Generativity: transforming and transmitting midwifery practice

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Abstract
Objective. To explore midwives’ perceptions of developing their practice knowledge and skills, concerning maternal postnatal genital tract assessment (GTA); and to highlight how midwives pass on their practice knowledge and skills to student midwives.

Design. A constructionist grounded theory methodology was employed to guide the design and processes. 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 were collected using narrative style in-depth interviews involving 14 midwives.

Setting. A small maternity unit providing midwifery care to childbearing women in both the hospital and community setting in the north east of England.

Findings. The findings of this study suggest midwives engage in two processes: transforming practice and transmitting practice. Transforming practice involved the midwives progressively changing their practice over time. The principal factor that affected the midwives transforming their practice was engaging in diverse practice experiences, which facilitated competence and confidence with a range of assessment methods. Transmitting practice involved the midwives creating learning opportunities for student midwives and articulating their clinical reasoning. However, the midwives voiced concerns that changes to maternity services provision limited the contact midwives and student midwives had with women postnatally. They believed this impacted upon the ability to develop and pass on their practice knowledge and skills concerning maternal postnatal GTA. The findings suggest midwives engage in generativity, a process in which adults attempt to develop a future legacy by initiating change in the thoughts and actions of themselves and others.

Conclusions. This study provides a rich understanding, from the midwives’ perspectives, of how and why their midwifery practice knowledge and skills concerning maternal postnatal GTA has changed. The significance of opportunities to engage in diverse experiences and opportunities for discourse and reflection to transform experience into learning is highlighted.

Key words: Postnatal care, genital tract, assessment, education, student midwives, evidence-based midwifery

Introduction
The demands upon UK healthcare provision are increasing, reflecting changing public expectations, complex health needs, advances in care and restraints upon financial and human resources (NHS England, 2014). This, together with an increased complexity in their caseload, creates challenges for healthcare practitioners and requires healthcare staff to be responsive and adaptive with changing skill sets, reflecting a commitment to lifelong learning (Department of Health and NHS Commissioning Board, 2012). This paper presents findings from a research study exploring midwives’ experiences and practice in relation to their assessment of maternal genital tract health. It will present data from the study concerning how the midwives perceived they had developed their practice knowledge and skills post-registration, and how they attempted to pass on this midwifery expertise to students.

Background
Midwives have a professional responsibility to provide midwifery care to women and their families throughout the childbirth continuum (WHO, 2014; NMC, 2012). Following childbirth, women experience a range of physical and emotional health needs, which are complex and interrelated and, if unfulfilled, may impact upon their health and wellbeing, including social roles such as childcare and employment (Woolhouse et al, 2014).

Maternal physical health needs include those associated with the genital tract, particularly perineal morbidity and uterine bleeding and infection (East et al, 2011). Therefore, the assessment and prompt identification and treatment of postnatal genital tract health is a maternal health priority (Knight et al, 2014). As assessment underpins care decisions, the ability to provide safe, effective and sensitive care rests upon the ability of the practitioner to make appropriate assessments utilising effective clinical reasoning abilities (NMC, 2015). Professional guidance suggests a holistic and individualised approach to maternal postnatal genital tract health. Therefore, midwives must decide if and what form of genital tract assessment (GTA) method they will employ (NMC, 2012).

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 (Jefford et al, 2011; Simmons, 2010).

Clinical reasoning involves thinking about issues, decision-making processes and produces knowledge in and for practice, which influences practice actions (Simmons, 2010; Mattingly and Fleming, 1994). It results from the integration of knowledge and insights concerning practice, the client, practitioner and context to inform the most appropriate selection of practice decisions and actions for that particular client on that particular day (Jefford et al, 2011; Simmons, 2010). This is sometimes referred to as praxis, an integrative, ethical and action-orientated response to client needs, initially proposed by Aristotle (Kilpatrick, 2008; Connor, 2004). There is an established body of work examining how healthcare practitioners develop and refine their reasoning.
abilities, suggesting engagement with an increasing repertoire of practice experiences, professional knowledge and skills are significant factors (Bonis, 2009; Higgs et al, 2008; Hunter, 2008; Eraut, 1994). This occurs pre-registration, with practice mentors and educators providing appropriate learning opportunities for students, but also post-registration, as practitioners engage in the diversity of practice experiences and respond to a range of evolving healthcare demands and practices (Skirten et al, 2012; NMC, 2008; Eraut et al, 2005). However, work to date has not explored how midwives evolve and develop their practice knowledge and skills in relation to postnatal GTA.

