language as access would impact upon the development of a rapport and therapeutic

relationship and therefore potentially modify the method of and motivators for maternal genital tract assessment.

7.2.1.3 Reciprocity

The third constituent of a rapport identified from my data is reciprocity. The Oxford dictionary (2011h) defines reciprocity as “the practice of exchanging things with others for mutual benefit”. In the context of this study reciprocity involved a mutual aspect to the relationship between the midwife and woman, which would facilitate the development of a rapport, and therapeutic relationship. It included a social exchange of information between the woman and the midwife.

The midwife getting to know the woman was facilitated by two factors, continuity of carer, particularly community midwives getting to know women and their families over one and sometimes several pregnancies; and secondly the conversational approach, in which women were encouraged to share personal information.

Half of the midwives in this study identified that they reciprocated this social exchange of information and this was expressed by midwife N (line 109) as the woman getting to know the midwife as a “person”. Several of the community midwives felt the woman getting to know her midwife happened over a period of time and facilitated greater disclosure from the women. Midwife N (line 94) recounts a practice experience involving a woman who did not disclose during the antenatal booking interview that she had previously been treated for a sexually transmitted disease, despite being directly asked the question as part of the booking interview dialogue. However the woman spontaneously raised the subject later in the pregnancy and informed the midwife she had been previously treated for a sexually transmitted disease. The midwife felt this was a direct result of the woman now knowing and trusting the midwife.

Several of the midwives suggested that where a woman forms a relationship with the midwife, benefits for providing postnatal care accrued. Assessment of and advice on the genital tract, was more likely when women were more responsive to midwifery care and advice.

“So I’m the family midwife to that family really because I’ve looked after them all . . . when mothers come back with their children having babies, they’ll say, “Eeh, she was my midwife!” you know, and it’s an immediate ice-breaker and it’s really good . . . Whatever I recommend seems to be, “Oh yes, right, we’ll do that,” through that familiarity.” Midwife M (line 62 & 450).

Midwife D suggested this preference for a known midwife was why attempts at establishing a drop in service were not successful, with poor attendance. Midwife D considered women preferred their own homes, but also particularly were not keen to attend when they realised it was likely that the midwife may not be “their midwife.” Midwife D indicated postnatal women prefer to see “their midwife” as “a lot of them see the last visit as part of a journey” which they had shared with that midwife. Ending the journey with their midwife was important for the women.

The data indicate, getting to know the midwife may also involve sharing some information concerning the midwives’ personal background, such as if they had children, family, their own childbirth experiences and common interests and hobbies. This was articulated by several midwives during interviews and also noted by me during observations. The intention of the sharing of information appeared to be to form a reciprocal connection, or bond between the midwife and woman. Particularly for the midwives based on the hospital postnatal ward they had to form this connection quickly (midwife I line 717), to enable the women to feel comfortable with the midwife.

“If there’s a book sitting on the bedside table, I love reading so if I see a book on the bedside table . . . you’ve got something in common . . . you can sometimes mention your children or they’ll say, “How old are they?” or what they’re doing, and then you can go on a bit chatting and that makes you human. You’re just a woman doing her job, you’re not the midwife just doing her job.” Midwife K (line 158).

In addition the midwives acknowledged they also used humour as a means to develop a reciprocal relationship. Four midwives explicitly mentioned using humour in an attempt to be perceived as humane, connect with the woman and diffuse tensions in potentially embarrassing situations. This usually involved genital tract clinical observations as articulated by midwife N who suggested she used humour to diffuse any embarrassment and help maintain maternal dignity.

“I would make it a bit jokey, to be honest. I’ll say, “Oh, I hope you’re not embarrassed. I’m a midwife, I’ve seen more bums than faces,” and laugh along with them and just put them at ease really.” Midwife N (line 352).

Some of the midwives, particularly midwife B and midwife G, highlighted that with women who appear particularly embarrassed greater investment is needed by the midwife to ensure a rapport is developed to facilitate accurate genital tract assessment. Midwife K (line 138), suggested with some women a reciprocal relationship can happen spontaneously, easily and quickly, but with other women the midwife has to “work a bit harder” to develop a rapport.

However three midwives did explicitly acknowledge there were boundaries to midwife disclosure and reciprocity in personal exchange of information. The midwives would be friendly but not a social friend, maintaining a professional approach. Thus balancing the potential tensions and contradictions of being both friendly but also a health care professional, that may need to undertake intimate examinations, have expert knowledge greater than the woman’s and also have the responsibility and authority to disclose information to others if necessary, such as in safeguarding incidents (midwife N line 146).

Five midwives considered that for reciprocal information exchange to succeed they must demonstrate a non-judgmental approach concerning the woman’s personal details and circumstances. This must be reflected in all activities and interactions whilst undertaking postnatal care to facilitate a rapport and trustful therapeutic relationship. However this non-judgmental

approach was identified by some of the midwives as needing to be reciprocated by the women. This was generally expressed in terms of the women accepting the advice and care offered by the midwives. However midwife K suggested there is an optimum level for women's demands for midwifery care, with some women's demands ranging from women

“Who are buzzer happy to those who don't want to disturb you.” Midwife K (line 609)

Midwives C and D suggested that some women were more accepting of the midwives care and advice but others, usually older and more educated, would be more questioning and less accepting. Midwife K suggested some women do not value the midwives contribution to her care.

“I'll do what I like when I like and you will ... so can I have my discharge now?” Midwife K (line 581)

These midwives acknowledged they preferred their role when they could offer more guidance and support to the women and when their roles and responsibilities as a midwife were valued and reciprocated by the women.

As already discussed in section 7.2.1 “rapport”, maternal trust in the midwife is an essential ingredient for a therapeutic relationship and arises from a successful rapport. However the midwives in this study also indicated that midwives must reciprocate this trust and trust women. In relation to postnatal genital tract assessment this is most evident when the midwife utilises maternal self-assessment and responses to questions, as this is the basis of her assessment of maternal genital tract condition.

“I put a lot of trust with them as well. You know, I'll say, “I trust you. You're sensible. Explain to me exactly what's happening.” Midwife B (line 268).

The data suggest reciprocity involves women and midwives getting to know each other, being non-judgemental and developing trust in each other. It contributes to the development of a rapport and as with the other codes in this section, conversational approach and language as meaning, may

modify the midwives ability to negotiate an appropriate approach to assessment of maternal genital tract well being.

7.2.2 Meaning making

As part of the therapeutic relationship the majority of the midwives discussed and demonstrated a form of midwife and woman interaction in which meaning making of the woman's childbirth and postnatal experiences was the focus. The term meaning involves understanding what an event, action or word expresses and represents and its significance (Dictionary.com 2011b). Within the context of this study, I used the term meaning making to denote how midwives and women construct understanding and significance from childbirth and postnatal experiences. Meaning Making was undertaken using narratives or stories involving childbirth and postnatal experiences. Three formats of meaning making were evident in the research data, women telling stories, midwives telling stories and horror stories.

7.2.2.1 Women telling stories

The midwives either articulated during interview or demonstrated during observations, facilitating women telling stories regarding their childbirth and postnatal experiences. The women provided narratives of their daily lives, activities, thoughts and feelings to express their experiences. This was usually achieved as part of the conversational approach in which midwives used general open questions to commence their discussion with the woman. With the majority of midwives (10) they actively encouraged the women to share their experiences by explicitly asking them to discuss them. Several of the midwives considered this an opportunity for women to "debrief" (midwife E line 252) and a routine aspect of a community first postnatal visit. Midwife E (line 206), as did other midwives, suggests providing the opportunity for women to tell their stories is significant as it lets the women know "they are important". Two midwives (midwife F and N) describe the activity as women "telling their stories" and suggest this allows women to share their interpretations of events, experiences and what is meaningful and significant

for them. Midwife F recounts a practice experience example in which the woman's story of her experience highlighted she was finding it difficult to come to terms with the episiotomy she had sustained during birth rather than the long labour or instrumental birth she had experienced.

The midwives in this study also used the opportunity of women expressing their stories to bolster the woman's morale and self esteem and help them perceive their childbirth and postnatal experiences and their role within them as positive and effective. Midwife J (line 597) as did several other midwives considered some women may feel "let down" by their birth experiences and the midwife needs to "build them up again". The midwives attempted to achieve this by using compliments and flattery in response to the women's stories. In relation to the genital tract the midwives discussed and demonstrated complimenting the women upon how well her abdominal or perineal wound appeared and was healing, her abdominal tone and the woman's care of her genital tract.

"Whatever you're doing is excellent because that is a really neat, good wound. Continue to do that . . . she actually said she was doing all of those things and I said, 'That's excellent.'" Midwife D (line 305).

I often observed women telling stories and midwives' attempts to bolster self-esteem via compliments. One example is of a midwife (midwife I with Carol) who used a woman's potentially negative childbirth experiences as a way to compliment Carol on her personal traits and negotiating becoming a mother whilst managing the challenging situation of her birth and early postnatal period.

7.2.2.2 Midwives telling stories

The majority of the midwives (13) responded in kind to the women telling stories by also using stories to acknowledge, relate to potential meanings and develop the woman's insight into life following childbirth. Ten midwives indicated they used stories to help women negotiate and adapt to the challenges which childbirth brings. The stories tended to contextualise childbirth events including those in relation to the genital tract, with the

intention of letting the woman know her experiences were normal within the new physical, social and emotional experiences, changes and adaptations following childbirth. As discussed in the previous chapter, the midwives felt some women had limited insight into what to expect postnatally. As suggested by midwife F the women needed guidance regarding their new normality.

“‘Is it only me who looks like this? Is everybody else walking round and everything is absolutely fine?’ So it’s trying to say to them, ‘This (the woman’s perineum) is probably normal. This looks normal considering you’ve had a baby.’” Midwife F (line 554).

The midwives used the stories from their professional (and occasionally personal experiences) to help the women to develop “realistic expectations” of what to expect and what the future may hold in relations to their genital tract and postnatal recovery and health (midwife A line 795). The data indicates that the midwives attempted to reassure women their experiences and anxieties were common postnatally and therefore they were normal in an attempt to bridge the gap between ideals associated with childbirth and the reality of the postnatal period.

“You try and make them feel that this is normal, which it is, that they’re not doing anything wrong and you sort of encourage them and tell them how well they’re doing.” Midwife E (line 262).

Half of the midwives suggested they used stories to articulate to the woman care and advice she may find useful. This included accounts of other women who had followed particular advice and occasionally their own experiences.

“I’ll say, “Oh, when I had my son and I did this and this,” I’ve got loads of just daft little stories and daft little things that really helped me that I’ll pass on, but I don’t so much mention other women. I don’t think that’s really appropriate, just about myself.” Midwife L (line 460)

Some of the midwives acknowledged they were careful to anonymise stories involving other women’s experiences. Three midwives stated they used the phrase “some women have found” in an attempt to ensure the narratives remained anonymous.

The use of stories to articulate care and advice may help contextualise and personalise the information and therefore make it more meaningful to the woman than a standard list of information regarding what to expect and advice for the postnatal period. Using stories to help make meaning may facilitate the women being able to apply the information to their personal situation. As suggested by midwife M;-

“There’s information in the pregnancy book about postnatal care and what to expect and what not to expect, but sometimes women don’t always have time to read every leaflet that you give them. So I think it’s a personal approach is more reassuring probably than a leaflet.” Midwife M (line 673).

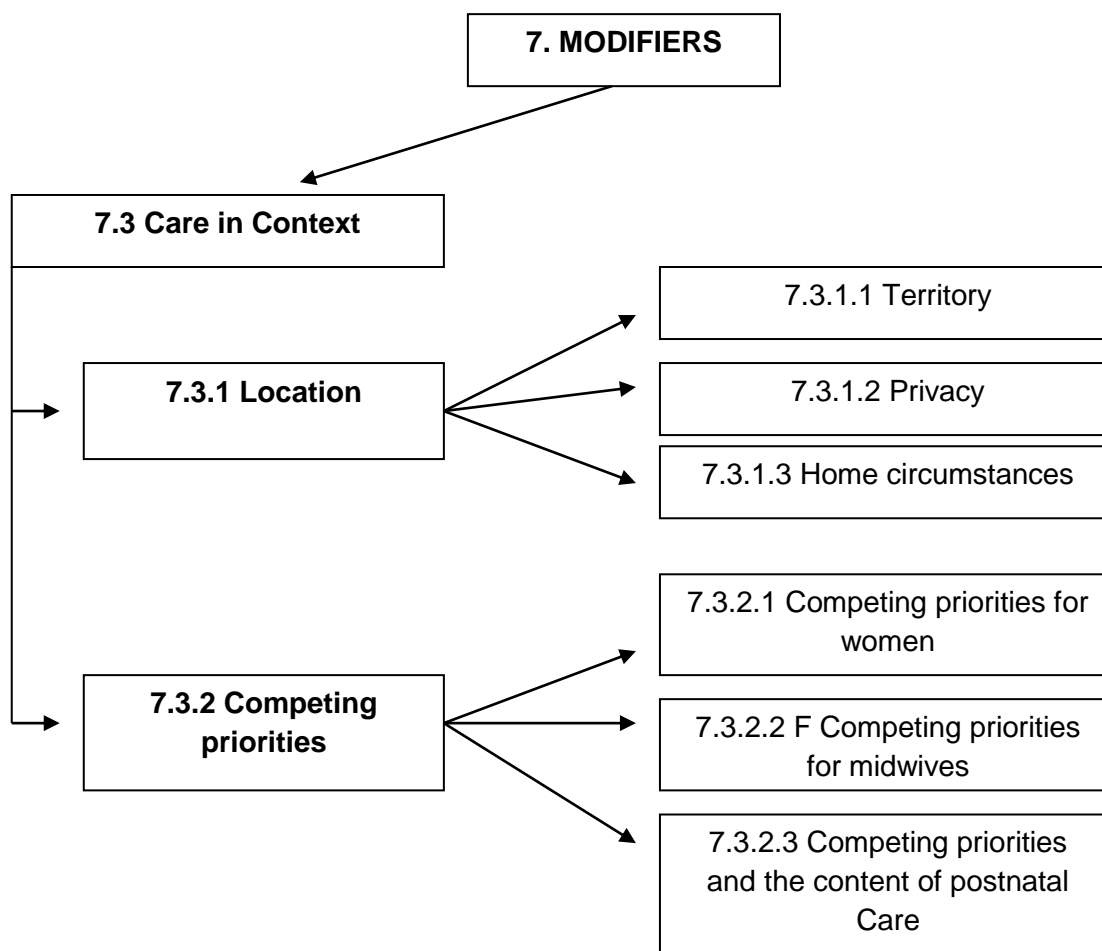
7.2.2.3 Horror stories

A couple of the midwives did express concern that stories can become a means of frightening women by becoming accounts of negative experiences or horror stories. They suggested this may occur with family members who recount stories of their experiences to the women focusing on negative aspects and suggesting their experience is not uncommon.

“The Mum says, ‘Try not to frighten her but she needs to know the truth, you know, about what can happen when you have these babies and how I ended up in intensive care after I had both of mine and I had tubes down my throat,’ and I said, ‘But that’s you, that’s what happened to you, that’s not going to happen to her.’ So I just think sometimes, using other people’s situations can have a negative effect.” Midwife G (line 642).

My data indicated that midwives and women construct stories to make meaning of and from childbirth and postnatal experiences. The stories helped midwives to understand events from the woman’s perspective and as a vehicle to bolster maternal self esteem via compliments. In addition midwives used stories to help women comprehend the changes and adaptations which occur postnatally and care and advice that may be relevant. Meaning making may contribute positively to the woman’s postnatal well-being and therefore contribute to the midwife and woman’s therapeutic relationship.

7.3 Care in context



The second category within the modifier theme is care in context. This consists of factors arising from the research data relating to the conditions and circumstances in which postnatal care and genital tract assessment is undertaken. These contextual factors have the potential to modify the midwives ability to negotiate an appropriate approach to assessment of maternal genital tract during the postnatal period. All of the midwives provided data that have contributed to this category, grouped into two focused codes. The first is location, which discusses the impact factors and considerations within the place of postnatal care. The second focused code presents data relating to simultaneous events impacting upon postnatal care and is titled competing priorities.

7.3.1 Location

Location is a particular place (Oxford Dictionary 2011i). Two principal locations for postnatal care and genital tract assessment are included in this study, the woman's home or place of residence in the postnatal period and a hospital postnatal ward. All of the midwife participants raised and discussed issues during interview data collection, which have contributed to this focused code. The interviewed midwives consisted of nine who were based in the community and provided postnatal care within the woman's home or place of residence and five who were based on the hospital postnatal ward. In additional observational data, provided insights into the impact of the location upon the midwives ability to effectively negotiate maternal genital tract assessment. The location of the observational data comprised of seven individual observations in the community setting involving seven women and two midwives and eight individual observations in the hospital postnatal ward involving eight women and three midwives.

7.3.1.1 Territory

A territory is an area, which is considered as belonging to a person, or persons, which they may try to control (Cambridge Dictionary 2011b). In whose territory postnatal care was undertaken would influence who had most jurisdiction and ability to control the territory. The potential to impact upon and modify the midwives' ability to negotiate postnatal assessments has territorial antecedents. Several of the community midwives discussed difficulties in ensuring the home environment ambience was conducive to effective mother and midwife interaction. The territory belongs to "others" and is difficult for the midwives to control. Noise was frequently cited as a problem, making effective communication difficult, as suggested by midwife N.

“You can't hear yourself speak for the telly or the Playstation. You know, their partner's sat killing somebody on the Playstation.” Midwife N (line 643).

A couple of the midwives suggested they did attempt to influence the noise levels in the community setting, however this was not always successful as the following quote from midwife G demonstrates.

“It’s their territory, I suppose. How dare I, how dare I ask them to leave the room when they’re watching Jeremy Kyle! You know, because there’s always a telly on. The telly never goes off.” Midwife G (line 260).

During interview data collection none of the hospital postnatal ward based midwives identified ambient noise levels as an issue. However during observational data collection I noted in five of the eight observations that the environment was very noisy, busy and distracting. Much more so than my community observations I had undertaken. The following is an extract from my field notes relating to one such hospital-based observation.

“Ward busy, lots of health workers, e.g. midwives but also support staff cleaning (vacuum cleaner making a lot of noise) and making beds, paediatricians (with medical student) to review babies ready for discharge, neonatal hearing screening service staff to perform neonatal hearing tests and a woman taking infant portrait photographs. During the postnatal assessment the paediatrician was in the bay next to this woman’s talking very loudly.”

High levels of noise and simultaneous activity can be distracting for both woman and midwife, making interaction difficult and potentially affecting the woman’s ability to comprehend and assimilate the high level of new information being provided. However during the observation of midwife I on the postnatal ward, the ambiance was much calmer and quieter, despite a similar number of women and babies and time of day. Midwife I is the ward manager, she tended to close the door to the corridor when she was in a four bedded bay undertaking postnatal assessments and other staff members, such as cleaning staff, tended not to enter the bay during that time. Perhaps on the postnatal ward, not all midwives have equal influence upon the territory.

7.3.1.2 Privacy

The majority of the midwives (11), reflecting both hospital and community based midwives, identified privacy as a location factor impacting upon

postnatal assessments. Other people in the location, was the most common concern for midwives when they attempted to ensure privacy. On the postnatal ward this was sometimes other health care staff undertaking activity. The presence of partners, family and friends of the woman could also make privacy difficult to attain. Accessing women when they did not have visitors was difficult when other women in the communal 4-bedded bay did. The midwives suggested both they and the women might be uncomfortable discussing personal issues such as genital tract trauma and exposing their bodies for clinical observations when visitors are the other side of curtains.

“I wouldn’t even contemplate doing a postnatal check during visiting time because it’s just not very nice when you could have three or four people round each bed and you’re behind a curtain, that’s not very nice.” Midwife L (line 427).

A couple of the midwives suggested they would take the woman to a side room rather than assess her during visiting time, however this did depend upon the availability of a side room. Several of the postnatal ward midwives identified that they attempted to complete maternal postnatal assessments in the morning prior to visiting time in an attempt to ensure privacy. The midwives did acknowledge that sometimes women wanted partners to be present and these midwives stated they would ask the woman her preference regarding the presence of partners during postnatal assessments.

In the community location the midwives also articulated privacy as a concern. Midwife E suggested not all women appreciated the potential intimate nature of the postnatal assessment and therefore did not always seek or provide privacy for the assessment.

“They’ll say, ‘Oh no, it’s fine,’ and you’re thinking, ‘It’s fine and you’ve got all these visitors sitting in the house? And I could possibly want to check your bottom and feel your tummy and things.’” Midwife E (line 333).

Five of the midwives discussed experiences in which others present during postnatal assessments began to contribute which they felt resulted in the

woman receiving confusing and conflicting advice which could be detrimental to her care. The majority of the community midwives stated they would request to go somewhere private in the woman's home if they felt unable to undertake the postnatal assessments effectively. They felt on most occasions women were amenable to this suggestion.

“I always say, “Get the baby and we'll go upstairs and do this,” and I think half the time, they're glad that you've said that because it gets them out of the room. Lots of times when you get them upstairs, they'll say, “They're doing my head in down there, passing my baby about,” you know, the normal things that women say so I think they're quite glad sometimes to get away.” Midwife N (line 622).

However the midwives ability to gain access to a private location may also be modified by the woman's home circumstances.

7.3.1.3 Home circumstances

Three of the community midwives identified circumstances and conditions within the woman's home, which may modify the midwives' ability to successfully undertake genital tract assessment. A couple of the midwives stated that over crowding may make accessing a private location in the community setting difficult. This appeared to be particularly the case for younger mothers who may live or have moved back to the family home because of the pregnancy. Midwife G provided several narratives from her practice experience involving overcrowding impacting upon genital tract assessment. In one account she considered the overcrowding was instrumental in a woman declining genital tract clinical observations and therefore preventing appropriate and timely intervention to prevent wound breakdown.

“She's actually sharing a bedroom with her two younger sisters and the baby, so there's nowhere to go. There's nowhere to go to examine her. There was no privacy, ... and that was why she didn't want to be examined and didn't want anybody going into the bedroom . . . she couldn't even put the baby in a cot, she was bed-sharing with the baby which led to a referral to Social Services.” Midwife G (line114).

Three of the midwives highlighted home conditions involving hygiene and resources that had impacted upon maternal genital tract assessment. This may be due to limited access to bathing facilities, due to overcrowding or limited finance and the cost of heating water, resulting in poor perineal hygiene.

In addition the midwives discussed the difficulty of undertaking clinical observations involving visual inspection in some homes due to poor levels of lighting.

“You can go into some houses, I mean, some of the houses I go into, there’s a lot of poverty to be honest and sometimes it’s a dark room, really quite dark, dingy. And sometimes there isn’t enough light.” Midwife M (line 401).

I also noted this during the observational data collection. A very young woman was living in a house with bare walls, no paint or wallpaper or floor coverings and there was one low wattage energy efficient light bulb in the room. Despite it being daylight the light levels were poor, luckily this woman did not need clinical observations. Midwife G discussed an example involving a woman who delivered at home unplanned, but the midwife arrived at the time of the birth. The midwife could not successfully examine the condition and integrity of the perineum due to the poor lighting and had to transfer the woman to hospital so the perineum could be assessed effectively.

7.3.2 Competing priorities

Competing priorities is the second focused code within the category of care in context. All of the midwives in this study provided comments or activities that contributed to the data within this focused code. The data highlight a range of demands all of which may have a claim to priority or higher ranking for attention due to greater significance or importance in the context of postnatal care. The ability of the midwife to respond to these demands was affected by the range and simultaneous nature of the demands placed upon them. These created tensions and contradictions and could modify their

ability to effectively assess the woman's genital tract health. The competing priorities identified within the data are clustered and presented in three codes; competing priorities for women, competing priorities for midwives and competing priorities and the content of postnatal care.

7.3.2.1 Competing priorities for women

Three midwives during interview data collection identified occasions in which they felt postnatal women had other priorities competing with their need for midwifery postnatal care and advice. These competing priorities modified the woman's ability to engage in the postnatal interaction and care. Midwife N identified other children needing attention as a competing priority for the woman, as the following quote indicates.

“They've got three other kids running around, the last thing they want to be doing is getting undressed for you to be checking them out. They're more worried about what the kids are doing in the kitchen because they're too quiet.” Midwife N (line 615).

Similar situations were noted by the researcher during observational data collection either involving older children or the neonate needing maternal attention.

Midwife G identified the sometimes complex personal circumstances of women as competing priorities for their attention. For example an incident involving a woman's estranged partner and his family who visited the baby. The woman, feeling distressed, left the house during the paternal visit and was subsequently not at home when the midwife visited.

Some women have limited finances and this may modify their ability to respond to midwifery advice concerning bathing but also purchasing sanitary towels to change them as frequently as advised (midwife H line 113).

7.3.2.2 Competing priorities for midwives

Half of the midwives identified the diverse range of their activities as contributing to competing priorities. Midwives in the community may need to complete postnatal visits in time to commence antenatal clinics or attend safe guarding meetings. The midwifery staff working in the hospital had to deal with a diverse range of activity as the ward was mixed antenatal and postnatal. As suggested by midwife K this created further competing demands for the midwife.

“You could have anything, maybe six or seven patients that were yours to manage and obviously prioritise care. And that’s just a different skill needed from delivery suite, and learning how to do that, all the different scenarios . . . It depends if you’ve got a mix of patients, if you’ve got antenatal patients that you’ve got to get on CTGs that you know doctors are going to come up to review.” Midwife K (line 43).

In addition a couple of the community midwives discussed challenges they faced when trying to get appropriate medical support for their women. During observational data collection midwife G was observed telephoning the General Practitioners surgery to inform the General Practitioner (G.P) a woman possibly needed antibiotics for abdominal tenderness. The G.P receptionist stated she could provide the woman with an appointment with the GP for a couple of days later. Therefore the midwife spent more time on the telephone until she was assured the woman would be seen that day within a few hours by the doctor. Midwife C provided a similar account involving a woman who had a perineal wound infection and using the out of hours doctors service.

“I rang the out of hours service while I was there, explained what we needed but you still have to go through the rigmarole of . . . they will ring a woman back, they will then arrange to see the woman, not at their home, they have to go somewhere to be seen before they can be got the antibiotics but that’s the protocol here.” Midwife C (line 129).

The midwife left instruction to the women if they did not ring back she was to again ring the midwife or the postnatal ward. Seven hours later the woman contacted the postnatal ward because the out of hours service had not telephoned.

The midwives in this study attempted to overcome these organisational difficulties usually by undertaking additional activities such as collecting prescriptions themselves. However this further increased the diversity and competing demands upon their activities and time.

Three of the five hospital based midwives that were interviewed explicitly identified staffing levels as a concern which modified the midwives' ability to respond to all the demands upon their time. The midwives suggested when the ward was busy there was not sufficient staff. This was exacerbated by staff on the postnatal ward being asked to help on delivery suite. This either resulted in less staff to provide midwifery care on the postnatal ward or the midwife would return from helping in delivery suite half way through the shift to find her workload on the ward still needed completing but now with less time to do so. One of the postnatal midwives felt strongly that competing priorities and resources should not impact upon assessing maternal genital tract well being, but she was the ward manager and therefore perhaps had more confidence and the professional clout to say no if other areas wanted staff and the postnatal ward was busy.

