

'Passing through but needing to be heard'

**An ethnographic study of women's perspectives of their care on the
postnatal ward.**

MARGARETA IRENE RIDGERS

A thesis submitted in partial fulfilment of the requirements of Bournemouth
University for the degree of Doctor of Philosophy

October 2007

Bournemouth University

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ABSTRACT

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Background.

There is a wealth of literature demonstrating that women are critical of their care on the postnatal ward, but little information as to why. This ethnographic study therefore explored the context of care on the postnatal ward and women’s views of that care.

Method.

The study was undertaken in one Acute NHS maternity unit in the South of England. Non-participant observation was undertaken to explore activities and interactions between the care-givers and women within the ward environment. This was followed by in-depth interviews with twelve women between two and five weeks postnatally about that experience.

Findings.

Analysis revealed the impact of the hierarchical structure within the organisation which pervaded through and rendered the care of women marginalised. Midwives maintained efficiency in their interaction with the women and their main focus was on ‘processing’ the women through the ward.

Care was articulated through the procedural language of ‘checks’ and ‘work’ illustrating an ethos of ‘task-based’ contacts between midwives and women. The midwives felt ambivalent and physically withdrew from the women upon completion of set ‘tasks’, comprising primarily physical care. Women, as passive recipients, were not able to make themselves heard and therefore individual care needs were not always met.

This ‘functional relationship’, valued and supported by the organisation, offered an ‘unconnected presence’ to the women. Women sought a ‘connected presence’ from the midwife in recognition of their needs. In the absence of emotional or physical support, some women sought support from the other women or ‘opted out’ by transferring home earlier than originally intended to receive support from their immediate family and their community midwife.

Conclusions.

A formal definition of ‘care’ which encompasses physical and emotional aspects appears lacking. Midwives must reconsider how individualised care, desired by the women, can best be provided.

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This thesis is presented in the memory of two women who both influenced my life:

Inger Margareta Alén 1949-2003

Karin Borghild Martinsson 1924-2006

AUTHOR'S DECLARATION

I declare that the thesis is my own work and is original material, which has not previously been used or published.

Margareta Irene Ridgers

October 2007

CHAPTER 1: INTRODUCTION.

BACKGROUND TO THE STUDY.

The purpose of this study was to seek to understand women's experiences of care on the postnatal ward, and to examine the context in which that care was provided by care-givers. The provision of postnatal care is complex and the evidence from a major report would indicate that women are less satisfied with postnatal care in hospital than with care during the antenatal period, the birth itself or postnatal care provided by midwives at home (Audit Commission 1997).

In this chapter I will discuss the context in which postnatal care is provided; a discussion and critique of the studies referred to will be offered in the subsequent chapter.

1.1 Historical background to the place of postnatal care.

At the beginning of the last century, the majority of births took place at home, where the woman was attended by a midwife whom she knew and who would visit daily following the birth of the baby (Leap & Hunter 1993). With the introduction of the National Health Service (NHS) in 1948, the trend towards birth in hospital began and subsequently intensified, ostensibly in order to safeguard maternal and infant health (Robinson 1990). In 1932 the rate of home birth was 74% (Leap & Hunter 1993), however, by the early 1970s, birth in hospital had increased to over 80% of all births (Robinson 1990). This trend has continued, with the majority of women (98%) now giving birth in hospital (Audit Commission 1997, The Information Centre 2006).

As the number of women giving birth in hospital increased, women were initially expected to remain in hospital for the duration of the 'lying-in' period of ten days. However, as active medical management continued and with the resulting increasing demand for antenatal beds in the 1960s, early discharge home from hospital following the birth of the baby was introduced (Theobald 1959, Robinson 1990, Campbell & Macfarlane 1994). As a result the focus of the provision of postnatal care shifted to care by community midwives undertaking home visits (Garcia & Marchant 1996).

The Royal College of Midwives (RCM) initially opposed the introduction of early transfer home from hospital, fearing that this would lead to a lack of continuity of care in the postnatal period (Robinson 1990). The RCM acquiesced on the basis that early transfer home was a temporary measure. However, the trend for going home within 24-48 hours of the birth or earlier has continued to the present day (Audit Commission 1997, The Information Centre 2006). It seems likely that the change to early discharge from hospital was based on organisational needs as opposed to any evidence of the value to, or request from, women for this change (Robinson 1990). When early transfer was first introduced, the midwife undertook daily visits to the mother and her baby; however, the pattern of postnatal visiting gradually changed with midwives undertaking 'selective' rather than daily visiting (Garcia et al., 1994). The definition of the period following the birth during which the midwife is required to attend the mother and her infant has likewise changed during recent times. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1998) up until the late 1990s defined the postnatal period as not less than ten days and not more than 28 days; the requirement of not less than ten days remains, but may now include an extended period at the midwife's discretion, as advised by the Nursing and Midwifery Council (NMC) (2004). More recently The National Institute for Health and Clinical Excellence (NICE) (2006) advocated a length of between 6-8 weeks after the birth of the baby, during which time the woman should have access to a health professional and receive care based on her individual needs.

Midwives are the main care-givers in the immediate postnatal period and thus have the main responsibility for providing care appropriate to the needs of each individual woman (UKCC 1998, NMC 2004). Increasingly, although the provision may vary between individual maternity services, midwives are assisted in the immediate postnatal period in hospital by health care assistants or maternity care workers who may thus have significant contact with the new mother, often performing tasks previously undertaken by midwives (Baxter & Macfarlane 2005). This may lead to a lack of clarity as to the responsibilities for the various tasks and the concept of care as provided by different health professionals, in the immediate period after the birth of the baby.

1.2 Current pattern of length of stay on the postnatal ward.

The concept of woman-centred care endorses the right of women to have a choice in the care provided for them, to feel in control and involved in that care, as well as having their individual needs met (Department of Health 1993). Specifically, the Department of Health (DoH) advised that each woman should be consulted in the planning of her care. The majority of women give birth in hospital and, generally, they are able to exercise a choice as to how long they wish to remain in hospital; the woman's decision on when to return home may relate to her own or her baby's health. Therefore, the period of time spent in hospital after the birth of the baby could be a few hours or several days. Whereas the majority of women are well following childbirth and elect to transfer home early, some women will doubtless wish to continue to receive care in hospital in the early postnatal period (Audit Commission 1997).

However, the length of stay in hospital following the birth may be determined more in accordance with the organisational and financial constraints of the maternity services, possibly leading to women going home, or being 'discharged' by the ward staff, before they feel ready (Jackson 1996, Baker 2006). In the United Kingdom (UK), postnatal care in hospital whether provided under a system of shared care or of midwife managed care, would appear to be more expensive than either antenatal care or intrapartum care (Young et al., 1997). Young et al., (1997) carried out an economic evaluation of midwife managed care and shared care during childbirth, concluding that midwife managed care in hospital, which aimed to offer a homely environment, was more expensive at £138 per day for each mother, when compared to £99 for shared care in hospital in the postnatal period. They attributed this difference to the existing resources already available within the organisation for shared care, but having reworked the costs based on an increased case load of women for each midwife, midwife managed care remained more expensive. The age of the paper by Young et al., (1997) is acknowledged.

Walsh (1997) has suggested that hospital postnatal care should be abolished in favour of care exclusively in the community. Consultation on the occupancy of beds within NHS hospitals, at the request of the Government (Kaufmann 2000), may impact on the number of beds available for postnatal care to the extent that women may not be

able to exercise a choice in their length of stay on the postnatal ward. Debate has also raised the issue of utilising vacant maternity beds for non-maternity care (Haley 2001). Midwifery resources are not infinite and have to be managed effectively; however, reducing the number of hospital beds may not necessarily produce a financial saving to the maternity services as women may need to be visited at home more frequently by their community midwife (Audit Commission 1997). Donovan (2005), in expressing a personal view, argued that the employment of nurses and support workers to deliver care on the postnatal ward, with midwives responsible for planning that care, would free the midwife to provide care predominantly during the antenatal and intrapartum period and at home, once the woman had transferred home.

1.3 Purpose of postnatal care.

Historically, at a time when a high maternal mortality rate was heavily influenced by puerperal sepsis, haemorrhage or thrombosis, postnatal care focused on the detection and prevention of life threatening morbidity (Leap & Hunter 1993, Garcia & Marchant 1996, Garcia & Marchant 1999). The midwife was required to monitor the mother for any signs of infection during the 'lying-in period', (defined as a minimum of ten days but no longer than 28 days) during which the 'continued' attendance of the midwife was required (Central Midwives Board 1962). Despite women and infants today enjoying better health and an improved standard of living, this emphasis on the clinical screening component of care has continued unchanged (Garcia & Marchant 1999, RCM 2000a). It should, however, be noted that thromboembolism remains the most common cause of maternal death directly related to pregnancy (Confidential Enquiry into Maternal and Child Health 2004); clearly, midwives need to remain vigilant to any immediate changes in the woman's health in the post partum period.

In 1998, the World Health Organisation (WHO) published a guide in support of the Safe Motherhood Initiative, which gave specific recommendations in respect of the prevention and detection of infection in the mother and the infant; the report is relevant to all health care professionals supporting and caring for the newly delivered woman, providing clear guidelines on the potential needs of individual women. Specifically, WHO (1998) advised health professionals that the first few hours after birth are important for the mother and her new infant. During this time, care-givers

are advised to have regard for the physiological well-being of the woman and her infant. Thereafter, care should be sensitive to the mother's physical and psychological needs.

Ball (1994) argued that making the hospital the normal place for childbirth has contributed to the 'medicalisation' of postnatal care over a period of time, with care becoming less woman-centred and more managed by protocols and policies. The historical context of the provision of clinical care, with the emphasis on the detection of pathological conditions, was referred to above. Garcia and Marchant (1996) argued that there were no agreed core descriptors for the content of postnatal care in hospital and that this inevitably impacted on the care women received. Furthermore, there remained a current lack of consensus on what postnatal care was supposed to achieve and, therefore, the value to women of this care (Audit Commission 1997). The publication of the NICE guideline (2006) on postnatal care aimed to offer clear guidance to care-givers on evidence based care, specifically in the first six to eight weeks after birth.

In examining the literature, the following were broadly identified as the aims of postnatal care:

- aiding maternal physical and psychological recovery
- assisting the mother with infant feeding
- enabling good maternal-infant relationships
- aiding the mother to feel confident in caring for herself and her infant within her own social structure

(Rush et al., 1989, Ball 1994, Garcia & Marchant 1996, WHO 1998).

The current approach to postpartum care would appear to be based on routine clinical observations, such as examination of the woman's breasts, assessment of uterine involution, vaginal loss and recording physical signs of health (Rush et al., 1989, Marchant & Garcia 1995), thus reinforcing the primary focus on the physical and clinical aspects of care and monitoring of the woman's health.

The Maternity Services Advisory Committee (1985) had argued that postnatal care was of equal importance to the provision of care in the antenatal and intrapartum period, advising that physical care should be sensitive and suit the needs of the individual woman. This report made little reference to psychological or emotional care in the postnatal period. More recently, however, the results from a survey indicated that women themselves distinguish between their needs for physical care and a need for information and emotional support (Singh & Newburn 2000). Despite this requirement, only half of the 960 women in the survey reported that they had received emotional support adequate to their needs whilst in hospital; it is possible that women with an unsatisfactory experience may have been more likely to respond. Midwives, by virtue of their close contact with the women they are caring for, are arguably ideally placed to provide emotional support in the immediate postpartum period. However, whilst women may welcome an opportunity to 'talk' about the birth itself or related issues with a health professional, it is important that such services, or change in practice if they are introduced, are evaluated to ensure that the services meet the needs of the women (Alexander 1998, Marchant & Garcia 2000, Wiggins 2000).

1.4 The purpose and organisation of postnatal care in hospital.

Postnatal care commences with the birth of the baby and, hence, initial care will be provided within the birth environment, such as the labour ward, where the new parents are given time to 'greet' their new baby before being transferred to the main postnatal ward or to their home. The Audit Commission (1997) detailed how women need time to recover physically and emotionally following the birth. Arguably the stay in hospital should facilitate women to begin this period of adjustment and provide for them to be supported in their own understanding of their individual needs.

The organisation of postnatal care within the hospital environment and the levels of staff available impact on the level and quality of care provided to women during their stay in hospital (Audit Commission 1997, Bick 2000). The Audit Commission (1997) and Forster et al., (2005) reported how new mothers were on occasions cared for within a mixed ward of antenatal and postnatal women and how, as a result, the needs of the new mother may get 'lost'. The two documents published by the RCM (2000a,

2000b), whilst offering guidance to midwives on the provision of postnatal care, nevertheless do not separate out care in hospital, possibly leading to a lack of clarity. This may contribute to women, as new mothers within the ward environment, reporting postnatal care as unsatisfactory.

Postnatal care in hospital is regarded as the province of midwives, with little or no medical influence. Williams (1997) documented how midwives are simultaneously compliant in and affected by the emphasis of medical surveillance and dominance within maternity care. Although she was referring primarily to aspects surrounding the birth, it would appear that in providing postnatal care midwives remain influenced by the organisation (Bick 2000) which possibly impacts on the care offered to the women.

The gradual hospitalisation of birth has been referred to (Robinson 1990) and how this also led to women receiving care in hospital after the birth of their baby. Leap and Hunter (1993) detailed the work of community midwives in the middle of the last century and the autonomy which they were able to exercise leading to a meaningful relationship with the women for whom they were providing care in their homes. Hunt and Symonds (1995) referred to how the women on admission to the labour ward were expected to adhere to the rules of the organisation. Essentially, the women were encouraged into the role of being a patient and expected to fit in with the process of progressing through the maternity unit.

1.5 Maternal health following childbirth.

It would appear that postnatal care, as currently organised, is predominantly based on the need to detect infection and disease; a legacy from the period when puerperal sepsis contributed to the then high maternal mortality rate (Garcia & Marchant 1999, Bick 2000). It is known that women report a variety of long-term health problems following childbirth, such as tiredness, painful perineum, breast problems and backache, and that maternal morbidity would appear to be extensive and under-reported (MacArthur et al., 1991, Glazener et al., 1995). Glazener et al., (1995) described in their survey of 1249 women, how 85% of the women experienced at least one health problem during their postnatal stay in hospital. Therefore, the prevention,

detection and management of maternal morbidity remain a vital part of postnatal care. However, the current available evidence suggests that this objective is not achieved for a great proportion of women (Bick & MacArthur 1994).

In the current organisation of care, midwives undertake routine observations in the early postnatal period for the purpose of monitoring maternal well-being and detecting health problems. It is, therefore, concerning that many of the problems experienced by women are neither reported by them nor identified by health professionals responsible for delivering care in the immediate postnatal period (MacArthur 1999). This is a period when the new mother is expected to adjust to life with her new infant. Women must be assisted in the immediate postnatal period to identify possible concerns or issues in respect of their own health or that of their infant. Efforts to improve the detection of maternal morbidity following childbirth may be dependent on and enhanced by a sound structure in the planning and delivery of postnatal care (Glazener et al., 1993).

MacArthur et al., (2002) and MacArthur et al., (2003) undertook a randomised controlled trial (RCT) examining the effects of care in the community by midwives, following a redesigned care pattern which aimed to deliver care tailored to the needs of each individual woman over an extended period of three months. A total of 2064 women were recruited with 1087 women receiving the new model of care. Data were collected using a postal questionnaire four months following the birth of the baby as well as twelve months postpartum. Results showed that there was no difference in the physical health of the women, however the women in the intervention group scored significantly better in respect of psychological health. There was no difference in the overall satisfaction with care between the two groups, although the women in the intervention group were significantly more likely to report care as better than expected.

An emphasis on the clinical component of care only, may neglect the women's need for psychological and social support (Garcia & Marchant 1999, Royal College of Midwives 2000b, Singh & Newburn 2000). Arguably, before going home, women should feel that they have received care which enables them, as individuals, to begin

to adjust physically and psychologically to the demands of motherhood and life with a new baby.