The present demands and challenges upon the UK healthcare system make this exploration timely. Within maternity care, postnatal care and service provision is frequently perceived to be marginalised and potentially at risk during times of service change and limited resourcing (Wray and Bick, 2012). There has been concern expressed in the professional literature about the content and provision of contemporary postnatal care (RCM, 2014a; Care Quality Commission (CQC), 2013). Issues raised include a potential ‘decline in the standard of care received’: a reduction of inpatient stay and a reduction in the number of postnatal contacts between midwives and postnatal women (Wray and Bick, 2012: 495). A national survey of midwives conducted by the RCM identified the most significant factor influencing the decision about the number of postnatal visits a woman receives is organisational pressures rather than maternal need (RCM, 2014b).

Design and method

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 (Charmaz, 2006).

Ethical approval was gained from the regional and local ethics committees. The data collection site was a local maternity unit. Recruitment to the study involved the researcher attending team meetings, distributing information posters and leaflets and one-to-one information-giving with potential midwife participants. Participants were sought among midwives who provided postnatal care in either community or hospital setting. As the research process developed, theoretical sampling was also employed to allow the data to determine the direction of the inquiry, in keeping with principles of grounded theory methodology (Silverman and Marvasti, 2008). Confirmation and elaboration of the evolving theory was made possible and disconfirming cases enabled exceptions to be highlighted and inform the theory construction.

Narrative-style, in-depth interviews were undertaken at a location identified by each midwife participant – usually a meeting room at the hospital site – and lasted up to one hour. The interviews were recorded and transcribed verbatim and the midwives were provided with a copy of the transcript for comment and ‘respondent validation’ (Silverman, 2006: 291). Recruitment to the study continued until data saturation was achieved (Charmaz, 2006).

The data were reduced by sorting, shortening and summarising into descriptive and abundant codes. This was followed by several cycles of coding to develop focused codes and categories representative of the data (Saldana, 2009). 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 safeguard 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 act as a coding filter when analysing data and constructing codes and categories. However, engaging in constant comparative analysis and discussing thoughts with the supervision team, helped minimise potential bias (Silverman and Marvasti, 2008).

Findings

The data for this study originates from interviews involving 14 midwives, qualified between one and 29 years, employed in a small maternity unit in the north east of England. The findings have been grouped into two data categories: ‘transforming practice’ and ‘transmitting practice’. As each data category is presented, the focused codes that construct the categories will be explored and supported with quotes from the interviews. The relationship between the categories is conceptualised in the theoretical code of generativity and this will be presented at the end of the findings section and supported by a visual representation of the research findings (see Diagram 1).

Transforming practice

Transformation is a process that involves change (Oxford Dictionaries, 2014). The notion of change and transformation has become topical in healthcare literature, with changing service user needs and expectations necessitating associated practice and health service transformation (Ham et al, 2012):

“Over the years, you adapt your practice because of the experience that you’ve had in the past. So you change the way that you work” (Midwife E).

Practice experience

Practice experience was the factor most frequently cited by the midwives as transforming their practice:

“I think the main reason why I do what I do and the way in which I do it has been built upon the experiences that I’ve had in the past” (Midwife A).

Several of the midwives recalled when they had been newly qualified, with limited experience; they frequently used clinical observations to confirm maternal genital tract condition, due to limited confidence in their assessment skills:

“I think when you first qualify… you’re frightened that you’re going to miss anything… 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).

However, as time and their experience progressed, so did...
their confidence to utilise a range of assessment methods:

“But I guess what the experience has done is it 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).

The midwives highlighted how encountering a wide range of women with differing genital tract issues had developed their repertoire of clinical experiences to support when and how to undertake maternal GTA:

“The experience of looking at so many perineums and, you know, discussing so many bladder care things over the years, it’s given me a sort of knowledge where I can look at a perineum now… ‘Oh okay, I’ve seen worse than that’, or ‘I’ve seen better than that’, or ‘I’ve never seen as bad as that’. This needs to be acted on. And there is a personal element of my knowledge” (Midwife C).