Other midwives raised a similar issue but instead of focusing upon less staff they focused upon less time. Half of the midwives stated they did not always have sufficient time to attend to all of the activities, roles and responsibilities expected of them during a working day. Several midwives indicated insufficient time would impact negatively upon their ability to establish a rapport with the woman. In addition the midwives suggested insufficient time lead to activities being undertaken quickly, trying to "contain" the content and focus of their activity and keep to time. Midwife N made more time for her midwifery activities by using her personal time.

"But, you know, that's just the job, isn't it? We all know that. Don't have any lunch and going in after five." Midwife N (line 250).

Several of the midwives suggested this limited time reflected an increased midwifery workload with greater diversity of activity. One activity cited by the

midwives was multiple, repeated and numerous completions of documentation. Particularly for the hospital midwives who needed to document activities in several locations. Frequently the content of the documentation related to recording what a midwife had done or given rather than what a woman's care needs were. Within the motivator theme documentation was identified as a driving force for midwifery action. It also appears it may modify the midwives' time to respond to other maternal needs.

7.3.2.3 Competing priorities and the content of postnatal care

Half of the midwives also identified competing priorities arising in relation to the content of postnatal care. Several of the midwives suggested the content of postnatal care, although it still included traditional aspects such as maternal genital tract assessment, now had a larger remit and content than previously. This included greater emphasis upon emotional and social issues and health promotion, particularly neonatal advice and screening including undertaking detailed neonatal examinations previously undertaken by medical staff. This was very evident during observational data collection particularly when observing the midwives working on the hospital postnatal ward. The amount and range was staggering and the observational data confirm the following account provided by midwife L.

“I feel sorry for the women sometimes because we've got so much information to give them on their first day, once they've delivered and they come up . . . then you've got your postnatal check and all the information that you give them regarding the postnatal check. Then you've got the baby check and new information about the baby check, and then you've got all your leaflets to go through the SIDs recommendations and the TOG values with them and then obviously you've got contraception . . . you've got the registration form to give them, the birth to 5 book to discuss, jaundice – they're just absolutely bamboozled, and then the hearing screening comes round and gives them more information. And then the paed comes round and does the baby check, contraceptive nurses come round. We had a smoking adviser at one point, the bounty lady and sometimes they'll get all of that on one day and sometimes I just think that it's hard enough to get them out to have a wee never mind bombarding them with all that information.” Midwife L (line 506).

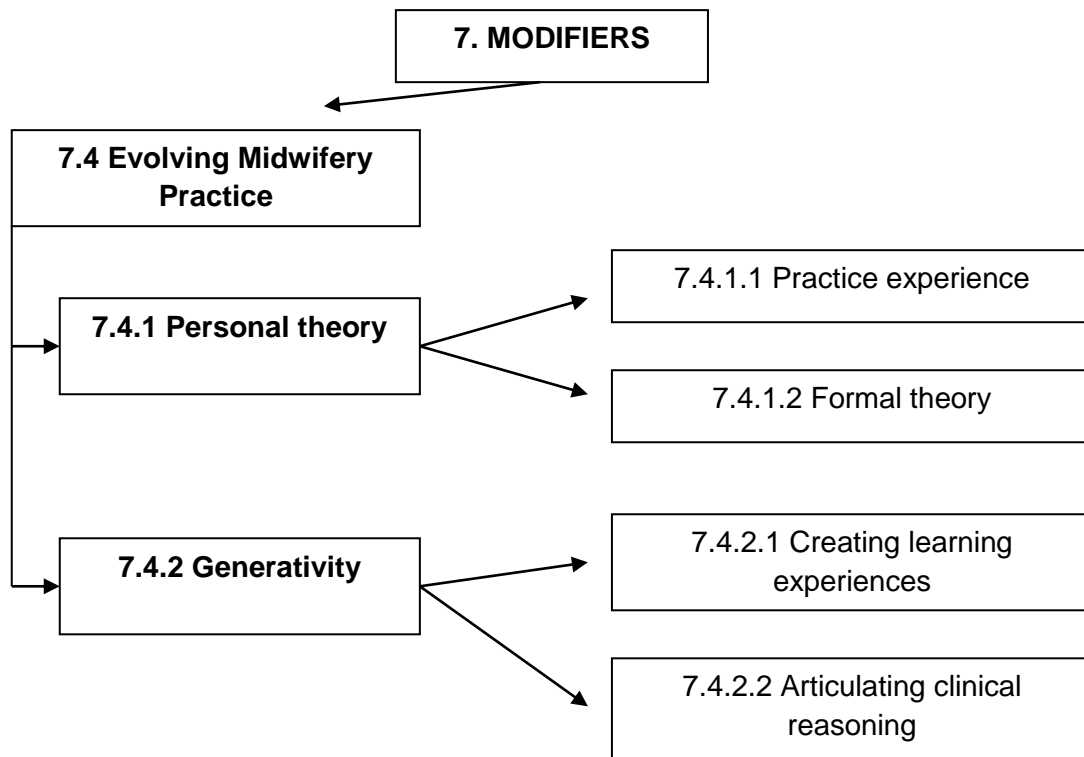
Several of the interviewed midwives and the observational data suggested women are exposed to information overload as described in the quote above. This allowed midwives to tick the box that information had been given, however I as did several of the midwives, wondered if the information was comprehended or assimilated by the women.

Over half of the midwives suggested that information overload is accentuated by the decreasing time given to postnatal care. Time on the postnatal ward for the majority of the women in the study locality is less than 24 hours. Therefore much of the interaction with the woman and midwife in the postnatal ward involved the midwife greeting the woman, trying to build a rapport, giving them information and simultaneously discharging them (midwife L line 539).

Several of the community midwives acknowledged the number of postnatal visits had reduced considerably over the past ten years, to an average of three visits. The timing of the visits tended to be around neonatal screening requirements, for example to weigh the baby or complete blood spot screening tests. The midwives acknowledged a reduced number of postnatal visits were appropriate for many women, however midwife G, line 453, considers “it has gone too far the other way.” There does appear to be a contradiction between the diminishing time given to postnatal midwife and woman contact and the increasing content and remit of postnatal care. As concluded by midwife E;-

“We need to raise awareness of the importance of postnatal care for women. I mean it is a Cinderella service as we know.” Midwife E (line 221).

7.4 Evolving midwifery practice



The third and final category within the theme of modifiers is evolving midwifery practice. The term evolve is “to develop gradually, especially from a simple to a more complicated form” (Oxford Dictionary 2011j). Here I identify and discuss the midwives’ accounts of changes to their practice knowledge and actions, which they considered might have modified their approach to maternal genital tract assessment. In addition it includes the midwives’ thoughts regarding the learning experiences available for student midwives regarding genital tract assessment. All of the data for this category originate from the midwifery interviews as none of the observations of the midwives practice involved student midwives. Asking the midwives if and how their practice had changed was one of the areas in the original interview guide I had developed prior to commencing data collection. However several of the midwives did spontaneously articulate how their midwifery postnatal practice had evolved over time. All of the interviewed

midwife participants made comments, which have contributed to this category.

The data relating to evolving midwifery practice are clustered and presented in two focused codes. The first is personal theory in which the midwives discuss how and why their practice has evolved. The second code presents data related to how midwives attempt to pass on their practice knowledge to the next generation of midwives and is titled generativity.

7.4.1 Personal theory

All of the midwives in this study articulated their personal theory that is their individual ideas and beliefs concerning postnatal care and maternal genital tract assessment. Personal theory is “theory in use” which directs the actions of the individual midwife (Argyris & Schon 1974). The midwives highlighted and discussed factors that had contributed to the development of this personal theory of maternal postnatal genital tract assessment, throughout their midwifery careers. These included practice experience and formal theory.

7.4.1.1 Practice experience

The most frequently cited influence upon the midwives’ personal theory was practice experience. Several of the midwives considered when they had been newly qualified midwives, with limited experience; they frequently used clinical observations to confirm maternal genital tract condition. However the majority of the midwives suggested as their repertoire of diverse practice experiences in relation to maternal postnatal genital tract assessment grew, so did their confidence and ability to use a broader range of genital tract assessment methods. The midwives suggested practice experience developed their skills and abilities to interpret and respond to signs and symptom, provided from a range of sources concerning genital tract condition. Therefore the midwives no longer felt they needed to depend upon personally undertaking clinical observations but to differentiate when clinical observations may be useful.

“But I guess what the experience has done has given me the confidence in my own beliefs, my own knowledge and my own...yeah, I know what I’m doing and this woman’s absolutely fine.” Midwife I (line 573).

Half of the midwives suggested learning from and with others in practice helped to develop their understanding and skills. Three midwives identified how their initial pre-registration experience had influenced their evolving personal theory by exposing them to appropriate practice experiences and enhancing their skill development. This was phrased by midwife E (line 646), whose pre-registration experience had been over twenty years earlier, as working with “a really good midwife.” This suggests the desire to emulate perceived “good” practice might have a long lasting impact upon personal theory development.

Seven of the midwives identified learning from and with midwifery colleagues since midwifery registration. This involved discussing genital tract assessment experiences with colleagues. The midwives suggested by sharing their experience, and listening to the experiences and practice of other midwives, their repertoire of experiences was enhanced, developing their personal theory.

Therefore the midwives’ practice experience helped to develop their practice and their personal theory. However this was cyclical as their personal theory evolved concerning maternal genital tract assessment this would influence their future practice and therefore subsequent practice experience. For example, as the midwife felt she no longer needed to personally clinically observe all women’s perineum’s’, but use other methods such as questioning, her experience of using questions would grow which would refine the midwife’s personal theory.

7.4.1.2 Formal theory

Few of the midwives explicitly identified formal theory as contributing to their personal theory of maternal genital tract assessment. On a couple of occasions when I asked participants what knowledge influenced their

practice they appeared a little anxious, midwife J, line 574, responded “I hope that’s not a trick question!” My professional background as a midwife teacher and with some of the midwives this included contributing to their pre-registration curricula education, may have contributed to this anxiety of being perceived to be quizzed on formal theory. However the majority of the midwives implicitly discussed formal theory. This was most evident when they discussed signs of the genital tract condition and related these signs to postnatal physiology and principles of wound healing.

A couple of the midwives made general comments regarding reading midwifery literature to keep abreast of new ideas. In addition midwife E discussed reading and applying to her practice an alternative position for genital tract assessment, as discussed in the previous chapter.

Five of the midwives acknowledged that expectations regarding the content of midwifery postnatal practice had changed over time and this changing philosophy had influenced their practice. The midwives suggested in the past there had been more focus and expectations upon routine use of clinical and physical assessments of women. The midwives suggested there was now less emphasis upon routine tasks such as “checking women” physically, with more emphasis upon an individual approach to postnatal assessments and midwifery practice. These changing formal expectations of the focus and content of postnatal midwifery practice had modified the midwives’ practice actions. These midwives suggested they did not feel compelled to undertake routine activities and that this had helped to develop their clinical reasoning ability as they made practice decisions regarding the most appropriate method of maternal genital tract assessment for a particular woman on a particular occasion.

“I think years ago, because things were done routinely, we weren’t actually thinking, ‘Right, what are we looking for?’ and giving the woman some choice in that, to actually tell us if she had a problem. It was just that this is what we had to do, and then right, that task’s done so more task-orientated.” Midwife H (line 351).

7.4.2 Generativity

The midwives discussed how they attempted to pass on their practice knowledge concerning maternal genital tract assessment to the next generation of midwives. This concern with guiding and establishing the next generation is a recognised facet of life span development, with the term applied to this activity by its founder Eric Erikson as generativity (Shaffer 2005). Through this generative process the midwives could potentially modify future evolving midwifery practice. This guidance of practice novices was not an explicit aspect of my initial interview guide, but arose out of the analysis of the initial data collection interviews. Therefore not all midwives were asked about or discussed aspects of generativity, potentially reducing the data pool. The midwives discussed two principal approaches they used with student midwives, creating learning experiences and articulating clinical reasoning.

7.4.2.1 *Creating learning experiences*

Half of the midwives suggested student midwives needed experience of clinical observations of the maternal genital tract postnatally to enable them to develop a repertoire of experiences to draw upon. The midwives also considered clinical observations enabled the student to comprehend the physiological processes of the puerperium in action. These included the tone and position of the uterus and its involution, the differing amounts, appearance and smell of lochia and the appearance of the genitalia postnatally. The sequential changes during the wound healing process if the perineum had trauma or sutures should be observed. As suggested by midwife I;-

“If you know what a perineum looks like, or should be looking like when it’s healing, then you’ll know when it’s not healing correctly. So I think students still need to do that because until they’ve done that x amount of times, then they won’t get to the point of feeling confident.” Midwife I (line 627).

However several of the midwives believed contemporary student midwives gained less experience than previous students, of the normal physiological

parameters of the postnatal period. This rationale for this was suggested to be two fold. Firstly there was less postnatal contact with women due to a reduction in the number of postnatal visits and secondly there was less routine physical assessments including clinical observations used by qualified midwives. Some midwives felt this reduced exposure to experience for student midwives was inevitable and unavoidable, whilst other midwives tried to find ways to maximise upon learning experiences for students.

A tension was created for these midwives between the need to provide individualised care for postnatal women, avoiding unnecessary visits or clinical observations and the need to create learning experiences for student midwives to ensure the future generation of midwives had the skills and abilities to employ a full range of genital tract assessment methods. To provide learning experiences for student midwives seven of the midwives stated they would adapt their postnatal practice to create learning experiences. For several midwives including midwife G (line 692), this involved making sure she employed “a full check” of maternal physical health so that students would become aware and competent at all potential aspects of postnatal assessment.

The most frequently cited adaptation of practice, by five midwives, involved palpating the uterus of women whom the midwife may not otherwise have felt the need to palpate, to enable the student to appreciate normal uterine involution.

“I think when you’ve got a student, you probably have to do it more because they’re learning so they’ve got to be able to know what a postnatal fundus feels like . . . so they can tell if involution’s taken place. And that’s something that they have to learn, whereas us oldies who’ve been doing it for years, you can tell if somebody’s lochia’s normal and they’re not passing any clots and the colour of it, you know. You don’t have to put your hand on them.” Midwife E (line 589).

Several midwives suggested if they were using clinical observation to assess the woman’s perineum they would ask the woman’s consent for the student to also be involved in the assessment. Two midwives suggested

they might clinically observe the woman's perineum more frequently to create a learning experience for the student midwife.

Midwife H, identified creating learning experiences for student midwives in relation to assessing lochia. This may involve requesting to see a woman's sanitary pad or asking her to leave a used pad in the sluice.

“I would make sure they knew what a normal amount was, so I think it would just depend on the student's experience. Probably if they were a new student and I thought the woman was a good candidate, I probably would say, ‘Do you mind if I have a look at your pad?’ just for the student's experience, so she knows how much lochia there should be on day one . . . we would ask the woman, when she changed her pad, just to leave it in the sluice so we could have a look. “ Midwife H (line 446).

In the above quote, midwife H identifies “a good candidate”. Several midwives suggested they would involve women selectively in such learning situations, limiting the inclusion to those women they felt would be amenable and comfortable to such involvement. In addition, Midwife H as do other midwives acknowledges creating learning experiences for student midwives will depend upon the individual needs and experiences of the student. Midwife N suggests as the student becomes more experienced she encourages them to move away from ritualistically moving through the various aspects of postnatal assessments, to basing the assessment around a discussion with the woman.

7.4.2.2 Articulating clinical reasoning

Half of the midwives, usually in addition to creating learning experiences for students midwives, suggested they attempted to provide students with exposure to their clinical reasoning processes. Seven midwives stated they would articulate and explain what they were doing and also why and what factors had influenced the assessment approach they adopted. Two of the midwives also identified that with more experienced students they would reverse this process, encouraging the students to provide analysis and rationales for their practice actions and findings. Therefore some of the

midwives in this study created learning experiences and encouraged the articulation of clinical reasoning to pass on their knowledge of genital tract assessment to student midwives. This generative process enabled the midwives to modify the knowledge and practice experiences of student midwives and therefore influence future midwifery practice.

7.5 Conclusion

In this final data chapter I have identified, modifiers that facilitate or inhibit the midwives' ability to negotiate an appropriate approach to assessment of maternal genital tract during the postnatal period. These include the qualities and attributes of the therapeutic relationship between the midwife and woman; contextual factors including location and competing priorities and evolving midwifery practice. These data have provided evidence of midwives using conditional, interactive and narrative clinical reasoning within their postnatal practice. In addition several of these modifiers created tensions or contradictions for the midwives, which could amplify the facilitative or inhibitory effect upon the midwives' practice.

The chapter has also provided some insight into how some midwives attempt to involve women in the process of the assessment of their genital tract utilising components of the therapeutic relationship to engage and negotiate with women. The therapeutic relationship is also used to provide an opportunity via telling stories to help women make meaning of their childbirth and postnatal genital tract experiences.

Within this chapter the data suggest that occurrence of these potential modifiers and the ability of the midwives to maximise facilitative and minimise inhibitory aspects, may modify the midwives ability to negotiate an appropriate approach to maternal genital tract assessment.

Chapter 8

8. Chapter 8 - The Discussion

8.1 Introduction

In the previous three chapters of this thesis I have presented my analysis of the research findings. This chapter intends to integrate and discuss the principal findings from the data with the existing evidence base. I will highlight how this thesis contributes to midwifery knowledge concerning the experiences and practice of midwives in relation to the assessment of maternal postnatal genital tract health.

The findings of this study provide a comprehensive exploration of the experiences and practice of the participant midwives, in relation to assessment of postnatal genital tract health. No other contemporary midwifery research has explored this particular focus of midwifery practice from the perspective of the midwife. Therefore the findings will make a unique contribution to the professional knowledge base. In addition some of the issues raised from the findings have transferability for other aspects of midwifery practice, such as factors impacting upon midwives' care decisions and the clinical reasoning process. In turn, as I have used a breadth of literature from a range of professions including occupational therapists, social workers and the nursing profession, I would hope that the findings of this research may be relevant to other professional groups.

The discussion will commence by returning to the original research intentions developed upon commencement of this study. I will consider and summarise the extent to which this work has achieved those intentions. The grounded theory conceptual model developed from the study will then be critiqued. The discussion will include how the theoretical concepts drawn from the research data integrate to form the grounded theory. The evaluation of my grounded theory conceptual model will also highlight how these theoretical components connect but also elucidate conflicts and

tensions within the data and how this understanding contributes to the grounded theory.

I will sequentially discuss each of the research themes, identifying and relating the principal findings to existing midwifery knowledge. I will highlight areas, which confirm or develop the existing knowledge base and those, which offer new and unique contributions. In a constructionist study it is the reader who takes meaning from the account and develops new perspectives and potential areas of transferability. However I will offer potential suggestions from the insights gained from the grounded theory for others to consider. These will include implications for midwifery practice, education and research.

8.2 Achievement of the research aim and objectives

My findings suggest midwives do recognise the need to assess maternal genital tract health postnatally and employ a range of assessment methods. These findings help respond to the research aim and objective 1 (chapter 2), by providing insights into how and the potential range of, approaches to assessment of postnatal maternal genital tract health contemporary midwives employ. These reflect the midwives use of procedural reasoning, involving the application of existing technical and procedural knowledge, regarding genital tract morbidity and assessment processes within their practice (Mattingly & Fleming1994).

The midwives also highlighted a range of factors, which motivated and modified how and when they undertook maternal genital tract assessment. The conclusions drawn from the discussion of these findings contribute to objectives1 and 2 by providing insights into how and why midwives determine their approach to assessment of postnatal maternal genital tract health and the range of interactive, conditional and narrative reasoning which informs their practice (Mattingly & Fleming1994).

The discussion arising from the motivators and modifiers themes, particularly the findings related to the categories of verification and sensitive care contribute to responding to research objective 3 by discerning the midwives' experiences and practice of involving women in determining the approach to genital tract assessment. However the degree of maternal involvement was more difficult to elicit and is discussed later in this chapter.

8.3 Towards a grounded theory

The findings have enabled me to construct a new theory of midwifery practice in relation to maternal postnatal genital tract assessment (appendix 11). The grounded theory framework, which has been discussed in detail in chapter 3 of this thesis, draws out Methods, Motivators and Modifiers themes. However these themes are dynamic. They interact, relate and simultaneously apply to the midwives' reasoning as they undertake postnatal genital tract assessment. For each midwife, woman and context there are different connections, resulting in differing midwifery practice responses.

Connections can result in the midwife employing a particular genital tract assessment method, reflecting her application of procedural reasoning. For example heavy maternal vaginal blood loss stimulates a midwife to undertake clinical observations of the lochia and uterus. These areas are easily identified, as are any omissions in anticipated response, and they are critiqued later in this chapter when the themes are discussed in turn. However simultaneously impacting issues from within the motivators and modifiers themes can create tension, particularly when differing concepts appear contradictory. In addition these tensions synthesise to create new challenges making the clinical reasoning process increasingly complex for the midwife.






8.4 Contradictions & tensions

The tensions and contradictions identified by the midwives arose from interactions impacting upon aspects of midwifery activity in relation to

maternal genital tract assessment. For example as highlighted in chapter 7, midwives state they need to provide more information to women following childbirth, however they simultaneously report less contact time allocated to postnatal care, as discussed in section 8.7.1.2 in this chapter.

In addition the findings of my research suggest tensions and contradictions are also evident within the midwife and woman relationship. The midwives recognised that trust and rapport were important attributes that could modify their ability to provide appropriate and effective care, which is discussed in detail in section 8.7.1.1 in this chapter. However they also identified contradictions, which resulted in potential tensions within the relationship and communication they had with women. If the tensions were not effectively managed by the midwife this could impact upon the success of the therapeutic relationship and therefore their ability to assess the woman's genital tract. I have summarised these contradictions, below, with the arrow indicating the area of potential tensions between.

8.4.1 Table 2 Contradictions and tensions

Friendly		But not a friend
An equal partner		Having expert knowledge
Maintaining dignity		Undertaking intimate examinations
Being non-judgmental		Making judgements re when to disclose information
Facilitating privacy		Enabling disclosure

Relationship dialectics such as these are a recognised feature of communication within close relationships (Baxter 2004; Griffen 2009). However these communication tensions have not previously been articulated, applied or identified to midwives' experiences and practice regarding maternal genital tract assessment.

Downe (2010) suggests childbirth is a process, which is complex and dynamic living in a "state of flux". The conclusions of Skinner (2010), a midwifery lecturer in New Zealand, who developed a model of midwifery practice, which includes "working with complexity" are brought to mind. She suggests tensions and contradictions are natural phenomena, which are not inherently negative attributes but may stimulate creative and innovative responses, rather than a standardised approach to midwifery practice. To provide individualised care requires clinical reasoning, which utilises an abductive approach, integrating all form of reasoning and knowing, to provide a midwifery response more sensitive to the needs of the individual woman, family, midwife and context (Rolfe 1996; Fleming & Mattingley 2008).

Several authors stress the need to ensure evidence for practice reflects a range of perspectives. These are not only those traditionally seen at the pinnacle of the evidence hierarchy, randomised controlled trials, but also findings from qualitative research, incorporating midwife expertise and women's preferences. This would ensure a broader understanding which prevents a particular interpretation dominating and a one size fits all approach to care and practice (Gerrish 2003; McCourt 2005; Kinsella 2007; McCracken & Marsh 2008; Rycroft-Malone *et al* 2009). These concepts can be seen in the categories and codes within my study as midwives articulate the need to reflect maternal preferences and provide sensitive care within a therapeutic relationship. Such characteristics have also been identified as requisite for expert midwifery practice. A meta synthesis, exploring accounts and qualities of expert intrapartum midwifery skills, concluded that expert midwives integrate a range of forms of knowing and knowledge, reflecting a woman focused, individualised approach (Downe, Simpson & Trafford

2007). This holistic approach is fostered by the values and beliefs held by the midwife, concerning the processes of childbirth and the abilities of the woman

My research indicates that some midwives' practice responses fluctuated, in response to individual maternal and contextual considerations. The discussion in categories such as maternal preference, verification of accurate information and utilising genital tract assessment as access or subterfuge when providing sensitive care, provide evidence of these individualised midwifery responses. My study suggests in some instances and circumstances, midwives can negotiate and operate within the complexity, tensions and contradictions inherent in the process of providing effective genital tract assessment. However the data also identified some instances, which fostered dominance of a particular tension, such as the needs to complete documentation overcoming the belief that vital signs are not required. Another tension was observed where the woman was burdened with a plethora of information despite the midwife being aware that her client had reached information saturation. The expectations and requirements of external agencies assume a centrality in the care processes. Such practice resulted in care that was not individualised or holistic. Downe, Simpson & Trafford (2007) also identified "practice paradoxes" in which competing and contradictory evidence influences the midwives' practice that could result in some midwives conforming to such influences and suppressing their expert midwifery insights and practice, resulting in providing standardised care that they did not necessarily support.

These practice tensions and contradictions must be acknowledged within the professional literature and midwifery education to provide midwives and student midwives the opportunity to consider and rehearse for the reality of contemporary midwifery practice.

8.5 Methods of assessment

Midwives recognise the need to assess maternal genital tract health postnatally and employ a range of assessment methods including, risk assessment, questioning and clinical observations. These contain aspects, which are similar to those advocated within the professional literature and national guidance and confirm the midwives application of procedural knowledge during their assessment of maternal genital tract health.

8.5.1 Findings that contribute to the existing evidence base

Some of the issues raised in relation to risk assessment as a method of genital tract assessment, such as insufficient dietary intake and obesity, concern aspects of practice already identified and discussed in the midwifery evidence base. However the qualitative nature of my study highlights how particular issues such as these may apply to postnatal genital tract health, associated midwifery assessments and practice. Therefore the findings from this study will enhance the professional knowledge base by contributing to the complexity and situated understanding of these factors in relation to genital tract assessment.

The findings of my study suggest the universal use of behavioural cues and observing if the woman looked well to indicate morbidity including pain and lethargy associated with poor wound healing, infection or anaemia was widespread. The remaining observations, which involved specific midwife and maternal actions, such as vital signs, observing lochia, perineum and palpating the uterus, were not used universally, but selectively, as advocated by national guidelines (NICE 2006).

In this study there was no evidence that midwives used any particular tool to identify women's perceptions of pain, but relied on the women's qualitative comments and comparative assessment of symptoms over time. Steen (2008 p. 386), as part of an evaluation of the analgesic effect of a perineal cooling system involving 317 women, identified women's perceptions of their

perineal pain from birth to the fifth postnatal day. On day one and two, women used words associated with acute wounds such as “*sore, throbbing, aching tender and stinging*” and thereafter the women’s descriptions of their pain appeared to reflect that the pain severity diminished over the five-day period.

These views appear to support the actions and expectations of the midwives in this study, who encouraged the women to use descriptive terms to describe their pain. They anticipated that women’s descriptive responses should normally reflect a reduction in pain and corresponding changes in descriptive words, over time and that midwives would suspect perineal morbidity if this was not the case. Further research of this area is warranted to explore and develop a descriptive rating scale which would be useful for women to self assess their progress, for midwives when making pain and potential morbidity assessments and contribute to student midwives’ learning experiences (Research and education implication A).

8.5.2 Findings that conflict with the existing evidence base

From my research I also identified issues, which conflicted with the existing evidence base and these findings make an original contribution to the midwifery knowledge base concerning midwives’ experiences and practice of genital tract assessment. The midwives demonstrated some omissions and limitations regarding perception of risk factors, their use of questioning and clinical observations for genital tract morbidity.