1.6 Recent policy framework on the provision of postnatal care.

Current statute places the midwife in the position of lead practitioner in the provision of care for the new mother and her infant in the immediate postnatal period in hospital (NMC 2004). How the provision of that care is organised will have an impact on the care available to the mother. The Royal College of Midwives (RCM 2000a, 2000b) argued that the lack of consensus about what postnatal care was aiming to achieve had contributed to a failure to address the wider context of public health in relation to care after birth and women's perception of the relevance of this care to them. Hence, the RCM (2000a, 2000b) urged midwives to review the structure and provision of postnatal care and the two publications by the RCM; 'Midwifery Practice in the Postnatal Period: Recommendations for Practice' (2000a) and 'Life after Birth: Reflections on Postnatal Care' (2000b) were intended to encourage and assist midwives to review their current practice.

More recently, the DoH (2004) has offered guidance to health professionals on providing flexible and appropriate maternity services to women during the continuum of childbirth and into motherhood. This document, published by the DoH (2004), advocated the introduction of maternity care support workers; the role of the maternity care support workers and their contribution to care of the mother and her infant will be discussed more fully in the section describing the findings from my study. Similarly, the recently published guideline by NICE (2006) provides a framework for care in the postnatal period, including a care pathway for providing individualised core care to women and their babies. NICE (2006) advised that women should be informed about care for themselves and their infant and that women should be informed about expected recovery in the early postnatal period. They should also be offered information on how to recognise serious morbidity to themselves and their infants.

1.7 Conclusion.

Midwives must be responsive to women and their individual needs. Hospital postnatal care must have the potential to influence maternal health positively and, importantly, to meet the needs of women as expressed by those women themselves. Arguably, postnatal care commences on the labour ward with the birth of the infant, with the new mother and her baby transferring to the postnatal ward soon afterwards. Bick (2000) described how organisational constraints in hospital may unintentionally override the needs of women, who may thus come to view their care in hospital as unsatisfactory, perceiving that effective postnatal care does not commence until they transfer home to receive care from their community based midwife.

Having transferred home, care is provided by midwives undertaking home visits and women generally express satisfaction with this service (Audit Commission 1997). In contrast, women perceive hospital care as less satisfactory, indeed women make more negative comments about their hospital stay in the early postnatal period than any other aspect of care during childbirth (Audit Commission 1997, Garcia et al., 1998, Singh & Newburn 2000). The reasons for their dissatisfaction were not clear, but women described not being offered the help, support and information which they required for themselves and the baby. It was therefore crucial to understand women's experience on the postnatal ward in order to seek to understand why women rate this care as less favourable than postnatal care in the home.

CHAPTER 2: LITERATURE REVIEW.

In the introduction, I have referred to women's views about postnatal care in hospital and the fact that women rate that care as unsatisfactory. A brief account was offered on the current provision of postnatal care and the rationale for that care. The historical context of postnatal care was similarly explored. A literature review was undertaken to specifically identify studies which had examined postnatal care in hospital from the women's perspectives; the studies identified are discussed below.

2.1 Review of studies relating to women's views of postnatal care in hospital.

An initial thorough search of databases from the early 1980s forwards, including BNI, Medline, CINAHL and the Cochrane Database, using the key words 'women's views' and 'postnatal care in hospital', failed to reveal any ethnographic studies which focused exclusively on women's care in hospital after the birth of their baby. A small number of studies which sought women's views of their experience of postnatal care both in hospital and at home, or as part of childbirth in its entirety, were identified, and these are discussed below. As the study progressed, the literature review continued, and newly published studies were reviewed concurrently with the data collection in the two phases of the study.

2.1.1 Studies from within the UK.

The report 'First Class Delivery - A national survey of women's views of maternity care' (Garcia et al., 1998), concluded that, predominantly, women perceived hospital postnatal care as failing to meet their needs. A total of 2406 women participated in this national self-completed survey, which built on the findings from the main report published by the Audit Commission (Audit Commission 1997), making this the largest and most comprehensive survey of the views of new mothers. A random sample of women who had given birth during June and July in 1995 were sent a questionnaire, at around four months after the birth of their baby. The women's views of their childbirth experiences were sought, and in relation to care in hospital following the birth of the baby women described not always receiving consistent advice from care-givers. Although the survey highlighted the difference between

women's expectations of assistance and help for themselves and the infant, and what they actually received, little detailed information of this discrepancy was provided within the discussion, making it difficult to explore the context of this aspect. The women who participated in Garcia et al's., (1998) study were surveyed four months after the birth of the baby; the response rate of 67% indicated that women were keen to have their views heard. The detailed responses provided by the women would appear to imply that women's recall of their care was good. The women's written comments offer an insight into their view of the care provided but, in common with other studies reviewed below, this survey focused on women's experiences of care during the childbirth continuum and not exclusively on postnatal care in hospital.

The findings from a fairly recent study, seeking women's views of postnatal care in hospital and at home (Singh & Newburn 2000), broadly supported the findings from Garcia et al., (1998). Singh and Newburn (2000) used a questionnaire to collect the data. This was completed electronically or by post, and a total of 960 women participated nationally. This sample must be regarded as somewhat unrepresentative, as it was distributed to members of a voluntary organisation only, through the members' journal, and posted on an independent internet site which contained general information about pregnancy and childcare. Not every woman in the UK will have had access to the internet; the authors therefore warn against generalisation of the findings. Although offering some positive comments about their care, the women were, overall, generally dissatisfied with the care provided in hospital for themselves and their infant. The women differentiated between the need for physical care and for emotional support, with only half of the women indicating that they had received the support and assistance on the postnatal ward which they required, particularly identifying emotional care as an aspect of care which had not been met in hospital. They were also critical of the ward environment with one third of the women considering the staffing levels to be inadequate. They were, however, appreciative of the care provided by the midwife once home.

Wray (2002) carried out a review of the provision of local maternity services at the request of three local NHS hospital trusts and the local Maternity Liaison Committee. Postnatal care was chosen for the focus, as this area had previously been identified as an area of concern by women. A self-completion questionnaire was used and

distributed to 1202 women by their community midwife on the 10th day postnatally; women were asked about 'care after birth' in hospital and in the community. As the survey was regarded as an audit, full ethical approval was not sought; the level of ethical security obtained was not given. The findings confirmed that women rated care at home after birth more highly than care in hospital, consistent with previous findings as detailed above (Audit Commission 1997, Singh & Newburn 2000). In particular, women requested more help and support with infant feeding and baby care as well as provision for rest and recuperation on the postnatal ward. Women were critical of the ward environment and described a need to be orientated to the ward. They wanted more time to talk to the midwife, regarding this as an important area for improvement. However, it should be noted that only 452 women, just over a third of the 1202 women contacted, responded to the questionnaire, giving a response rate of 38%. Wray (2002) acknowledged that approaching a mother ten days after the birth of her baby may have been too early for some mothers and that this may have been reflected in the low response rate. The response rate was nevertheless considered adequate to inform the planning of care to women by local NHS trusts.

Two earlier UK studies also reported women describing inadequate provision for rest and lack of care and assistance by midwives for themselves and their infants whilst they were in hospital, as well as problems and lack of support with breastfeeding (Moss et al., 1987, Woollett & Dosanjh-Matwala 1990). The sample studied by Moss et al., (1987) consisted of 96 primiparous women and their partners; all the women gave birth in the same hospital. The women and their partners were interviewed both in the antenatal and postnatal period; the study sought to explore the experiences of parents of their hospital stay during childbirth. The majority of the women (78%) remained in hospital for one week. Early transfer home for women who were having their first baby, as currently available to all women (Audit Commission 1997), was not common practice at the time of Moss et al's., study. The researchers concluded that the fathers, although included in the birth itself, were less likely to be included on the postnatal ward; for instance, fathers were not allowed in the nursery, and could therefore not participate in bathing or changing their baby.

The survey carried out by Woollett and Dosanjh-Matwala (1990) involved Asian women and explored the women's views of their postnatal care experiences. The

researchers reported that whilst the 32 women interviewed expressed concerns that were broadly similar to those of non-Asian women, the Asian women perceived that women with poor command of English received inferior care. The most common concern identified by the women related to the 'relations' (page 182) with the midwives; the researchers concluded that this appeared to relate to cultural differences between the women and the care-givers. The women described having the expectation that the care-givers would be there, available to offer assistance personally to them and with infant care. When this support was not provided, there was potential for conflict between the women and the care-givers as the women perceived that the staff were unwilling to offer help.

McCourt and Page (1996), comparing care across two maternity hospitals which offered a new model of care of 'one-to-one' support from named midwives, with women receiving pre-existing shared care acting as the control group, reported dissatisfaction by the women with care in hospital regardless of the system of care they received. Questionnaires, interviews and focus groups were used to elicit the views of the women on their care. The women who were cared for by a 'one-to-one' midwife reported resentment by hospital midwives on the postnatal ward of the 'one-to-one' midwives, although they did not feel that this affected their care. Both groups of women described conflicting advice, lack of rest and poor support with feeding whilst on the postnatal ward. The women in McCourt and Page's study reported that the problems they experienced were greater at night and generally they were more critical of the night staff. McCourt and Page (1996) achieved varied response rates to the two questionnaires which were used at two weeks and thirteen weeks postnatally to evaluate postnatal care, ranging from 38% to a maximum of 61% across the groups of women surveyed. The researchers thought this reflected geographical differences and demographic characteristics. The lowest response rate was in the group of women who received the new model of 'one-to-one' care. McCourt and Page advised that caring for a newborn infant is time consuming and may limit the new mother's time and energy for participating in or responding to surveys. These aspects need to be considered in interpreting the results. It is perhaps possible that the low response rate in the group of women who received the 'one-to-one' care reflected an increased satisfaction with care and therefore women were less likely to respond. It should also

be noted that the study was undertaken to inform policy locally prior to the expected new build and integration of maternity services to one site.

More recently Ockleford et al., (2003) carried out semi-structured interviews with women on their 'feelings and opinions' (page 167) about postnatal care in hospital and at home, using a set of predetermined questions, the majority of which related to care provided at home by the community midwife. As a high proportion of the women giving birth at two local maternity hospitals were of Indian ethnicity, the researchers were particularly interested to gain the perspectives of this group of women; however, white women were also included in the survey. In all, 39 women (21 white women and 18 Indian women) participated across two sites; the women themselves identified their ethnicity. The women, who included both first time mothers and experienced mothers, were interviewed at approximately 13 weeks following the birth. The two groups of women identified broadly similar concerns; for example a perceived shortage of staff and feeling unprepared for leaving hospital. Arguably, predetermined questions, whilst providing an indication of women's perspectives, may not allow for women to express their views fully. Based on their findings, the researchers concluded that women should be informed of the transitory nature of care in hospital, which they argued should be regarded as a period of 'surveillance'. The researchers further suggested that the community midwife should reassure the woman that the majority of care would be offered once the woman had returned home. Arguably, this would appear to be a somewhat negative view and does not adequately address the concerns that women have about care in hospital in the immediate postnatal period.

2.1.2 Studies from outside of the UK.

In view of the dearth of studies relating to care in the UK studies from outside of the UK were included in the literature search. This search was limited to studies written in the English language. Similar findings were identified despite differences in the provision of care to new mothers, as will be discussed below.

Bondas-Salonen (1998), as part of a longitudinal study of maternity care in Finland and the culture in which that care is provided, interviewed women about their

postnatal experiences. Bondas-Salonen sought to explore the women's experiences of care from the perspective of suffering and care. Nine women participated in this study which used a phenomenological approach; the women were interviewed at 36 weeks of pregnancy and at three weeks, three months and two and a half years after the birth of the baby. The women remained in hospital for between four and six days, with the length of stay decided by the obstetrician who undertook a daily round to assess the new mothers and their babies. Despite care focusing on the principle of maternal rest and that therefore the infant should be cared for independently of the mother, the women nevertheless reported 'absence of care' (page 174) as a cause for dissatisfaction. Thus, even in a health care setting which purported to endorse the concept of 'care', the women failed to feel supported or rested. The women also described the need for accurate information from midwives and wanted time with their family to get to know their new baby together. Bondas-Salonen (1998) concluded that the new mother needs to be both cared for and supported to care for her infant herself.

In a recent study, undertaken in China, which sought to understand women's views of the quality of care after birth, women again described their need to receive advice about caring for their baby. They also reported needing the reassurance of a medical examination of the baby (Lomoro et al., 2002). A total of 50 women participated, of whom 95% were first time mothers; the data were collected using semi-structured interviews. Postnatal care differs in China from that in the UK, in that home visits are undertaken at prescribed intervals within the first month. Given the women's expressed need for access to care-givers, the researchers concluded that there was incongruity between what women wanted and what they actually received; the provision of service fell short of their expectations. Although the provision of care is organised differently in China, when compared to the UK, Lomoro's et al's., (2002) study is included here, as the women's concerns were similar to those identified from the UK literature.

Studies conducted in Australia were identified: Kenny et al., (1993), Stamp and Crowther (1994), Brown and Lumley (1997), Yelland et al., (1998), Brown et al., (2005), Forster et al., (2005). It is recognised that the organisation of maternity services in Australia differs from that in the UK, with a wider availability of private

maternity care, a limited service of home visiting and, therefore, women possibly remaining in hospital for longer (Stamp & Crowther 1994). However, the concerns identified were similar to those detailed by the women in UK surveys. Women reported a lack of assistance and support from care-givers often leading to tension and communication difficulties between themselves and the care-givers (Stamp & Crowther 1994, Yelland et al., 1998).

Stamp and Crowther (1994) surveyed women at six weeks after the birth of the baby, on the helpfulness of the midwife during the postnatal period, this included care in the hospital and at home. Although the women found the midwives helpful in providing emotional support, offering advice and information, they nevertheless reported that midwives were sometimes insensitive and judgemental. Women furthermore reported that midwives were preoccupied with policies and rules.

Kenny et al., (1993) specifically compared the views of two groups of women on the quality of care provided by the care-givers. Women in the first group (n=135) elected to go home before three days and therefore received care at home by a community midwife; the second group of women (n=153) remained in hospital for longer than three days with no follow-up care at home. Both groups of women completed a questionnaire between the third and fifth day postnatally. The findings illustrate that only 35% of women who received care in hospital felt that the care-giver had been able to always spend enough time with them, compared to 91% of the women cared for predominantly by their community midwife.

Immigrant women of Filipino, Turkish and Vietnamese origin were interviewed about their postnatal stay in hospital by Yelland et al., (1998). A total of 318 women, equally distributed between the three groups of women, were interviewed using predetermined questions between six and nine months postnatally; the interviews were undertaken in the language of the woman's choice. The researchers were able to demonstrate that the length of stay had no impact on the women's satisfaction with care, leading to the conclusion that the care itself provided for the women is more significant than the location. They were also able to demonstrate that dissatisfaction with care did not relate to the women's own cultural practices or any possible inability to speak or understand English.

Brown and Lumley (1997) sought to explore women's views and experiences of the length of postnatal stay; a survey was posted to 2138 women who had given birth during a two week period in Victoria in Australia, at six to seven months postnatally. A total of 1336 women returned the survey, giving a response rate of 62.5%. The data were analysed statistically. Reasons given by the women for wanting to stay in hospital for five days or more were a desire to rest and recuperate, to receive support in caring for their baby and to receive support with breastfeeding. The majority of the women (64%) stayed in hospital for five days after the birth of the baby, which was slightly higher than the number of women (50%) who in the antenatal period had indicated a preference for a stay of five days or more. Overall 80% of the women, this included all the women irrespective of length of stay, reported their stay in hospital as good or very good, however many of these women nonetheless described problems with rest and recovery and a lack of support in caring for their infant. A total of 105 women (16%) stayed in hospital for less time than they had planned for; an inability to sleep or rest in hospital and wanting to be with their family were reasons for transferring home earlier than planned. The authors concluded, as did Kenny et al., (1993), that a busy ward environment may not provide the best opportunity for the women to rest before returning home. This assessment is not unique to Australia; women in the UK described the postnatal ward as noisy and busy and also reported finding the rules and procedures of the ward inhibiting (Singh & Newburn 2000).