The midwives in this study identified how they assimilated practice experiences and insights to transform their practice. This involved developing a repertoire of experiences, skills and responses that they could draw upon, developing their own personal theory of GTA. Personal theory is theory in use, which directs the actions of the individual midwife (Argyris and Schön, 1974). Theory in use provides a working premise of options and actions appropriate for that individual on that day.

The majority of the midwives suggested as their repertoire of diverse practice experiences grew, so did their confidence and ability to use a broader range of GTA methods. This included utilising effective communication skills with women to provide more personalised assessment reflecting individual maternal needs and preferences:

“I think I’ve developed more confidence in myself… like listening to what people are saying. And more confidence… with communication skills… what works and looking at people, like how they react to you to try and adapt things and change things… so I think that has changed a lot” (Midwife B).

Effective communication and assessment skills include active listening and effective questioning. Midwife N suggested effective listening and questioning skills help to identify incongruence in assessment information and differentiate which women may benefit from additional assessment methods.

“I think the big thing is experience, the more confident you are as a practitioner, picking up on what women say… Questioning women, when they say, ‘I’m all right,’ “Well, are you really all right or are you just saying that?” I think experience is the big thing” (Midwife N).

Half of the midwives suggested learning from and with others in practice helped to develop their understanding and skills. This involved discussing GTA experiences with colleagues. The midwives suggested that by sharing their experience, and listening to the experiences of other midwives, their repertoire of experiences was enhanced:

“Have you tried this, have you tried that? You know, and someone will say, ‘I did this and that seemed to help.’ So I think we do sort of confer between us. You pick up things from other people” (Midwife H).

Formal theory
Less explicit reference was made by the midwife participants in this study to formal theory contributing to changes in their practice. 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:

“The healing process, the time that it takes, thinking is it pink, is it granulating?” (Midwife N).

A couple of the midwives made general comments regarding reading midwifery literature to keep abreast of new ideas:

“Looking at research, reading articles will sometimes help to influence, sort of, how often you check the perineum” (Midwife A).

Several of the midwives acknowledged their practice had been influenced by changing expectations reflected in professional literature, such as the NICE postnatal care guidance (NICE, 2006):

“I suppose the major change for here is the changes in guidelines” (Midwife C).

The midwives suggested there had been more focus and expectations upon routine use of clinical and physical assessments of women in previous years. The midwives suggested, as there was now less emphasis upon routine tasks, they did not feel compelled to undertake routine activities. This had helped to develop their clinical reasoning abilities as they made practice decisions regarding the most appropriate method of maternal GTA 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” (Midwife H).

The findings suggest the midwives developed their practice knowledge and skills concerning maternal postnatal genital assessment via engagement in diverse practice experiences and to a lesser extent formal theory. These practice experiences and formal theory had the potential to transform and change the midwives’ practice over time. The research data also provided examples of the midwives transmitting their practice knowledge and skills.

Transmitting practice
The midwives discussed how they attempted to pass on their practice knowledge concerning maternal GTA to the next generation of midwives. This guidance of practice novices was not an explicit aspect of the interview guide, but arose from the data analysis. The midwives discussed two principal approaches they used with student midwives, creating learning experiences and articulating clinical reasoning.

Creating learning experiences
Half of the midwives suggested student midwives needed experiences of clinical observations of the maternal genital tract postnatally to enable them to develop a repertoire of experiences to draw upon:

“You’ve got to be going through the full check… they’ve got
The midwives 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:

“I’ll always get them to palpate the uterus because then they’re feeling the normal or they’re hopefully picking up the abnormal... But to understand the abnormal, you sometimes need to know what normal is, because otherwise, how would you know?” (Midwife C).

Midwife I believed that by engaging in a range of practice experiences, the student midwives also developed confidence in their developing insights and skills:

“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).