The midwives tended to identify and associate risk factors and questioning with the health of the woman’s perineum. They were significantly less likely to make explicit reference to risk factors or employ questions that pertained to uterine morbidity such as for postpartum haemorrhage or genital tract sepsis. A number of the general symptoms midwives questioned women about are non-specific symptoms, which occur with most illnesses (National Institute for Health 2011). Other general symptoms, which have a potentially greater association with genital tract sepsis, were not articulated

by any of the midwives, such as symptoms of beta-haemolytic streptococcus Lancefield Group A (*Streptococcus pyogenes*) (GAS) infection including sore throat or upper respiratory tract infection and generally occurs over the winter months (CMACE 2011). None of the midwives identified women who work with or have young children as being at greater risk of Group A streptococcal infection (CMACE 2011).

Similarly, despite many of the midwives in my study perceiving that a woman looking well was a reassuring sign of health, many childbearing women are relatively young and fit and their bodies are able to physiologically compensate until the later stages of acute illness, such as genital tract sepsis (CMACE 2011). The women tend to appear well and very suddenly become extremely ill with generalised symptoms of morbidity, at which time "*it may be too late for effective treatments*" (CMACE 2011 p.92). Therefore a woman appearing to look well cannot be interpreted as a confirmation that she and her genital tract is healthy. In addition none of the midwives identified noting the woman's respiratory rate as a clinical observation method for genital tract sepsis. As highlighted by CMACE (2011 p.92) "*tachypnoea (respiratory rate higher than 20 breaths per minute) is sepsis until proven otherwise.*" Bick, MacArthur and Winter (2009) also suggest that midwives encourage the woman to palpate her own uterus, to develop awareness of physiological changes. However none of the midwives in my study articulated or demonstrated encouraging maternal self-assessment of uterine palpation.

Only one third of my study midwives made an explicit reference to questioning the woman regarding uterine or abdominal pain, in comparison with all midwives identifying perineal pain, and none identified asking about diarrhoea. Uterine pain, particularly tenderness and diarrhoea may be indicative of uterine morbidity such as genital tract sepsis (NICE 2006; Bick, MacArthur and Winter 2009; CMACE 2011). Midwives C and M identify flu like symptoms, but did not specify what they considered these symptoms entailed. Flu symptoms include raised temperature, sore throat, cough, general aches, fatigue, sneezing, diarrhoea and loss of appetite (NHS

Choices 2011). Therefore there is overlap between flu symptoms and those of GAS. During observation of midwife C with “Vanessa” the midwife did imply similar symptoms when enquiring if the woman felt “fluey” and perhaps if the woman had responded yes, or demonstrated other symptoms midwife C may have become more specific in her questioning. This may be also true for the other midwives in the study; potentially on different days they might provide different narratives of their practice. In addition morbidity and mortality from genital tract sepsis remains relatively rare (CMACE 2011) and perhaps therefore correspondingly unlikely to routinely appear in this study’s relatively small sample.

Risk factors and questions to identify signs of genital tract sepsis and postpartum haemorrhage, are not as readily recalled and identified by midwives in comparison to risk factors and questions for perineal trauma, which involves recognising existing morbidity, and then the potential risk of secondary morbidity such as wound infection. The rationale for this decreased sensitivity to potential risks and associated questioning is not clear from my small study. McIntosh (2011) acknowledges postnatal morbidity associated with the uterus, such as genital tract sepsis had been assumed to be no longer a viable threat. Its emphasis within midwifery practice and education has therefore diminished. The call from the recommendations from the CMACE Report (2011) for a “back to basics” improvement in midwifery practice including history taking and the signs and symptoms of emerging serious illness appear to support these conclusions. This highlights a need to raise awareness of the risk factors associated with genital tract sepsis and secondary postpartum haemorrhage (Research and education implication B).

Several of the midwives encouraged the women to self assess their own perineums, including viewing with a mirror. I have been unable to find within the professional literature a recommendation or any previous reports of midwives encouraging women to view the perineum to self assess its condition. Professional texts tend to suggest that women may self assess how the perineum feels, but would probably find directly viewing the

perineum difficult (Marchant 2009). It must be acknowledged that some women may find it physically difficult to view the perineum, particularly if they were obese. Other women may not wish to undertake self-assessment and as discussed later in this chapter in section 8.6.1, some women may have limited genital tract understanding to base a self-assessment upon. However maternal self-assessment of the perineum may potentially offer a more consistent approach to assessment of maternal genital tract well being, with one person, the woman, observing and noting changes. This may be particularly useful when there is limited continuity of a particular midwife providing postnatal genital tract assessment and hence is a recommendation from my research (Practice implication A).

8.6 Motivators

The midwives highlighted a range of factors, which motivated how and when they undertook maternal genital tract assessment. These motivating factors were conceptualised within this study as verification, personal preferences and sensitive care. Most of the principal findings within this theme are new contributions to the midwifery knowledge base.

8.6.1 Findings that conflict with the existing evidence base

Midwives used a pattern to their questioning, usually reflecting a head to toes linear approach which provides the midwife with her own informal symptom checklist. Concern has been expressed that rigid adherence to set patterns of assessing maternal well being, or in this instance set questioning, could be a task orientated approach to maternal assessment, which does not reflect individual need (Marchant 2009; Bastos and McCourt 2010). As suggested by Higgs and Jones (2008) when discussing clinical reasoning skills, pattern recognition if applied in a rigid manner by the practitioner, may focus too much upon trying to identify the prescribed pattern and overlook other salient client or context features. However the midwives within my small study suggested they did not let the pattern of questions, or the midwifery documentation dictate the questions they asked postnatal women, but acted as a safety net to help them remember what

they may find useful to ask about. To facilitate rapport the pattern of questions was embedded within a conversational approach with the midwives initially using broad opening questions, which tended to engage the woman and produce a more detailed women led response.

As discussed within the literature review chapter, “a symptom checklist” has been suggested to be useful to identify maternal health problems (MacArthur *et al* 2002; Bick, MacArthur and Winter 2009). As such some of the midwives appeared to have internalised their own “symptoms checklist.”

The majority of the community midwives suggested that a baseline of clinical observation of the genital tract was their preferred and common practice as it was useful to identify present condition and if future comparative assessments were required. Baseline clinical observations are recommended by Bick, MacArthur and Winter (2009). However this conflicts with the National guidelines (NICE 2006), which do not advocate any routine clinical observations unless the woman articulates a concern, or requests the midwife to examine her.

Bastos & McCourt (2010 p.122) consider the change in professional guidelines, to clinical observations by exception, may make midwives reluctant to use “proactive checking” raising their threshold sensitivity as to when they would employ clinical observations of the woman’s perineum during the postnatal period. However the midwives in my study suggested not all women had an accurate understanding of genital tract anatomy and physiology or knew what to expect in relation to their genital tract, following childbirth, including the physiological changes during the postnatal period. In addition the midwives highlighted that some women may not have the confidence or verbal skills to articulate concerns and initiate contact with the midwife and breach social taboos by asking for their genital tract to be examined. This resulted in the midwives needing to verify the woman’s understanding of her genital tract health. Some authors suggest reporting of morbidity is problematic, as some women may not know what constitutes “normal” physiological parameters following childbirth or lack the confidence

or motivation if they feel unwell, to articulate their concerns (Marchant *et al* 1999; Cattrell *et al* 2005; Herron-Marx, Williams & Hicks 2007; Gale 2008; Bhavnani & Newburn 2010; Beake *et al* 2010).

The midwives also suggested some women may find professional assessments of their genital tract condition reassuring, a finding also of the NCT survey of women's experiences (Bhavnani & Newburn 2010 p.27). Conflicting tensions for the midwives in my study were evident. To follow a perceived woman led and directed approach to care encouraging women to be autonomous, as advocated in a plethora of national strategy documents (Department of Health 2007; Midwifery 2020 Project 2010; Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010; Department of Health 2011a). However, also recognising and being sensitive to those women who are unable to identify or articulate their genital tract health or needs; or those who prefer more direction from the midwife.

Patients and service users demonstrate a range of "role preferences" in relation to the degree of involvement in clinical decisions influenced by individual patient motivators, engagement with information and support sources (Atkins & Ersser 2008 p.81; Edwards, Davies & Edwards 2009). However, Trayner (2003) suggests the ideologies of empowerment; consumerism and individual responsibility can underplay the impact of structural barriers. These limit empowerment and ability to engage in shared decision-making and include factors such as poverty and access to resources including knowledge and articulation skills. Cronk (2010 p.59), highlights that some women, particularly those who are young or disadvantaged may feel "quite threatened" by receiving limited direction, reflecting comments made by the midwives in my study.

In addition, lack of focused assessment of the genital tract by questioning or clinical observations may send an implicit message to women that their genital tract health is not a critical concern. As some midwives indicated women can feel that postnatal care is only about their baby. The literature

suggests this can reduce the likelihood of the woman raising any queries she may have or requesting more information or clinical observation. Dugdale and Hill (2005 pp 648) identify that many women do not disclose problems associated with perineal trauma for years and suggest “*midwives often fail women by their nominal interest*”. Findings from the national enquiry into maternal deaths identified women “*do not disclose or trivialised significant symptoms that might have allowed earlier intervention*” CMACE (2011 p.90). A content analysis of qualitative comments made by women in the Swedish longitudinal Survey highlighted some women felt “*they had been forgotten*” and had become “*disengaged*” regarding their postnatal physical health care needs (Rudman & Waldenstrom 2007).

A meta synthesis, exploring accounts and qualities of expert intrapartum midwifery skills, found that experts had the skills to be both responsive and led by the woman but also be responsive and when the need arose “*seize the woman*” and be more directive (Downe, Simpson & Trafford 2007 pp.134). Within my study, the midwives suggested a similar response. Women did not always raise concerns; on occasions they requested reassurance from the midwife undertaking clinical observations and for some women a more midwife led approach was deemed more appropriate. However if used indiscriminately, midwifery involvement can become controlling with inappropriate use of professional knowledge and power. Fahy (2008) discusses and applies the theories of Foucault to the midwife and woman interaction suggesting midwives may use power to induce submission and compliance of women, with women wanting to be seen as “*nice.*” There is some evidence that the midwives attempt to engage and negotiate with women when identifying their individual needs and preferences. However this effort is not consistent. My findings provide a small number of examples of how midwives can control women’s involvement in decision-making regarding their genital tract assessment.

On occasions the midwives appear to identify maternal individual needs focused upon the midwives’ consideration and interpretation of the woman’s individual needs. For example in the sensitive care category of the

constructed grounded theory, only one midwife stated she asked the woman which position they would prefer to adopt whilst her perineum was clinically observed. The remaining midwives articulated and employed what they considered was most appropriate practice response. In addition, despite several midwives acknowledging women were concerned about their sexual health, only one midwife acknowledged asking women and providing individual information and advice regarding sexual health. Although the midwives in this study appear to recognise and attempt to respond to individual needs, it is not always evident if they engage women in this process. This is an area which needs further research including determining the thoughts and preferences of postnatal women (Research and education implication C).

There is a need for midwives to remain flexible and adaptive, responding to different maternal needs, but to avoid polarised perspectives of genital tract assessment being either woman led or midwife led or unnecessarily controlling the woman's involvement. To facilitate this, a partnership model is advocated. Cronk (2010) argues that effective partnerships should mirror a transactional analysis of equal adult-to-adult relationship. However, partnership models must also be flexible dependent upon the individual needs, skills and contexts both the woman and midwife bring to the interaction, with power, knowledge and decision making being shared (Hook 2006; Millard, Hallett & Luker 2006; Brody & Leap 2008; Edwards, Davies & Edwards 2009; Pairman 2010; Mander 2011).

The midwives in this study suggested women needed practical guidance regarding their postnatal health rather than another leaflet to read, and that they prefer to undertake a baseline of maternal genital tract health. Therefore a practice suggestion arising from my research is that this baseline assessment could be explicitly undertaken within a partnership approach. For those women who would benefit from a more proactive approach, the midwife and woman can palpate the woman's uterus, observe lochia and perineal trauma together. They can then compare and relate what they have both seen and felt to anticipated physiological changes and

responses of the genital tract. This approach can then be reinforced with written information, a symptoms checklist approach, which can be a shared information resource for both woman and midwife. Women may thus become engaged in effective and meaningful self-assessment, including self-palpation of the uterus (Bick, MacArthur and Winter 2009), and as suggested by the study midwives also maternal viewing of the perineum. For those women who prefer or have no need for clinical observations the partnership model can involve shared use of questions to identify and compare with the written symptoms checklist, potential factors that would warrant referral (Practice Implication B).

8.6.2 Findings that contribute to the existing evidence base

My study identifies how midwives attempt to verify if they have sufficient information on which to base their assessment of maternal genital tract health. Most of the midwife participants attempt to integrate and use several assessment approaches simultaneously, using a sliding scale approach from the least intrusive form of assessment method, risk assessment, through questioning and then using clinical observations if the previous methods indicated a potential need, risk, or if there was inconsistency in the assessment information which needed verifying.

My study found several factors that would tip the sliding scale to suggesting clinical observations were warranted. These included a history of significant trauma during the birthing process, severe perineal pain, heavy or offensive lochia, abdominal pain or the woman feeling unwell. The contemporary literature and guidelines support such a response, suggesting these findings would warrant clinical observations (Macarthur & Macarthur 2004; Bick, MacArthur and Winter 2009; Marchant 2009; Bastos and McCourt 2010; Steen 2010; CMACE 2011; East *et al* 2011). Therefore the recommendation of a sliding scale approach is a useful practice strategy highlighted from my research (Practice Implication C).

The midwives suggested they recognised that postnatal women had a diverse range of competing physical, emotional and social needs and that for some women their genital tract needs may be a priority, but for other women this may not be the case. Some of the midwives in the small qualitative study by Cattrell et al (2005) also highlighted how the intimacy of genital tract assessment can be used to give time and permission for the woman to express other needs. However my study has provided insight into what these needs may be and if and how midwives and women use genital tract assessment to access them.

Several of the midwives recognised women had concerns regarding their genital tract function and appearance. The Swedish research by Olsson et al (2005) involving 27 postnatal women identified that women wanted professional guidance regarding sexual life following childbirth and reassurance that their body was “normal”. However only one midwife in this study suggested she explicitly used this opportunity to discuss sexual functioning and health. In addition there appeared to be limited appreciation of the frequency and genital tract implications of domestic violence, such as genital tract injuries and the pivotal role midwives are expected to play in identification of domestic violence (CMACE 2011; DOH 2011b). Some midwives may be missing a valuable health promotion opportunity during postnatal care interactions to provide information and guidance regarding women’s sexual health and information and referral to agencies in relation to domestic violence.

The midwives suggested a range of general advice measures concerning the care of their genital tract following childbirth, reflecting the advice advocated in midwifery texts (Marchant 2009; Jackson 2011). However on two occasions in my study, midwives were noted to provide premature advice, in which they did not specify when a symptom which may occur commonly in the immediate time following childbirth, would be considered as indicative of needing medical referral if it persisted. Herron-Marx, Williams & Hicks (2007) suggest women don’t always seek help about genital tract morbidity as they are influenced by a process of “normalisation” of postnatal

morbidity, fostered by advertising the use of lubricants and continence aids as normal following childbirth and also the approach of some midwives who trivialised and dismissed women's physical health concerns. Therefore it is imperative that when discussing postnatal genital tract concerns with women, midwives differentiate signs and symptoms, which may indicate morbidity, within a timeline of occurrence. This could be reinforced by incorporation into a postnatal symptom checklist (Bick, MacArthur, & Winter 2009; Herron-Marx, Williams & Hicks 2007).

A pertinent finding from my study concerns the perceptions of some midwives that women enter the postnatal period with their dignity "lost." How this loss impacts upon the woman's and midwives threshold for undertaking clinical observations of the genital tract postnatally is a unique finding. The loss of dignity was thought to occur during the woman's labour and birth as a result of repeated exposing of the woman's genitalia to health care professionals during examination. The midwives also discussed public and private areas of the maternal body. The midwives considered that women were more comfortable for their abdomens to be palpated but that genitalia were private and therefore women were more uncomfortable during perineal clinical observations. The findings suggest this notion of public and private areas affected not only the women (as reported by the midwife participants) but also the midwives, as they were significantly more likely to use clinical observations upon a wound in a woman's abdomen than they were with a perineal wound.

Other authors have suggested midwives' actions are influenced by their emotional responses. The student midwives interviewed in Hunter's (2007) study acknowledged they felt embarrassed by aspects of postnatal care, including viewing and touching women's breasts. Twigg *et al* (2011) suggest health care professionals attempt to distance and sanitise their actions in relation to the body to protect the dignity not only of the clients but also for themselves. The research by Stewart (2005) exploring the perceptions of midwives to vaginal examinations during labour identified how midwives tended to distance themselves from the procedure, whilst

undertaking vaginal examination, through ritualised actions and articulations, perceiving the woman's body as 'polluted'. Pollution following childbirth is associated with the lochia and trauma to the perineum and genitalia (Newell 2007). Avoiding clinical observations may distance midwives from post birth 'pollution' and help to perpetuate the separation of bodily needs from emotional and physical needs. Although there is insufficient evidence from my small study to determine why the midwives felt less inclined to clinically assess a wound located in the perineum rather than a wound located in the abdomen it is an interesting finding warranting future further exploration (Research and education implication D).

8.7 Modifiers

The final theme constructed from the data is modifiers, which are factors, persons and contexts, which facilitate or inhibit the midwives' ability to negotiate an appropriate approach to assessment of the maternal genital tract during the postnatal period. The midwives identified modifiers within the therapeutic relationships they attempted to develop with women, the contexts in which midwifery care was provided and how midwifery practice was and is evolving. These modifiers are the most critical to the midwives' practice as the modifiers underpin the other two research themes, facilitating or inhibiting the influence of motivators and the successful implementation of methods of maternal genital tract assessment.

A number of the issues raised within the theme of modifiers have previously been identified within other areas of midwifery practice. However the findings from my study provide unique insights of how particular issues are applied within postnatal genital tract health and associated midwifery assessments and practice. The findings from this study enhance the professional knowledge base by contributing to the complexity and situated understanding of these factors in relation to genital tract assessment.

8.7.1. A Therapeutic relationship

Relationship features have been analysed and researched generally and applied to midwifery previously, however this research demonstrates for the first time how relationship features are fundamental to the ability of midwives to negotiate appropriate postnatal genital tract assessment methods. The key aspects of a therapeutic relationship identified from my study were rapport and meaning making.

The midwives in my study identified that developing a rapport, involved a form of intimacy and trust by utilising effective interpersonal skills, language and reciprocity. Open and honest information exchange, utilising a conversational approach, made assessments more accurate and also enhanced the woman's confidence in the midwife. These relationship features and qualities are also identified as important for effective midwifery care in a number of other midwifery research studies, including those which focus upon the woman's views (Beake et al 2010; Byrom & Downe 2010; Nicholls, Skirton & Webb 2011). The research by Hunter (2006) identified midwives' attempts to build a rapport with women included teasing, personal disclosure and use of colloquial language, factors that have also been identified in my study.

Within my study the use of accessible language in relation to the maternal genital tract assessment involved midwives negotiating with women words they could both comfortably use to identify aspects of genital tract anatomy and physiology. My study suggests accessible language enables mutuality in the relationship, which reduces potential power gradients between midwives and women and enables women to engage in decisions about their postnatal care. Knowing the woman, her family and social context helped the community midwives, to pitch accessible language, whilst hospital based midwives used heuristic judgements involving age and educational attainment. Cioffi & Markham (1997) identified how midwives use probability judgments (heuristics) by identifying similarities with previous

clinical encounters with women when making practice decisions. Although this saved time and could enhance the decision making, it was also subject to the limitations of the midwives individual experience. As highlighted by Edwards (2010 p.99) without developing a relationship and therefore understanding of the individual women, such communications can become “formulaic” and not necessarily sensitive to the individual woman’s needs. Hospital based midwives have increasingly limited time to develop relationships with women postnatally.

Several authors discuss how words and phrasing can be used in midwifery to reflect dominant discourses and influence the thoughts and actions of the recipients (Leap 1992; Hewison 1993; Hastie 2005; Kitzinger 2005; Hunter 2006). Research involving nurses advising women on contraceptive choices, exposes how language is utilised to influence and control client interactions (Hayter 2007). More medical terminology was used to gain compliance, as it has assumed authority, whilst lay terms are used when issues and risks are minimised. Similar findings were identified by the midwifery research exploring midwives use of language when supporting breastfeeding women, in which information was presented in a way that minimised discussion and debate (Furber & Thomson 2010). The midwives in my study appeared to attempt to reduce this imbalance by utilising accessible language. However language may still be used as a means of control, by employing minimising words, such as “little” and “quick”, in relation to gaining access to the woman’s genital tract.

Half of the midwives in my study suggest that rapport development was also enhanced by reciprocity, in which the midwife reciprocates a social exchange of information to enhance a reciprocal connection with the woman. The woman reciprocates by accepting the midwife’s advice and care, with both parties demonstrating they trust each other. Reciprocity is a known factor in interpersonal relationships and communication theory, suggesting those involved in intimate communication tended to match and reciprocate disclosure (Berger 2008). Several midwifery research studies, exploring emotional work, have also identified and discussed the reciprocal

nature of the woman and midwife relations and the significance it has for the development of trust (Hunter 2006; Lungren & Berg 2007; Deery 2009; Edwards 2009; Kirkham 2009; McCourt & Stevens 2009; Leap 2010). Downe, Simpson & Trafford (2007) suggest “*mutuality and reciprocity of the trust*” between women and midwives, acts cyclically to reinforce and perpetuate the trust, reciprocity and mutuality. The small qualitative study by Frei & Mander (2010) also highlighted reciprocity of information exchange being a tool to promote trust between midwife and woman.

For woman, Edwards (2010) suggests trust is a vital ingredient, particularly during times of vulnerability such as childbirth. Goering (2009) in her theoretical critique of autonomy and trust following childbirth, suggest trust between the health care provider and parents is fundamental to promoting client autonomy by fostering their skills, confidence and self trust to engage in decisions concerning their health in a manner that is appropriate for them. If midwives develop trust as part of building a rapport and therapeutic relationship it may help to involve women in the decision making process and provide sensitive and effective genital tract assessment. I would therefore recommend therapeutic relationships are an integral aspect of promoting maternal genital tract health (Practice Implication D).

As part of forming a reciprocal relationship, both the midwives and the women in my study used story telling to help meaning making. Such sharing of stories enables midwives and women to connect, understand and to form a bond. The midwives used the opportunity of women expressing their stories to bolster the woman’s morale and self esteem and help them perceive their childbirth and postnatal experiences and their role within them as positive and effective. Narrative can not only express meaning and identity but also construct meaning and identity (Bruner 1991; Holloway & Freshwater 2007). Clark-Callister (2004) also identified that the sharing of their birth narratives enabled the woman to integrate the experience into their personal history and self-identity including personal strengths and limitations.

All of the midwives in this study either articulated during interview or demonstrated during observational data collection, facilitating women to tell stories regarding their childbirth and postnatal experiences. This finding contributes to the evidence base concerning narratives but also provides new findings concerning the significance of story telling during the postnatal period in relation to genital tract assessment. There is a growing pool of literature, which highlights the significance of women telling stories regarding their childbirth experiences (Kirkham 1997; Clark-Callister 2004; Kitzinger & Kitzinger 2007; Leamon 2009). Bruner (1991) suggests narratives are a version and way of organising, representing, constructing and making sense of reality, which people use to understand, make sense and enable the meaning of an experience or event to be expressed. Such accounts stretch back to early oral histories such as parables and folktales, as discussed by Vladimir Propp in the early 20th century and written accounts such as the bible and Koran (Czarniawska 2004).

Some of the midwives also used stories from their professional (and occasionally personal experiences) to help the women to develop “realistic expectations” of what to expect and what the future may hold in relations to their genital tract and postnatal recovery and health. Mattingly and Fleming (1994) suggest a significant part of therapeutic relationship is developing meaning, by helping people make sense of their situations. Antonovsky (1987) suggests a sense of coherence and partnership in practice decisions helps clients cope with health related stresses. Individuals may perceive, remain and improve their health despite the co-existence of health stresses (Lindstrom & Eriksson 2006). Conversely the absence of coherence will have a negative impact. Within the research by Rudman, El-Khoury and Waldenstrom (2008) women who were dissatisfied with aspects of their physical assessment and postnatal care had a lower sense of coherence and higher levels of depressive symptoms. Midwives in the Australian study by Schmied et al (2008) talked about helping women postnatally to normalise their experiences during group discussion with other women and the midwife. As suggested by Bastos and McCourt (2010 p.122) postnatal midwifery care is a “balancing act” between identifying morbidity and

reassuring women about the usual and relatively normal adaptations and changes following childbirth. Postnatal midwifery practice is not only about observing presence or absence of health or morbidity but helping to explain, facilitate predictability and provide a sense of coherence to create for each woman a unique therapeutic journey. Therefore the sharing of stories and use of bolstering strategies by the midwives in my study concerning postnatal physiological adaptation may help women to construct a new identity in relation to their postnatal genital tract health and appearance, providing a sense of coherence.

Helping women with meaning making through narratives is an area worthy of consideration within midwifery practice and requires further research and evaluation (Research and education implication E).

8.7.2 Care in context

The findings also identified particular conditions and circumstances, related to the context of care, which could modify the midwives' ability to undertake maternal genital tract assessment. The location of postnatal care highlighted a number of practical problems the midwives in this study had to negotiate including high levels of noise and lack of privacy making interactions difficult. A range of contemporary literature, reflecting the views of women and midwives also highlights the negative impact of high noise levels, particularly within the hospital postnatal ward, which is at times described as "chaotic" (Wray 2006b; Rudman & Waldenstrom 2007; McLaclan *et al* 2008 p.361; Bhavnani & Newburn 2010). A recent qualitative study involving 20 women identified the postnatal ward environment as not conducive to sleeping and resting with routine practices contributing to high noise levels (Beake *et al* 2010). In addition Beake *et al* (2010 p.7) discuss how many women feel "on view" during their time on the postnatal ward, with limited privacy and the women reported valuing visitor free rest periods. Other studies highlight the tension between women wanting flexibility regarding visiting arrangement for their own visitors and wishing to restrict the visitors of other women, as this reduced rest, privacy

and opportunities to receive midwifery information and support (Wray 2006b; McLaclan *et al* 2008).

These issues are reflected in the findings of my research. What this study contributes to the knowledge base is how these factors impact upon midwives' practice, particularly in relation to genital tract assessment. The midwives working in the postnatal ward attempted to complete postnatal maternal assessments prior to visiting, therefore restricting the time available for this activity to usually morning time. This concentrated activity then also contributed to excessive noise and activity levels, highlighting the difficulties of attempting to provide sensitive postnatal care in a traditional hospital ward. Some maternity units have introduced the integrated labour, delivery, recovery and postnatal (LDRP) system, in which labour, birth and postnatal care are provided in one room until the woman returns home, which may help alleviate some of the noise and privacy issues identified in this study. However the midwives in my study also identified noise and privacy concerns occurring in the community environment. They considered these were exacerbated because women did not appreciate the content of postnatal care, the potential need for privacy and for some women their overcrowded living circumstances. There is a need to increase women's understanding of the content of postnatal care antenatally, however the ability of the midwives to respond to overcrowding concerns may be more limited, particularly in an economic climate in which limited resources including welfare provision for those in need is increasingly restricted (Gould 2011). Further research to explore the impact of differing models and locations of postnatal care would be useful to visualise potential recommendations for service organisation.