In a more recently published study, Brown et al., (2005) detail their findings from investigating women's views and experiences of care in hospital following the birth of their baby. Women (n=2412) who had given birth in Victoria during the two week study period in 1999 and met the inclusion criteria were included in the survey. They were sent a questionnaire at between five to six months after the birth with a total of 1616 (67%) women participating; the data were quantitatively analysed. The questionnaire, developed from previous studies undertaken by the researchers, covered aspects of the antenatal, intrapartum and postnatal period. Of the women who participated, only 51% rated their care in hospital following the birth as 'very good'; the rating of 'good' was considered by the researchers to indicate some level of dissatisfaction with the care provided and was therefore not included as a positive result.

The researchers were able to demonstrate a relationship between 'busy' and 'hurrying' care-givers who failed to offer support and advice and women's dissatisfaction with their stay, concluding that women's perception of their interaction with their care-givers influenced the women's rating of postnatal care in hospital. On further analysis, four variables were 'significantly associated' (page 118) with decreased rating of postnatal care: namely lack of continuity of midwife carer ($p < 0.001$) and model of care ($p < 0.04$) [see below]. Women who left hospital early ($p < 0.001$) (within four days) and women who were single or divorced ($p < 0.02$) were more likely to be dissatisfied with their care in hospital.

The findings from the above studies have to be interpreted in the light of the differences in the provision of care in the UK. Brown et al., (2005) advised caution in generalising from the results as minority groups of women were underrepresented in the study. Brown et al., detail six different models of care being provided for the women who participated and they acknowledged that there were differences in the responses from the women, depending on which model of care they received. In this respect, the organisation of care in the UK is more uniform, and caution must therefore again be used in the interpretation of the findings.

Forster et al., (2005) examined the provision of care in Victoria, Australia, in two phases. The first phase involved the collection of data from units which provided postnatal care about how that care was organised and structured. The second phase involved interviewing of care-givers and managers on their views of postnatal care, thus providing a more detailed description of care offered to the women. Aims of postnatal care were identified, such as education and support for the women as well as enabling the women to rest and feel cared for. Barriers which militate against these aims were described as a general busyness of the ward, inadequate levels of staff and the low priority of postnatal care. The differences in the provision of care in Australia when compared to the UK are referred to above and therefore it is not possible to make a direct comparison. However, the similarities of the concerns expressed by the participants must be noted. In total, 38 health professionals were interviewed in the second phase; it should be noted that only eight were clinically based midwives with the majority of the respondents being in management. The report does not indicate the level of clinical involvement of the managers and it is therefore possible that these

respondents were less involved in actually delivering care to the women when compared to the midwives. It is important to note that the study by Forster et al., (2005) did not involve seeking the views of the women using the maternity services.

Parsons et al., (1999) described an alternative model of postnatal care in the United States of America (USA) which included the introduction of a 'Family Suite' following early discharge from the postnatal ward. Early discharge home following the birth of the baby had previously been introduced as a cost-cutting measure. The aim of the 'Family Suite', separate but attached to the main postnatal ward, was to provide support to the new mother and continued access to a health professional; the unit was staffed by Patient Care Assistants but with the availability of a Registered Nurse if required. Initial feedback from the families using the service indicated that 99.7% of the families felt that their expectations were met and that the stay had enabled them to rest and receive the support needed. The number of staff allocated to the service was reduced as a result of the mothers caring for themselves and their infants more than had been anticipated. A further unexpected outcome of the introduction of the 'Family Suite' was an increase in the number of women booking to give birth at the maternity unit; the resulting increase in the revenue enabled the continuation of the policy of not charging for the 'Family Suite' service. The authors do not discuss whether any care was given following early discharge home from the main postnatal ward but described the requirement for women to be 'medically cleared' prior to discharge; this needs to be reflected upon when comparing care in the UK. The authors referred to the increased ability of obstetricians and paediatricians to monitor the well-being of the mother and her infant with the introduction of the 'Family Suite'; in the UK the woman would receive such care from a midwife.

Petrou et al., (2004) undertook an RCT in Switzerland, which involved 459 women and their infants (all singletons), in order to compare economic differences between early discharge and hospital based care. Early discharge was defined as between 24-48 hours following a vaginal birth and 72-96 hours following a caesarean section. Women in the early discharge group (n= 228) were visited twice at home by a midwife who provided care based on the needs of the women. Women receiving hospital based care (n=231) remained in hospital for between four and seven days with no follow-up at home. Early discharge and care at home was associated with a

significant ($p < 0.001$) reduction in costs when compared to care in hospital; the researchers therefore concluded that early discharge from hospital was more cost effective. Reporting elsewhere, Boulvain et al., (2004) detailed that there were no differences in the clinical or psychosocial outcomes or satisfaction with care at 28 days between the two groups but there were some differences, although not statistically significant, in relation to breastfeeding. Women receiving care at home reported less use of supplementary feeds; they also described fewer problems and were generally more satisfied with the support received with breastfeeding.

2.2 Summary of studies reviewed.

In the studies reviewed, women were surveyed or interviewed between three days after the birth of the baby (Kenny et al., 1993) and two and half years after birth (Bondas-Salonen 1998), but the rationale for the timing of the data collection was generally not documented or supported. Asking women just three days after the birth of the baby about their views of care may be regarded as early; in the UK women are still receiving care from a midwife and may not be able to evaluate the provision of care or the relevance of that care to themselves and their infant, at that time.

The response rate in the studies reviewed varied: Stamp and Crowther (1994) achieved a response rate of 95% to their questionnaire at six weeks postpartum; Moss et al., (1987) reported a response rate of 77%. It would thus appear that women are keen to contribute and have their views heard and acknowledged. The low response rates achieved by Wray (2002) at 38% and similarly by McCourt and Page (1996) at 38% for one of their groups, were discussed above. Despite the women in Kenny et al.'s., (1993) study being asked to participate early in the postnatal period at between three to five days following the delivery, the researchers nevertheless achieved a response rate of 90% and 76% respectively from the two groups in the study. This would again indicate that the women were keen to participate to have their views heard; however, it should be noted that the women who remained in hospital for longer completed the questionnaire before transferring home, possibly contributing to the lower response rate of 76% for this group. These women may not have felt able to disclose fully about that care as they were still receiving care on the ward.

The studies reviewed above used mainly questionnaires and/or interviews to collect the data. The methods were predominantly quantitative, although Bondas-Salonen (1998) used a phenomenological approach for her study. Quantitative research will undoubtedly generate volumes of data, as demonstrated by the findings from the studies reviewed, however, such data may not necessarily illustrate the perspective or experience of the woman herself (Grant 2001) or capture the culture in which that care is provided.

It is important to note that, apart from the study by Forster et al., (2005), none of the studies reviewed focused exclusively on hospital postnatal care; Petrou et al., (2004) compared the cost of postnatal care depending on the place of that care and Parsons et al., (1999) reported women's satisfaction with an alternative model of care. Generally, the studies sought to identify women's views of their experiences of childbirth or postnatal care in its entirety, where postnatal care in hospital would have been provided for a short period only, although Brown and Lumley (1997) sought women's views on the length of stay in hospital postpartum, as reported above. Stamp and Crowther (1994) surveyed women before discharge and again at six weeks postnatally; however, the women were not asked to differentiate between care in hospital and any care in the community.

2.3 Review of ethnographic studies in maternity care.

No ethnographic studies were identified which sought exclusively to explore the women's perspectives of care within the postnatal ward environment. However, a number of studies were identified which explored other aspects of maternity care and these will be referred to briefly below.

Kirkham (1989), in her seminal study, examined the provision of information to women in labour through undertaking observations of interactions during normal labours and later interviewing the women about their experiences. The data collection was conducted within the different settings of a consultant unit, general practitioner unit and women's homes. She found that the giving of information by midwives was influenced by the setting. The process of providing women with the information which they sought was condensed to a mechanistic procedure in the consultant unit;

the women were processed and reduced to 'passive work objects' (page 131) and their needs remained unmet. Women received more information within the general practitioner unit as the midwives were more responsive to their needs; Kirkham (1989) described this setting as the 'territory' of the midwife. The women who elected to give birth at home experienced a positive process of information giving with the midwife.

Hunt and Symonds (1995) explored the culture and the interactions between the midwives and the women within the labour ward environment in two maternity units. They described the efficiency with which women were processed on admission to the labour ward and how this prepared each individual woman to comply with the hospital routine. The midwives in their study adhered to the culture of 'getting through the work' with an emphasis on undertaking tasks.

Wishing to explore methods used by the women to achieve privacy led Burden (1998) to explore, using participant observation, the positioning of curtains within the maternity ward environment in relation to privacy. She was able to identify different positioning of curtains in the antenatal ward and the postnatal ward: the positioning of bed curtains was different again when antenatal and postnatal women were in the same ward. Burden (1998) referred to how antenatal women adopted a 'signalling' approach to attract the attention of a member of staff. On the mixed ward, or where only postnatal women were present, the women's use of closed bed curtains appeared to indicate a lack of confidence in caring for their baby or a feeling that they were being judged by other mothers within the ward. She discussed how, prior to undertaking the study, the midwives had speculated that the women's closure of bed curtains might indicate their desire to occupy a single room rather than sharing a bay with other women and that this was how she came to explore the concept of privacy.

In her ethnographic study comprising non-participant observation and semi-structured interviews, Woodward (2000) compared care within a palliative care setting and a mixed antenatal and postnatal ward; she particularly wished to explore the interpretation by midwives and nurses of the concept of care. Although Woodward (2000) acknowledged the difference between and the uniqueness of the two settings, such as the higher staff-to-patient ratio within the ward providing palliative care, she

nevertheless argued that both settings aimed to deliver care to a defined group of service users; namely those of patients and women. She described how within the palliative setting, a caring practice culture was facilitated through daily debriefings by clinical leaders of the staff on the ward and how this ensured that care met the needs of individual patients. Woodward (2000) did not find a similar practice of support to the staff within the maternity setting, thus leading to non-reflective practice with midwives concentrating on the 'doing' which meant that they were occasionally unresponsive to the needs of the individual woman.

Cloherty et al., (2003), explored supplementation of breastfed infants; a total of 30 mothers and 30 health professionals were included in the study. They described how, although health professionals were aware of the benefits of breastfeeding, few were aware of a possible link between supplementation and early cessation of breastfeeding. Their main priority appeared to be to protect the mother from tiredness and distress. The researchers highlighted how in the absence of evidence on the best method of supplementing the infants, health professionals would use a variety of methods to supplement the infants and how this created a degree of confusion for the mothers.

Dykes (2005) explored the interaction between breastfeeding women and midwives on the postnatal ward; a total of 61 women, of mixed parity, and 39 midwives participated. Five main themes were identified: 'communicating temporal pressure', 'routines and procedures', 'disconnected encounters', 'managing breastfeeding' and 'rationing information'. She concluded that the midwives were prevented from offering their availability to the women, described as "an absence of 'taking time' or 'touching base'", because of organisational constraints.

Emotion work in midwifery was explored by Hunter (2002). Data were collected in three phases using focus groups, observation and interviews. For the purpose of her study Hunter (2002:61) defined 'emotion work' as 'the work involved in managing feelings in both self and others'. The midwives practised in the hospital or the community setting with some midwives in integrated practice, similar to the team midwifery described later in this report (see Chapter 4). The midwives and student midwives who participated were asked about aspects which they found emotionally

rewarding or emotionally difficult. The findings indicated that two different occupational ideologies governed the work of hospital based midwives and community based midwives: 'with institution' and 'with woman' respectively. Hunter (2002) referred to midwives using emotion work when they were unable to practise according to their ideal of practice; strategies included seeking support from colleagues and seeking opportunities to provide 'real' midwifery care. Despite the limitations acknowledged by Hunter (2002), such as the sample being drawn from one location only and few senior midwives participating, her study is nevertheless important as it highlighted the emotion work in relation to the organisation and the conflicting ideologies.

The literature review identified only a few ethnographic studies in relation to aspects of care in hospital after birth and the woman's experience of care in hospital following the birth of her baby has not previously been studied in depth. The ethnographic studies referred to above do however contribute to midwives' understanding of maternity care in general.

2.4 Impact of hospitalisation on women.

The literature review revealed the impact of hospitalisation on the care of women, and this was referred to above. It was evident that women did not feel able to rest or recuperate; they also reported that on occasions they experienced difficulties in communicating with the care-givers (Bondas-Salonen 1998, Garcia et al., 1998). Women frequently referred to the busy environment and how midwives did not always have the time to assist them with their concerns (Forster et al., 2005). The midwives and managers who participated in the study by Forster et al., (2005) identified the general busyness of the ward and the low priority given to delivering postnatal care as aspects which impacted on their ability to care for the women. It was apparent from some of the studies reviewed that care was not always available to the women, but also that the women had an expectation that care would be provided for them whilst on the postnatal ward (Kenny et al., 1993, Brown & Lumley 1997, Singh & Newburn 2000).

The impact on women's experiences of receiving care in hospital also emerged in the review of the ethnographic studies. Specifically, Hunter (2002) described how midwives based in hospital identified with the ideology of 'with institution' in their interactions with the women and as a result they were not able to provide woman-centred care. This was in contrast to the 'with woman' care offered by the midwives based in the community. Similar findings were reported by Woodward (2000) who detailed how midwives, at times, failed to engage with the women within the ward environment. It would therefore appear that care is influenced by the environment in which it is received and that midwives are similarly influenced by that environment. Bick (2000) offered the view that care in hospital is organised around activities which aid health care professionals but may not immediately recognise the requirements of the women. The adherence to rituals and routine, for the benefit of the ward and the midwives, and how this led to fragmented care, had similarly been lamented by Ball (1994). The admission procedure to the labour ward described by Hunt and Symonds (1995) is a powerful example of women being expected to fit in with the organisation and how the midwife was implicit in ensuring this.

2.5 Conclusion.

The review of the literature in relation to the provision of postnatal care identified that currently this care appears to be based primarily around physical care, through observations of the mother and infant, with the aim of reducing postpartum morbidity and mortality. The literature review suggested that there was scant recognition of women's need for emotional support or commitment to helping them adjust to motherhood or to caring for their infants.

The literature review identified some specific aspects of care which women were dissatisfied with. Broadly these related to the ward environment, the care-givers and the care provided to them. Although these aspects were identified as being of concern to the women, the review of the studies included above revealed little insight as to why women were detailing these concerns, or why they were dissatisfied with the care they received in the postnatal period in hospital. This study was undertaken in order to seek to understand women's perspectives and experiences of the care they receive and the context within which that care is provided.

In summary, what emerged from the literature review was evidence of an apparent mismatch between what women wanted and what they received and, possibly as a result, women describing feeling uncared for. Clearly, women received a care experience which fell short of their expectations. Arguably, the postnatal ward environment should be more conducive to the new mother's physical and emotional recovery and to facilitate her in getting to know and be assisted in caring for her new baby. Currently the service provision would appear to concentrate on clinical observations of the mother and her infant. Furthermore, the extent of maternal morbidity is only just beginning to be recognised (MacArthur et al., 1991, Glazener et al., 1995, Glazener & MacArthur 2001), but most of it appears to remain undetected in hospital. Similarly, the woman's need for emotional support appears not to be recognised (Marchant & Garcia 2000, Singh & Newburn 2000). It was necessary and timely to ask what prompted women to describe the care received as ineffective and inappropriate to their individual needs.

CHAPTER 3: METHODOLOGY AND METHODS.

The previous chapter has demonstrated the lack of detailed knowledge of women's views of their care in hospital in the postnatal period; this was based on the literature review undertaken. Although certain aspects were identified as being of importance to the women, the data in the main related to findings from quantitative studies and therefore provided limited recognition of the views of the women. This lack of detailed knowledge was an important aspect in considering undertaking this study, as was the insight that I had gained as a community midwife at that time, into women's descriptions of postnatal care in hospital once they had returned home. This reinforced for me the dissatisfaction felt by women with their care; women spoke openly about their relief of having returned home, giving a sense of having 'escaped' from the ward. However, what was striking about their comments was that they were generally unable to explain why it was necessary to 'escape' or what had contributed to making their stay in hospital an unsatisfactory experience. In essence, this provided my professional motivation for undertaking the study, consistent with Lofland and Lofland's (1984:10) view of the importance of emotional engagement by the researcher in order to sustain a continued interest and momentum of the study. This study was undertaken in the context of the lack of detailed information available to midwives on women's perspective of their care on the postnatal ward following the birth of the baby.