Several midwives suggested that if they were using clinical observation to assess the woman’s perineum, then they would ask the woman’s consent for the student to also be involved in the assessment:

“I would always ask permission from the woman for the student to be (involved). I would always say to the woman, ‘Do you mind,’ if we’re looking at something, ‘Do you mind if I just explain this to them, to the student’” (Midwife C).

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 (of lochia) 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” (Midwife H).

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:

“The women where they’ve known the student and they’ve had them in their antenatal care and they’ve seen them for a while” (Midwife C).

However, several of the midwives believed contemporary student midwives gained less experience than previous students, of the normal physiological parameters of the postnatal period:

“I don’t think they (student midwives) get as much as we got (exposure to postnatal clinical skills), definitely not... Because they’re working in the culture now of... reduced visits” (Midwife G).

The rationale for this was suggested to be twofold. 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. 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 have the skills and abilities to employ a full range of GTA methods. To provide learning experiences for student midwives several of the midwives stated they would adapt their postnatal practice to create learning experiences. For several midwives, including Midwife G, 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 has taken place” (Midwife E).

However, not all the midwives in this study adapted their practice to facilitate additional learning opportunities for student midwives:

“No, I don’t think I would change because I don’t do anything different if I’ve got a student” (Midwife L).

Articulating clinical reasoning

Several of the midwives in this study suggested that they attempted to provide students with exposure to their clinical reasoning processes. This included relating practice experience regarding maternal genital tract health and assessment to physiological processes of the puerperium:

“When you have students out, you talk a lot about the anatomy and physiology and the physiology of postnatal recovery” (Midwife E).

The midwives stated that they would articulate and explain what they were doing and why and what factors had influenced the assessment approach they adopted:

“I involve them... I will show them... I’ll always explain... we’ll discuss... I’ll get back in the car and I’ll always say to them, ‘So what did you think of it? What did you think of the perineum?’” (Midwife C).

Some of the midwives suggested where this discussion took place would depend upon the content of the discussion and maternal considerations:

“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” (Midwife F).

Other midwives suggested discussion was very important and helped to compensate for limited practice experience:

“I wouldn’t do anything differently with a student, but I would talk through everything I was doing and letting her know why I have made the decision not to feel her

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Expectations of the student midwives’ skills and abilities changed as the students progressed through the midwifery programme. They acknowledged the students initially had a limited repertoire of responses, usually copied from their midwifery practice mentor:

“And it’s funny, I’ve heard her [the student midwife] saying the same words that I do and I think that’s for now, because that’s fine, you’ll do that and then you’ll get your own” (Midwife K).

However, as the students progressed through the programme, the midwives’ expectations increased, with students now expected to articulate their reasoning process and leading care interactions. In addition, the midwives anticipated the students would develop a range of postnatal GTA methods, with the assessments becoming more individualised and holistic utilising a more discursive and women-focused approach to assessment:

“I’ll sit back and say nothing and let the student midwife do the talking. Obviously if I feel I need to interject, then I will” (Midwife N).

Generativity

The midwives in this study provided accounts of changes to their practice knowledge and actions, which had evolved over time and that they considered had transformed their approach to maternal GTA. In addition, they provided examples of how they attempted to transmit their practice knowledge and skills to the next generation of midwives:

“I think [that your practice] changes every week, every year, in fact every day it’s always on the go, it’s generating forward” (Midwife C).

The relationship between these dual processes of transforming and transmitting practice identified in the research findings have been conceptualised in the overarching theoretical code of generativity (see Diagram 1). Erikson and Erikson (1998) developed an eight-stage theory of development and change occurring during the human life cycle. The seventh stage involves generativity, the process in which adults attempt to develop a future legacy by initiating change in the thoughts and action of themselves and others (Slater, 2003).

Discussion

The midwives in this study suggested practice knowledge and formal theory had the potential to transform their practice. However, the findings of this study imply formal theory has limited impact upon midwives’ practice. This resonates with established work suggesting that practitioners do not consider continuing professional development necessarily benefits their clinical practice, or impacts upon practice changes and patient care (Poell and van der Krogt, 2014).