In addition to location, the category of care in context included findings, which identify a range of competing demands, which modify the midwives' ability to assess and respond to women's postnatal genital tract health needs. One of the most significant factors identified by the midwives was being too busy or having insufficient time to always provide the quality of postnatal care they would like to. This factor was related to the diversity of

their roles, increased workload and insufficient staff. Staff shortages and lack of staff time, particularly for postnatal wards is a dominant theme in much of the research concerning postnatal care (Forster *et al* 2006; Rudman & Waldenstrom 2007; McLaclan *et al* 2008; Dykes 2009; Ellberg, Hogberg & Lindh 2010). Care quality is exacerbated by a high bed occupancy rate, diverse and extended tasks and roles, administration tasks and staff relocation to the delivery suite (Wray 2006a; Lavender 2007; Frei & Mander 2010). These were factors identified by some of the midwives in my study. A recent Australian survey suggested 57% of women received no more than 10 minutes or less uninterrupted time with the midwife during their postnatal ward stay (Schmied *et al* 2009).

Several midwives in my study indicated insufficient time would impact negatively upon their ability to establish a rapport with the woman. Women recognise that staff are busy and are reluctant to ask for help (Beake *et al* 2010; Dykes 2009). In addition the midwives suggested insufficient time led to activities being undertaken quickly, trying to “contain” the content and focus of their activity and keep to time. Similar findings are identified in the research by Olsson *et al* (2011), in which midwives distance themselves from the postnatal women, using a more task orientated approach. This reduced the likelihood of midwives engaging women in the decision making process (Spendlove 2005; Porter *et al* 2007). Hunter (2011) also highlighted conflicts in midwives’ day-to-day practice, between working “with women”, providing individualised care and “working with the institution”, meeting the demands of the employing organisation regarding activity and productivity. Bryson & Deery (2010) suggest such “women’s time” is not valued in the time dominant, outcome orientated “men’s time” in contemporary maternity services, resulting in community midwives adopting unsustainable responses, such as working for longer, in an attempt to fill these care deficits, as did some of the midwives in this study. As the economic climate tightens, so does the focus upon the efficient use of resources in health care. However as highlighted by Kirkham (2010a) the “soft” processes such as effective communication and relationship building are difficult to capture in resource identification tools, which place more

emphasis upon technical interventions when identifying payment by result. Therefore perpetuating the under resourcing of effective midwifery care.

Findings suggest lack of time and competing priorities negatively impact upon how information is provided to women postnatally, particularly in the postnatal ward setting. Information overload results, decreasing the likelihood of the women being able to assimilate and integrate the information. The midwifery knowledge base is enhanced by providing evidence of the impact lack of time has upon the information provided to women. Within the NCT survey 26% of the women stated they received little or none of the information they needed (Bhavnani & Newburn 2010). The National Care Quality Commission (2010) survey of over 25,000 women also indicated only 42% of women felt they had definitely been given enough information regarding their health after birth. Many women are left feeling unprepared for the postnatal period, with unmet informational needs (Beake *et al* 2010; Ellberg, Hogberg & Lindh 2010; Persson *et al* 2011). Fenwick *et al* (2010 p.19) suggest lack of time results in a standardised approach to information giving not sensitive to individual women's needs and frequently leaving the postnatal women to "*sift through and discern for herself what is most appropriate*". On occasions this was evident in my study, with postnatal women left with a bundle of leaflets and booklets. The assumption underpinning maternal self-assessment of genital tract health is placed in a difficult position, for if women are not receiving adequate information concerning their postnatal health, their ability to make accurate self-assessments is jeopardised.

The postnatal women in a Swedish study considered it was the midwife's responsibility to prepare them for events following birth, as they did not know the questions to ask. The authors concluded that preparation for the postnatal period needed to be improved during the antenatal period (Persson *et al* 2011). An Australian comparative analysis of women's satisfaction with postnatal care, prior to and after the implementation of strategies to enhance postnatal care, including an emphasis for planning for the postnatal period during pregnancy, with discussion and a consumer

written information leaflet, demonstrated a significant improvement in maternal satisfaction rates (Yelland, Krastev & Brown 2009). There is a need to more effectively space and plan the delivery of information throughout the childbirth continuum and I would recommend further research to explore women's preferences and potential models of providing postnatal information in a timely and effective manner (Research and education implication F).

8.7.3 Evolving midwifery practice

The final category constructed from my data is titled 'Evolving Midwifery Practice'. The midwives identified how and why their postnatal practice had evolved over their professional lifespan, involving the development of their own personal theory of genital tract health, informed by their practice experience and to a much lesser extent formal theory. Earlier research exploring decision-making in midwifery practice also identified experience informing midwives' practice, suggesting the more experience the midwife had the greater her repertoire and more likely she was to make an appropriate practice decision (Cioffi & Markham 1997). However it is also acknowledged that experience constructs an understanding of reality, which is then reaffirmed through actions, which in turn perpetuate particular experiences (Berger and Luckmann 1966 pp.66). Cioffi & Markham (1997) suggest the experiences of individual midwives might contain bias and therefore potentially limit their subsequent reasoning processes, recommending the need for personal reflection and developmental updating to try and minimize such factors. The midwives in my study discussed learning from and with others, which enabled them to some extent to broaden their practice experience, and debate issues concerning practice decisions; a learning strategy also identified by others (Kirkham 1997; Steele 2009; Cioffi, Swain & Arundell 2010).

During a debate staged in London on postnatal care, Debra Bick, an experienced midwifery researcher who has spent most of the past 20 years researching postnatal care, emphasised her concern at "deskilling students"

in relation to postnatal assessments and care (Bick 2010b). The findings of my study provide evidence, which supports her concerns. The midwives highlighted concerns that contemporary student midwives gained less experience of postnatal assessments, which had implications for skill development. Some of the midwives in my study discussed strategies they employed in an attempt to maximise the opportunity for students to gain appropriate learning experiences, with the support of the postnatal women. Ensuring students engage in appropriate experiences to develop their practice skills is a recognised practice teaching strategy and responsibility of a midwifery sign-off mentor (Midgley 2006; NMC 2008). In addition some of the midwives discussed using articulation of clinical reasoning processes to help students understand the rationale behind their decision-making and why such decisions varied. This is a useful means of facilitating understanding of complex reasoning processes (Fowler 1997; Downe 2010; Levett-Jones 2010).

Creating learning opportunities such as suitable practice experiences and articulation of clinical reasoning processes as identified in this study, may be valuable contributions to the repertoire of practice teaching and learning approaches. They may help to meet the recommendations of the national review of midwifery in the UK, that pre-registration midwifery programmes need to be strengthened regarding the knowledge and skills required to support women and their families during the postnatal period (Midwifery 2020 (2010)). I would recommend further work to identify student midwives skills and experiences regarding maternal postnatal genital tract assessment and review the potential contribution of teaching and learning strategies to enhance the student skill development (Research and education implication G).

8.8 Implications, opportunities and further work

The grounded theory I have constructed from this research will provide an opportunity for a realistic consideration of midwives' experiences and practice in relation to the assessment of maternal postnatal genital tract

health. The framework includes detail of the individual attributes, which contribute to genital tract assessment, but also the interactive, dynamic and unique nature of each midwife and woman interaction. This includes how midwives must simultaneously manage and prioritise individual maternal needs and competing service and professional demands to provide unique and responsive midwifery care. Therefore I will share the findings with relevant individuals and organisations, through local and national publications and presentations. Through my day-to-day practice as a midwifery educationalist utilising the grounded theory I will also be able to enhance the education of midwives and student midwives.

From the analysis and discussion of the findings from this study I offer the following potential implications and opportunities for midwifery practice, research and education.

8.8.1 Research and education implications

My findings highlight the following opportunities, for others, and myself for further research and educational activity; -

- A. Further research to explore and develop a descriptive rating scale that would be useful for women to self assess their progress, for midwives when making pain and potential morbidity assessments and contribute to student midwives learning experiences

- B. Create opportunities to share the findings of this research with relevant individuals and organisations, to enhance the appreciation of the components of and dynamic and interactive nature of postnatal genital tract assessment and midwifery practice. This will include raising awareness of the risk factors associated with genital tract sepsis and secondary postpartum haemorrhage.

- C. Further research to explore postnatal women's thoughts and preferences regarding self assessing their genital tract and their involvement in determining the assessment approach.
- D. Further research to explore the concept of public and private areas of a woman's body and the impact this has for women and midwives in determining postnatal genital tract assessment approaches.
- E. Further research to explore and develop the application and implications of helping women with meaning making through narratives involving their genital tract health.
- F. Further research to explore women's thoughts and preferences regarding information they require about their postnatal genital tract health and potential models of responding to maternal preferences, providing postnatal information in a timely and effective manner.
- G. Further research to identify student midwives skills and experiences regarding maternal postnatal genital tract assessment and review the potential contribution of teaching and learning strategies to enhance the student's skill development

8.8.2 Practice implications

My findings suggest midwives may wish to consider the following discourses as potential practice development opportunities;-

- A. If the woman is able and willing to view her perineum and palpate her uterus it may be a useful adjunct to the range of assessment approaches to maternal genital tract well being.
- B. To consider employing a partnership approach to maternal genital health assessments, utilising a symptom checklist to enhance the

inclusion and recollection of pertinent questions when assessing the genital tract for use by both women and midwives.

- C. The potential to integrate a range of approaches to assessing maternal genital tract well-being in a sliding scale approach.
- D. To acknowledge and integrate into practice therapeutic relationship features that enhance trust; including a conversational approach, accessible language, interpersonal skills and reciprocity.

8.9 Conclusion

This chapter of my thesis has integrated and discussed the findings from my research. I have returned to my initial research aims and objectives and identified how my study findings have achieved these intentions. I have critiqued how I have assimilated my research findings to construct a grounded theory of the experiences and practice of midwives in relation to the assessment of maternal postnatal genital tract health. This discussion has included how the research findings have highlighted tensions and contradictions, which have been incorporated into the grounded theory. This provides a more realistic construction of the complexity and dynamic nature of midwifery practice. Each of the themes I identified from my research has been discussed and comparisons drawn with the existing knowledge base. This has enabled me to highlight how my research confirms the existing knowledge but also findings which conflict with the existing evidence. In addition I have identified how my study has provided new insights into midwives' experiences and practice, either providing more detail and situated understanding and complexity to the knowledge base and in some instances providing unique insights. This analysis has culminated in my offering eleven potential implications identifying opportunities for practice discourse and research and education development. The sharing of this grounded theory of midwives experiences' and practice of assessment of maternal postnatal genital tract health is

offered as a means to foster debate, discussion and new insights regarding postnatal maternal genital tract assessment.

Chapter 9

9. Chapter 9 - Conclusion

9.1 Introduction

My research has explored midwives experiences and practice in relation to the assessment of maternal postnatal genital tract health. I have presented and critiqued the research activity undertaken to produce this thesis. This includes a review of related literature concerning postnatal genital tract assessment, research technique including philosophy, methodology and methods; data analysis and discussion and recommendations chapters.

This concluding chapter summarises the activity and achievements of this thesis and the whole research process. The discussion will include a reflexive account of my research activity, highlighting strengths, limitations, challenges and lessons learnt during the process. I will evaluate the extent to which my initial aspirations and intentions of the research project have been achieved. The contribution my thesis makes to midwifery will also be acknowledged and its doctorate level substantiated. Through my reflections I am able to establish how engaging in a professional doctorate has contributed to my personal development and how the experience may impact upon my future academic activity.

9.2 Commencing the doctorate journey

On commencement of the professional doctorate programme in 2006, I had some practical experience of contributing to evaluative research activity, however I did not have any formal education in research processes, techniques and philosophy. Recognising this limitation I embarked upon a professional doctorate award, which enabled me to develop my research knowledge base whilst refining my initial ideas regarding the focus for my study. The taught elements of the programme enhanced my comprehension and appreciation of research and also included modules exploring critical theory. These enabled me to diversify my perceptions of

knowledge, research and practice by accessing alternative perspectives and discourses.

I had commenced the Professional Doctorate programme with a general idea of researching postnatal care, as this is recognised as an area which is relatively under researched within midwifery (Demott *et al* 2006) and an area of particular interest to me. In addition I had been involved in some action research, as discussed in chapter 1, which identified postnatal care was an area of conflict for the students I supported within my role as a midwifery tutor. However, my initial ideas tended towards being generalised and descriptive, a focus upon only “what” midwives were doing in practice. Throughout the first two years, as I completed various modules and completed the associated assessment, my ideas became simultaneously broader and more focused. More focused because I recognised I needed to concentrate upon a relatively small aspect if I was to hope to produce work of sufficient detail and complexity to achieve doctorate status. Simultaneously the breadth of the module content and supporting reading of differing philosophical positions and critical theory changed my perception of the practice issues. These became broader and more theoretically complex. I came to appreciate that the research approach would be qualitative. To ensure my work met both professional and doctorate requirements it would have to include exploring why and how the midwives practiced in relation to assessing maternal postnatal genital tract health. This approach would enable me to not only relate the midwives practice experiences to espoused theory of “best practice” but also to identify the midwives practice knowledge in action.

9.3 Undertaking the research process - lessons learnt during the journey

The literature review in chapter 2, broadens my research terms to ensure inclusion of diverse and transferable information relevant to the research focus of midwives assessment of maternal postnatal genital tract health. However I recognise at times I became distracted and “lost” in the literature.

Some of this activity, although at the time frustrating, by the end of the process proved useful as it gave me a broad as well as detailed insight of the research area. Exploring the literature also helped me to appreciate the need to be focused upon the area for investigation and therefore to further refine my research focus. For example I became quite curious by the theory regarding clinical reasoning, particularly the model advocated by Mattingly and Fleming (1994). However, I came to realise that my focus was not to detail or produce another theory of clinical reasoning. The theory of clinical reasoning helped me to consider how midwives' approach to assessment may be influenced and guided the development of interview and observation schedules. The theory I have developed from the research data is of the midwives experiences and practice in relation to assessment of maternal genital tract, which involves reasoning processes, rather than a theory of clinical reasoning related to midwifery practice.

The intentions of my research were;-

Aim

To explore the experiences and practice of midwives in relation to the assessment of maternal postnatal genital tract health.

Objectives

1. To explore how midwives determine, and the potential range of approaches to, assessment of postnatal maternal genital tract health.
2. To consider why midwives decide upon and negotiate a particular approach to assessing maternal genital tract health, highlighting the plurality and range of influencing factors including the woman, midwife and practice context.
3. To discern how midwives involve women in determining the approach adopted for assessment of genital tract health

I have successfully achieved the aim of this research, through utilising research methods, which enabled access to midwives' experiences, via narrative style interviews and their practice via observational data collection. The integration of these research methods enhanced the detail and complexity of the data and added depth and credibility to the research findings. However as detailed within Chapter 4, the reality of undertaking research within the midwifery practice area brought challenges. These included gaining access, negotiating with gatekeepers, interview and observational techniques. At times, particularly in the research data collection and analysis processes, seeing and hearing the data with "fresh" eyes and ears was challenging. I needed to avoid making assumptions regarding the midwives' meaning or intentions of actions, utilising my own "embodied knowledge." During the initial data collection and analysis periods I found moving the data from abundant descriptive codes problematic. Some elements emerged with relative ease, whilst other areas for example when attempting to express how the focused codes and categories related to each other in the development of the grounded theory, were more difficult.

My interest in the background literature, such as Mattingly and Fleming's (1994) clinical reasoning model, initially influenced how I attempted to conceptualise the data and attempted to "fit" the research findings to the clinical reasoning model. However I recognised my mistake, although I acknowledge that perhaps the use of the term "meaning making" as a focused code, is influenced by this background reading. In addition being an educationalist may have sensitised me to perceiving and conceptualising particular aspects of the data. My role could act as a coding filter. As a midwife educator I tend to consume information relating it to its potential impact, on my teaching activities or midwifery education in general. The impact that practice experience has upon student midwives and their learning needs, as one of the focused codes, is therefore not unexpected and may have been brought into sharper focus because of my interest in the education of others. The factors acknowledged will have impacted upon the data collected and the conclusions drawn. However I feel that my reflexive

approach has minimised any potential bias and excessive subjectivity, whilst being open and acknowledging what my subjective influences have been.

My declared position sits comfortably with the research methodology of constructionist grounded theory, as discussed in chapter 3. This approach does not propose an objective uncovering of a truth in the research area, but a constructed account of potential truths. This research paradigm acknowledges that representation is inherently time and context bound. Temporal and situational influences are reflected in the midwives' actions, the data collection methods and my own accessing and privileging particular data. For example the participant sample involves only one practice location and was self-selecting. The data collection methods such as interview may be influenced by characteristics of the interviewer and interviewee, as discussed in Chapter 4.

How I have conceptualised, analysed and presented the data must also be understood within these contexts. Generalisation of my research findings may therefore be limited. However as I have ensured the research processes are explicit and have been attentive to maintaining quality principles such as trustworthiness, there are transferable aspects. These are identified in the discussion Chapter. I found that maintaining a research journal was a valuable tool in facilitating a reflexive approach. The journal enabled me to question my values and pre-conceptions throughout the research process. In addition I brought to the research activity particular skills, qualities and abilities, which enhanced the process, and which, in turn, were further, enhanced and developed by exposure to the research activity. For example interpersonal skills enhanced the collection of data, from ensuring informed consent, to sensitive interviewing technique and my professional insights into the area of investigation.

9.4 Summary of principal findings

The research data, analysis and discussion have met the research aim and particularly the first two objectives of this study. I have developed a theory,

which reflects the potential range of approaches to maternal genital tract assessment employed by the midwives, including why and how they determine their approach. The theory emerges from the research themes of Methods, Motivators and Modifiers and the various categories and focused codes within them. The midwives discussed and demonstrated utilising a range of genital tract assessment methods, risk assessment, questioning and clinical observations, these are discussed in chapter 5. The data demonstrated aspects of practice consistent with most of the midwives and which reflected contemporary thoughts on best practice. For example identifying birth history with potential perineal trauma and integrating findings from uterine palpation with observations of the woman's lochia.

However differences were also identified, between the practice of midwives and contemporary evidence and guidance. One such difference was evident where methods of identifying maternal genital tract sepsis in which potential risk factors and questions did not include relevant aspects. Midwives tended not to ask whether women worked with or had young children with recent sore throats. There was also less questioning concerning uterine, abdominal pain and whether the woman had diarrhoea. In addition all of the midwives in my study did not appear to appreciate the significance of some clinical observations. No midwives, for example, identified the potential of respiratory rate as being indicative of genital tract sepsis. My findings also suggest midwives have differing levels of appreciation of the impact of risk factors such as social support upon physical health. There is some indication that the location of practice, hospital or community may influence the midwives views, with community-based staff more likely to perceive social support as a health determinant.

Chapter 6 presented data which suggested midwives were motivated to employ particular methods of assessment to meet verification of maternal genital tract needs; personal preferences and a desire to provide sensitive care reflecting individual maternal needs. These data provided insight into how and why midwives adopted a particular approach to maternal genital tract assessment. They appear to employ a sliding scale approach when

verifying genital tract health. Their approaches moved along a continuum of less invasive methods which tended to be more woman lead, such as risk factors and questioning, to more invasive methods such as clinical observations which tended to be more midwife lead. The motivators, which influenced where along this continuum of genital tract assessment methods, a particular assessment for a particular woman was placed, would depend upon maternal, midwife, and obstetric factors. The midwives suggested the ability of individual women to take the lead, and their preferences, in relation to genital tract assessment differed from woman to woman. These findings touch upon a number of contemporary debates concerning consumer lead health care and the reality of what this means in day-to-day practice. Together with other motivators such as sensitive care, there is evidence that the midwives in this study attempted to reflect women's individual needs in their approach to maternal genital tract assessment. However, it was difficult to elicit whether the woman was always involved in making the decision, or if the midwives determined the level of the woman's involvement in the decision about the assessment approach.

As such I feel I have been less successful at fulfilling objective three, discerning how midwives involve women in determining the genital tract assessment approach. The data has provided useful insights and raised some interesting issues, however on reflection perhaps this objective was a little ambitious alongside the other aspects I was attempting to research. To illuminate detail of the midwife and woman interaction, from the perspective of "involving" the woman in decision-making a different methodological approach is needed. For example more intensive prolonged observations could be undertaken with conversational analysis methodology. Or the postnatal women's perspectives could have been explored through in depth interviewing. I intend to develop this particular aspect by returning to the research field to explore the experiences and practice of postnatal women, rather than midwives. Such a study would compliment and enhance the findings of this thesis, providing a more complete picture of maternal postnatal genital tract assessment.

Within chapter 7 the findings presented indicate factors and contexts, which modify the midwives' motivators and methods of genital tract assessment, responding to objective 2 and 3 of my research. The modifiers are identified as a therapeutic relationship, care in context and evolving midwifery practice. This study has contributed to the developing body of knowledge pertaining to relationships within professional practice and offers a unique insight upon the significance of these relationships for areas of midwifery practice, including assessment of maternal genital tract health. This includes how narratives can be used to share and explain experiences, facilitating predictability and a sense of coherence. In addition a range of contextual factors pertaining to the location of practice and resource issues, which may modify the midwives' ability to undertake maternal genital tract assessment have been presented. These reaffirm and develop findings from other work in midwifery, which highlights the impact that contextual factors have upon midwifery practice.

The data discussion in Chapter 7 concluded with the category evolving midwifery practice. This presented research data pertaining to how midwives considered their practice had evolved over time informed by their practice experiences and to a lesser extent formal theory. The impact of the changing philosophy regarding the midwifery practice of assessment of maternal genital tract health by midwives has influenced the practice of the midwives in my study. Several midwives who have been in practice for over twenty years, acknowledged their practice had changed. They felt this was for the better. Changes to midwifery practice have resulted in less experience of genital tract clinical assessments for student midwives, which was a concern for some of the midwives in this study. They identified potential strategies in an attempt to maximise on experiences for midwifery students they supervised.

The research data demonstrates most midwives attempt to provide practice responses, which reflect and respond to maternal, midwife, contextual and organisational drivers. This reflects clinical reasoning incorporating procedural, interactive, conditional and narrative aspects, utilising

procedural and practice based knowledge. However as discussed in Chapter 7 and Chapter 8, the midwives in this study experienced contradictions and tensions. The tensions and contradictions identified by the midwives related to interactions between differing aspects of maternal need, midwifery practice, service organisation and provision impacting upon aspects of midwifery activity. These were inherent to particular aspects of activity and others resulted in conflicts between simultaneously occurring motivators and modifiers. For example as highlighted in chapter 7, midwives state they need to provide more information to women following childbirth, however they simultaneously report less contact time allocated to postnatal care.

The research has highlighted strengths, limitations and challenges in relation to midwives' experiences and practice of maternal genital tract assessment. Some of the findings I had anticipated, as they confirm existing guidance regarding postnatal midwifery practice, such as the methods of assessment the midwives used and the procedural knowledge, which influenced their practice. However unanticipated findings are also evident. Such as genital tract assessment as subterfuge, the midwives perceptions of public and private areas of the body and how maternal dignity is lost and regained throughout the childbirth continuum. Some findings add unique contributions to midwifery professional knowledge whilst others confirm suggested practice and theory as highlighted in Chapter 8. The findings have been woven into a grounded theory representing a small strand of midwifery practice, concerning maternal postnatal genital tract assessment. How a range of concepts and factors interact and relate within that practice activity have been illuminated. In keeping with a professional doctorate, the midwifery practice and profession focus has been maintained, rather than developing theory in isolation from the complexity of practice activity. This combination of unique contributions to the knowledge base with a professional practice focus and application substantiates why this thesis is of doctorate level and due to its professional focus, a professional doctorate.

I wanted my research to remain grounded in practice, using the words phrases and conceptual understanding of the practice world that midwives inhabit. I wanted to construct with the midwives in this study a theory of their practice, which could be comprehended and utilised by them, reflecting the intentions of the research and the research philosophy. The research has produced several practice-orientated recommendations, as identified in Chapter 8, with the intention of strengthening midwifery practice. In response to these recommendations I intend to instigate a range of activities to enable the findings of this thesis to be shared, critically reviewed by my peers and where appropriate acted upon.

9.5 Future intentions and conclusion

Producing and disseminating research findings, implications and recommendations is an important aspect of research activity. As suggested by Cutcliffe (2005 pp 423) *“qualitative research needs to pass the so what test . . . to have utility in the real world”*. One of the aims of the National Health Research Strategy (Department of Health 2006) is to ensure research findings are appropriately integrated within practice and are open to “critical review” (Department of Health 2005 p. 14). Presentation to research peers, those involved in planning midwifery services and education, midwives and midwifery clients completes the research journey. I plan to present the findings in a range of methods, contexts and formats. At a local level there will be presentations to the midwives and service managers where the study took place. They will receive a written summary of the information. The presentation has the potential to instigate an action learning cycle, in which the local midwives may wish to take forward some of the issues raised to enhance their practice. This could be formalised into an action research cycle, collecting and evaluating data during the developmental process. Another potential research development from this thesis could include reviewing the data undertaking a narrative analysis to explore the construction and individual meaning making. This would involve using fewer data sources, possibly just one midwife and one woman and

explore in much greater depth the meaning and meaning making evoked, reflecting individual, relational and cultural nuances.

At a national and international level, journal articles and conference presentations are anticipated to an audience including professionals, educationalists and researchers. A summary of findings will be developed in lay terminology and forwarded to local and national maternity user organisations for review. The dissemination of findings will enable others to identify transferable areas and implications for practice they may wish to apply or further investigate.

The process of undertaking the professional doctorate has had several implications for my personal and professional development. I have developed a range of knowledge, skills and personal attributes, which will positively contribute, to my future professional endeavours. One of the most explicit pertains to my knowledge and skill development in research philosophy, methodology, techniques and processes. These have enabled me to successfully carry out research and have also developed my ability and confidence to undertake further research work. However it is not only the particular present knowledge I have assimilated that facilitates the potential of future research endeavours, but the realisation throughout this journey that I have the insight, skills and abilities to identify what I do and do not know and instigate a strategy to successfully rectify any knowledge or skills deficits. I now feel I have greater insight concerning my strengths and limitations and will be more able and confident to embark upon new and challenging encounters.

I have enhanced and developed a range of qualities and abilities by engaging in activities such as application for research ethical procedures, research supervision and data collection involving interviews and observations of midwives' practice. These qualities and abilities include organisational skills, presenting my thoughts and ideas to others both verbally and in writing, negotiating skills and interpersonal qualities and abilities to facilitate effective communication. In addition my critical skills

have greatly developed during this doctorate journey whilst critiquing the existing evidence base, conceptualising theory from the research data and then discussing and evaluating the findings and drawing implications and recommendations.