I have chosen to write the account of my study in the first person in the hope that this will bring the study, the women and the care-givers closer and, possibly, more alive to those reading my account. It is also hoped that the use of the first person will assist in interpreting and understanding choices and influences during the study itself and their possible effects on me and/or the research process. Inevitably, there is a part of me as a person and practitioner in my study and, in a sense, the write-up of my study will chart this professional and personal journey as my studies progressed (Webb 1992, Wolcott 2001).

3.1 Defining the research question.

Postnatal care in hospital is an area of care which had not previously been studied in depth and, hence, there was little detailed information on women's views of this care. The purpose of the study was to seek to understand the women's experiences of care on the ward, and to examine the context in which that care was provided by care-givers.

This ethnographic study was undertaken in two parts:

Phase one – non-participant observation to explore the context of care on the postnatal ward and women's experiences of that care.

Phase two – in-depth interviews with women about that experience, undertaken some time after leaving the ward environment.

The aim was to explore in some detail the current organisation and structure of postnatal care within the hospital environment, for the purpose of seeking a greater understanding of its impact on the care provided for women in the immediate postpartum period. The objectives of the study were necessarily broad to allow for an open and flexible investigation. In essence, I wished to observe what activities occurred within the ward environment and to observe interactions between women and health professionals. This involved describing what care-givers 'do' with and for women within the postnatal ward and was explored in the observational phase of the study. In the second phase of the study, which used in-depth interviews with women, the emphasis was on facilitating the women to express their views in their own words and to describe their experiences and perspectives. In addition, the second phase sought to further explore with them issues identified from the observational phase of the study.

The observation was carried out before the interviews as I felt that it was important to explore the postnatal ward from the perspective of an outsider; I was aware that the postnatal ward environment was familiar to me as a midwife. I hoped to be able to gain a more objective understanding of the setting in which women received care. The recent debate on where postnatal care should be provided and the possible utilisation of postnatal beds for non-maternity care (Walsh 1997, Kaufmann 2000, Haley 2001) further influenced this decision of undertaking the observation before the in-depth

interviews. The observational phase revealed aspects which informed the in-depth interviews with the women.

3.1.1 The setting for the study.

The study took place within the maternity unit (described in more detail in section 4.1) in a hospital trust in the south of England. There were approximately 3700 births annually at the time of the study. Team midwives were responsible for delivering care in the community and aimed, where possible, to offer intrapartum care to the women within their team. However, the team midwives did not routinely provide care on the postnatal ward; this was provided by core midwives within the maternity unit. A small number of midwives provided traditional community midwifery; they were not expected to provide care in hospital. The core midwives rotated within the unit in order to maintain expertise within all areas of clinical practice. On transferring home, the new mother and her infant continued to receive care from her team or community midwife.

3.2 Methodological considerations.

The literature review undertaken had demonstrated the lack of detailed knowledge of women's views of postnatal care as delivered in hospital. The review had further highlighted the limited use of qualitative approaches in seeking the views of the women, specifically in relation to care in hospital following the birth of the baby. An emphasis on the collection of numerical data, although important, which enable health care providers to quantify the outcome of treatment by providing a clinical measurement, does not allow women to describe their perspectives and experiences of their care (Grant 2001) or health professionals to understand women's views of their care. A quantitative approach, possibly using questionnaires, relying on a large number of participants aiming to produce findings which might be generalisable to a wider population, was not considered appropriate as this would not have captured the essence of the women's experiences or allowed for an exploration of the culture of the postnatal ward.

Given the desire of seeking to understand the women's views of their care and the context in which that care was delivered, it was evident that a qualitative approach would be appropriate. In particular, in view of the lack of knowledge of how women made sense of the postnatal ward, the qualitative research approach of ethnography was considered appropriate. I wished to seek to understand and explain what was happening within the postnatal ward environment for the purpose of contributing to care-givers', and particularly midwives', knowledge of women's experiences of their care there. Ethnography seeks to understand and explain phenomena observed from the perspective of the people within that setting (Hammersley & Atkinson 1995) and has been used in midwifery (for example Kirkham 1989, Hunt and Symonds 1995, Burden 1998, Hunter 2002, Dykes 2005) and elsewhere (Stockwell 1972, Holland 1993, Koch 1994, Hassell et al., 1998). The literature review undertaken had not revealed any ethnographic studies with reference to general care on the postnatal ward in hospital. Spradley (1980) described the important aspect of ethnography as being not merely studying people but learning from them; I would argue that this was important in the current study where the lack of detailed information about postnatal care in hospital from the women's view had led to a lack of understanding of this care by the midwives.

The two phases of the study will be described separately, commencing with the observational phase.

3.3 Phase one: non-participant observation.

The first phase of the study involved an observational study using non-participant observation. Reviewing the literature in relation to the research method had revealed descriptions of observation to be broad and interpretative (Schatzman & Strauss 1973, Spradley 1980, Lofland & Lofland 1984, Eisner 1991, Hammersley & Atkinson 1995). The observational method is also referred to as 'naturalistic research' (Lofland & Lofland 1984:19) and 'field research' (Burgess 1982:2). Schatzman and Strauss (1973:14) considered the 'field method' to be a heading under which the investigator was invited and encouraged to use a variety of methodological techniques, in order to order to obtain the information required.

The observational method is not new; Ashworth (1994) described how Florence Nightingale recognised observing as integral to nursing and Morse and Field (1996) described it as a method frequently used by nurse researchers. Observation allows the investigator to observe people and their actions within their own environment (Lofland & Lofland 1984, Holloway & Wheeler 1996). Observational studies allow for an examination of events as opposed to relying on self-reported behaviour and can serve to highlight gaps between views and actions (Pope & Campbell 2001).

The observational method enabled me to enter and observe within the field of interest with the ultimate aim of describing the phenomena observed. This allowed for an examination of the activities and aspects of care to women on the postnatal ward.

The postnatal ward represented the culture or setting, the focal point of interest (Schatzman & Strauss 1973) and was thus the 'social situation' involving three aspects, namely: actor, activities and place (Spradley 1980:39). Mothers and their infants with their immediate family, as well as care-givers, were part of this setting.

3.3.1 Choice of venue - observing within my own culture.

Having reviewed the literature in relation to venue for the study, initially, a decision was made to seek to undertake the observations outside my normal place of work as a practising midwife. However, the maternity unit approached, although very interested in my proposed study, subsequently explained that due to imminent building works and upgrade of their facilities, that they would not be able to accommodate the study. I therefore approached the Head of Midwifery within my own place of work, who immediately offered her support.

Observing within my own setting provided a springboard, emotionally and personally, and assisted in keeping the research agenda alive (Lofland & Lofland 1984). Prior knowledge adds strength to the research (Reed & Proctor 1995) and a degree of familiarity with and an interest in the culture has the potential to make a positive contribution to clinical practice (Hanson 1994). Reed and Proctor (1995) support the practitioner researcher from the inside, as opposed to an academic researcher entering

as an outsider into an unfamiliar field, arguing that this provides an enhanced understanding of the phenomena under investigation.

In view of my familiarity with the immediate setting, the postnatal ward and ultimately the maternity unit as a whole, it must be recognised that I entered the research culture with a number of my own assumptions and a degree of pre-conceived positive judgement of the value and validity of what I was observing (Hanson 1994). The possibility of bringing my own beliefs and experiences to the observations had to be acknowledged, because of my familiarity with the postnatal ward and postnatal care but, equally, the setting of my normal place of work provided a creative framework; I wished to understand the provision of care from the women's perspective rather than what was already familiar and known to me, and ultimately midwives. Early on in the observational phase I was reminded, by a comment from a midwife, that as practitioners we may hold assumptions on the meaning of care on the postnatal ward - *'but you know all there is to know about postnatal care!'*; in essence she expressed surprise that I should wish to observe within an area which midwives regarded as familiar and understood. Reflecting on her comment throughout the study assisted me to remember why it was important to seek to understand women's views on care on the postnatal ward. Arguably, as midwives we believe that we know or understand what women want or require, and this assumption has led us to fail to recognise fully the importance of care on the postnatal ward to the new mother.

As a midwife in clinical practice and having an awareness of women's anecdotally reported critical appraisal of care on the postnatal ward, provided me with a 'privileged' knowledge from within the maternity services of care available to women (Kingdon 2005). Such 'privileged' knowledge could be seen as a hindrance and I sought at all times to remove myself from this knowledge; keeping a diary aided reflection and my thought process. Documenting my feelings, both as a midwife and a novice investigator, at the end of each period of observing allowed me to return to and compare my entries.

3.3.2 My role within the research setting.

As the 'investigator' I was required to assume a role within the research setting, for the purpose of collecting the data; I had to decide on the appropriate level of methodological 'activity' or involvement within the postnatal ward, whilst observing. The variety and complexity of roles or types of participation are well documented with Gold (1958) offering his now classic description of involvement of the researcher in the field of four discrete categories: complete participant, participant-as-observer, observer-as-participant and complete observer. Spradley (1980:59) described five different levels of participation, namely: complete, active, moderate, passive and non-participation. Schatzman and Strauss (1973:58) had previously outlined six different roles that the investigator might adopt: participant with hidden identity, observer as participant, watching from the outside, active control, limited interaction and passive presence. The investigator is advised to consider these roles along a continuum but whilst intending to observe primarily within one role, the researcher should remain open to the possible need for flexibility within the chosen role (Schatzman & Strauss 1973). The decision to observe as a non-participant observer was an important consideration in deciding on the level of involvement within the current study; I did not wish to undertake covert observations. Essentially, a degree of involvement was required as I was entering a 'social situation', (Spradley 1980:39) and, arguably, I would be part of the culture during a period of data collection (Hammersley & Atkinson 1995).

3.3.2.1 Rationale for the adoption of the role of non-participant observer.

Observing as a non-participant observer was chosen in order to separate the two roles of practitioner and investigator, giving enhanced freedom to the task of observing. The postnatal ward is generally regarded as a busy clinical area; during the study the midwives made frequent references to their workload and the women also commented on the 'busy' midwife. Attempting to fulfil the roles of practitioner and investigator simultaneously would have presented a dilemma; I felt it was important to remove myself from my midwifery duties. In acting as the role of 'main investigator' in gathering the data (Burgess 1984:45, Hammersley & Atkinson 1995) I needed to temporarily remove myself from my employment role of practitioner and allow myself the freedom to observe from within, for the purpose of viewing the setting or

culture afresh. Morse and Field (1996:88) cautioned against adopting the simultaneous role of clinician and researcher for fear of missing a 'rare' event, previously not observed. They argued that the clinical role may override the needs of the researcher who may thus neglect the collection of data. Furthermore, I was mindful that undertaking the simultaneous roles of practitioner and observer might have led to reduced energy and enthusiasm for the study (Koch 1994, Burden 1998). Burden (1998) had previously described how, as a participant observer, on occasions she interrupted the flow of data collection in order to maintain an acceptable level of care for the women; this inevitably prolonged the period of the study. Equally, intent on collecting the data, the observer in the simultaneous role of clinician may overlook the needs of the women and their babies (Morse & Field 1996). I needed to have regard for the time and resources available to me to carry out the data collection; several methodological aspects were thus considered in my adaptation of non-participant observer. The ethical considerations, such as when I would or would not intervene in order to protect the safety of the mother and her infant, will be discussed later.

3.3.2.2 Moving from 'doing' to passivity.

The decision to observe as a non-participant observer, essentially a passive role, removed all sense of activity and the need for 'doing'. This challenged me whilst in the role of the observer, effectively producing a loss of identity and an element of feeling bereft in not providing care for women and infants. Paradoxically, it is precisely this enforced inactivity which allowed me the freedom to observe and reflect on what was observed; I had to detach myself and stand back from professional and assumed knowledge. Holding onto aspects which I may have regarded as 'known and assumed', which I think could have happened if I had retained a degree of active involvement, would have prevented me from viewing the activities within the ward environment ethnographically rather than clinically. Focusing on the long term objective of the study, that of seeking an understanding of the postnatal ward environment as that in which women received care, assisted me in adapting to a new and different, albeit temporary, role. As such, the midwife as the researcher may have to review two definitions of roles – occupational (Handy 1993) and methodological (Schatzman & Strauss 1973); the occupational role is likely to be more familiar. For

instance, on observing women indicating an immediate need or desire for assistance for themselves and their infants, as I frequently observed in relation to breastfeeding, my occupational role had to be resisted and denied as remaining with this role would have assumed an immediate understanding of what was observed. Remaining within my methodological role enabled me to observe from the outside how midwives and health care assistants within the ward environment responded to the needs expressed by the women.

It could be argued that a degree of active passivity was required; my presence within the ward was not static. Informal discussions with women and care-givers during a period of observing were integral to the data collection (Schatzman & Strauss 1973, Hammersley & Atkinson 1995, Woodward 2000). Women would spontaneously provide information or seek to describe their view of the postnatal ward and the care provided. In common with Burden (1998) I discovered that new mothers are keen to have even the briefest of conversation about issues which concern them or relate to the care of their babies. A small number of women, at the time of seeking their written consent to observing within the bay, asked to talk to me about their experience of receiving care on the postnatal ward; such interactions, included in the data, were of a private nature as they took place with the woman within her environment, that of her bed space. Midwives would spontaneously approach me to explain their reasons for their actions or activities in relation to clinical practice. In any informal conversation with women and midwives I strove to remain methodologically focused, whilst at the same time paying attention to and indicating my interest in the thoughts which they offered to share with me. The information offered by women and midwives alike, provided additional and valuable data complementing the field notes from my observations.

3.3.2.3 Interacting with people within the setting.

Although electing to adopt the role of non-participant observer, I never sought to hide or conceal my identity as a midwife as the intention was to conduct overt observation; covert observation would have caused ethical and moral dilemmas (Johnson 1992) and was not acceptable to me. Others have taken a different view, for example, Burden (1998) felt that it was inappropriate to ask for consent from participants as the

advantage of a natural setting would have been lost. She worked as midwife during the episodes of data collection.

The many relationships the researcher may enter into or the experiences they may have during the research process are complex, and this current study involved interacting with fellow practitioners and mothers and their infants. The postnatal ward acted as the 'host' for my study and, as such, within that environment I was not only a 'guest' but also a learner (Schatzman & Strauss 1973:21, Kirkham 1989, Morse & Field 1996:63). In the capacity of a 'learner' I was able to explore and look afresh at the chosen particular aspect of midwifery practice. My reflections on undertaking research as an 'insider' are included in Chapter 9.

I acknowledge the possibility that the study may have altered the behaviour of the care-givers or that of the women in their descriptions of their care. Polit and Hungler (1991) referred to the phenomenon of the 'Hawthorne effect' which is thought to occur when participants temporarily alter their behaviour or performance as a result of being observed; in the study which lent its name to the 'Hawthorne effect' the productivity of factory workers was observed to rise regardless of the type of environmental changes introduced. Polit and Hungler (1991) caution the researcher to be aware that the study may influence the way people behave because of the attention they receive from the investigator. The health professionals, as participants, would initially have been aware of my presence on the ward as an observer undertaking an observational study. During the observations I was visible within the bay and, to a lesser degree, within the ward. It is possible that my physical presence may have influenced the behaviour of the care-givers so that they aimed to provide a 'better' or a 'higher' standard of care or behave in a way which they perceived would benefit them as care-givers, the study or the observer. The desire for demonstrating proficiency may have been the reason behind the midwives' wish to explain in-depth to me their use of the bed curtains or the reasons for how they allocated the midwives during their shift as co-ordinator.

When observing in the bay, midwives would approach to ask what I had been able to observe or if I was 'pleased with' what I was observing. This possibly reflected their desire to offer a favourable impression of themselves as practitioners and of the ward.

I also sensed the midwives' need for their activities, 'the work', to be documented and highlighted.