The midwives in this study suggested the principal factor to transform their practice was experience. This included developing a repertoire of direct practice experiences concerning maternal genital health, assessment and care which enhanced their practice knowledge, skills and confidence. Experience is an established component of professional learning (Poell and van der Krogt, 2014). Experiential learning can be implicit, with each practice experience becoming part of the catalogue of encounters, or deliberate, involving reviewing experiences, eliciting feedback, planning specific learning opportunities and developing confidence and commitment (Eraut, 2004). Within the learning theories developed by Kolb and Boud, learning is considered to be personal, interactive and spiral, involving an integration of subjective experience and critical reflection (Segers and van der Haar, 2011). Bonis (2009: 1328) considered ‘knowing’ is a personal type of knowledge, which comprises of ‘objective knowledge interfaced with the individual’s subjective perspective on personal experience,’ as such knowledge needs experience to become ‘knowing’. A key ingredient of this personalised knowing involves engaging and appreciating the unique perspectives of the recipients of care. The midwives in this study suggested their practice learning was ‘personal’ and evolved from engagement in a range of rich and diverse practice experiences.

Bonis (2009) stated a consequence of knowing is transformation, in which practitioners change and improve their practice. Transformative learning theory was developed by Mezirow and involves the three core elements of individual experience, critical reflection and dialogue (Mezirow and Taylor, 2009). It focuses upon ‘how adults learn to reason for themselves, advance and assess reasons for making a judgement’ – this involves a revision or transformation of the individual’s thinking, beliefs and actions, a perspective transformation (Mezirow and Taylor, 2009: 23). Experience alone is insufficient to ensure transformative learning, as experience constructs an understanding of reality, which may then be reaffirmed through actions, which perpetuate particular experiences, therefore perpetuating a particular understanding of reality (Berger and Luckmann, 1966). Cioffi and Markham (1997) suggested that the experiences of individual midwives might contain bias and, therefore, potentially limit their subsequent reasoning processes, recommending the need for reflection to try and minimise

Diagram 1. Generativity: transforming and transmitting midwifery practice

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such factors. The midwives in this study discussed learning from and with others, which enabled them, to some extent, to broaden their practice experiences, and debate issues concerning practice decisions, a learning strategy also identified by others (Gray et al., 2014).

Phillips et al. (2002) suggest professional conversations are an important social component in creating and sustaining practice knowledge. Active participation is required to develop knowing through collectively sharing and shaping a community of practice (Wenger, 1998). Situated learning theory explains how practitioners develop new skills and knowledge through social interactions, sharing similar practice experiences and challenges, within their community of practice, stimulating a body of local knowledge of potential solutions (Hargreaves and Gijbels, 2011). This highlights the importance of ensuring opportunities for midwives to interact with colleagues and women.

The midwives in this study suggested that as they developed a repertoire of practice experience and learning, so their confidence in their postnatal GTA skills grew. This confidence enabled the midwives to further develop their repertoire of skills by utilising more women-centred assessment methods, including listening, questioning and discussion. Interactive reasoning involves the face-to-face interactions between midwife and client that help the midwife to better understand the woman’s individual needs (Higgs and Jones, 2008). 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 (Frei and Mander, 2011). In addition, women value effective and sensitive communication skills, feeling more able to express their healthcare needs and have a more positive experience of postnatal care (MacArthur et al., 2002).

The research data also provided examples of the midwives transmitting their practice knowledge and skills to student midwives by creating learning experiences and articulating clinical reasoning. Practice experience is recognised as having a central role in professional learning, as it enables students to develop skills in messy, unpredictable and unique practice situations providing rich data for critical reflection, moving experience to learning (Stuart, 2007). The research by Finnerty and Collington (2013) highlighted the importance of midwifery mentors in supporting students’ practice learning through scaffolding and fading techniques. This consisted of three components: providing individual support that is gradually removed; being an appropriate role model and offering debriefing opportunities, such as those discussed by the midwives in this study.