The whole experience has not only changed my knowledge of research areas but also made me review my thoughts and philosophy upon midwifery practice and my role as an educationalist. The findings of this thesis identify a number of particular recommendations, which I can implement during teaching and learning interactions, as content area, such as increasing awareness of risk factors for genital tract sepsis and potential methods of assessment. However it has also brought into acute focus the overwhelming impact tensions and contradictions have upon midwifery practice and these areas I feel need much sharper focus within the midwifery curriculum. Areas such as the qualities of a therapeutic relationship and the identification of competing priorities within practice need to be included. Equally relevant would be the development of innovative teaching and learning strategies, which enable midwifery students to rehearse the necessary skills and facilitate opportunities to consider and develop strategies for them to work effectively within the complex world of contemporary midwifery practice.

This thesis has presented the author's aspirations, activity and achievements in relation to the research "an exploration of midwives' experiences and practice in relation to the assessment of maternal postnatal genital tract health." It encapsulates five years of activity, a small unique contribution to midwifery knowledge and hopefully the beginning of a new contributor to midwifery research.

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Appendices

Appendix 1 - Literature search strategy

There exists an increasing plethora of literature available via a range of media. Booth, Papaioannou & Sutton (2012) suggest this information explosion may lead to information overload and necessitates the researcher must be information literate, to enable appropriate identification, analysis and synthesis of the literature relevant to the proposed research. This appendix summarises the search strategies used to support the literature review presented in chapter 2 of this thesis.

Booth, Papaioannou & Sutton (2012) discuss the mnemonic SALSA, which represents 4 key stages of a literature review; **s**earch, **a**ppraisal, **s**ynthesis and **a**nalysis. The literature search guidance provided by Fink (2010) suggests more stages, including selecting sources of literature; choosing search terms; applying practical screening criteria; applying methodological screening criteria; do the review and synthesis the results. I will utilise the literature search steps articulated by Fink (2010) to structure this examination of my search strategy, as it enables me to provide more detail of my search strategy. However, as this appendix focuses upon the search strategy only, focus will be given to the initial 3 steps, as the remaining steps are presented within the literature review within chapter 2 of this thesis.

My search for literature to support this thesis was not only undertaken on commencement of my study. As my research methodology was Constructionist Grounded Theory, further reading and literature searching became an ongoing feature of the research process, as new concepts were constructed, with both initial and ongoing reading enhancing my theoretical sensitivity (Charmaz 2006). In addition, as my professional doctorate study time stretched over a five and a half year period, there were key times and research process gateways at which I need to refresh my literature search. These included;-

- Initial project approval event - *June 2009*

- Completion and submission of detailed research proposal, including analysis of existing evidence base and identification of the “gap” in the professional knowledge to be the focus of my research - *December 2009*
- During the research process, simultaneously collecting data and analysing. This included ZETOC alerts in place to maintain knowledge base & additional searches when new concepts are constructed from the data - *Ongoing throughout the process*
- Writing up stage, renew and refresh literature searches - *March 2011*

Selecting Sources of Literature

When selecting the sources of the literature to support my research the following issues were considered. The literature source should;-

- Ensure sufficient literature to yield appropriate data
- Be specific to those pieces of literature which illuminate the area for exploration

(Centre for Review and Dissemination 2009; EPPI Centre 2010)

Therefore the following sources of literature were accessed as part of the search strategy for this research.

- Books - A useful source providing an overview of professional thought on the area, however frequently primary data needed to be sought, to examine the detail and quality of the study. For example key studies such as Cluett & Pickering (1995) & (1997) are frequently mentioned in textbooks but summarised in a sentence or two. However books were a useful source of theory, for example regarding clinical reasoning and communication theory; both are issues I explored during the research process.
- Reviewing the reference lists of high quality research and researchers in the area e.g. work by Debra Bick and Sally Marchant, known experts in the field. Also hand searching past contents pages

and setting up alerts via ZETOC to receive future contents pages of key midwifery texts, to ensure past and old material is not missed during the search process. This included Midwifery; British Journal of Midwifery; RCM Midwives; Evidenced Based Midwifery; Practising midwife; Midwives Information and Resource Service (MIDIRS); Journal of Advanced Nursing and searching Midwifery textbooks. In addition I utilised known experts in the field as author searches and alerts via ZETOC, e.g. Debra Bick.

- Grey Material - Government publications, including NICE Guidelines and Department of Health Publications. In 2012 this has included accessing the British Library's electronic theses on-line service (EthOS). This search identified 9 theses pertaining to postnatal care, these included the work of Sally Marchant and Julie Wray, whose publications concerning their work I have accessed and referenced in my thesis (Marchant 1999; Wray 2006a; Wray 2006b). I did not identify any work that mirrors the particular focus of my thesis.

- Online Bibliographic Databases pertinent to the research field, those which explore health and midwifery, where searched (Thames Valley Health Libraries Network 2005; EPPI Centre 2010; Centre for Review and Dissemination 2012). These included;
 - ASSIA (Applied Social Sciences Index and Abstracting service)
 - Blackwell Synergy
 - Centre for Reviews and dissemination website
 - CINAHL (Cumulative Index to Nursing and Allied Health)
 - Cochrane Library
 - Ingenta Connect
 - Medline
 - Proquest Nursing journal
 - Science Direct
 - ZETOC (The British Library's Electronic Table of Contents)

Choosing Search Terms

The literature search strategy also involves identifying words and phrases to enable access to appropriate texts, particularly when utilising online bibliographic databases.

Booth, Papaioannou & Sutton (2012), highlight the use of the PICOC model as means of defining the scope of the research and potential research terms.

PICOC Term	Applied to my research
Population	<i>Postnatal women / midwives</i>
Intervention OR Exposure	<i>Ways of assessing maternal genital tract health Clinical reasoning process</i>
Comparison	<i>None</i>
Outcome	<i>Genital tract assessment method used</i>
Context	<i>Economically developed countries with patterns of midwifery care, health care and social systems comparable to the United Kingdom.</i>

However, it is acknowledged that PICOC, as with similar tools are more focused upon outcomes and quantitative research and are not such a comfortable fit with qualitative research, such as mine.

The content of bibliographic databases are sectioned under subject headings. One of the most commonly referred to is the medical subject heading system (MeSH) (Fink 2010). Postnatal care is a MeSH heading, its scope identified as *“the care provided to women and newborns for the first few months following childbirth”* (National Library of Medicine 2012). An alternative term of postpartum care was identified in the MeSH expanded concept view and was also used as a search term. In addition Boolean operators were used to expand or reduce data, such as “and”, “or” & “not”. Frequently the Boolean operators were used to reduce data by combining in various connotations the following search terms;-

Initial search Terms

- Postnatal (postpartum) care
- Postnatal (postpartum) morbidity
- Maternal postnatal (postpartum) health
- Midwifery assessment
- Midwifery clinical skills
- Midwifery observations
- Postnatal observations
- Postnatal perineal assessment
- Postnatal vaginal bleeding
- Postnatal uterine involution
- Postnatal uterine assessment

Broader search terms

- Clinical reasoning
- Decision-making
- Critical thinking
- Midwifery expertise

Search terms continued to be refined during the literature search process, for example when a pertinent piece of literature was identified, the associated key words were examined to see if they would identify further relevant areas, e.g. decision making identifying clinical reasoning.

Applying Practical Screening Criteria

This is a screening technique to enhance specificity and therefore reduce the amount of data to be screened (Fink 2010). In my search strategy this included utilising the following 2 practical screening criteria;-

- Language - limited to work published in English
- Timeframe - Focus given to publications over the preceding 20 years, to reflect changing philosophy and practice of maternal genital tract assessment.

Applying Methodological Screening Criteria

It is important to ensure the literature identifies a range of perspectives, concerning the area for exploration, to illuminate the research area and also build theoretical complexity. Within my literature search strategy this included data reflecting;-

- Differing research methodologies, both qualitative and quantitative methods; incorporating theoretical and empirical perspectives.
- Ensuring professional, academic but also maternal voices were included in the data reviewed. For example including large-scale surveys of maternal views of postnatal care and also smaller qualitative studies highlighting maternal perspective (Bhavnani & Newburn 2010; Beake et al 2010).

In addition, I ensured the quality assurance of the literature I appraised by ensuring how well the study had been designed and implemented. This involved utilising pertinent quality tools relevant to the research methodology, as discussed within chapter 2.

Undertaking the review

When potential literature was identified from search results appropriate texts were identified via a deductive approach. Firstly titles were scanned for relevancy and those, which seemed hopeful then had their abstracts read, this further reduced the potential pool of literature. For the literature of which the abstracts appeared relevant, the full article was then accessed and proof read. The literature identified as a result of this literature search strategy were then analysed and synthesized to form a review identifying salient themes and conceptual frameworks and forms chapter 2 of this thesis.

Appendix 2 - Interview guide

Introduction

- Self
- Intentions of interview (establish no right or wrong answers)
- Time
- Clarification of terms (genital tract)
- Ethical issues – reiterate and ensure consent, confidentiality and data issues, including need to ensure client confidentially in narrative telling.

Beginning the interview

- Personal facts – age, gender,
- Professional biography - years in practice, range of locations and experiences, entry route (direct or post nursing)
- Present practice – Since when, location and range of activity.

Provoke narrative (story) telling

- From your practice experiences during the last 3 months can you tell me about a typical practice interaction involving an assessment of maternal genital tract well-being?
- From your practice experiences during the last 3 months can you tell me about an unusual practice interaction involving an assessment of maternal genital tract well-being?
- Facilitation / probing
- (as / if required by interviewer), including non-verbal and verbal.

Verbal probes, if appropriate to include *“can they provide an example from their practice that provides an illustration”* to maintain the development of narratives.

- General probes (Content mapping – sensitising concepts) – headings

To open up a range of issues, develop breadth

- What they did / happened next

Location

Contextual factors

Key characters

Motives

Actions

Consequences

Specific probes (Content mining) - subheadings

To elaborate and explore detail and develop depth, move from description to action orientation, evaluative / attitudinal.

Procedural reasoning

- What potential means of observing and assessing genital tract well being
- Use of maternal questioning
- Use of visual cues
- Use of clinical observations
 - How do they identify the most pertinent / need identification potential cues such as;-
- Visual cues (e.g. pain)
- Risk factors relating to client known health status / obstetric history
- Questioning
- Response cues – colour, amount, smell of lochia, pain, malaise.
 - Why do they observe for these cues (hypotheses generation, cue interpretation and knowledge sources)
 - What influences their choice of information sources / observation method
 - What practice action would a particular cue necessitate (hypotheses evaluation)

- Impact of experience on future practice actions

Interactive reasoning

- What potential means of facilitating / interacting do they use to uncover women individual needs
- How / do they attempt to integrate women's individual needs into the reasoning process
- Why do they attempt to integrate women's individual needs
- What practice knowledge informs this
- How does it reflect their values and beliefs about practice and have these changed and if so why

Conditional reasoning

- What conditions facilitate or minimise their practice response when assessing maternal genital tract well being
 - What problems do they encounter and what are the sources of these problems.
 - What contextual factors influence their practice reasoning and actions
- Location of practice
 - Organisational / resource concerns
 - Practice traditions / values
- How does it influence their present and future practice reasoning and actions.

Narrative reasoning

- Do they use practice examples and stories with women about their postnatal genital tract well-being?
- How do they do this – can they provide examples
- Why do they / do they not use stories with women

Specific probes (Content mining)

- What make them say that
- Why did they think that

- How did they feel
- What effect did that have on them
- Did they consider other practice actions
- What conditions facilitate or minimise their response
- What effect did that have on their practice actions

Ending the interview

- Summarising discussion
- Any concluding remarks midwives would like to contribute
- Is there anything else they think I should know to understand their reasoning processes better?
- Thoughts for the future
- Verification
- Is there any thing they would like to ask me
- Potential follow up interview / observation
- Reassurance regarding confidentiality / ongoing consent
- Thanks

Appendix 3 - Field notes guide

Introduction

- Self
- Intentions of observation
- Time
- Ethical issues – reiterate and ensure consent.

General considerations

- Location
- Identify venue
- Contextual factors
- Identify time, noise other contextual factors / activities (e.g. postnatal very busy or mothers baby crying to be fed)
- Key characters, identify and note relevant data e.g.
- Midwifery professional biographical details, years in practice, range of locations and experiences, (direct or post nursing) (coded e.g. midwife 1)
- Postnatal women, age, parity, type of birth, type of maternity care provision, previous and present physical, social and emotional needs focusing care.
- Actions - what was done / said (As clarified in next sections)
- Non verbal communication (As clarified in next sections)
- Consequences (As clarified in next sections)

Procedural reasoning

- What potential means of observing and assessing genital tract well being
- Use of maternal questioning
- Use of visual cues
- Use of clinical observations

- How do they identify the most pertinent / need identification potential cues such as;-
 - Visual cues (e.g. pain)
 - Risk factors relating to client known health status / obstetric history
 - Questioning
 - Response cues – colour, amount, smell of lochia, pain, malaise.
-
- What practice action does a particular cue necessitate (hypotheses evaluation)

Interactive reasoning

- What potential means of facilitating / interacting do they use to uncover women individual needs
- How / do they attempt to integrate women's individual needs into the reasoning process

Medical Interview Aural Rating Scale - observational instrument

- 3 levels of patients cues;-

Level 1 - Hint of a worry (/non- verbal)

Level 2 - An expression that explicitly mentions worry or concern.

Level 3 - Clear expression of emotion (e.g. crying).

- Then response is coded by;-

Function – i.e. if cues are

Explored by;-

Eliciting, clarification or an educated guess.

- Acknowledged but not explored by;-
Empathetic statement, reflection, checking

- Distanced from by;-

Inappropriate reassurance, premature advice or switching focus.

- Form

e.g. use of directive open questions, screening questions, negotiation questions or summarising.

Non verbal response / communication

Conditional reasoning

- What problems do they encounter and what are the sources of these problems.
- Location of practice
- Organisational / resource concerns
- Practice traditions / values

Narrative reasoning

- Do they use practice examples and stories with women about their postnatal genital tract well-being?
- How do they do this

End of Observation

- Reassurance regarding coding of data, confidentiality and ongoing consent
- Ask midwife to check field notes for accuracy

Thanks for participation

Appendix 4 - Biographical details of midwife participants

Code	Female	Male	Years as a M/W	Post nursing entry	Direct entry	Practice history	Present practice Location	
							Comm	Hosp.
A	X		25	X		Mainly worked in locality, on the community for 18 years, same practice / area for the past 6 years	X	
B	X		6	X		practiced as a nurse for 15 years On the community for 4 years, same practice / area for the past 4 years, role as young woman's pregnancy service, all women under 18 years of age in locality	X	
C	X		12		X	Mainly worked in locality, (1 year in another midwifery unit), 3 years in hospital setting and then 9 year worked on community. Worked in various localities, encompassing a diverse range of client groups. Present role (past 2 years) includes a role as drug and alcohol specialist midwife	X	
D	X		6	X		Was a nurse for 14 years in same locality in a range of areas including medicine, intensive care and gynaecology. Worked first 4 years in hospital setting gaining a range of experience. Last 3 years on the community. Present role a mixed traditional case role and specialised caseload involving non-English speaking women locality. Role is to engage women who may have difficulty accessing the service. All interactions involve use of interpreters.	X	

Code	Female	Male	Years as a M/W	Post nursing entry	Direct entry	Practice history	Present practice Location	
E	X		22	X		Worked around the locality in hospital and community midwifery In present post for 12 year, key roles a community midwifery manager and safeguarding	X	
F	X		9	X		6 months as nurse. Always worked in same locality, however 7 years hospital midwifery experience (rotated around all areas) and last 2 year community midwifery experience	X	
G	X		20	X		Was a nurse for 2 ½ years prior to midwifery 16 years on community	X	
H	X		27	X		Has worked nationally as a midwife and in the region for most of the time. Has worked in hospital and in community settings.		X
I	X		16	X		worked in region and locality for past 13 years, hospital rotation Worked in present post as postnatal ward manger for past 5 years.		X
J	X		1	X		Never practiced as a nurse. Always worked in the immediate locality (during nursing course, midwifery course and as a qualified midwife).		X
K	X		4		X	Since qualifying worked at same midwifery unit. Has worked on the postnatal ward for the last 8 months.		X

Code	Female	Male	Years as a M/W	Post nursing entry	Direct entry	Practice history	Present practice Location	
L	X		18	X		Since qualifying worked at same midwifery unit. Has rotated around all areas including community. Has worked on the postnatal ward for the last year		X
M	X		29	X		Since qualifying worked at same midwifery unit. Has rotated around all areas. Worked as a community midwife for last 15 years.	X	
N	X		10		X	Since qualifying worked at same midwifery unit. Has rotated around all areas. Has worked on the community for the past 6 years.	X	
Z	X		8		X	Always worked in this locality.		X

Appendix 5 - Biographical details of women participants

Pseudo-nym	Biographical Details	Location	Contextual Factors
Harriet	Age 17 years, 1 st child, 11 days post LSCS	Home visit. Harriet at present living with her parents, with her partner.	Morning, Baby crying and needing a feed. Woman's father answered door but stayed in another room during the visit. Harriet's partner stayed in room for most of the visit, helped with baby and started feeding baby.
Tracy	Age 16 years, 1 st child, 11 days following normal vaginal birth, with an intact perineum.	Tracy at present living with her partners parents in a council house.	House extremely dark, very little natural light and no light bulbs in light fittings. House appears to be half way through some refurbishment, some bare pipes, no floor covering, no decorations on some of the walls. However has been like this for all the postnatal visits. House smells of dogs and cigarettes. Despite others living in the house (and door opened by a young male), no one else present during midwife visit.
Erica	Age 17 years, 1 st child, 6 days following vacuum instrumental birth, with an episiotomy	Home visit. Harriet at present living with her parents, and younger brother.	Lunch time visit. Erica's younger brother answered the door. Friend with Erica who then said she was going and left. Erica's mother present and contributing to most of the postnatal visit. Not in contact with babies father. Does have own accommodation, which she will return to in a couple of weeks.
Catherine	Mid twenties 1 st child. Day 13 following a normal birth. Vicryl sutures to the perineum.	Home visit. Catherine and partner present.	Lives with partner in council house with large dog. No medical, social history of note. No other visitors during visit. Dog kept up stairs for some of the visit and then brought down stairs Midwife had 12 postnatal calls that day.

Pseudo-nym	Biographical Details	Location	Contextual Factors
Kate	30 years old 2 nd child. Day 5 following a planned LSCS.	Home visit. Kate, partner and other child present.	Lives with partner and other child (1 ½ years) in comfortable home. Kate, partner and other child present. Visitor left on arrival of midwife. No other visitors during visit. Midwife had 12 postnatal calls that day
Vanessa	23 years old 2 nd child. Day 11 following normal birth with an intact perineum.	Home visit.	Vanessa only present throughout visit. Other child asleep upstairs. Possibly partner also upstairs. Midwife had 12 postnatal calls that day
Wendy	25 years old. 3 rd child. Day 1 following a normal birth perineum intact.	Home visit.	Wendy in living room with one other child (2 ½ years old). Other child (age 1) asleep. Partner and male friends in kitchen during the midwives visit. Midwife had 12 postnatal calls that day.
Debby	Mid twenties. 2 nd child previous emergency LSCS 3 years ago. This pregnancy had a normal birth 12 hours previously. Perineal tear repaired with vicryl sutures.	Postnatal ward, in “bay” with 2 other women and their babies	Midwife had been allocated 5 women and babies to care for, most of which the midwife considered “straight forward” i.e. No major physical social or emotional problems necessitating referral and liaison to other services. However expected that 4 of the women would be returning home today and therefore discharge procedures and paperwork would need to be completed. Ward busy, lots of health workers, e.g. midwives but also support staff cleaning and making beds, paediatricians to review babies, neonatal hearing screening staff to perform neonatal hearing tests and family planning nurse to provide contraceptive advice.

Pseudo-nym	Biographical Details	Location	Contextual Factors
Lesley	<p>Early thirties, 2nd child</p> <p>Normal birth with intact perineum.</p> <p>Woman identified as group B strep (from previous urinary tract infection) so baby being observed for 24 hours, with temperature being monitored.</p>	<p>Postnatal ward, in “bay” with 2 other women and their babies</p>	<p>Midwife had been allocated 5 women and babies to care for, most of which the midwife considered “straight forward” i.e. No major physical social or emotional problems necessitating referral and liaison to other services. (As “Debby”)</p>
Barbara	<p>30-year-old woman. 3rd child, Day 1 following planned LSCS for breech presentation.</p> <p>Postnatal recovery to time of observational - no issues / problems identified.</p>	<p>“Bay” on postnatal ward, with 4 beds and cots at present 2 beds occupied.</p>	<p>Morning time, a number of other health care professional present on ward, but not in bay e.g. paediatricians, neonatal hearing assessment staff and medical staff. However atmosphere quite relaxed with women aware of who was caring for them and when midwife would be spending time with them individually. Baby asleep.</p>

Pseudo-nym	Biographical Details	Location	Contextual Factors
Carol	<p>23-year-old woman. 1st child, Day 7 following Nbfd for failure to progress. During pregnancy Carol had E coli identified in her urine and had been treated with antibiotics. During labour she developed a low grade pyrexia. E coli was cultured from her urine and on blood cultures. Carol was treated with antibiotics as was her baby.</p>	<p>“Bay” on postnatal ward, with 4 beds and cots at present 2 beds occupied.</p>	<p>Carol hoping to go home today. Morning time, a number of other health care professional present on ward ,but not in bay e.g. paediatricians, neonatal hearing assessment staff and medical staff. However atmosphere quite relaxed with women aware of who was caring for them and when midwife would be spending time with them individually. Baby asleep.</p>

Pseudo-nym	Biographical Details	Location	Contextual Factors
Jenny	29-year-old woman. 3 rd child, Day 2 following planned LSCS as previous LSCS. Postnatal recovery to time of observational - no issues / problems identified.	“Bay” on postnatal ward, with 4 beds and cots at present 2 beds occupied.	(As above for Carol) Another baby being bathed so some background noise initially. Baby asleep.
Jill	37 year old woman, 1 st child, day 1 following a normal birth involving an episiotomy.	“Bay” on postnatal ward, with 4 beds and cots at present all beds occupied, including mother with twins.	Midwife had been allocated 5 women and 6 babies to care for, all of which needed breastfeeding support. Ward busy, lots of health workers, e.g. midwives but also support staff cleaning (vacuum cleaner making a lot of noise) and making beds, paediatricians (with medical student) to review babies ready for discharge, neonatal hearing screening service staff to perform neonatal hearing tests and a woman taking infant portrait photographs. During the postnatal assessment the paediatrician was in the bay next to this woman’s talking very loudly.

Pseudo-nym	Biographical Details	Location	Contextual Factors
Karen	<p>Woman's third pregnancy (2 older children). Emergency LSCS for twins at term (twin 2 transverse). One twin less than 25000gms. Both breastfeeding.</p>	<p>"Bay" on postnatal ward, with 4 beds and cots at present all beds occupied, including mother with twins.</p>	<p>(As above for Jill) Partner present.</p>
Rachael	<p>18 year old woman, day 1 following a normal birth, perineum intact. No history of note.</p>	<p>"Bay" on postnatal ward, with 4 beds and cots at present all beds occupied, including mother with twins.</p>	<p>(As above for Jill) Rachael had no visitors</p>

Appendix 6 - Data collection sequence

Interview Midwife A

Interview Midwife B

Interview Midwife C

Interview Midwife D

Interview Midwife E

Interview Midwife F

Interview Midwife G

Interview Midwife H

Interview Midwife I

Observation Midwife G - Woman 1 Harriet
Woman 2 Tracey
Woman 3 Erica

Observation Midwife C - Woman 1 Catherine
Woman 2 Kate
Woman 3 Vanessa
Woman 4 Wendy

Interview Midwife J

Observation Midwife H - Woman 1 Debby
Woman 2 Lesley

Observation Midwife I - Woman 1 Barbara
Woman 2 Carol
Woman 3 Jenny

Interview Midwife K

Interview Midwife L

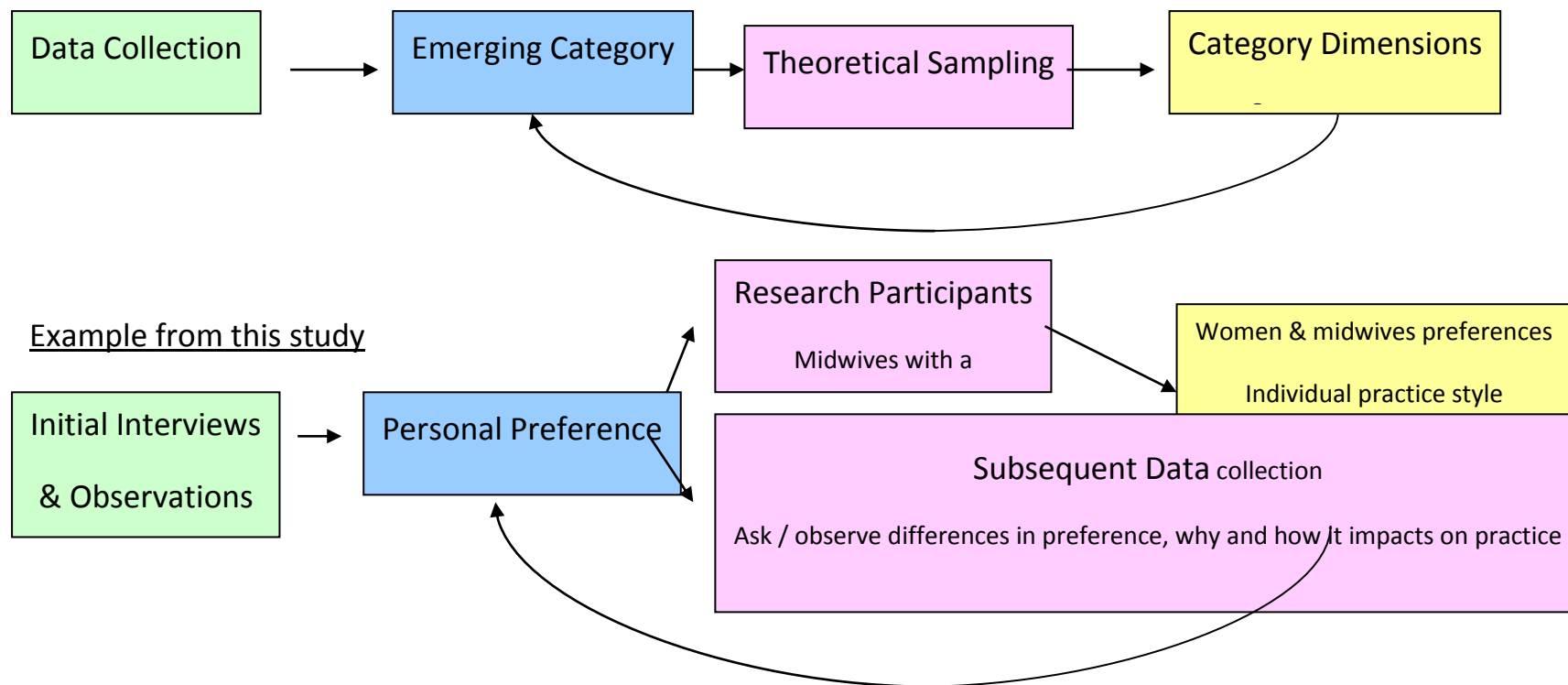
Observation Midwife Z - Woman 1 Jill
Woman 2 Rachael
Woman 3 Karen