I was undertaking my clinical practice within the ward environment on days when not observing, and as the observational phase progressed, I began to 'recognise' aspects or behaviour which I had observed, such as the limited presence of the midwife in the bay or the midwives' use of the bed curtains. It may therefore be reasonable to assume that the care-givers were adjusting to my presence as an observer and that this lessened any effect on behaviour. Indeed the literature suggests that the 'Hawthorne effect' diminishes over time as the participants become accustomed to the presence of the investigator (Kenney & Marchant 2000). My colleagues appeared to accept my presence on the ward with curiosity rather than guardedly.

When observing I was conscious that my presence within the setting would be noticed by all the participants, and possibly particularly so by the health care professionals, who might consciously or subconsciously have perceived me to be making judgments about what I observed (Field 1991). Equally, I was observed by my colleagues and possibly also the women, as an additional person, familiar yet unfamiliar, within the ward environment; a colleague inquired if I was '*the observation lady*' whilst somebody else asked '*have you got your observation hat on?*'. Clearly, to my colleagues I had assumed a different role from that of my normal role of clinical specialist. The importance to the midwives in particular of my temporary role was evident; they appeared pleased that someone was taking an interest in **them** and inquired – '*you are counting the number of times we go in and out of the bay, aren't you?*'. This question assumed relevance as the data collection continued and the general busyness of the bay and the organisation of the 'work' became apparent and how this impacted on both the care-givers and the women. Koch (1994) described being asked by the staff if her research would demonstrate the need for more staff. At the end of one period of observation, the midwife who was undertaking the drug round called to me from the desk area before she entered the bay – '*you want to see a midwife in the room, don't you?*'. I accompanied her, at her request, into the bay where I had previously observed in order to watch her undertake the drug round in that bay; in essence, I complied with her request even though I had concluded the observation, to indicate my regard for her as a midwife. Schatzman and Strauss (1973)

described how once the researcher has been accepted in the field, the participants want him/her to be present as they are working; clearly the midwife wished to be seen 'in action'.

Midwives also approached me to give specific information, for example a midwife who requested a quiet word away from the ward area, in order to describe her concerns about the lack of support from managers, as she perceived it, for midwives whilst working on the postnatal ward. Although unable to assist her directly, I hope that by listening to her concerns that I was able to offer a degree of support. It would appear, then, that the midwives, in common with the women, were anxious to have their views heard.

The spontaneous sharing by midwives of their views on postnatal care and on being a midwife within this environment also appeared to increase with the progression of the study. On arriving for the report or handover one morning, a midwife commented to me - *'can't do this any more'* about having been on a late duty the day before and now followed by an early. This indicated a degree of intimacy. The observational data, as referred to later in this thesis, indicated that midwives required support in their role of supporting new mothers on the ward and some sought this from me in my observer role. The need for support for care-givers has been highlighted elsewhere (Kirkham & Stapleton 2000, Lynch 2002).

In my new role of observer I entered as a 'guest' within the ward environment. At the time of starting the non-participant observation I had taken on the role of clinical specialist and was no longer wearing a uniform. I therefore elected not to wear a uniform or white coat when observing, hoping that this would support the normality of my presence on the ward; the successful use of a white coat in the role of an observer had previously been described (Hunter 2002, Hunt & Symonds 1995). Unfortunately, my chosen dress code of non-uniform meant a lack of voluminous pockets in which to store my note pad!

Prior to commencing the observational study, leaflets explaining the study were displayed within the maternity unit. A brief presentation was given to the staff, providing a short outline of the study and an opportunity to ask questions. This was

felt to be important, not least because an observational study had not previously been undertaken within the unit. A number of midwives and one manager, who sat amongst them, attended the presentation. Hunter (2002), who similarly offered a presentation to the midwives, described how she was invited to sit with the managers facing the midwives; this led her to speculate on the midwives' possible perception of her as the researcher aligning herself with the management. I am therefore, in retrospect, appreciative of the manager positioning herself with the midwives and not me; at the presentation the manager offered her full support for my study and at that meeting she signed the written consent form required by the Local Research Ethics Committee (LREC) to indicate her willingness for her unit to participate.

The decision to conduct the observational study within my own unit inevitably altered, albeit temporarily, the relationship and the dynamics with my colleagues for the duration of the observation period. The decision not to conduct covert observation, hopefully, conveyed sincerity in my regard for not only my colleagues but equally the women; mutual respect is important. At the end of the observation phase of the study, I returned to the more familiar role of being active within the ward environment as a practitioner and my usual collegiate relationship with my colleagues.

3.3.3 'In the field' – the data collection.

Observations were carried out at different times on all seven days of the week with each session lasting between 2-5 hours. A decision was made not to observe after midnight; the literature review had revealed the women's desire for rest and sleep. A total of 18 observation episodes were undertaken between October 2001 and March 2002. Field notes were used to record the data. Maintaining a diary aided the process of reflection on what was being observed. Local documents detailing official guidelines and policies relevant to the provision of postnatal care and results from local service-user satisfaction surveys were also studied. Clarification was sought from the care-givers on aspects observed which appeared relevant to the investigation but were unclear to the observer (Schatzman & Strauss 1973, Woodward 2000).

Morse and Field (1996) advised that an observer should be free to enter and leave the field without prior arrangement; however this may not be acceptable or practical for

the observer or those participating. Burden (1998) acknowledged the need to negotiate access to the field for each period of observation. On arriving on the ward and prior to commencing an episode of observing, I obtained verbal agreement to observe from the co-ordinator for the shift, who thus acted as the gatekeeper within the immediate area of observation (Mander 1992); access was never denied. A letter outlining the purpose of the study was available, via the antenatal clinic and midwives based in the community, for distribution to women in the antenatal period (see Appendix 1). On the day of observing, leaflets were distributed to women within a bay seeking their written consent (see Appendix 2).

Observations were not undertaken in the post-operative care bay or in the bay where women whose babies were cared for in the neonatal unit received care; the object of the study was to explore women's perspectives and views of care within the general postnatal ward environment. Although I decided not to observe in the post-operative bay, where women received care within the first twenty four hours following a caesarean section or a difficult instrumental delivery before they were transferred to the general postnatal bay, observing within the general postnatal bays did include women who had had an operative birth but only after they had ceased to receive more highly resourced care. They were therefore also included in the interview sample. The interview data revealed that the women who had a caesarean section had issues which related to their subsequent care on the general postnatal ward and this will be discussed in Chapter 7.

At the end of each observation the women and the care-givers were thanked for their willingness to participate. Any questions from the participants were answered. Throughout the observations only two women declined to participate; no observations were conducted in that bay. One of these mothers explained that she did not wish to be observed, although she had no objection to me observing the other women in the bay; I explained that this would not be possible but also that it would not be a problem to move to another bay. The second woman, who declined, gave the reason of *'already feeling pressured with the breastfeeding'*. As the study progressed the data helped to begin to achieve an understanding of her comment. Written consent was also required from the care-givers within the ward environment and consent forms were distributed at the beginning of the study; this will be discussed later.

3.3.3.1 Observation schedule.

In reviewing the methodological literature there appeared to be some evidence in support of an observation schedule in an observational study. Polit and Hungler (1991:328) advised that this should not be an exhaustive list but rather an attempt to guide and assist the investigator in the collection of the data. An observation schedule was drawn up following informal discussions with midwives on the ward, in the community and at an RCM branch meeting. Barlow (1994) advised that the construction of such a schedule should involve practitioners whose insight and experience enabled them to be considered as experts; ten midwives contributed to these discussions. The schedule which resulted represented the views of these midwives as to what postnatal care in hospital should consist of (see Appendix 3). However, following pilot work the observation schedule was discontinued as it essentially acted as a tick list corresponding to the midwives' assessment of the required components of postnatal care and thus prevented me from observing care on the ward from the woman's perspective. In placing a tick I felt that I had already made an assessment of what I had observed, possibly based on an assumption as a practitioner of what I could expect to observe; I was therefore not placing what was observed within the context of where and how it was observed. In essence, the observation schedule represented the tick list used by midwives in undertaking the daily physical examinations of the mother and her infant; this tick list will be discussed in Chapter 5, section 5.4. It was also time consuming to locate and tick the relevant category; but more importantly 'ticking' closed my mind and eyes to what was happening within the bay and the interactions between the care-givers and the women. I therefore abandoned the schedule; the need to watch and listen continuously was imperative (Schatzman & Strauss 1973, Hammersley & Atkinson 1995). Ceasing to use the observation schedule liberated me from the assumed and accepted and opened up and exposed each episode more fully, thus allowing me to observe activities within the bay and interactions between care-givers and new mothers from a different perspective.

3.3.3.2 Field notes.

Written notes and prompts were made during the actual observation, either in or away from the bay. At the end of each period of observation I would have a mind picture or

image of what I had observed on that occasion; such as the atmosphere in the bay, the women's responses to each other, the general busyness of the ward, and the interactions of individual care-givers with the women. These images were documented; often in the form of a memo (Robson 1993, Hammersley & Atkinson 1995). Okely (1994:21) had detailed how such experiences are recorded cerebrally 'in memory, body and all the senses'.

Field notes were written up at the earliest opportunity and emergent analytical constructs were noted. As the data collection continued, emergent themes were used to guide the observations in order to confirm or refute emergent thoughts. Maintaining a reflective diary aided my thinking and reflection on what was being observed. Eisner (1991), whilst emphasising the importance of taking notes, nevertheless advised the researcher that it is not possible, nor desirable, to record everything but that the notes made must facilitate the researcher to remember in some detail what was observed as this contributes to the credibility in the interpretation of the data.

If I needed to record aspects immediately on leaving the ward at the end of a period of observation and before arriving back home, I would spend a brief time in my car making notes before starting my return journey. Such writing of memos was always undertaken away from the ward; quiet time with space and distance away from the immediate area aided my reflection on what had been observed.

3.4 Phase two: in-depth interviews.

The aim of the second phase of the study was to seek the views of the women about the care they had received on the postnatal ward. The observational data had confirmed the urgent need to seek to understand the postnatal ward from the perspectives of the women. Therefore, the second phase of the study used in-depth interviewing (Patton 1987) to collect the data.

Holloway and Fulbrook (2001) have described the interview as the most commonly used method of data collection in qualitative inquiry. In-depth interviewing involves the interviewer not only listening to what is said but also observing for non-verbal cues provided by the participant; it is acknowledged that there are different types of

interviews or interviewing (Patton 1987, Fielding 1993, Holloway & Fulbrook 2001). I elected to use a trigger question at the beginning of each interview (see Appendix 4), thus ensuring that I as the interviewer was able to explore issues or aspects of relevance to the women and maintained the focus of the interview. Holloway and Fulbrook (2001) had described the need to value the individual person's experience(s).

Essentially, the interviewer must remain free to explore in order to elicit the respondent's views in their own language (Patton 1987, Eisner 1991). A further aim of the second phase was to seek clarification of some aspects which had emerged during the observational phase and from the literature and which appeared relevant to the care offered to the women; for example the use of the bed curtains by the women and women interacting with other mothers in the bay. Midwives had indicated during informal conversations, that they felt it important for women to talk to each other whilst on the ward; they described how this was particularly important for a mother having had her first baby. However, such communication between the women was rarely observed and was therefore explored during the in-depth interviews.

Probes were also used aiming to achieve a full and detailed response from the women (Fielding 1993). Patton (1987) had highlighted the importance of the interviewer conveying their interest in and respect for the participants and the meanings or views expressed by them. Equally, as the researcher is the main instrument of data collection, the researcher must be aware of a personal 'mind set' based on professional knowledge or experience in the field of interest (Hammersley & Atkinson 1995, Holloway & Fulbrook 2001). I hoped that my experience as a midwife and my current clinical practice within the postnatal ward environment would convey my genuine interest in the views of the women. As within the observational phase, I needed to be aware of my experience as a clinical practitioner and any possible assumptions about care or the provision of that care, which resulted from this experience. Recording my thoughts in my diary aided my reflections on what the women were telling me. As with the observational phase, removing myself from the familiar 'doing' and moving to a 'listening' phase also aided this process.

3.4.1 Recruitment of women.

Sampling in qualitative research may present a particular concern or challenge to the researcher, and as such, modification and adjustment of the sampling strategy may be required (Burgess 1984). Sampling was purposive, whereby a group of people of interest to the investigator were identified (Burgess 1984); in the current study the group of interest was represented by new mothers of differing parity. It was recognised that this involved a degree of selection of participants (Holloway & Fulbrook 2001).

In order to obtain a breadth of views, both primiparous and multiparous women were included. It was initially proposed to exclude women whose infants were cared for in the Special Care Baby Unit (SCBU) as these infants were less likely to be transferred home at the time of the mother's discharge and these women had not been included in the observational phase; however the Local Research Ethics Committee (LREC) suggested the these women should be included and this was done. Women for whom I had personally provided care were not included in the study as, possibly, they might have felt obliged to participate and to offer a positive account only of their time on the postnatal ward (Holloway & Fulbrook 2001). The women who participated in the interviews were a different group of women to those observed. In the period between the two phases of my study, I completed my transfer report and sought LREC approval for the second phase of the study. During this period I was able to further reflect on the observational phase before starting the in-depth interviews.

In recruiting the women into the study, I proposed to ask the community clerks to approach the women in order to provide written information about the study (see Appendix 5). The community clerks were responsible for the register of women transferring home each day; it was the responsibility of the clerks to provide the women with their discharge letter on going home. The clerks were happy to provide the information to the women at my request. If, after having received the information, a woman indicated that she would like to hear more about the study, I would personally provide further information to her. In the initial research protocol I had proposed that each woman thus approached would be given a stamped addressed envelope and a consent form (see Appendix 6) giving her contact details, which could then be returned to me once the mother had returned home, should she be willing to

participate. In the event, all the women, except one who returned her completed consent form by post, spontaneously elected to sign the consent form at that initial meeting; again possibly indicating their keenness to participate and to have their views heard. Two women approached by the community clerk, declined to see me to receive further information although they declared their support for the study; one mother felt that this being her fourth baby she would not have the time and the other mother described limited time due to an imminent house move. McCourt and Page (1996), reflecting on the varied response rate which they achieved to their survey, advised researchers to have regard for the time invested by mothers in looking after a new baby. The literature review for my study further revealed tiredness as a major concern to the new mother (Glazener et al., 1995). I designed my recruitment strategy to be as non-coercive as possible.

Following on from our initial meeting on the ward, I phoned each woman at between seven to ten days following the birth of her baby. At that telephone contact I ascertained that she still wished to participate in the interview, none of the women withdrew from the study, and we arranged to meet at a time and venue convenient to her, such as her home or a health care facility. All the women elected for the interview to take place in their home. During this telephone contact I reminded each woman about the purpose of my study.

It was hoped to interview the mothers within two to four weeks following the birth of the baby. The studies reviewed, and referred to in the literature review, had not offered any rationale for the precise timing of the collection of their data; the time frame in the current study was chosen in order to maximise women's recall of the period in hospital. In the event, the interviews were conducted at between just over two weeks to just less than six weeks postnatally, this being governed by what suited the individual woman. The recording of the interviews varied in length from 35 minutes to just over one hour; although some women carried on talking about their time on the postnatal ward after having indicated that there was nothing further which they wished to discuss and the tape recorder having been switched off. In total, 12 women were interviewed; a profile of the women is presented in Appendix 7.

Early on in the recruitment for the second phase it became evident that the clerks attempted to identify ‘nice’ women, perceiving this as more pleasant for me as the researcher. This prompted a discussion on the need to regard all women, who fulfilled the inclusion criteria, as potential participants.

3.4.2 Conducting the interviews – the data collection.

The interviews were carried out in the home of the woman; I was mindful of the fact that I was essentially an invited guest in their home. On arriving a few minutes would be spent inquiring about the well-being of the mother and her baby. I would remind her of the purpose of my study, asking her if she still wished to participate; verbal consent for recording the interview was sought. The interview started with the trigger question – *‘Please tell me about the care you and your baby received on the postnatal ward’* (see Appendix 4). As the interview progressed I would, if appropriate, seek clarification on aspects which the women raised. Clarification on aspects which had emerged during the observational phase and which appeared relevant to the care offered to the women was similarly sought.