The midwives suggested practice experiences enhanced the development of students’ skills and confidence. Research involving final-year student midwives in Australia also highlighted the interplay between confidence levels, exposure to experiences and development of professional abilities including independence and decision-making (Carolan-Olah and Kruger, 2014). Engagement in care interactions enables students to develop an appreciation of the subtle nuances involved in developing a trusting relationship with women to facilitate the identification of individual needs (Schmied et al., 2008). As highlighted in the study by Botti and Reeve (2003), as case complexity increases, the experience of students becomes an important factor in determining their reasoning abilities. Research involving medical students also identified engagement in practice experience was a critical component to develop clinical reasoning abilities, but voiced concerns that limited practice opportunities would negatively impact upon building appropriate practice knowledge (Durning et al., 2013). Studies focusing upon pre-registration midwifery and nursing curricula highlight students value opportunities to practise and integrate skills into their practice. However, the research suggests there are less occasions for students to rehearse skills and to reflect in and on practice and, therefore, to transform their practice experience to learning due to workload pressures (Newton et al., 2015; Baldwin et al., 2014).

The Department of Health’s (2014) mandate to Health Education England states students need to have appropriate support and this includes practice experience with sufficient opportunities and time to gain appropriate experiences. However, the midwives in this study expressed concern that exposing students to appropriate and sufficient learning experiences in relation to postnatal GTA was increasingly challenging due to changes in the content and organisation of postnatal care and the wider challenges affecting midwives and the maternity services. Such concerns have also been expressed in national surveys and forums (RCM, 2014b; 2010).

The relationship between the processes of transforming and transmitting practice have been conceptualised in this research as ‘generativity’. The midwife participants engaged in generativity, as they had transformed their practice over time and were keen to transmit their practice knowledge and skills to student midwives. Slater (2003) suggested during midlife, adults engaged in generativity, work hard to develop areas they believe are important and worthwhile. The midwives in this study were motivated to transform their GTA practice to enable them to provide care, sensitive to the individual needs of the women they encountered. A study in Australia exploring midwives’ views upon developing their practice, highlighted similar issues, suggesting the need to provide effective care is motivated by the relationship midwives and women develop, driving the midwife to become ‘the best midwife they could’ (Gray et al., 2014: 862). Such a sense of caring is an important component for sensitive practice and ensuring a productive and healthy organisation (NMC, 2015; Francis, 2013).

However, the opposing psychological stage to generativity is stagnation, in which the individual becomes unproductive and a sense of inertia prevails (Erikson and Erikson, 1998). Although none of the midwives in this study suggested their practice had the characteristics associated with stagnation, midwife I suggested, despite experience, not all midwives utilised the potential breadth of midwifery skills, providing a routine and standard form of postnatal assessment and subsequent care:

“I do know midwives who will do postnatal care and go and stick a blood pressure cuff on and feel her [the woman’s]
The findings from this study do not provide any insight as to why the postnatal practice of some midwives may become stagnant. However, it is widely reported and acknowledged, including by the midwives in this study, that postnatal care is undervalued and resourced. This impacts upon the midwives’ ability to spend time with women assessing their needs and may erode some midwives’ enthusiasm and motivation (Schmied and Bick, 2014).

Douglas et al (2014: 2691), when exploring the factors which influence nurses’ assessment practices, suggested that assumptions that healthcare staff use assessment methods most relevant is ‘overly simplistic’ and that greater attention needs to be focused upon the barriers, such as lack of time, and lack of confidence, which may limit the use of a wider repertoire of assessments.

Conclusion

The findings of this study suggest midwives transform their practice in relation to maternal postnatal GTA through a repertoire of practice experience, developing enhanced communication skills and learning from others. Less influential was formal learning processes and theory. In addition, the midwives in this study felt it was important to transmit their practice knowledge to student midwives, by facilitating appropriate learning opportunities and engaging the students in clinical reasoning processes through reflection and discussion. However, all of the midwives acknowledged workplace pressures and changes had diminished practice learning opportunities for student midwives and not all of the midwives compensated for this deficit by creating learning opportunities for students to develop their midwifery skills and insights. While acknowledging healthcare resources are precious and thinly stretched, the implications of limited engagement in postnatal assessment and care may have long-term implications for the practice knowledge and skill development of future midwives, with potential consequences for the care received by women.

Further research exploring student midwives’ perceptions of the learning opportunities available within the pre-registration midwifery programme regarding postnatal GTA would be a useful adjunct to this study. In addition, it would be useful to identify student midwives’ confidence at undertaking postnatal GTA in the final year of the programme to enable recommendations for curricula enhancement.

References


References continued