Interview Midwife M

Interview Midwife N

Appendix 7 - Theoretical sampling process

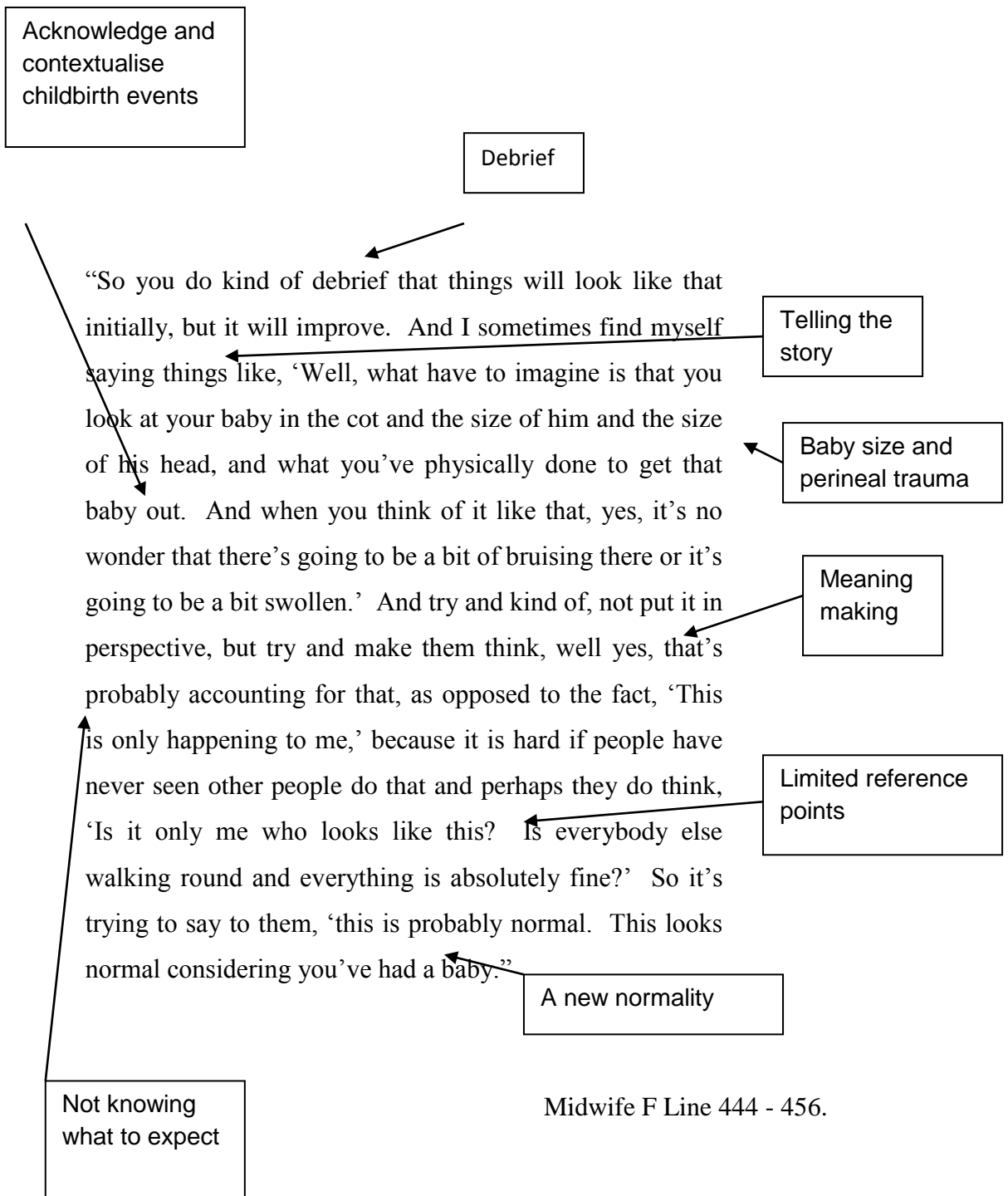
As tentative focused codes and categories are constructed from the data, constructionist grounded theory encourages the researcher to return to the research field and employ theoretical sampling. Theoretical sampling involves attempting to collect data, which will expand and provide substance to the developing categories of the grounded theory (Charmaz 2006). This can involve recruiting participants who may have specific data, which may contribute to the evolving categories and also seeking more detail upon particular areas during interview and observational data collection (Bryant & Charmaz 2010). Below is an example of how theoretical sampling has been employed within this study.



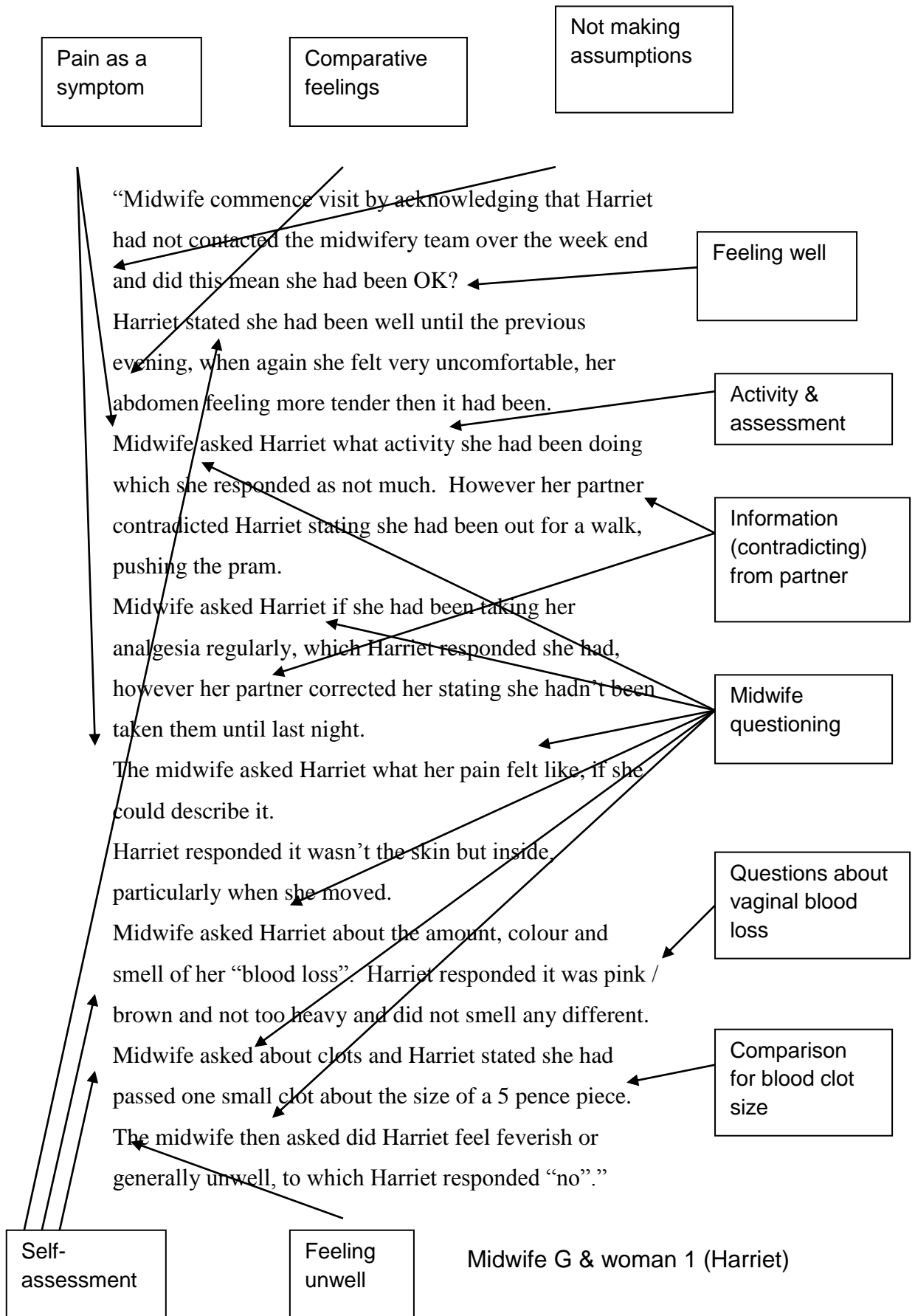
Examples of other categories within this study that were developed utilising theoretical sampling;

Emerging Category	Theoretical Sampling Via Research Participants	Emerging Category	Theoretical Sampling via Subsequent data collection methods <i>Interview Data / Guide (I) / Observational data Guide (O)</i>
Women's Lifestyle	<ul style="list-style-type: none"> • Midwives with a known diversity of client group • Substance abuse specialist • Young Mother Specialist 	Accurate Information	<ul style="list-style-type: none"> • Why some women may not provide accurate information (I)
Care in Context	<ul style="list-style-type: none"> • Impact of differing locations • Approach both community and hospital midwives 	Sensitive Care	<ul style="list-style-type: none"> • Other maternal needs • Identifying and responding to sexual health • Domestic violence • What is dignity and how is it lost? • How does the midwife maintain / regain dignity? (I) & (O)
Personal Theory and Generativity	<ul style="list-style-type: none"> • Midwives with different amounts of experience 	A therapeutic relationship	<ul style="list-style-type: none"> • Means of using communication to develop rapport • Gaining access • Experiences of story telling (I) & (O)
		Care in Context	<ul style="list-style-type: none"> • Competing priorities • Contextual factors (I) & (O)

Appendix 8 - Example of initial coding process interview data



Appendix 9 - Example of initial coding process observational data



Appendix 10 - Example interview transcript

Midwife F

- Interviewer: I'll just leave that there. Is that all right?
- Respondent: That's fine.
- Interviewer: And then we forget about it after a bit.
- Respondent: Yes, that's okay.
- Interviewer: So how long is it since you qualified?
- Respondent: I've now been qualified for nine years.
- Interviewer: Yes.
- Respondent: Is that right?
- Interviewer: Yes.
- Respondent: Yes, nine years.
- Interviewer: And that's as a midwife?
- Respondent: That's as a midwife, yes. So I qualified as a nurse in 1999 and worked in X for six months as a nurse at the X and then I came here.
- Interviewer: Into midwifery.
- Respondent: Into midwifery.
- Interviewer: So you had just six months as a nurse...
- Respondent: Six months as a nurse and then came into midwifery, yes.
- Interviewer: And did your shortened course.
- Respondent: Yes.
- Interviewer: So when you first came into midwifery, just for the tape, I know that you did your midwifery in this locality as a student.
- Respondent: Yes, that's right.
- Interviewer: And then you've worked here ever since, haven't you?
- Respondent: I have. I've worked here ever since. I've rotated between delivery suite and the antenatal/postnatal ward for most of that time, and then I came into the community as a community midwife two years ago,

after I returned back from maternity leave. So I've done a lot on delivery suite and in the ward, and then I've enjoyed the last two years here in the community.

Interviewer: Good. So the last two years in the community, have you also been aligned with...because I think you have GP alignment, don't you, or a particular caseload?

Respondent: We do, yes.

Interviewer: So have you always been with the same GP?

Respondent: We have, yes, I have. We've got two GP practices and at any point, you know, we can have a shuffle around and get changed but for the last two years, I've done the same caseload, the same two GP surgeries in the area, so that's worked out really well. And I do a job share.

Interviewer: So do you have quite a mixed and varied caseload, then, coming through?

Respondent: Yes, I have. Yeah, I would say we do. Sometimes, the GP tends to take patients from quite a wide area really and obviously you meet different people from various social backgrounds, so it's quite varied, yeah. We've now started seeing people coming back. Sometimes, I think we've looked after somebody second and third subsequent pregnancies, you know, that have been quite short.

Interviewer: That's nice.

Respondent: So this year, that is definitely starting where they've come back and you know them straight away because you've looked after them the last pregnancy. So that is quite nice because you instantly have that relationship anyway, and so it's just kind of catching up on what's been happening over the last year or so. So yes, it has been good.

Interviewer: Very good. Okay. Well, as you know, I'm trying to get at 'what, why, how,' the thinking behind when midwives are making assessment of women's genital tract well-being postnatally. So I wonder if you could think back, just some time over the last three months, and talk me through just an everyday, usual run-of-the-mill situation where you'd go and see a woman postnatally, and it would involve you making decisions about ways and means of assessing this woman's genital tract. So just, you know, if you think of the last couple of days going into someone's house, just a usual one.

Respondent: A usual one, if it was the first visit and you went in after they'd delivered and you would obviously ask them about their...I would obviously ask them about their delivery, how did it go and from that, you tend to get a lot of information anyway because then you get the

stories. So before you've even looked at what's written down, you kind of know if it's been fairly straightforward or if it's been complicated or if it's been long or short. And you kind of get their impression of if it was traumatic or if it was better than what they'd expected, you know? And then I would have the notes that they'd hand to me, their hand-held notes which would give you a brief summary of their delivery and from that, I would then be saying, 'So, how are you feeling now?' And then that would bring us on to, 'Did you need any stitches? How's everything feeling now? What's your blood loss like now?' and all the sort of questions that just come from chatting, and then that would lead me on to decide if I needed to do anything physically then, to assess them, or whether they feel that there's absolutely no problems.

Interviewer: Yeah. It's interesting, you started there by saying, 'I get their story.' That's an interesting choice of words. Why did you use that word?

Respondent: Because everybody's interpretation of events are completely different so sometimes, say, if I've looked and I've seen that on a delivery summary, it says that the first stage of labour was six hours and then the second stage was thirty-five minutes, I might look at that and think, 'Ooh, that's fantastic, they've done well, first baby,' or whatever. But sometimes then, when you speak to them, they think the whole thing was terrible and it was traumatic and yet other times, you look at something and you think...or you know that they've been in the delivery suite for two days because you've seen their name on the board when you've come in. So you know that they've had quite a long time of it, but when you go in, they say, 'It was brilliant.' So their interpretation of their experience is completely different to what you as a midwife might think was really good. For example, we did look after a lady who came into delivery suite and was already fully dilated, and delivered really quickly. So when I'd seen her name on the board and the girls had said, 'Oh, she came in, she was really quick,' I'd gone up to the ward to see her and I always think, 'She's done fantastic, she's just come in, delivered this baby,' but she was actually really, really traumatised by the whole thing because her memory of it is the pain that she had at home, and feeling that there was nobody there. I think she had her partner there but she really needed, at that point probably, some pain relief and a midwife and so she was really, really traumatised about that. So even though we look and think, 'She's just come in and delivered and she's got an intact perineum and everything's straightforward,' to her, that was a really traumatic experience. So it's about getting what they feel about that.

Interviewer: Right.

Respondent: And yet other times, sorry, you have people who've had a forceps delivery and an episiotomy and yet you ask them about it and they go, 'Yeah, it was fine.' They haven't actually given it a second

thought. It hasn't featured in...they're just so happy they've got their baby and it's not an issue to them, and yet you could look at that on paper and think that's all gone terribly wrong, you know.

Interviewer: Does any of the differing sort of interpretations apply to their genital tract postnatally, do you think?

Respondent: Yeah, I think obviously women's expectations...some women kind of expect or they prepare that they might have a tear or they might need to have stitches, and yet other women aren't prepared for that and are very antenatally...didn't want that at all, so therefore if that happens, they're a bit traumatised by that. For example, I had a lady who did have a forceps delivery and had had an episiotomy, but she was really horrified by the experience of the episiotomy, even though it wasn't infected. It was repaired properly and you know, for the duration that I visited her, she kept wanting me to check it because she kept feeling that there was something wrong, but to be honest, it was healed. There was no sign of infection and eventually she did start to feel better about it, but every time you mentioned the word episiotomy, she was really upset by it. She was really upset that that had to happen.

Interviewer: So did you feel, in a way, your approach to how you assessed her genital tract, particularly her perineum, was more focused on meeting her needs for reassurance rather than your needs to look at it?

Respondent: Yes, absolutely. Because I wouldn't have...the first day I checked it and it was fine. I think the next day, I probably wouldn't have. The following day, I probably wouldn't have looked at it, had she not asked me to but every visit, she wanted me to look at it and I think a lot of that was about body image, even though to me it looked absolutely fine and to me, it looked well healed. But to her, it was terrible that she'd had to have that. So yes, a lot of the things I did...for example, she also was convinced she had an infection so I actually did take a swab, even though my professional judgement felt that that was not infected at all. But I felt that was appropriate to do that because that would reassure her and that would satisfy her when I could then say to her, which I then did a few days later, 'Look, it's shown that there's no growth and there's no infection there,' which satisfied her.

Interviewer: Yeah.

Respondent: And I felt, if I hadn't have done that, she would have perhaps not believed that it was healing as well as it was.

Interviewer: And what implications do you think, then, that would have had for her generally? It seems like you weren't worried about her physically but it's almost as if you were worried that something else was going to happen if you didn't...what was your thinking with that?

Respondent: Yes. Well actually, I did because she actually hadn't been out for...I think the last visit I did was round about day twelve and at that point, she still hadn't really been out because she said she didn't feel up to it. And a lot of the conversation with her was about how she didn't feel a hundred per cent and she didn't feel completely well, and in all other respects, was absolutely fine. But she did feel that it was painful, which I'm sure it is, but it was definitely affecting her mental well-being, not to the point of kind of forcing a depression, but it was definitely affecting her. It was on her mind, so there was a lot of reassurance about physically, she was okay and a lot of discussion about...you know, at each visit, we discussed the birth again and again. A lot of it was reassurance and it seemed like each visit, there was another question, 'Why did they do this? Why did they do that?' because I think it happened in a bit of a rush. And she was planned for a home birth so therefore, I don't really think she'd considered that any of these things might happen, so it was all a bit of a shock to her, even though I had felt that I'd tried to prepare antenatally that if this doesn't work out, this may happen. But she was very much focused on a very normal, natural delivery, so when things didn't go to that plan, it was a bit traumatic for her.

Interviewer: Right, right.

Respondent: So I almost felt as though, in that situation, I was just guided by her and the fact that she wanted to know there was no infection, that she wanted me to check to know that it was healing and so I commented on the fact that the bruising was going down and it wasn't oedematous any more. And perhaps if she hadn't have been focused on that, I wouldn't have wanted to examine...I wouldn't have needed to inspect the perineum as often and I probably wouldn't have taken a swab. And I probably would've just got that it was fine by what she was saying about it.

Interviewer: Do you think almost, because one of the things you mentioned there was, every time you went, she had a new question. It's almost like she was unpeeling her issues about her birth experience. In some ways, do you think this fixation with the perineum was...I'm not saying consciously, but somewhere was to keep you going and engaged so she could do that with you?

Respondent: Yes, quite possibly.

Interviewer: Were you conscious of that?

Respondent: Yes, because there were occasions where she phoned and if we'd agreed that I'd come and see her in two days, there were occasions that she phoned and said, 'Could you come tomorrow?' and kind of bring the visit forward.

Interviewer: So do you almost feel like the perineum was used as her excuse because she couldn't say, 'Actually, I just need to talk to you about the birth'? I'm not saying on a conscious level but just almost...

Respondent: Yes, possibly. Yes, possibly.

Interviewer: Interesting.

Respondent: Because she was definitely finding it difficult to come to terms with the delivery, even though when I spoke to her about it and tried to say, 'Well, look, you've got this beautiful baby and it's gone this way because of x, y and z and not because of anything that you've done, just the course of events that, you know, you can't always predict.' But she hadn't actually had a lot of visitors to the house, through her choice, so I did kind of feel as though, for a while, I was the only one going in apart from her husband. And I did suggest a few times, 'Have you not let your Mum or whatever come in?' and she hadn't actually wanted any visitors. She felt that she wanted to bond with the baby. Her and her husband wanted to bond with the baby on their own, which possibly is a good thing but also, I felt as though it might have been a bit more...she might have had more chances to kind of de-brief if she'd let other people in, but that wasn't her personality. Her personality was quite independent, quite strong and she probably didn't find it as easy to just chat about her experiences with friends, possibly.

Interviewer: Right. But why with you, do you think?

Respondent: Well, possibly because it's not like a friendship, it's like a professional relationship so even though I knew her really well and looked after her antenatally, I suppose they know that your time then ends. And hopefully they recognise that we wouldn't judge them and I don't know really.

Interviewer: Do you think almost - and I'm saying the uniform but you don't wear a uniform - but the professional hat can sometimes potentially give women...what would be the right word? Almost like the okay to disclose these things and discuss them, if they don't normally do that with other people. Do you think it's almost like a...?

Respondent: Yeah, I do because it is quite intimate, what you discuss, and you wouldn't normally ask a friend to look at your perineum, for example, and I think that while some women are embarrassed, a lot of women just feel as though, well, you've seen it before and it's your job and you know, you try to convey things to them that that is part of your job and that it's not an issue to you at all. You know, for example, some women will always say, 'Well, I need to go in the shower first,' which is fine, but sometimes you just have to give off these cues that, 'It doesn't matter. You don't need to...it's not important to us because we're so used to it, we don't think about it.' You know, we should think about it but we're aware that sometimes

these things are quite intimate and embarrassing for them but that it's not for us. So it's hard to get the balance right but you're just trying to let them know that it's fine, this is part of it. Because obviously, when you're looking at them antenatally, it's probably not as intimate as that. You're palpating their abdomen and whatnot, but then all of a sudden, you're hit with this, 'Oh Crikey, this is what...' You might have never done that before. You might have never had to disclose yourself in that way or discussed what your lochia's like or how you go to the toilet and things and then obviously you're discussing contraception and things like that towards the end. So it is quite intimate, I suppose, really.

Interviewer: Right. Right at the beginning there as well, you mentioned body image as being perhaps an issue for this woman. Do you think that's something that, when you're thinking of genital tract health, that's an issue for women?

Respondent: Yes, but I think everyone's so varied that some women just seem to be more concerned with it, you know, they'd be happy that it's not infected, 'No,' and they're quite content that it'll heal and it'll be fine. They don't seem to mention it too much to you and yet other women will ask about, 'What's this going to look like?' or if there's some bruising, you know. Sometimes you can just look at a perineum that is really bruised, really oedematous, you know, it looks really sore and yet the woman is taking it all in her stride and doesn't really think too much of it. And she'll say, 'No, it's fine. It'll heal.' And yet other women, it can be quite small when you look at it but to them, it looks awful and they might say things to you like, 'Oh, I've had a look at it myself.' Often, they'll say, 'I've had a mirror there and I've looked at it myself and it looks horrendous.' And so you have this image in your head of something that's going to look horrendous and when you look, there's a little tiny bit of bruising. You know, it's everyone's interpretation of what's important to them.

Interviewer: It's just I was thinking round the words 'body image' because body image is something we associate with, say, faces and plastic surgery. Do you think women are more concerned now about how their genitalia look?

Respondent: Yes, yeah, I do. I think for some women, not all women, but for some women definitely it seems to be an issue.

Interviewer: Do you think we are sensitive enough to that?

Respondent: I think possibly not, because sometimes we kind of, because we've been used to seeing worse things, if you like, or we've been used to seeing things that don't look very good, that when you see something that to you...or with hindsight, you know that's going to heal and you think, 'Well, I know that that bruising's going to go down. I know that's not going to look as swollen as that in a week's time.'

But to them, that looks terrible and it's hard because I'm saying, 'That'll all settle down and that won't look as bad and it will return to normal,' you know, talking about pelvic floor exercises and things. But to them, they think that, they've had the mirror to it and it looks horrendous. So it's about what's important to that individual person and knowing that they have not seen all of the things that you've seen in the past so to them, that's really bad because that's never looked like that before. I think it's the same thing with stretch marks. You do an abdominal palpation, you don't really think about it. You don't look at an abdomen and think, 'Oh, that looks terrible,' but sometimes a woman will be really, really hung up on it and they've bought all the expensive creams and lotions and done this, which is fair enough, but sometimes you haven't even registered. You're too concerned thinking, 'Where's this baby lying? Is the head engaged?' and they're quite, 'Don't look at my stretch marks,' you know. So everyone's different really, aren't they? Some people it won't bother them and some people it will. I suppose it's trying not to be general and say...try not to shrug it off and say, 'Ah no, but it'll get better or improve.'

Interviewer: So when you're trying to sometimes sort of reassure them or give them an idea of what it might be like for them in the future because we do say, 'It'll go back to normal,' but if you've had an episiotomy or something, if you've had any wound, it's never going to quite go back, is it, to how it was before?

Respondent: No, that's right.

Interviewer: So do you ever give them anecdotes, if you like, stories of, 'Oh well, I knew a woman and it all ended up...' Do you ever sort of do that with your women?

Respondent: I tend to use the word 'some' women because I wouldn't ever discuss...I would never say a story about myself. I would never say, 'Well, this happened to me.' I don't know why, I just don't...I wouldn't often say that, and I would tend to say, 'Well, some women find that this helps,' as opposed to, like, an individual story. Maybe occasionally, I've said, 'Oh, I looked after a woman that that happened and she tried this, or whatever, and that worked,' but I probably tend to say things like, 'Well, some women find that if you do this, that really helps.' I would tend to use that phrase.

Interviewer: Yeah. Okay. Is there any sort of, you know, other evidence that you would use to give them information about their genital tract?

Respondent: Well, I would always let...the first especially, if there was a problem, then I would always reinforce hygiene. I would always discuss pelvic floor. The girls, the midwives on the ward normally would say all this so I kind of say, 'Did the girls give you advice on the ward about this?' and if they said, 'Oh, yes, I know that,' then I

would just reinforce it. If it was somebody that I particularly felt needed that, I would go through all the steps of trying to use the shower head, if they didn't have a bidet, trying to be hygienic, trying to drink plenty of water, you know, for passing urine. I would go through all those sort of things at the visit. Sometimes you'll find that they'll say, 'Oh, everything's fine down there,' and they don't want you to have a look at it. So I would be quite happy if I just said, 'Are you quite happy with everything?' and I would ask, 'Is it painful? Have you had to take any paracetamol or anything for it? Do you feel like you're going to the toilet normally?' And if they say, 'Oh no, everything's fine,' then I wouldn't necessarily say I need to inspect your perineum.

Interviewer: Is there any occasions where either you would press the point a little bit, if you like?

Respondent: If they'd had an episiotomy or they'd had a repair rather than just kind of one suture to the skin - because obviously I've got that information in front of us as well - so once I've got the history of their delivery and I would, 'Did you have any stitches?' and if they said, 'Oh, she just put one in,' or something like that, 'She said it was a first degree tear,' I would always offer. I would always say, 'Would you like me to have a look at that?' And if she said, 'No, no, it's fine, I'm not taking anything for it. It's fine,' and I thought that everything else appeared normal, I wouldn't push it. But I think if they'd had an instrumental delivery, an episiotomy, something like that, I would say, 'Well, do you want me to have a look at it? It's perhaps good just to see that it's all healing well,' and if they declined, then I would just say, 'Well, it's important if you've got any concerns,' and I would go through the concerns, 'If it's really painful, if you feel as though it's really sore to the point where the pain relief isn't helping at all or if you feel as though it's infected or it's got an unusual smell or anything like that, please get one of the midwives to have a look at it.'

Interviewer: Right. So you're saying that sometimes, if the woman started...you're using questioning with the woman to see if her perineum's all right, to decide whether you may or may not want to ask her permission to have an actual look at her perineum, is there other things that you use sometimes? Are there any other cues that you might pick up on off a woman?