It was evident early on in the second phase of the study, that each individual woman had issues which were of concern to her, resulting from the care provided on the postnatal ward; they would often bring these aspects up at the beginning of the interview. In order not to bias the data collection and the interpretation of the data, I sought not to exclusively single out such data but also attempted to look for the wider picture (Patton 1987) later in the interview. However, these issues had clearly contributed to their assessment of their care on the ward. The issues did not relate to unsafe practice but rather to the women’s perspectives of how they were cared for as an individual. This finding was not surprising, given the fact that women nationally report that postnatal care in hospital is failing to meet their needs (Audit Commission 1997, Singh & Newburn 2000). The disclosure by the women of aspects and issues which mattered to them was hugely important, not only because of the aim of the study but also because of the willingness with which women shared their experiences and views.

As the women elected for the in-depth interview to take place in their home, it would appear that women felt more comfortable in that environment. The setting for the research was now the woman's territory and not mine; the ease felt by the women was evident. There were practical challenges for me in undertaking the interviews in the woman's home such as their video playing to keep the toddler occupied, toys being played with by a toddler or presented to me, delivery of groceries, maintenance people checking domestic equipment, telephone calls, other visitors to the home and/or the toddler needing attention. Arguably, complete detachment from the women and her immediate environment, during the interviews was not possible, nor desirable, as I wished to convey my genuine interest in hearing their views. Consequently, there were some shared moments which did not directly relate to the research question.

Each interview with the women was, with their verbal consent, recorded with a small handheld tape recorder. Although the tape recorder used during the interview was of adequate quality for the purpose, I was nevertheless dependent on being close to the mother; no data were lost due to seating arrangements. At the end of the interview the women were again asked for their written consent to indicate their willingness for me to include the data in my study (see Appendix 6). This dual consent had been requested by the LREC.

3.4.3 Interview transcripts.

I attempted to make written notes during the interview itself to add to the data recorded if applicable and practicable. However, I also felt that it was important to maintain eye contact with the woman, looking for non-verbal cues and to demonstrate to her my interest in her comments by listening. Again, as with the observations, following the completion of each in-depth interview a sense of the interview as a whole emerged; this image was written down on return to the car. Whereas the journey to the maternity unit was of a relatively short distance, the travelling for the interviews were of considerably longer distances and I therefore sought to document main themes which had emerged at the interview while recall was optimal. Similarly, areas of key significance were noted. The possible loss of recall when delaying such documentation has been highlighted (Koch 1994). On returning home I listened to the full tape, again recording aspects which appeared of interest and noting emergent

themes within the data. The tape was then transferred to Microsoft Media Player, which enabled me to listen and transcribe the tape simultaneously. I transcribed the interviews myself as an important component of immersion into the data.

3.5 Ethical considerations.

The safety and privacy of the participants in a study is of paramount importance as is the aspect of informed consent indicating their willingness to participate in the study. In this study, the participants included women and their infants, as well as health care professionals within the ward environment. Reference was made above to some of the issues arising from undertaking an observational study within my normal place of practice. In this section I wish to describe more fully the ethical considerations relating to both phases of the study, in recognition of their importance (Johnson 1992, Lathlean 1996).

3.5.1 Departmental approval.

Having decided to seek to undertake the study within my normal place of practice, I sought a meeting with the Head of Midwifery who thus acted as an initial gatekeeper to the setting (Mander 1992); she offered her support for the study. Having gained departmental approval, which included approval from the Clinical Director of the maternity unit (a Consultant Obstetrician), and consent from the Research and Development committee of the Trust, a copy of the protocol was submitted to the Local Research Ethics Committee (LREC) for review and opinion. The committee members, whilst in agreement that written consent should be sought from the women prior to each separate observation (see Appendix 2), also advised that written consent from health professionals, in essence my colleagues as participants, was regarded as sound ethical practice and would therefore be required. The Head of Midwifery attended the necessary second meeting with the ethics committee, in order to lend further support to the study and the study was subsequently given a favourable opinion. Staff willingly accepted my request for their written consent (see Appendix 8). One midwife, who had recently returned from a brief spell at a neighbouring maternity unit, elected not to participate; she nevertheless offered her support for the study. I remained on the ward, observing in a bay to which a different midwife had

been allocated; subsequent contact between us during the observation was purely collegiate.

Departmental approval was similarly sought for the second phase of the study, the in-depth interviews, and prior to the submission of the protocol for LREC review. The membership of the Trust's Research and Development committee included a midwife. I was therefore able to submit a copy of the full proposal on each occasion, to her prior to the meeting of this committee; the midwife stated that the majority of proposals the committee normally reviewed involved quantitative studies. She was concerned that the members would be less familiar with a study using a qualitative approach and having a copy of the proposal, enabled her to provide additional information and to answer any possible questions relating to the study.

3.5.2 Regard for persons involved in and affected by the study.

Koch (1994) described how during the data collection she intervened in life-threatening situations and also in situations where, in the interest of the patients, she felt able to provide care and offer a role model to the staff. However, in situations which were not deemed life-threatening she maintained the role of the researcher, arguing that completing the study would have the potential to impact positively on clinical practice. Essentially, I proposed to intervene in situations which were potentially life-threatening to the mother and/or her infant but not in situations where I perceived that there was no immediate threat to life (see Appendix 9). In the event, I undertook midwifery practice on one occasion only, immediately on my arrival on the ward, in an obstetric emergency, primarily to offer additional assistance to my colleagues. Once the safety of the mother and her unborn child had been achieved, I entered my methodological role of non-participant observer, having documented my reversal into the role of midwife in my field notes as part of my reflection and the ensuing data collection.

The protocol outlining the observational phase, also included information on proposed action in the unlikely event of observing unsafe practice; this adhered to the principles and purpose of supervision within midwifery (UKCC 1996, NMC 2004). How an episode of unsafe practice is resolved may possibly depend on the situation at the

time, the relationship between the care-givers on the ward and the observer. The maternity unit displayed a list of named supervisors for individual midwives and therefore, in the event of unsafe practice being observed, I would have raised this with the individual practitioner and her supervisor. Happily, this need did not arise. Witnessing unsafe practice would have undoubtedly caused conflict within me as a researcher; I had a duty of care to the participants having promised confidentiality but equally an ethical obligation to ensure the safety of those participants.

In respect of the women who participated in the in-depth interviews, I was mindful that for some women talking through their experiences of care may have highlighted personal and unresolved issues in relation to their care or that of their infant. In the event of such an occurrence I proposed that these women would be offered, with their consent, the opportunity to discuss any concerns with an appropriate health professional, such as their own General Practitioner (GP) or midwife. Although, as referred to above, the women described aspects of care relating to their stay on the postnatal ward which they wished to discuss, none of them expressed or indicated a need to take their concerns further. It is possible that being able to discuss their concerns at the time of the interview and, in essence, providing information which potentially would be used to inform the practice of those responsible for delivering future care, assisted the women in reflecting on their concerns and may have been a positive event for them (Peddie et al., 2006).

The participants during the two phases of the study were assured that data obtained would remain anonymous to me as the investigator; individuals would not be identified in subsequent reports. All the tapes were transcribed by me and pseudonyms were used in the reporting of the findings. Observation schedules, field notes, tapes and transcripts, and information which may potentially have identified individuals were kept in a locked cupboard to which only the researcher had access. The tapes will be stored for two years and the transcript for five years following the completion of the study.

3.5.3 Feedback to participants.

Those involved in the two phases of the study were thanked at each episode of data collection for their willingness to participate. The women who were included in the observational phase were offered a short report of the findings (see Appendix 10). Six women out of the total of 43 declined the offer of a report, however the rest eagerly accepted. At the time of the in-depth interviews all the women were offered a full transcript of the interview and a short report of the findings; none of the women requested a transcript but all requested a short report of the findings (see Appendix 11). The women who participated in the second phase of the study were sent a 'Thank you' card a few days after the interview, in appreciation of their time and readiness to share their thoughts and perspectives.

The requirement to share the findings with health professionals and women is understood; results which are not disseminated nor made available for a wider discussion or examination will fail to impact on care or midwifery practice. It is hoped that sharing the findings demonstrated the importance afforded to the women's and the care-givers' willingness to participate. Following the interviews some women made suggestions which they felt could be implemented within the maternity unit, such as making the evaluation form given to all the women on transferring home, more applicable to the women who had had an operative birth. These suggestions were, with the women's consent, forwarded to the midwife responsible for Quality and Audit and subsequently acted upon. It is intended to feed back to the staff on completion of the study.

3.6 The data analysis.

Undertaking research generates a substantial amount of data. Reference was made earlier to quantitative research examining outcome measures to treatment offered, and such data are managed through the classification of numbers, groups and the application of statistics; the purpose being to demonstrate the effectiveness and safety of treatment. In contrast, qualitative research attempts to describe the experience of a defined group; however, there is no definitive method of approaching the task of analysing qualitative data (Robson 1993, Bryman & Burgess 1994, Coffey & Atkinson 1996). The researcher is advised, and challenged, to select a method which

best suits the investigation and the investigator's preference for managing and organising the data, ultimately aiming to make sense and explain it (Patton 1987). With reference to postnatal care in hospital and the women's perspectives on that care, the data analysis sought a representation of what was observed, allowing for both the expected and unexpected to be brought to prominence.

Essentially, the process of analysis is not a distinct or separate phase of the study; it is undertaken concurrently with the data collection. Initial or tentative analysis of the data helps to guide the data collection further (Hammersley & Atkinson 1995). Patterns in the data which appeared interesting or relevant were noted and examined for repeat occurrence. However, in order not to bias the data collection and the analysis, an alternative explanation for each possible emergent phenomenon was sought. Accepting initial hunches at face value early on in the data collection may bias additional collection of data (Patton 1987). Ultimately and hopefully, the data analysis will lead to the identification of analytical concepts contributing to an emergence of theory; however the linkage between concepts and theory may be tentative (Bryman & Burgess 1994, Wolcott 2001).

As the researcher acts as the main instrument in the data collection, this might impact on the research process (Hammersley & Atkinson 1995). Equally, the researcher's personal view or bias may impact on the interaction between data collection and concurrent analysis. Eisner (1991) warned that neutrality or objectivity is difficult to achieve, arguing that the decision of what to observe or to describe is a deliberate and conscious action. This does not imply that objectivity should be disregarded, rather that the possibility of not achieving absolute neutrality should be acknowledged. Abandoning the observation schedule early in the study required me to examine and view the data from an unfamiliar perspective. It is therefore possible that I might have looked specifically for aspects which were unfamiliar to me, however everything became unfamiliar when seen from this new perspective and it was all 'interesting'. Similarly, the observer is not able to observe or record 'everything' (Hammersley & Atkinson 1995), a fact which is acknowledged in respect of the study reported here. It is recognised that important aspects might potentially have been 'missed' or not observed, during a temporary absence from the observational field.

The field notes from the observations were read and re-read, patterns and codes were identified and the initial thoughts documented at the end of each observation period were re-examined. This process was further supported by referring to memos and entries in the field work diary. Gradually, and contemporaneously with the data collection, as codes or small units emerged these were linked to larger categories which were merged into the main constructs or themes (Patton 1987, Hammersley & Atkinson 1995, Coffey & Atkinson 1996). The codes were written on pieces of paper and were physically cut up; moving these around assisted me in examining and visualising the 'fit' of the data. Using the material to think with, allowed for hunches to be accepted or dismissed; referred to by Okely (1994:32) as moving between the 'visible and invisible'. Okely (1994) described the liberation she experienced when thoughts flowed at unexpected times and she allowed herself to extract subconscious thoughts and ideas. Webb (1999) offered a critique of the two approaches of using a computer software package or a manual technique in the analysis of qualitative data. She argued that the 'manual' process should be recommended for the neophyte researcher handling small amounts of data; describing the importance of the 'thinking' aspect of the analysis. My physical interaction with the data was central to me in seeking to understand the meaning of what had been observed or communicated to me. Okely (1994) had similarly argued that a computer programme would not be able to capture the essence of what had been observed.

Gradually, as patterns and thoughts began to take shape, the raw data became 'alive' thus conveying a sense of what was being observed. The memos or notes made at the end of each observation period helped to reinforce the process of thinking through the data and examining a particular event. Reflecting on the data and moving pieces of data around to establish their belonging within a category, helped to ensure a fit consistent with the data merging into a natural order. Issues such as whether the physical distance from the women exercised by midwives was an artefact of the ethos of the institution or created out of the midwives' need for detachment, or both, were explored and clarified in this way.

Recalling the physical sense of the bay during an observation period aided in the process of analysis; for example reflecting on entries in the field notes such as the midwife's shoes dragging noisily across the floor whilst the women were attempting

to sleep. Similarly the midwife who on entering the bay conveyed a strong physical presence as she 'took command' of the bay at the beginning of her shift on duty, and the women's apparent acceptance of this. Where discussion with the care-giver had been sought in order to clarify what was observed, these situational or informal conversations were considered part of the data (Schatzman & Strauss 1973, Woodward 2000), thus looking for a tangible connection between events observed and the care-provider's explanation of such an event.

The transcripts from the in-depth interviews were read and re-read. They were also read in their entirety in order to gain a sense of each separate complete in-depth interview. In this way, the individuality of each woman who participated in the interviews was portrayed and the occasion recalled. Aspects stood out for me because of their prominence within the conversation with the mother and the importance attached to such revelations or disclosures by her; for example the new mother who mentioned her concern several times of not having her observations undertaken at regular intervals whilst on the postnatal ward. Each separate interview had a thread which appeared to be sustained throughout the conversation. These accounts could possibly be explained within the context of my inside(r) knowledge as a midwife, and needed to be understood and interpreted from the woman's perspective.

Halford and Leonard (2003) examined space and place within nursing, using non-participant observations and in-depth interviews with nurses. They described how in combining the two sets of data, they were aware that the observations reflected their own voices but following the interview data the voices of the nurses were generated. The observational data had generated an understanding of the postnatal ward as a setting in which women received care in the early postnatal period, but the voices of the women brought out a different dimension. In this sense, the interview data greatly added to the observational data, as this was the women's account of their care on the postnatal ward. However, although the observational data had generated a rich description of the ward and the interactions between care-givers and the women, the analysis of that data reflected what had been observed by me but, possibly unlike Halford and Leonard (2003), not necessarily my voice as the challenge had been to look for the unfamiliar.

Each woman told her 'story', and as these narratives unfolded with the identification of categories in the data, the significance of the 'story' to her, conveyed her experience on the ward. Savage (2000) described the dual analysis of a small section of data using both thematic and narrative analyses and how this assisted in uncovering a second meaning of the data. She advised that both methods require structure in the way the data are analysed. Although the data from the current study were analysed through looking for themes within the data, as described above, in examining the data from the in-depth interviews, the threads identified appeared to offer each woman's narrative of her perspective of her care. Whilst accepting each woman's 'story', it is acknowledged that the woman's narrative was not identical to the experience itself; the task was to seek to represent that experience in presenting the themes generated from the woman's account (Eisner 1991). A copy of a transcript is included (see Appendix 12).

Significant choices of words and words used frequently by the women were noted. For example, one new mother referred to the midwives on the postnatal ward as '*they*' but her team midwife as '*my own midwife*'; this mother transferred home after her first night in hospital as she felt that she would receive more support at home.

3.7 Trustworthiness of the research process.

Koch (1994) argued that the rigour or trustworthiness of a study can be established if the reader is able to assess the events, the influences and the actions of the investigator. In the section above I have attempted to describe the process of the study in some detail; explaining and justifying what was done and why. I have also attempted to reveal my professional or personal assumptions which I may have brought to the study. Knowing who the researcher is would appear central, as the researcher's background may influence how data are interpreted and described (Eisner 1991). In common with Koch, I acknowledge that I will almost certainly have brought my thoughts or assumptions with me in carrying out this study and I continued to document my thoughts and possible prejudices in my reflective journal throughout the study. However, in observing the midwives carrying out maternal, and to a lesser degree, infant examinations, processes which I was arguably familiar with, I was not prepared for the significance of these examinations to the midwives. Similarly, I have

previously discussed the construction of an observation schedule, essentially as a result of what I, and other colleagues, thought I would be observing and how I subsequently decided against its use in order to open up my horizon for what was observed.