Respondent: Sometimes how they're walking because sometimes, they run up and down the stairs and they might say, 'Oh, it is a bit painful,' but they've just run up for their notes and they've come down so yes, it may be painful but you know that they're walking fine. That's always a good sign. Sometimes when they kind of come hobbling in or if they find it difficult even to just get off a chair to move if you ask them, or the baby starts crying and they get up and you can see them walking, you kind of think, 'What's going on there?' Obviously, you're asking them as well about how they're passing

urine and their blood loss, the lochia, so if any of that didn't seem right when you were questioning them, I would generally say, 'Well, I'll just have a look,' probably more so on the first visit and then depending on what happened on subsequent visits. Because I think then, they'll generally say, 'Oh, it's much better than a few days ago,' or, 'It still hasn't got any better,' and obviously at times, we need to request a prescription for pain relief if what they had wasn't adequate or antibiotics if we felt it was infected. So yes, you are physically looking at what they're doing, where they've been. You know, sometimes people will come in and they'll say, 'Yes, well I've just been down the shops there,' so they're obviously getting out and about, so it's not affecting them to that point, whereas sometimes people are sitting on cushions and sitting in a certain way, or just telling you that they can only feed lying down because they're sore down below. So obviously if you come across that, you want to assess it further.

Interviewer: Okay. You mentioned lochia a little bit. So is there any sort of...what's your approach in relation to assessing the uterus, because we've focused a lot on the perineum there. Can you think of any occasion over the last three months where you've used any method of assessment?

Respondent: Yes. Well, yes, I would probably feel that that the fundus is firm but on the first visit home, especially if it had been...

Interviewer: So feel, you mean literally you're going to use your hands...

Respondent: Literally feel, so if it was somebody that had had a very short discharge, somebody who just came out the night before and it was the following day, I would probably, for the sake of what would take five seconds, ten seconds, I would probably just say, 'Do you mind if I have a little feel of your tummy, just to feel that the fundus is still firm?' And then I would probably just ask what the blood loss was like and people generally aren't bothered about giving you that information. They normally will just tell you and sometimes, if they say, 'It's really quite heavy,' then I would normally say, 'When you say heavy, how often would you say you have to change your pad?' Because sometimes what is heavy to one person is probably okay to another person, so obviously I'd be concerned if somebody had to change their pad every hour and it was soaked, every hour they had to change it. But if somebody said, 'Well, every couple of hours, when I got to the toilet, I change my pad,' but it's not dripping down their legs as they stand up, I would just assess the fundus and tell them the signs to look out for and explain that it will be heavier if they're doing more activity and if they've gone for a long walk or if they've been doing this. It obviously depends on their stage as well, when they've delivered.

Interviewer: Right. So you said, 'signs to look out for,' so what signs to look out for do you tell your women about?

Respondent: Kind of like if there's any clots, if they felt really unwell...

Interviewer: What do you mean by unwell?

Respondent: Well, if they felt as though they were...if they felt as though they had a temperature or just felt generally not right, or had passed a clot for example. I always would reinforce...I telephone them so at the end of the visit, I always agree with them when the next visit was going to be but if they felt that if there was any problems, if they passed any clots or if suddenly the lochia became a lot heavier, you need to call us or you need to call delivery suite. You probably do a lot of these things the first time you see them because you do give them a lot of information on that first visit and then just depending on what they were like on subsequent visits. I wouldn't feel the fundus again probably, unless they said there was a problem, on subsequent visits. If I'd felt and it was firm, I would be quite happy if they said it was no heavier or if it was improving or if it was getting less.

Interviewer: Right. Sometimes what other people have occasionally mentioned to me is other people giving them the information about a woman's well-being, so sometimes the woman might say they're all right, but they say there's a monster behind shaking their head or...have you had that type of experience?

Respondent: Yes, I have. Yes, I've had that where a woman is saying, 'Yes, yes, I'm absolutely fine,' and her husband or her partner or her mother has said, 'Well, no, you've been up all night or you've been sitting crying,' and they'll tell you things and it is hard, because then you're having a chat with this woman but you're trying to gradually bring in some of the aspects of what they've said without just believing what the mother said and, you know, sometimes you end up with a bit of a three-way conversation. And sometimes, there's cause for concern and other times, it's maybe that you feel that's the mother's interpretation if that's been really bad. And it's very interesting when the women are talking about their birth experience, when you get the other person's experience as well because often there's somebody else there who's been there as well, so you're saying, 'How did it go? How long were you pushing for? So what happened after you had the baby?' And they're both chipping in and you get the partner's account as well and that can often be quite different, how they feel that experience went to compare to what the woman felt.

Interviewer: Very good. Do they ever use their partners in relation to assessing their genital tract? You say they have a look. Do they sometimes get their partners to have a look?

Respondent: Yes, yes, I have had that before as well, yes. Or sometimes they've had somebody say, 'I've got my husband to check and he says there's a big gaping hole there,' and when you look, it's just a small amount of gaping, where to us that will still heal and you're explaining that the way they're sitting and the fact that it's a very vascular area, it will come together and it's well lined and there's no issues. But sometimes they have felt that looks worse than what it is.

Interviewer: Right. Sometimes, have you ever had to talk to partners about that and their perception? You know, tied it in with this body image thing?

Respondent: Yes, because often, the partners have felt that the experience, especially things I suppose like an instrumental delivery and episiotomy, that that was really traumatic and so I think sometimes you just debrief a bit about why there's lots of people in the room and how everything looks very clinical. So you do kind of debrief that things will look like that initially, but it will improve. And I sometimes find myself saying things like, 'Well, what have to imagine is that you look at your baby in the cot and the size of him and the size of his head, and what you've physically done to get that baby out. And when you think of it like that, yes, it's not wonder that there's going to be a bit of bruising there or it's going to be a bit swollen.' And try and kind of, not put it in perspective, but try and make them think, well yes, that's probably accounting for that, as opposed to the fact, 'This is only happening to me,' because it is hard if people have never seen other people do that and perhaps they do think, 'Is it only me who looks like this? Is everybody else walking round and everything is absolutely fine?' So it's trying to say to them, 'This is probably normal. This looks normal considering you've had a baby.'

Interviewer: Yeah, yeah. That's really interesting. So do you know sometimes when you're on about your...it sounds to me like you talk about you're starting first of all and it's starting with...it's almost like an engagement trying to chat with them. You're getting their stories, you want this that and the other, so quite fundamental to that I assume, but I need you perhaps to enlighten me really, is the need to be able to form this relationship so you can get them to tell you stuff, basically. So how do you do that? What's that based on?

Respondent: Well, it probably is a lot easier if you know, if you've looked after that woman so the continuity is good. I mean, it's lovely if you have looked after that woman right throughout her pregnancy, so you know all about her history, you know about her previous children and you know where she lives, you know about her husband and who is going to be there. You've perhaps gone through a birth plan with her or some sort of discussion about the labour at some point, antenatally. If you then go and do the postnatal visit, it's easier to go in because you don't have the formal introductions of, 'Hello, my

name's such-and-such and I'm one of the midwives.' It's great just to go in and say, 'Well, how did it go, congratulations. Look at the baby,' do that sort of thing like that, 'You've done fantastic,' and that bit first, the friendly kind of bit, and then they feel more comfortable. So when you say, 'How are you? How did it go?' and let them then tell you what they're...because I suppose by saying, 'How are you?' or 'How did it go?' you then get what's the most important thing to them, so you'll find for some women it won't be the birth, it'll just be, 'Well, I've been up all night,' and it might take it onto feeding issues straight away, so you're kind of straight onto the baby and the feeding and whatever has happened with the baby. And then later on, you'll bring it back to, 'So how are you, you know, physically how are you? What's happening?' And yet some women, the first thing that they would say is, 'My stitches feel terrible,' so by saying, 'How are you?' sometimes you'll get something completely different and then you just have to...I would just do my assessment from...I wouldn't sit with my sheet out and run through the thing and say, 'Right, we'll start with you and then we'll move onto the baby.' You would just be guided by what was their main concern, and sometimes you find that the delivery is of no concern to them. It's almost as if they've maybe de-briefed with the husband or they haven't really felt that there's any issues with it, so the whole thing is taken up about the baby with obviously me then saying, 'So are you quite happy with everything yourself? No pain, no discomfort?' whatever. 'No, no, I'm fine,' and then just bringing it back to the baby, so sometimes you find that'll happen and other times, they want to tell you straight away what's going on.

Interviewer: It seems like you've talked about this very discursive approach that you're using. Has your approach to how you make assessment of maternal genital track well-being, has it changed over the nine years you've been in practice as a midwife, do you think? Or has it always been constant?

Respondent: Yeah, because I think probably when you initially qualify, you probably look at things slightly different in that you feel as though things have to be...not ticking boxes, but I don't know what the word is...I think with experience, you learn to pick up on other things so you pick up on what they're saying. I think it's easier to make an overall picture of what's going on and I think having worked in a hospital and then gone out in the community, that definitely helps and when you see people in their own surroundings, it's easier to assess whether that's normal for them, just generally you know. Because sometimes when you meet someone in the delivery suite and you don't know them, that's why I was saying, if it's a woman that I know, it's easy to go in and say, 'How are you?' It's harder sometimes if you go in and you don't know that woman because you're then saying, 'Oh, hello, I'm such-and-such. Your midwife's on a day off today so I've come out,' but then I would probably still say, 'So how did your delivery go or how was your labour? How did

you find your labour?’ and then that just brings you on to the issues important to them. But I think it’s much easier to understand, when you’ve known somebody antenatally, it’s easier to see what is...how you can approach different things. Sometimes the terminology that you may use would be different, so sometimes you feel as though you would need to say all the correct terminology to somebody because you would feel that that is right for them because they’re very well educated or whatever, and that’s how you would speak to them and that’s how you spoke to them right throughout. And for other people, you might think I perhaps wouldn’t use...I would probably try and use the words that they were using to me, not always but if they said something...if they didn’t use the word ‘perineum’, if they said, ‘I’m really sore down below,’ then I would perhaps say, ‘Do you want me to have a look?’ rather than trying to change all of the terminology that they’re using. So you try to fit in to how individuals are, I think.

Interviewer: Right, right. So going back there, you felt your practice had changed, that perhaps...I’m just sort of making sure I’ve picked this up right. You talked about perhaps your experience - so increased repertoire, you’d perhaps been in hospital, been out in the community – had helped that and you seem to be saying that...and also, as part of that, perhaps initially a bit more, almost looking at...and I’m saying ‘almost’ because this isn’t quite what you said but I can’t quite think of how to phrase it at the moment...because you were on about utilising the list a bit more, where now you were talking about stepping back and seeing the woman more as a whole.

Respondent: Yes. I think when you first qualify...

Interviewer: Needing to integrate things more...

Respondent: You’re frightened that you’re going to miss anything, so you almost feel as though...probably when I first qualified, I probably almost felt that when I was doing a postnatal check, I had to mention every single thing that was written down. So it was almost, I feel like I need to say, ‘How often are you passing urine? Can I check your perineum,’ feeling the fundus, probably at each...say, for example, on the ward, each time you do a postnatal check, you felt as though this is what you’re doing. So it’s a bit more because maybe because of your lack of confidence because you’ve just qualified, you feel as though you have to physically do it to know that you’ve assessed that right. But then I suppose as you’re a bit more experienced, you know that if you’re happy with that one thing, probably that other thing is going to be okay and, without ignoring something, sometimes you get a lot of information without having to even ask a question about that. Because sometimes by you saying, ‘How are you feeling today?’ by just saying that, they’ve actually told you everything about what’s gone on. So you don’t necessarily have to sit and look

at your books and say, 'Are you passing urine?' because they've told you in a roundabout way.

Interviewer: Right, okay, that's good. So is there any other, if you like, knowledge or insight or whatever that have informed your approach to assessing general tract well-being over the last ten years?

Respondent: I suppose you're always going to get the situations where something's happened, whether it was you or another midwife's had this experience where they've said, 'Oh, I went out to see this woman and she had a third degree tear and this is what happened,' or whatever, and it makes you more aware of things. I sometimes think, actually, I'm going to...I suppose your documentation...the various experiences that have gone on over the last few years, it all kind of shapes how you eventually document things to make sure that you don't miss things out. I don't know how I'm trying to say this! Just experience really, I suppose, and from the past things that happened.

Interviewer: It sounds as if you're more worried about documenting to show you haven't missed anything rather than documenting what you find? It's interesting that your emphasis was on that.

Respondent: Yeah. Well, you're documenting what you find so that the next person coming in will know, obviously. But I think there's been instances where perhaps postnatal care has happened but because it hasn't actually been documented, things have happened because you haven't put that you've inspected the perineum and this is what you've found. And if something then has happened from that, it makes you more aware of your practice and making sure that you have documented for that reason.

Interviewer: Right.

Respondent: You're doing it for both reasons. You're doing it...

Interviewer: So is the reason we're getting at here, that sometimes you do things and it's do with the care that you're giving but that sometimes you do things and it's do with covering yourself, from a risk management point of view?

Respondent: I think you need to do both.

Interviewer: Right.

Respondent: Even though, you know, the latter probably isn't the best, I think in the climate that we're in, you'd be silly not to do that because if you, you know on our postnatal sheets, it'll have...I think it's got perineum. Now you can write NAD or whatever, but if there is any form of issue and you didn't document it, it doesn't look as though you've...it could almost be argued that you haven't asked the woman

about it. So I would tend to write on the first visit something about perineum, whether inspection declined if they didn't want to, 'Such-and-such feels comfortable,' or whatever. It might be something as simple as that. Or if I have examined it, I would definitely document what I'd seen. I wouldn't just assume that, because I'd examined it and it was fine, I didn't need to then document that.

Interviewer: Right, okay.

Respondent: So I'd put, 'Perineum examined,' and then I would put whether it was bruised or whatever, and for two reason – for the fact that it might not be me doing the next visit so that they can compare that, but also that it's documented that I have physically done that care.

Interviewer: Right, okay. If you had a student with you, do you ever do things differently, if you've got a student with you, a student midwife? Do you take a slightly different approach at all, or...?

Respondent: No, I don't think I take a different approach, it depends. Sometimes you might've discussed something before you've gone in the house, so if it's somebody that you know, you might say, 'We're going to this woman,' or you might've told the student what you're going to do, if it's a subsequent visit and you know what you've gone back to do. Sometimes it might be appropriate to explain something in front of the woman and other times, it might not be and it might be more appropriate to explain it once you've left that environment, and that just depends on lots of things, on your relationship with the woman, on how sensitive the issue is. So if somebody's very sensitive and very aware, I probably am not going to go into in-depth about explaining why I've done this at that time, but then perhaps when you've left the house and you've got in the car, I would then say, 'Did you see why I've done that?' and that sort of thing and let them ask any questions.

Interviewer: But in relation to assessment of the genital tract, palpating, particularly clinical observations, do you use them any more or less if you've got a student with you?

Respondent: No. I mean, I wouldn't palpate at each visit just if the student was in, unless...no, I don't think I would necessarily...

Interviewer: Okay. All right. Is there anything else, because I'm conscious we're running out of time now at fifty minutes. Is there anything else that you think, 'Oh, I want to tell Val about that,' that you think would help illuminate for me what happens when you're trying to make assessments of maternal genital tract well-being postnatally?

Respondent: No, I think you've got some written information about delivery but that's very brief and that doesn't really tell you an awful lot. It tells you what type of delivery they've had, and the most information that

you're going to get is through talking to them and through observation. And then obviously, if you have any further concerns, you're going to examine them and I have known having to refer somebody back into the hospital if I've felt that it's been...if there's something that's been majorly infected or a severe pain or sometimes if you've gone out and they've gone home really early, if they've said that haven't voided much urine and that sort of thing. But they are few and far between. The majority of women have no problems in that area so you do, every now and then, you'll come across one unexpectedly.

Interviewer: Is there any...I've just got one final question, if that's okay. Is there any, if you like, external factors, things like time, resources, competing priorities or anything else that sometimes impacts upon your ability to give these aspects of postnatal care?

Respondent: Because I think something like that is quite an important aspect, I wouldn't...I don't think I would neglect that as a time constraint thing, because I would rather be satisfied that that was okay as opposed to, say, sitting having a cup of tea and chatting about other things. But, for example, it is difficult if somebody says, 'Oh, I just want to have a bath first.' You know, sometimes these things and time can factor into that, definitely. You're very conscious that you're doing a visit and you're conscious that in an hour's time, your antenatal clinic's starting, you know, it's hard. So sometimes it's just weighing up, without sounding as though you're rushing somebody, not all the time but sometimes somebody will say, 'Well, I just need to have a bath first,' and you might think, 'I could be sitting here for half an hour.' It doesn't happen very often but you just have to be sensitive to that and do what you can really. I'd never tell anybody they couldn't do that.

Interviewer: Do you think sometimes there could be a danger of almost, not ignoring but asking a woman in relation to how they're feeling, 'Oh, well I'm all right,' and leaving it at that?

Respondent: Yes, because sometimes there possibly is...their issue is the fact that they've had no sleep or their issue is something else, so at times sometimes, without realising it, you've gone down the path and you've spent so long discussing and giving care about this one issue that then perhaps at the end, it's almost like, 'Right, we need to discuss this,' but probably a bit briefer, because you've discussed everything else at length.

Interviewer: Right, okay. Is there any other sort of, if you like, contextual factors that sometimes have an impact on the approach you may well not use?

Respondent: Sometimes depending on who's there. I mean, occasionally you go in the house and there's ten visitors sitting round and I do sometimes find that hard to say, 'Well, what's happening?' You probably lower

your voice a little bit and you probably look more directly at them, or sometimes I'll say, 'Is there anywhere a bit more private to go, just to check you over?' and it might not necessarily be because I want to examine them but because I want to ask them more personal questions than with aunts and uncles sitting right next to them. Some people you'll find that they just start talking to you about things when everybody's there so you just have to go with that, because if they start telling you, 'Actually, my stitches are really hurting,' and the whole family's there and that isn't bothering them, then I would respond because they haven't been bothered. If I get the cues that actually, it's not very private here, then I would say, 'Is there somewhere?'

Interviewer: What cues?

Respondent: Well, if they're looking as if...I would only discuss something like that with other people being there if they first started giving something intimate. So if they started discussing something and it was clear that they're not bothered that that person's there, then I could continue that conversation.

Interviewer: But what cues would you pick up where you thought, 'No, this woman wants me to find her somewhere else'?

Respondent: Probably when they were just saying, 'Yeah, I'm fine, I'm fine,' and not being very specific. I would then maybe think, well, if I look down and see that actually, she did have sutures or she did have a retention of urine or she'd had a catheter in, you know, something like that.

Interviewer: What about behavioural cues, how she looked?

Respondent: Yes, behavioural cues definitely, if she looked embarrassed. It's hard to describe how somebody looks embarrassed but if somebody looks embarrassed, I would say, 'Do you want us to go upstairs, or is there anywhere more private?' Sometimes people just say, 'No, I'm fine.'

Interviewer: Okay. One of the things that I've had mentioned to me is that sometimes almost using the excuse of checking them, doing physical assessments of the genital tract, to create mother / midwife time. Have you experienced that at all?

Respondent: Yes, yes. I would probably, in that situation, if I felt as though I couldn't ask...sometimes even things like your feeding issues, you know, I find it is quite off-putting if there's a lot of people in the room and they're all just chipping in talking about what colour Babygro the baby's got on and you feel as though you haven't really discussed anything in any detail. Not everybody will want to but it's when you've just got that time on your own, you are able to be a bit more honest about things and get a bit more depth in what you're assessing, as opposed to yes, I've got ten million visitors here. So

yeah, that is a good...so then, if we did go in another room to do that, that would lead you on to say, 'How's the breastfeeding going?' or that sort of thing.

Interviewer: What about trying to get women away from partners occasionally, particularly when I'm thinking of the genital tract and domestic violence? Has that ever been something you've experienced, or has crossed your mind?

Respondent: Probably the most women that I've seen...yeah, I mean it is a fact...obviously if you knew that there was a volatile relationship or if you suspected that there was something, then I probably would try and see that woman on her own if I could. Most of the time, if you ask that, my experience is that the woman has just come on her own. Occasionally, you do come across a partner who doesn't seem to leave the woman on her own and occasionally, I've had a woman...well, one woman that I think of, that whenever I looked at it, she wanted her partner there. I can remember doing a sweep on a woman who wanted her partner there to hold her hand and those sort of things. You do come across that situation as well, where the woman's actually said, 'Such-and-such will come with me.'

Interviewer: What about postnatally? Have you felt like sometimes it's the partner who wants to be there and you would like to create space in case there's anything they want to say to you?

Respondent: Occasionally, I've come across that, yeah. Occasionally.

Interviewer: Can you remember anything about it?

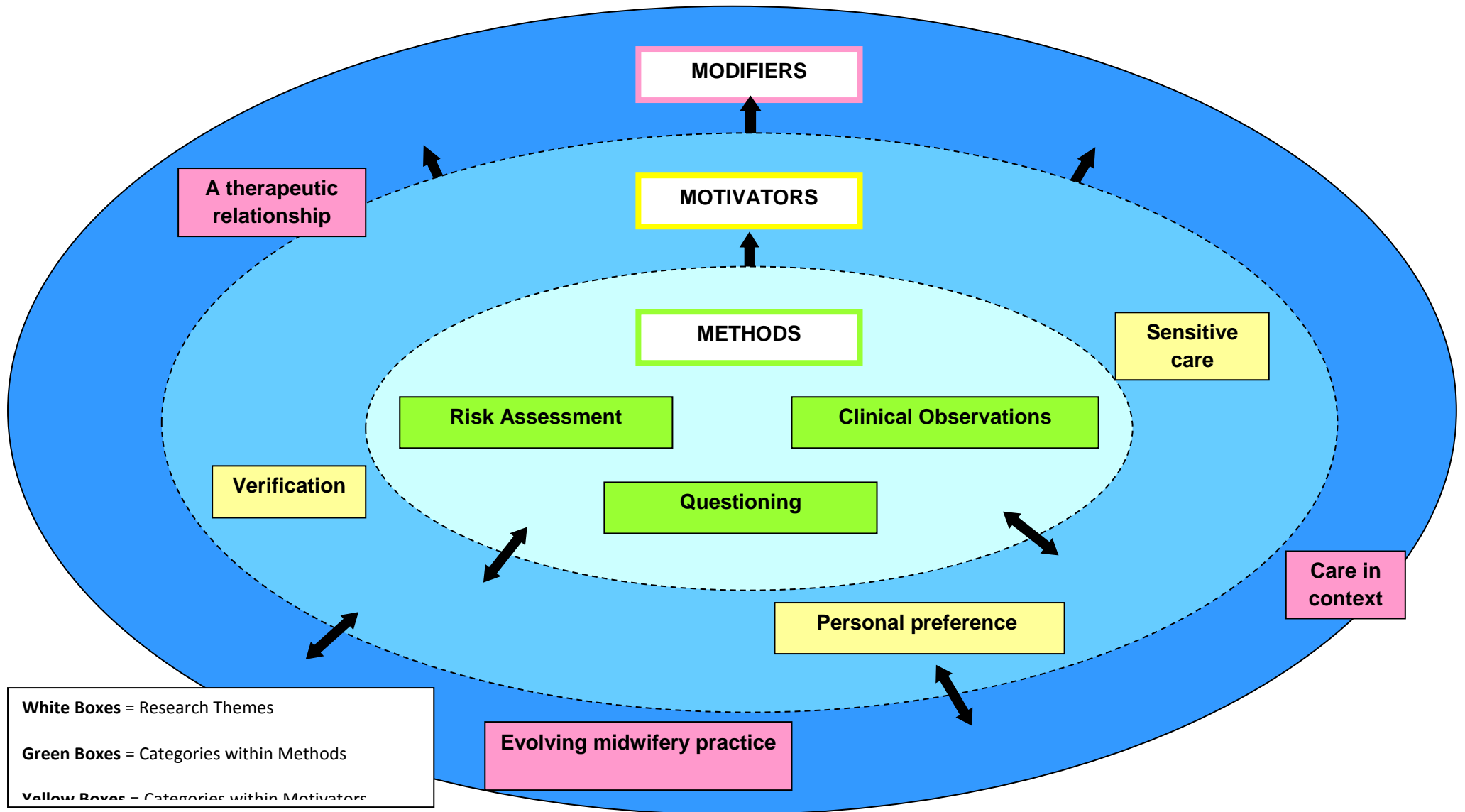
Respondent: I've come across women where the partner's...especially if I've known that the partner is like that generally, who's attended every antenatal visit and so you've known them quite well and they seem to be quite a bit of an intense character. I haven't come across anybody that I've suspected, that I couldn't...but I've suspected that there could be domestic violence issues or anything like that, where I couldn't get the woman alone. I've never really...I can't remember a situation where I've ever thought, 'Oh, I really need to get him out of the room,' particularly.

Interviewer: Right. So you've never felt the need to use...make using clinical observations of the genital tract almost as an excuse to get her by yourself?

Respondent: No. Only to be able to discuss things more intimately without it being embarrassing in that kind of social situation.

Interviewer: Okay, right. That's great. Right, I think we've probably run out of time.

Appendix 11 - Diagram of the grounded theory of midwives' experiences and practice in relation to the assessment of maternal genital tract health



Appendix 12 - Regional research ethics committee approval letter



National Research Ethics Service
Newcastle & North Tyneside 2 Research Ethics Committee

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29 January 2010

Mrs Valerie Larkin
Senior Lecturer
University of Northumbria
Room G206 - Coach Lane Campus East
Newcastle upon Tyne
NE7 7XA

Dear Mrs Larkin

Full title of study: An exploration of midwives experiences and insights of negotiating genital tract observation and assessment approaches with women when establishing postnatal well being
REC reference number: 10/H0907/3
Protocol number: v 1

Thank you for your letter of 29 January 2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 20 January 2010. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Email	Valerie Larkin	29 January 2010
Participant Consent Form: Midwife - Interview	v 2	29 January 2010
Participant Consent Form: Postnatal	v 2	29 January 2010
Participant Consent Form: Midwife - Observation	v 2	29 January 2010

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

10/H0907/3 **Please quote this number on all correspondence**

Yours sincerely

Gillian Mayer
Committee Co-ordinator

Appendix 13 - Participant information sheet (midwife)

I would like to invite you to take part in a research study I am undertaking to complete a professional Doctorate in Midwifery. I am Val Larkin a Registered Midwife working as a Senior Lecturer in midwifery at Northumbria University. I am a program leader for the pre-registration midwifery degree and also teach on post qualifying and post graduate courses.

Before you decide I would like you to understand why the research is being done and what it would involve for you.

I will go through the information sheet with you and answer any questions you have. This should take about 10 minutes

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.
- Please ask if there is anything that is not clear.
- Talk to others about the study if you wish.

Study title

“An exploration of midwives’ experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”

Part 1

What is the purpose of the study?

Over the last decade or so there has been a change in emphasis upon the content and focus of postnatal care. This has included the removal from professional guides any directives concerning the frequency and timing of physical assessment of mothers to assess genital tract involution and well-being. This study aims to explore the experiences and insights of midwives in relation to contemporary observation and assessment of maternal postnatal genital tract well-being. This will include what methods of

observation and assessment are used, how and why and what factors may influence the assessment method chosen. In addition the study hopes to identify if and how women influence the methods of observation adopted. The findings of the study may contribute to the insights of midwifery practice knowledge and the factors that influence practice decisions. This would be useful for midwives, women, educationalists and service providers.

Why have I been asked?

You have been asked as you fulfill the sample criteria, which are being a practicing midwife within the research site who currently undertakes postnatal midwifery care. I am hoping to identify approximately 10 midwives to participate in the study.

What am I being asked to do?

You will be asked to;-

Participate in an interview up to 1-hour duration in which you will be asked to discuss and give examples of how you have observed and assessed maternal genital tract well-being. This will include describing events (whilst maintaining client confidentiality), but also discussing why you thought or did certain things and how you felt about it. The interview will be audio taped and then written down word for word, to contribute to the study data. A follow up interview may be needed to verify the interview transcript and / or clarify issues raised. This should last no longer than 15 minutes.

AND / OR (you can decide)

The researcher accompanies you on a small number of visits to postnatal women. The researcher would be a participant observer, that is she would contribute to the social aspects of the practice visit but not directly partake in client care. The researcher would like to observe midwife and postnatal woman interactions regarding observation and assessment of genital tract well-being. Notes of location, those present and activities would be made

by the researcher immediately after the visit and you will be asked to check their accuracy.

Do I have to take part?

Participating in the study is entirely voluntary. The researcher will describe the study and go through this information sheet. If you agree to take part, you will be asked to sign a consent form.

What happens if I do not want to participate?

Nothing. Participation is voluntary, if you do not wish to participate, you need do no more.

What happens if I agree to take part and then change my mind?

You are free to withdraw at any time, including after you have consented, without giving a reason.

Part 2

Who is organising and funding the research?

The researcher is organising and funding the research as part of a professional Doctorate in Midwifery Programme she is completing with Northumbria University.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Northumbria University Research Ethics Committee, the local Research Ethic Committee and the Research and Development Committee for the local maternity services.

How will the study data (information) be collected?

Data for the study will be collected by 2 means;-

Face to face interviews that will be tape-recorded, an essential process to enable accurate recollection of the interview interaction. However if the respondent experiences any discomfort or distress during the tape recording and should request (or if the researcher deem it appropriate) the tape will be stopped and the data removed from the research sample.

and / or observation of a small number (from 1 to 3) of postnatal visits. This would involve the researcher observing the initial interaction you have with the woman, but not participate or necessarily observe any subsequent clinical / physical examinations. Maternal consent for researcher observation must be achieved prior to any researcher observation. The inclusion requirements relating to the postnatal women whose midwifery care will be observed will include;-

- Both first time and mothers with previous births
- The focus will be upon mothers who have had vaginal deliveries.

The exclusion requirements relating to the postnatal women whose midwifery care will be observed will include any complications of the intranatal or postnatal period which would make such observations insensitive / inappropriate. This would include;-

- Stillbirth, neonatal morbidity or neonatal death.
- As the focus of the observation is to observe how the midwife interacts with the client, it would be unhelpful to data collection to observe an interaction in which an interpreter was required.

The midwife participants will be made aware of potential inclusion and exclusion criteria and asked to identify potential women who may be approached for consent for one of their care interaction with their midwife to be observed. This may involve observing one midwife with several clients either in the hospital postnatal ward or during visits to the client's home.

Accessing and recruiting postnatal women to the observational aspect of the study will involve 2 similar approaches, dependent upon the location. When a community midwife has agreed to participate in the observational aspect of the study, you will be asked to identify women who fulfil the inclusion / exclusion criteria who are anticipated to require postnatal care within a one month time frame (June to July 2010). In the first instance the midwife will be asked to provide these women with the information sheet regarding the research and proposed observation. If the woman is amenable to allowing the researcher to enter her home with her midwife and observe the midwife providing care on one occasion, she will be provided with the researcher contact details and study information leaflet to enable her to access further information and clarify any queries.

After the woman has given birth and returned home, her midwife will again confirm with the women that she is happy to allow the researcher to observe the midwife providing one of her care interaction. Following this confirmation the researcher will then discuss with the women the research and gain informed consent to the observation. However the women will be assured that at any point she may change her mind and rescind her consent to participation.

When a hospital-based midwife agrees to participate in the observational aspects of the study, a date will be negotiated for the researcher to attend the postnatal ward when the midwife is on duty. Prior to the researcher meeting the women the midwife will identify women who fulfil the inclusion / exclusion criteria and provide them with verbal information and the information sheet regarding the research and proposed observation. Those women amenable to allowing the researcher to observe the midwife provide her postnatal care will be identified to the researcher when she attends the postnatal ward. The researcher will then discuss with the woman the research and gain informed consent to the observation. However the woman will be assured that at any point she may change her mind and rescind her consent to participation.

Will being involved in the study cost me anything?

The interviews and observations will be done at your workplace, to prevent any need for travel and minimize disruption to your working day. The head of service has agreed to those who wish to participate completing the activities during their working day.

What will happen to the study data (information) that are gathered?

The data (information) from the interviews and practice observations will be turned into written accounts. These will be anonymised, that means all information relating the data to you, your client or any other individual will be removed before it is written up and stored securely within a locked cabinet within a locked room. Anonymised data will be entered onto a computer (not a portable lap top), which is password protected. The researcher will examine the data for emerging themes and issues. The data will be securely retained for approximately 10 years and then disposed of securely, via shredding.

Will my taking part in the study be kept confidential?

Yes. The researcher will follow ethical and legal practice and all information about you will be handled in confidence, anonymised and stored securely. The contribution of individuals will not be divulged to other parties. Collective responses and themes and anonymised quotes will be presented in the study reports.

However there are exceptions to the maintenance of your confidentiality and anonymity. This would include an event in which legal or professional parameters had been breached, for example incidents reported or witnessed in which the safety, well-being or ethical and professional treatment of individuals was a concern.

What will happen to the results of the research study?

At a local level there will be presentations to the local midwives and service managers of the findings with a written summary of the information. At a national and international level journal articles and conference presentations are anticipated to an audience including professionals, educationalists and

researchers. A summary of findings will be developed in lay terminology and forwarded to local and national maternity user organisations for review. You will not be identified in any report / publication.

What if there is a problem?

If you have any concerns or questions regarding any aspects of the study and / or your participation in it, please discuss this in the first instance with the researcher (contact details at the end of this information sheet).

Complaints

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. Please discuss this with the researcher, who can try to solve the problem in the first instance (contact details at the end of this information sheet). If you remain unhappy and /or wish to complain formally, you can do this by contacting the institution supporting this study. Contact;-

Dr. Charlotte Clarke,
Associate Dean for Research,
School of Health, Community and Education Studies.
Northumbria University,
Coach Lane Campus West,
Newcastle Upon Tyne,
NE7 7XA

Who do I contact if I want to ask more questions about the study?

The researcher would be most happy to answer any questions. Please contact;-

Val Larkin
Senior Lecturer,
Continuing Interprofessional Education and Post Graduate Studies,
School of Health, Community and Education Studies,
Northumbria University,
Room G206,
Coach Lane Campus East,

Newcastle upon Tyne.

NE7 7XA

Tel. 0191 2156134

Val.larkin@northumbria.ac.uk

Appendix 14 - Participant information sheet (client)

You are invited to take part in a research study, which is part of a higher degree in Midwifery. The researcher is Val Larkin an experienced Registered Midwife who works as a Senior Lecturer in midwifery at Northumbria University, teaching both student midwives and qualified midwives. One of the researcher's particular interests is the health and well-being of women following childbirth.

Before you decide if to take part you need to understand why the research is being done and what it would involve for you.

The information sheet will be discussed with you and you can ask any questions you may have. This should take about 10 minutes

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.
- Please ask if there is anything that is not clear.
- Talk to others about the study if you wish.

Study title

“An exploration of midwives experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”

Part 1

What is the purpose of the study?

This study aims to look at how midwives find out about your physical health needs following childbirth, particularly how your womb (uterus), blood loss and any tears or stitches to your perineum (area around the vaginal opening) are healing. This includes different ways they may find out about how you are feeling and how you are involved.

The findings of the study will provide a clearer picture of midwifery practice and what can have an effect upon what midwives do. This would be useful for women using maternity services, midwives and people who organize maternity services.

Why have I been asked?

Your midwife has agreed to be part of the research and to allow me to observe her providing care to women following childbirth. This would entail the researcher observing and making notes of the discussion between your midwife and you during one postnatal visit. Your permission is required for this to happen.

What am I being asked to do?

This would involve observing you and your midwife during one visit after you have had the baby. The discussion between you and your midwife will be noted but the researcher will not participate or observe any physical examinations. The care you receive and what you do and say with your midwife will not be altered by any forms or activities needed for the research. The observation will involve listening to how you and your midwife discuss your physical health. The researcher may join in with any general social chat but she will not undertake any of your care. The researcher is an experienced midwife who is familiar with the intimate concerns that may arise postnatally.

Do I have to take part?

It is up to you if you decide to join the study. The study information sheet will be discussed with you. If you agree to take part you will be asked to sign a consent form.

What happens if I do not want to participate?

Nothing. Participation is voluntary, if you do not wish to participate, you need do no more. This will not effect the standard of care you receive.

What happens if I agree to take part and then change my mind?

You are free to withdraw at any time, including after you have consented, without giving a reason. This will not effect the standard of care you receive.

Part 2

Who is organising and funding the research?

The researcher is organising and funding the research as part of a professional Doctorate in Midwifery Programme (a higher degree) she is completing with Northumbria University.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Northumbria University Research Ethics Committee, the local Research Ethic Committee and the Research and Development Committee for the local maternity services.

How will the study data (information) be collected?

What is said and done will be observed when you and your midwife discuss your physical health. Notes will be made of this after the postnatal visit, to use in the study.

Will being involved in the study cost me anything?

No you will not be asked to go anywhere or do anything in addition or different to what you would be normally doing with your midwife.

What will happen to the study data (information) that are gathered?

The data (information) from the observations will be turned into written notes. These will be anonymised, that means all information relating the data to you, your midwife or any other individual will be removed before it is written up and stored. The information will be stored securely within a

locked cabinet within a locked room. Anonymised data will be entered onto a computer (not a portable lap top), which is password protected. The anonymised data will be securely retained for approximately 5 years and then disposed of securely, via shredding.

Will my taking part in the study be kept confidential?

Yes. Ethical and legal practice will be followed and all information about you will be handled in confidence, anonymised and stored securely. You will not be identified in any report / publication.

What will happen to the results of the research study?

At a local level there will be presentations to the local midwives and service managers of the findings with a written summary of the information, which can be forwarded to maternity service users, including those who have participated in the study. At a national and international level journal articles and conference presentations are planned to share the findings. A summary of findings will be developed in lay terminology and forwarded to local and national maternity user organisations.

You will not be identified in any report / publication.

What if there is a problem?

If you have any concerns or questions regarding any aspects of the study and / or your participation in it, please discuss this in the first instance with the researcher (contact details at the end of this information sheet).

Complaints

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. Please discuss this with the researcher, who can try to solve the problem in the first instance (contact details at the end of this information sheet). If you remain unhappy and /or wish to complain formally, you can do this by contacting the institution supporting this study. Contact;-

Dr. Charlotte Clarke,
Associate Dean for Research,

School of Health, Community and Education Studies.
Northumbria University,
Coach Lane Campus West,
Newcastle Upon Tyne, NE7 7XA

Who do I contact if I want to ask more questions about the study?

The researcher would be most happy to answer any questions. Please contact;-

Val Larkin

Senior Lecturer,

Continuing Interprofessional Education and Post Graduate Studies,

School of Health, Community and Education Studies,

Northumbria University,

Room G206,

Coach Lane Campus East,

Newcastle upon Tyne. NE7 7XA

Tel. 0191 2156134

Val.larkin@northumbria.ac.uk

Appendix 15 - The consent form midwife - interview

Study Title

“An exploration of midwives experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”

Introduction

This study aims to explore the experiences and insights of midwives in relation to contemporary observation and assessment of maternal postnatal genital tract well-being. This will include what methods of observation and assessment are used, how and why and what factors may influence the assessment method chosen. In addition the study hopes to identify if and how women influence the methods of observation adopted.

If you are willing to participate in the study, please read and tick the following boxes to confirm your participation and consent.

I have read and understood the purpose of the study

I have had the chance to ask questions about the study and these have been answered to my satisfaction

I am willing to be interviewed

I am happy for my comments to be tape recorded and then written into notes.

I understand that my name and details will be kept confidential and will not appear in any printed documents.

I understand that I can withdraw from participating in the study at any time.

I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Northumbria University, from regulatory authorities or from XXX NHS Foundation Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to Northumbria University recording and processing this information about me. I understand that this information will be used only for the purposes set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 1998.

Name _____

Signature _____

Researcher name _____

Researcher signature _____

Date _____

Appendix 16 - The consent form midwife - observation

Study Title

“An exploration of midwives experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”

Introduction

This study aims to explore the experiences and insights of midwives in relation to contemporary observation and assessment of maternal postnatal genital tract well-being. This will include what methods of observation and assessment are used, how and why and what factors may influence the assessment method chosen. In addition the study hopes to identify if and how women influence the methods of observation adopted.

If you are willing to participate in the study, please read and tick the following boxes to confirm your participation and consent.

I have read and understood the purpose of the study

I have had the chance to ask questions about the study and these have been answered to my satisfaction

I am willing to be observed

I am happy for my actions and comments to be observed and then written into notes.

I understand that my name and details will be kept confidential and will not appear in any printed documents.

I understand that I can withdraw from participating in the study at any time.

I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Northumbria University, from regulatory authorities or from XXX NHS Foundation Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to Northumbria University recording and processing this information about me. I understand that this information will be used only for the purposes set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 1998.

Name _____

Signature _____

Researcher name _____

Researcher signature _____

Date _____

Appendix 17 - The consent form postnatal woman

Study Title

“An exploration of midwives experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”

Introduction

This study aims to look at how midwives find out about your physical health needs following childbirth, particularly how your womb (uterus), blood loss and any tears or stitches to your perineum (area around the vaginal opening) are healing. This includes different ways they may find out about how you are feeling and how you are involved.

If you are willing to participate in the study, please read and tick the following boxes to confirm your participation and consent.

- I have read and understood the purpose of the study
- I have had the chance to ask questions about the study and these have been answered to my satisfaction
- I am willing for the discussion I have with the midwife to be observed
- I am happy for these observations of what is said and done relating to my health following childbirth, to be written into notes.
- I understand that my name and details will be kept confidential and will not appear in any printed documents.
- I understand that I can withdraw from participating in the study at any time.

I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Northumbria University, from regulatory authorities or from XXX NHS Foundation Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to Northumbria University recording and processing this information about me. I understand that this information will be used only for the purposes set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 1998.

Name _____

Signature _____

Researcher name _____

Researcher signature _____

Date _____

Appendix 18 - Power point presentation

Background

Why explore this issue?

- 1. Change in guidance**
 - Clinical observational methods may be useful to inform assessments of genital tract well being following childbirth and include palpation of the uterus and visualisation and smell of the women's perineum and blood loss (lochia) (Marchant et al 1999; Bick, MacArthur and Winter 2009).
 - Concerns expressed within the literature regarding their indiscriminate use to regardless of individual need or circumstance (Garcia and Marchant 1996; Marchant 2006). Indiscriminate use of clinical observations was felt to focus postnatal assessments upon physical health at the expense of social and emotional health.
 - In response to these concerns contemporary professional guidance does not direct midwives to undertake specific observational tasks but instead advocates a holistic approach to the assessment of maternal needs (NMC 2004; Marchant 2006; NICE 2006), with a focus upon questioning and client self assessment.
 - However there remains some controversy as CEMACH (2007 p. 102) recommends "Routine observations of pulse, BP, temperature, respiratory rate and lochia should be made in all recently delivered women for several days postpartum"

Background (Continued)

- 2. Findings from action research project involving local student and their practice dilemmas**
 - Varied experiences of students regarding means of observing and assessing genital tract well being. Some student felt "this isn't done anymore" others stated it was done "routinely" but student where unable to identify a rationale from their practice experiences of why particular observation may or may not be useful with particular women and or circumstances.
- 3. Author undertaking Professional Doctorate Programme**
 - Spent over 2 years developing ideas including critiquing potentially useful midwifery theory and completing research modules to develop skills and abilities regarding research process and technique
 - The impact of the changing philosophy upon the practice of observation and assessment of maternal genital tract health by midwives is ripe for evaluation. This is particularly relevant for those clinical observations that have been identified as having potential diagnostic value, observation of the genital tract – the uterus, lochia and perineum.

Inclusion / Exclusion Criteria

Midwives

Inclusion criteria

- Currently provide postnatal care in either community or hospital setting. Midwives may have entered midwifery via either 3 year or shortened (post nursing) entry routes and have a range of practice experiences, including the length of practice experience and location of practice. These factors will be identified in the biographical details at the beginning of interviews / observations.

Exclusion criteria

- would include any practitioner undertaking a period of supervised practice, or phased return to work following a period of sickness / absence, in which any additional pressure of interview or observation may be deemed inappropriate.

Women

Inclusion Criteria

- Both first time and mothers with previous births
- The focus will be upon mothers who have had vaginal deliveries.

Exclusion criteria

- any complications of the intranatal or postnatal period which would make such observations insensitive / inappropriate. This would include:
 - Stillbirth, neonatal morbidity or neonatal death.
 - As the focus of the observation is to observe how the midwife interacts with the client, it would be unhelpful to data collection to observe an interaction in which an interpreter was required.

Recruitment and gaining access

Access to women participants (observing a ward based midwife)

- When a hospital-based midwife agrees to participate in the observational aspects of the study, a date will be negotiated for the researcher to attend the postnatal ward when the midwife is on duty.
- Prior to the researcher meeting the women the midwife will identify women who fulfil the inclusion / exclusion criteria and provide them with verbal information and the information sheet regarding the research and proposed observation.
- Those women amenable to allowing the researcher to observe the midwife provide her postnatal care will be identified to the researcher when she attends the postnatal ward.
- The researcher will then discuss with the woman the research and gain informed consent to the observation.
- However the woman will be assured that at any point she may change her mind and rescind her consent to participation.

Dissemination

On completion the researcher will:-

- Present research findings to the local midwives and service managers of the findings with a written summary of the information.
- At a national and international level, journal articles and conference presentations are anticipated to an audience including professionals, educationalists and researchers.
- A summary of findings will be developed in lay terminology and forwarded to local and national maternity user organisations for review.

Research Proposal

Val Larkin

"An exploration of midwives' experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being."

Intentions of the Research

Aim

- To explore the experiences and insights of midwives in relation to observation and assessment of maternal postnatal genital tract well-being.

Objectives

1. To explore how midwives determine and negotiate their approach to observation and assessment of maternal genital tract well-being.
2. To consider why midwives decide upon a particular approach to assessing maternal genital tract well-being, highlighting the plurality and range of influencing factors including the woman, midwife and practice context.
3. To discern how midwives involve women in determining the approach adopted for assessment of genital tract well-being, in order to facilitate a unique postnatal therapeutic journey for the woman.

Intended research process

- In depth narrative type **interview** with approximately 10 midwives (should last up to 1 hour). Aims to capture what the midwives think they do and why – the knowledge and factors they think influences their practice, to encourage the use of narrative (stories) as this provides greater recall and clarity.
- **Observation** of initial discussion between midwife and women during postnatal interaction (heard or community) to observe how the midwives elicit information regarding genital tract well being. Hopefully up to 5 midwives agree to have 2 / 3 of their postnatal care interactions observed. Researcher a participant observer – involved with social aspects but not care. Aims to expose practice knowledge and theory in action. Bryans and McIntosh (2000 pp. 1249) suggest such observation of practitioner / client interaction is vital to access practice knowledge and theory in use, which the practitioner may be unaware of using or unable to articulate
- Constructionist approach to **Grounded theory** research methodology used to distil core themes from data in response to the research intentions.

Recruitment and gaining access

Fulfilled requirements for and received ethical approval from:-

- Northumbria University Research Committee
- Regional Ethical Committee
- Local R & D Office

Access to midwife participants

- Via information sessions / leaflets asking for willing participants Those interested will be provided with verbal and written information regarding the research and their participation, including the right to withdraw at any time without the need to give a reason.
- Confidentiality regarding the individual and their disclosure during discussions / practice observations will be maintained with the exception of any circumstances in which the ethical, legal or professional treatment of an individual was a concern.
- Signing of a written consent form is needed to reflect that I have provided all the appropriate information prior to participation.

Recruitment and gaining access

Access to women participants (observing a community midwife)

- When a community midwife has agreed to participate in the observational aspect of the study, she will be asked to identify women who are anticipated to require postnatal care within a one month time frame (June to July 2010). In the first instance the midwife will be asked to provide these women with the information sheet regarding the research and proposed observation. If the woman is amenable to allowing the researcher to enter her home with her midwife and observe the midwife providing care on one occasion, she will be provided with the researcher contact details and study information leaflet to enable her to access further information and clarify any queries.
- After the woman has given birth and returned home, her midwife will again confirm with the woman that she is happy to allow the researcher to observe the midwife providing one of her care interactions and that the inclusion / exclusion criteria are considered. Following this confirmation the researcher will then discuss with the woman the research and gain informed consent to the observation. However the women will be assured that at any point she may change her mind and rescind her consent to participation. These steps will occur in a sequential fashion facilitating decision-making time for the woman.

Appendix 19 - Participant thank-you letter

Continuing Interprofessional Education and Post Graduate
Studies,
School of Health, Community and Education Studies,
Northumbria University,
Room G206,
Coach Lane Campus East,
Newcastle upon Tyne.
NE7 7XA
Tel. 0191 2156134
Val.larkin@northumbria.ac.uk

Dear

I'd like to thank you for participating in my research project, exploring observation and assessment methods of maternal genital tract well being in the postnatal period. The contribution and insights of participants is vital if the intentions of the research project are to be realised.

I appreciate the time, effort and generosity you have shown to the research project. I hope you have found participating in the research interesting and that the experience has provided some insights into research methods.

As analysis from the data becomes available I will share the findings with you through local presentations and a summary sheet.

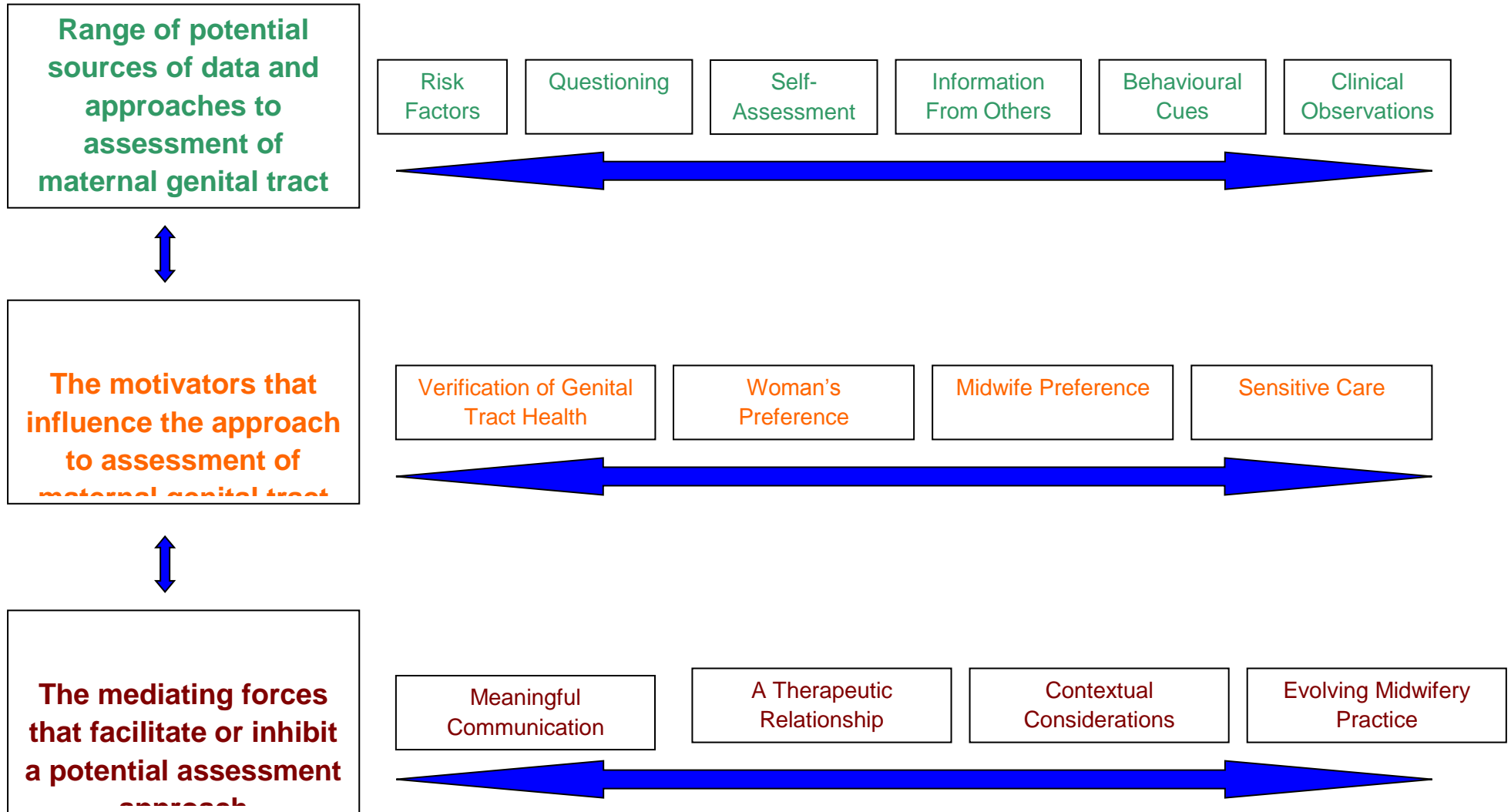
Once again, thank you.

Kind regards,

Val Larkin

Appendix 20 - Initial grounded theory model

“An exploration of midwives’ experiences and insights of negotiating observation and assessment approaches with women of their genital tract when establishing postnatal well being.”



Appendix 21 - Glossary

Anaemia	Deficiency in the quality or quantity of red blood cells
Caesarean Section Birth	Surgical Incision into the abdomen and uterus to deliver the fetus
Episiotomy	Surgical Incision into the perineum during childbirth
Forceps Birth	Use of metal spoon shaped instruments to aid the delivery of the fetus
Genital Tract	The organs of reproduction, in a female these are the uterus, ovaries, fallopian tubes, vagina and vulva.
Instrumental Birth	The use of forceps or vacuum instruments to assist the delivery of the fetus
Involution	The progressive reduction in the size and mass of an organ
Morbidity	Ill health or disease
Mortality	Death Rate
Multiparous	A woman who has given birth 2 or more times
Nulliparous	A woman who has never born a child
Oedema	Excess serous fluid causing swelling of the tissue
Post Partum Haemorrhage	Excessive bleeding from the genital tract after the birth of the baby and until the end of the puerperium
Primiparous	A woman who has given birth once
Puerperium	The first 6-8 weeks following childbirth
Simms Position	A position in which the patient lies on the side with the knee and thighs drawn upward toward the chest.
Sub-involution	A slow rate of involution
Supine position	Lying on the back with legs slightly drawn up and thighs abducted
Vacuum Extraction Birth	The use of a cup shaped vacuum device (or ventouse) as a traction instrument to aid delivery of the fetus