It is hoped that in describing the research process above and including a transcript (see Appendix 12), that I have demonstrated the credibility of the study. I have attempted to demonstrate the trail of methodological and analytical decisions during the two phases of the study, and as such, aspects and issues discussed are part of the audit trail of my study (Robson 1993, Koch 1994).

As advised by Robson (1993) the use of evidence from different sources (triangulation), such as situational conversations with participants and examination of documents which guided the practice of midwives, were used to aid this process; similarly, the use of my supervisors to read the interview transcripts. Furthermore, in triangulation the two data sets (observations and interviews) were examined for similarities and convergence of themes (Mays & Pope 2000). Mays and Pope (2000) suggested that triangulation contributes to the 'comprehensiveness' of the data.

Transferability relates to the generalisability of the findings from the study to another research setting (Robson 1993) and it is recognised that the findings from the current study are not directly transferable to another setting but, as discussed by Slevin and Sines (1999/2000), the findings themselves may be relevant and applicable to other sites, here other maternity units. The aspect of transferability was also aided by a systematic approach to the study.

The importance of reflecting on what was observed within the ward environment and disclosed by the women was vital, as well as realising how my presence within the research setting or in the home of the woman may have influenced the data collection; Hammersley and Atkinson (1995) referred to the possibility that the researcher's presence may shape the data. Appleton (1995), in examining the role of health visitors in working with vulnerable families used in-depth interviewing. She detailed how she addressed the issue of interviewer bias by maintaining a neutral stance through avoiding presenting her own perceptions as a health visitor. Although I never

concealed my identity as a midwife I nevertheless strove not to offer my opinion or perception as a midwife. On a few occasion women asked questions which related to their experience or care; I would always answer such questions.

3.8 Moving from the method to the findings.

Reflecting on and comparing the data from the two phases of the study, suggested a theme of women and midwives within the organisational environment in which ‘care’ is provided. Women sought to have their concerns heard and acknowledged, whilst midwives strove to offer ‘care’ while adhering to organisational constraints. The midwife conveyed her own need for control by actively managing the woman, who appeared unable to exercise control in an either upward or downward direction. The aim of the study was to seek to understand the women’s experiences and perspectives of care on the postnatal ward; as such I have continually sought to portray the concerns and the views of the women. In essence, I wished to place the women central to and within my findings and, therefore, sought to describe the findings from the women’s perspective. However, the influence of the organisation dictated not only the order in which ‘care’ was given and how that ‘care’ was prioritised within the ward environment but, ultimately, the order of the presentation of the data. The women were the passive recipients of contact by the care-givers. Although the time that the women spent on the postnatal ward was brief, their time there was nevertheless important to them. I hope that the title of the thesis – *‘Passing through but needing to be heard’* reflects their desire to have their individual needs acknowledged and met whilst on the postnatal ward.

In the next chapter I will describe the organisation and its impact on both care-givers and the women within that environment.

[For quotations, a bracketed number represents observational data and for the interview data I have used pseudonyms. Words emphasised by the women are in **bold.**]

CHAPTER 4: THE ORGANISATION AND ITS INFLUENCE ON BOTH CARE-GIVERS AND WOMEN.

In the previous chapter I referred to the process of conducting the study and methodological issues in relation to the data collection during the two phases of the study. The combined data analysis generated three main themes:

- the organisation and its influence on both care-givers and women,
- task-initiated care
- women wanting to have care needs acknowledged and receiving support on the postnatal ward

This section of the thesis will describe, in some detail, the influence of the organisation on women and midwives.

4.1 Description of the unit.

In order to provide a context to the findings, a description of the hospital and the ward where the study was undertaken is offered.

The study took place within a maternity unit in a hospital trust in the south of England. At the time of the study, there were approximately 3700 births annually. Core midwives were responsible for providing care solely within the hospital environment and therefore had no prior knowledge of each individual woman before her admission to hospital. Team midwives delivered care in the community and offered intrapartum care to the majority of women who were part of the team caseload, in order to offer continuity of care and carer (DoH 1993). However, the team midwives did not routinely provide care on the postnatal ward; this was provided by core midwives within the maternity unit. Traditional community midwifery was provided by a small group of midwives; they were not expected to provide any care in hospital. On transferring home the new mother and her infant would continue to receive care from her team or community midwife. However, whilst in hospital the woman might be cared for by a midwife whom she had not previously met. Health care assistants were part of the complement of staff for the labour ward area and the postnatal ward.

The postnatal ward consisted of five bays with six beds in each bay and six single rooms, (see Figure 4.1). One of the five bays was allocated to women whose infants were in the neonatal unit, another bay served as the post-operative observation area for women following an operative delivery. These women were moved to another bay within 12-24 hours, once they had been assisted out of bed and would then be regarded as 'up and about'. The desk area where midwives and other staff completed the paper work and other administrative tasks was situated at one end of the ward, near the post-operative bay. The telephone would be answered by the ward clerk, during weekdays and 'office hours' only, and the rest of the time by the midwives or the health care assistants. There was no cover for the ward clerk during weekends. The community clerks were responsible for ensuring that the administrative aspects were completed at the time of the woman's transfer home and would ensure that the team or community midwife was aware of the woman's transfer home. The community clerks' office was situated off the main ward but they moved freely on the ward and in the bays and therefore interacted with the women.

In the hospital concerned, at the time of the study, women who had given birth to their first baby, including those who had had an instrumental birth, were expected to remain in hospital for two to three days postnatally. Women who had given birth to their second or subsequent infant were expected to transfer home within 24-48 hours although a small number of these women elected to transfer home within a few hours of the birth of the baby. Following a caesarean section women would remain in hospital for between three and four days, irrespective of parity.

Midwives were the main care-givers on the postnatal ward. The ward sister was appointed to both the antenatal and postnatal areas but when on duty would work within one area only. When she was allocated to the antenatal ward, the postnatal ward would be co-ordinated by one of the midwives rostered to it. The selection of this co-ordinator varied between shifts and hence there was no continuity in the co-ordination or management of the ward.

The midwives on the postnatal ward were assisted by health care assistants who assisted women within the post-operative bay with personal hygiene and often provided support with infant care and feeding throughout the postnatal ward.

Midwives rotated to the antenatal, intrapartum and postnatal areas, for set periods. The allocation to the postnatal ward was the longest, comprising four weeks; the midwives generally described the period on the postnatal ward as too long (when compared with the other clinical areas). In addition to permanent night staff, midwives on day duty were expected to rotate to night duty at regular intervals in order to ensure an adequate number of staff on night duty. Health care assistants were either employed for day or for night duty.

Three shifts were worked over the twenty four hours; the administration of day and night staff differed. A larger number of midwives, on average four to five midwives, were rostered to the ward for an early shift, reduced down to three or four midwives for the afternoon shift and reduced further still for the night shift. Normally, one or two health care assistants were rostered for each shift, with the aim also of two health care assistants for night duty. Cleaning of the ward was undertaken by the housekeepers during the morning; the housekeepers were also responsible for serving hot drinks and meals at set times. Housekeepers therefore moved amongst the entire ward while on duty. Student midwives were also allocated to the ward and would either work with their mentor or independently. Although, as referred to above, the maternity unit provided team midwifery with an expectation that the same midwife would provide care, if possible, for the woman during the labour and birth of her baby, there was no expectation that she would provide care within the postnatal ward. Hence, loss of continuity resulted, with the new mother meeting midwives with whom she had not previously interacted. At the time of the study period the maternity unit had enjoyed a full complement of staff for a number of years; there were no midwifery vacancies. The midwife is referred to as 'she' throughout this document as there were no male midwives practising within the unit at that time.

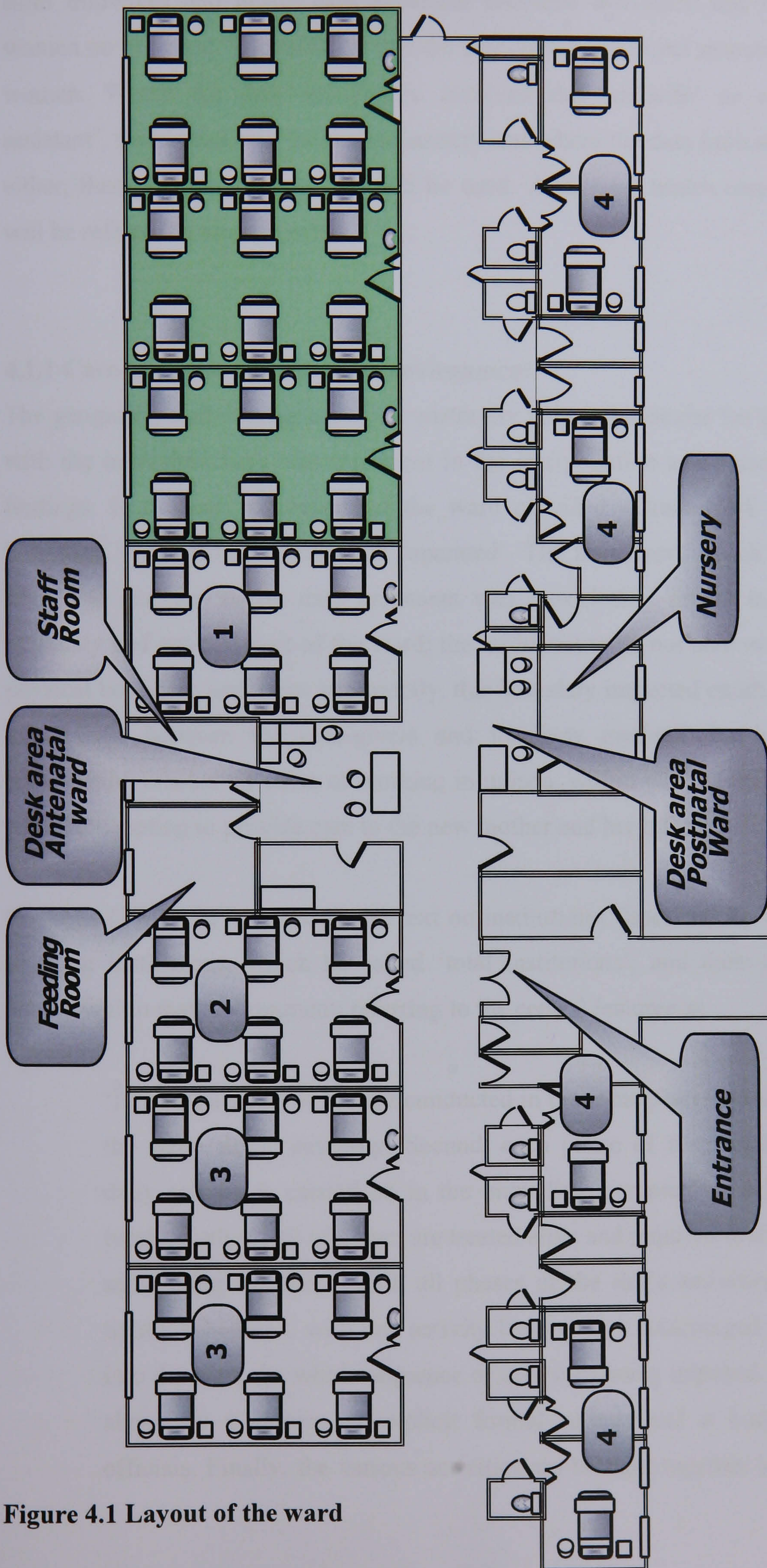


Figure 4.1 Layout of the ward

Key:	
Area of Observation	3 Antenatal Bay
1 Post Operative Bay	4 Single Rooms ante/postnatal
2 Mothers with babies in SCBU	

Both midwives and health care assistants provided assistance and support to the women on the ward. The midwife was the care-giver with direct responsibility for the women. Where the data specifically involved the ‘midwife’ or a ‘health care assistant’, these titles will be used separately and where the data indicate inclusion of either, then the term ‘care-giver’ will be used. Additional health care professionals will be referred to as appropriate.

4.1.1 Care-givers within the ward environment.

The geography and description of the maternity unit, in particular the postnatal ward with the individual bays was important in the interpretation and presentation of the findings. In a sense, the layout of the ward provided a framework or a physical boundary, within which care-givers ‘operated’. The framework which supported the midwives and the health care assistants was inextricably linked to the physical boundary and environment of the ward; the midwives were not able to influence this physical boundary and, most importantly, this boundary impacted on all aspects of the interactions between the care-givers and the new mothers. In this sense, the organisation created an ethos of working in unison, within which care-givers existed whilst attempting to provide care to the new mother and her infant.

Goffman (1961), in his now classic text on institutions, described the characteristics of those institutions, which he called ‘total institutions’, and their impact on the people within that environment; referring to the central features as:

‘First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member’s daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various activities are brought together into a

single rational plan purportedly designed to fulfil the official aims of the institution.’ (page 17)

The need for a ‘rational plan’ to assist the midwife in achieving the aims and expectations of the organisation within the postnatal ward was evident. The actions of the midwives had a purpose commensurate with the ethos of the organisation, including the interactions between the midwives and the women. I will demonstrate below that the strong unity created by the organisation, ostensibly for the purpose of delivering care to the new mother and her baby, rendered the women ‘invisible’ and passive simultaneously, and emphasised their temporary and lesser status within the ward environment and organisational needs.

It is acknowledged that Goffman (1961) in offering his analytical perspectives on institutions referred primarily to psychiatric institutions. However, he detailed several groups of total institutions, such as establishments for the protection of people or organisations offering sanctuary or retreat, under this heading. He does advise that the grouping is not definitive or exhaustive, describing some institutions as more ‘benign’ and less total (page 279) as these establishments are less prescriptive. I would argue, based on the data, and in particular the observational data, that the postnatal hospital ward, as a place for offering assistance, albeit temporarily, to the new mother fits within the definition of ‘total institutions’ submitted by Goffman. This does not imply that the maternity unit resembled a psychiatric institution, but rather that some of the key characteristics of ‘total institution’, as described above, are applicable and relevant to the maternity unit and are helpful in the interpretation of the data.

4.2 Complying with the organisation.

The observational data demonstrated the impact of the organisational setting on the interaction between care-givers and the women. The high priority afforded to the ‘work’ which the midwives were expected to undertake, as dictated by the organisation, and how this work was actively managed, emerged from the observational phase of the study. The ‘work’ defined the midwives’ contact with the women and activities which they were expected to undertake. A picture of how the whole ward ‘functioned’ over the twenty four hour period emerged, which

demonstrated that each shift had its own identity with different activities and responsibilities undertaken by the staff within the ward environment. This included midwives as the prime care-givers, health care assistants and, peripherally, administrative staff, such as the ward clerk or community clerks, and housekeepers.

4.2.1 Organising the ‘work’.

The observational data identified the need and desire of the organisation for the ‘work’ to be organised; this provided an orderly and systematic structure for the tasks ahead. Allocation, by the co-ordinator for each shift, of each midwife to a group of women was maintained during the early and late shifts; no allocation was observed during the night shift. The midwives identified during informal conversations that the aim of allocating midwives to a designated group of women was to provide individualised care and continuity of carer. The ‘workload’ was anticipated, taking the type of birth, the woman’s parity and the level of assistance she was expected to require with infant feeding into consideration, as well as the layout of the ward; for example, a midwife was not expected to care for women at opposite ends of the ward. This assessment was based on the information provided at the time of the handover report between shifts and also on knowledge from previous shifts; a more detailed discussion on the handover report is given in Chapter 5. In this sense, although the co-ordinator and the midwives themselves had regard for the needs of individual women, the anticipated volume of activities was nevertheless afforded priority and, hence, the assessment was managed by the midwife and not the woman. In essence, an attempt was made to balance the number of ‘women’ with the anticipated ‘work’ and ‘paper work’. This is illustrated by one co-ordinator who was describing the allocation she undertook on a late shift on a Saturday:

‘ ... I have allocated one midwife to A bay, six women, two have since gone home, and side rooms 1, 2 and 3. Side room 3 is op. day section with diarrhoea. The second midwife is in B bay, one blood transfusion, two women with chest pain and side room 4. I have taken C bay with four women and D bay, one first day section and one op. day section and side rooms 5 and 6.’

The field note for this conversation reads - The fourth midwife had been sent to labour ward to help out. The co-ordinator went on to explain that during the week she would have given herself 'less women' as the ward would be more busy and she would expect 'more paper work'. During this observation there were 21 women and 20 babies on the ward, with one infant receiving care in the neonatal unit. The ward appeared quiet with a low level of activities or interaction by the staff with the women. (17)

The midwife's use of language is interesting; the allocation was described in purely functional terminology and thus commensurate with the ethos of managing and structuring the tasks required to be carried out. The women were defined and identified through the number allocated to their bed space, rendering them an object with loss of personality. The quietness experienced on the ward during this observation episode on a late shift may have related to the emphasis, demonstrated by the midwives, on undertaking maternal and infant daily physical examinations during the early shift, which created a sense of a busy ward environment during that time: this is discussed in more detail later. In this sense, these busy periods corresponded to the organisation of activities within the ward environment and not directly to the needs of the women themselves.

4.2.2 Aligning with the organisation.

The postnatal ward provided the setting, or framework, within which care was offered, as part of the maternity services. The definition of an 'organisation' is somewhat complex, possibly depending on the context within which the organisation is referred to (Handy 1993). It may comprise a collection of people forming a productive community (Handy 1993), as demonstrated above with the midwives working collaboratively, but separately, within the ward during their shift on duty. Equally, the organisation can be taken to mean the context – here the postnatal ward - within which care is provided (James 1992). Arguably, a lack of clarity in the definition of the organisation impacted on the care received by the woman and/or on the care-giver providing the care.

Although the midwives were identifying with the organisation, they were providing care as midwives once out onto the ward itself. This possibly indicated the care-givers' attempt or need to satisfy the demands of the organisation as well as offering availability to the new mother. In essence, midwives as the main care-givers, were expected to operate and move fluidly and seamlessly between the needs of the ward in its entirety and the bay of women with individual needs and requirements and their responsibility to the women allocated to them.

The observational data indicated that midwives rarely entered a bay allocated to another midwife; each bay was regarded as the province of the midwife allocated to it – *'my bay'* and removed the obligation for another midwife to assist within that bay except in an emergency. This may have resulted from the importance attached to carrying out daily physical examinations in the morning and how this was managed by the midwife through the allocation. However, during the night shift there was no allocation of individual midwives to ward areas or individual women, the bays were shared between all the care-givers as illustrated by the following vignette where the midwives were progressing the work collectively:

'It is 22.00 hours, two midwives emerge into the corridor having just received the report, they both collect sphygmomanometers. One of the midwives is brisk and efficient in her manner – 'Which end shall we start?'. They both disperse out onto the ward, while a third midwife unlocks the drug trolley, ready to undertake the drug round. After twenty minutes the two midwives check with each other – 'How far have you got?'. The two health care assistants are topping up water jugs and switching the night lights on.'(17)

As the number of midwives rostered to the ward for the night shift was less than at other times, allocation of bays was possibly less feasible, but essentially the expectation was that the daily examinations ('the checks') would have been completed and therefore not part of the workload for that shift. The literature review had indicated that women wished to be able to rest and recuperate during their stay on the postnatal ward but this aspect was not referred to by the midwives in their discussion on undertaking 'the checks'.

4.2.3 Maintaining functionality.

Routine maternal and infant physical examinations were not perceived to be the responsibility of the midwife on night duty. In this sense, midwives and other care-givers appeared to perform a 'holding operation' at night until the morning, when the routine cycle of maternal and infant examinations would be repeated. Instead the staff on night duty conveyed an emphasis on getting through familiar tasks, such as the drug round, topping up of water jugs, measuring of infants' blood sugar and recording of maternal temperature or blood pressure as necessary. A sense of urgency was displayed, with care-givers wanting to complete tasks so that the main ward lights could be switched off in order for the women to rest and sleep. The tasks would be divided between the midwives and the health care assistants, each taking responsibility for specific tasks:

'The health care assistant, on arriving for the night duty shift, explained what is expected from her at the beginning of the shift – 'water jugs, bells, lights, bottles for women who are artificially feeding' (16)

The midwife described a different priority – 'I'll whiz round with the drugs'. (16)

Here, none of these care-givers referred to anything that required offering assistance to the women, although the observational data demonstrated that midwives would offer assistance whilst undertaking the drug round; organisational functionality was maintained as a priority. In undertaking the drug round, the midwife was providing contact with individual women, however, the emphasis as determined by the organisation, was clearly on the drug round, thus making any assistance offered incidental as opposed to focused to the needs of each individual woman. Arguably, the drug trolley itself acted as a physical barrier and indicated the busyness of the midwife but, equally, the midwife had a professional duty in the safe administration of medication (NMC 2004). This may have presented a conflict to the midwife who would not be available at that time to offer assistance to the women if required. Health care assistants were observed to respond to requests from the woman for assistance with feeding until the midwives had completed their immediate duties and would take over if required.

In allocating a large number of midwives to the postnatal ward for the morning, reducing down for the afternoon shift and further still to one or possibly two midwives for the night duty, the organisation impacted on the health care professionals and dictated their movements within the ward environment. The rostering of night staff was managed separately by the night shift co-ordinator. The staff allocated to day duty were attached to the ward for several weeks in order to provide continuity of care and carer, whilst the staff for night duty were allocated from the labour ward at the beginning of each night shift. This reinforced the expectation that midwives on night duty would not be asked to undertake routine maternal and infant daily examinations, identified as 'care', instead predominantly monitoring the ward until the arrival of staff in the morning when the 'routine' and 'rhythm' would commence all over again. The absence of prescribed 'tasks' would have provided an opportunity for the care-givers to respond to the women differently at night; this will be discussed in Chapter 5.

The description offered above of the rhythm of the postnatal ward is consistent with a 'steady state' where all activities are programmed and routine; this is likened to the production component of the organisation (Handy 1993:201). Within the activity of a 'steady state', rules and procedures existed and the observational data illustrated the standardisation of work processes through the allocation of 'the work' which ensured that everyone within the organisation did what they were supposed to do. This was referred to by Handy (1993) as the integration of the individual with the ethos of the organisation; the organisation's ethos of the 'task culture' (this is discussed further in the next paragraph) ensured uniformity, efficiency and continued smooth operation and efficiency.

The standardisation of the work, such as the allocation of a midwife to a group of women, ensured that the people within the organisation did what they were expected to do (Handy 1993, Ford & Walsh 1994). As a result, an efficient method of running the ward was achieved and could be likened to the efficient production sought within an organisation where the end result is the manufacture of goods and services. This relies on all activities being programmed and routine in order to comply with the functional needs of the organisation (Handy 1993). Handy (1993) described how the 'task culture' expects conformity through encouraging the individual to identify with

the objectives of the organisation in order to improve the efficiency and throughput. He referred to how within the 'task culture' the individual has a high degree of autonomy over the tasks or the work. However, the findings from my study indicated that midwives within the ward environment were not able to directly exercise control over their work, even though, midwives appeared to control their work indirectly through 'role culture'. In the 'role culture', the job or role description is more important than the individual (Handy 1993). The midwives did seek to exercise a degree of control over their work through their interaction with and availability to the women. This will be discussed in the next chapter.

Back in the early 1970s, O'Driscoll (1972) described the cost analysis of the introduction of active management of labour which reduced the cost of 'the unit of production' to £4.72, from £12, for each baby born. Although the aim was to reduce the length of labour for the women, it is interesting to reflect on O'Driscoll's use of the production terminology, use of similar terminology describing efficiency was evident in my study.

4.2.4 Compartmentalisation of tasks.

The midwives in the observation phase of my study did not refer to providing care to the women and their infants, instead vocalising the production component of:

*'the work', 'the checks', 'the discharges', 'the workload',
'the paper work', 'the letters', 'I have women to do', 'this end' (of
the ward), 'op. day section'*

This terminology was observed to be used amongst colleagues and also when talking with the women themselves. Task culture fulfils the requirement of the orientation towards jobs or tasks being undertaken, as it is efficient and entirely job or project focused thus allowing for prescriptive objectives to be met – 'getting the job done' and was thus valued by the organisation (Stockwell 1972, Handy 1993, Ford & Walsh 1994, Kirkham 2000, Woodward 2000). The data indicated that the midwives were socialised into the dominant culture of the organisation. They conveyed an acceptance and understanding of the allocation of responsibilities for a group of new mothers

within their shift on duty. A sense of urgency was always felt and demonstrated on early shifts:

'I try to do at least one [check] before breakfast because you never know what might happen I'm also doing C [bay] so I'm moving between the two.' (6)

'It's now eleven o'clock and I've not done any of the checks.'
The midwife was clearly anxious that she would not be able to complete expected tasks before the end of her shift. (8)

Through allocation the midwives strove to achieve continuity of care and carer during the early and late shifts on duty. Essentially, the allocation was an efficient method of mapping the work for each period which thus ensured consistency with the organisation's ethos. Continuity has different interpretations depending on the ultimate aim, whether it is the collective work for the staff on duty or aiming to interact with the women within the ward environment. Allocation therefore appeared to have two functions; a primary function of convenience allowing for the work to be carried out and, secondly, for the purpose of offering continuity of care and individual care. The observational data indicated that midwives were allocated to 'C bay', and **not** to named women within each individual bay. During informal conversations midwives indicated that they would, on occasions, request to be allocated to a different bay on consecutive shifts on duty, describing how they needed a 'change' or because they experienced emotional difficulties in providing care for an individual woman within that bay. In contrast to the midwives, health care assistants were not allocated to bays but were expected to work across the whole ward and would therefore interact with any woman who wanted their assistance.

Goffman (1961:18) described the need to organise people into blocks and how this was vital to the institution. In essence, the bays constituted blocks or units which were required to be managed to ensure the smooth running of the organisation. Within these units the midwife was required to separate out the individual woman and respond to her particular needs and those of her infant. Arguably, the lack of allocation for the night shift negated the need for offering continuity to the women,

but nevertheless served the organisation as functionality and operational processing were maintained.

The midwives who participated in Woodward's (2000) study indicated that they did not formally or collectively evaluate the needs of the individual woman; a deeper understanding of care was therefore not explored by the midwives. This led Woodward (2000) to refer to the dichotomy between formal and informal theory, where in informal theory midwives relied on the known and familiar aspects of practice. She concluded that the midwives, in contrast to the nurses, did not use formal theory to inform their care. The impact of the organisation on midwives in formalising theory for their practice must be acknowledged. This is illustrated by the findings of my study, for instance, in the use of language by midwives which was depersonalised and commensurate with efficiency and moving tasks forward.

Davies et al., (2000), examined the culture of the organisation within the NHS, in relation to quality. They described how the culture of an organisation implied the concept of shared beliefs, values and norms between colleagues which enabled the people within the organisation to make sense of each situation as it occurred. The acceptance of the normality of the situation by the people within that organisational culture ensured uniform practice.

4.2.5 Dealing with unpredictability.

Whilst midwives appreciated and understood the necessity for the labour ward to be adequately staffed at all times, they nevertheless expressed resentment at having to send a midwife from the postnatal ward to help out. Helping out on the labour ward was a regular occurrence, particularly at night. The decision for the movement of staff was often made by the co-ordinator for the labour ward and thus removed the autonomy of the co-ordinator within the postnatal ward. The postnatal ward co-ordinator on day duty described the disruption to the ward, the midwives and ultimately the women of having to send a colleague to the labour ward, often at short notice. Although the transfer of staff to the labour ward area was observed on one occasion only, the observational data did not support a change in or disruption to the ward routine with the movement of staff away from the postnatal area.

Women were not generally aware of unpredictability in the activities on the ward and reference was made in Chapter 3 to an obstetric emergency which involved all the care-givers. Concurrent with the obstetric emergency, another mother rang the bell to voice her concern about her baby bringing up mucous; she repeatedly requested, and received assistance throughout the morning. However, the midwife expressed uncertainty as to why the mother continued to seek assistance; the midwife felt that she had '*reassured*' the mother that '*the baby is fine*'. Here, the midwife had dealt with an obstetric emergency, but arguably the mother's concern for the well-being of her daughter would have been very real to her as a new mother. The mother commented that '*nobody has been to see me*' (06); she would not have been aware of the emergency which had impacted on the midwife's commitments during the morning.

Some of the women who participated in the in-depth interviews referred to the midwives being 'busy' and described a lack of staff. The Audit Commission (1997) reported that staffing levels on the postnatal ward were unpredictable, with midwives acting as additional resource for the labour ward, possibly leading to a compromise in the quality of care in the area where staff were drawn from. Singh and Newburn (2000) found that one third of the women who participated in their study, reported inadequate levels of midwives on the postnatal ward. The observational data suggested that the organisation of the ward and the level of provision of care to the women and their infants remained constant irrespective of the number of midwives available.

Woodward (2000) made a reference in her study to a higher staffing ratio within the palliative care setting and unpredictable activity within the maternity setting, which may have impacted on her findings. The findings from the current study suggested a degree of uncertainty as the midwives described not knowing '*what might happen*'; transfer of women in from the labour ward could happen at any time and this would increase the workload for the midwife and the throughput of women. This uncertainty prompted midwives to commence the daily checks as early as possible, thus allowing for a possible change in the work which they might be expected to undertake whilst on duty. Such a change was not within the control of the midwife but rather imposed

by the organisation. Essentially, the midwives were obliged to plan and manage for the possibility of the unpredictable at any time.

The provision of postnatal care is often referred to as the 'Cinderella' service of the maternity services (Drife 1997, Wray 2006) and it is interesting to note that transfer of staff from the labour ward during quiet periods, to the postnatal ward area was not observed.

4.2.6 Midwives reflecting on working on the postnatal ward.

In informal conversations with the midwives, aspects of providing care within the postnatal ward were explored in order to understand further what was being observed. Midwives who were based in the hospital perceived that working in the community was '*easier*' in relation to postnatal care because midwives in the community were able to be '*with one woman only*' (9). They reflected that '*three years ago it wasn't this busy*' adding that '*there is little support for what is expected of the midwife*' (8) describing how they were expected to undertake an ever increasing number of tasks. The midwives were referring to a belief that the organisation, and in particular the managers, were not able or willing to understand a possible conflict experienced by the midwives.

In contrast, midwives who were based in the community described having '*escaped from the postnatal ward*'. One midwife was adamant about '*not going back*' to the postnatal ward, detailing a lack of autonomy and the conflict she experienced by having to divide herself between '*too many women*' simultaneously. Reference was made earlier to the policy of encouraging team midwives to offer intrapartum care, however, there was no expectation that they would provide care to women known to them, within the postnatal ward. A small number of team midwives were observed on the postnatal ward during the observational phase of the study, congregating by the desk area with the core midwives. However, although they were occasionally observed to seek out women whom they knew in order to say '*hello*', sometimes leaving a note on the woman's bed in her absence, they were never observed to undertake routine maternal and infant examinations. It therefore appeared that team midwives did not wish to provide care on the postnatal ward.

A sense of resignation was described by the midwives; no reference was made to challenging the organisation and consequently the organisation retained control over the cultural dimensions of the ward (Davies et al., 2000). In the absence of self-determination the midwife may actively seek to remove herself from the conflict by 'opting out' as described by the midwives who were working in the community. Theoretically, the midwives working on the postnatal ward were able to grasp the opportunity to be with '*one woman only*' in undertaking the daily examinations of the mother and her infant; however, the organisational milieu made this difficult, this is enlarged upon in a later section.

Observational data from the current study identified a newly qualified midwife who confided that her mentor regarded her as being '*too slow*' when undertaking the maternal and infant checks; this midwife experienced conflict as she wanted to be able to '*give time to each individual mother, I thought that's what it's all about*'. The dissatisfaction experienced by junior midwives in not being able to practise in the 'with woman' ideal has been highlighted by Hunter (2002).

Hunter (2002) further described how the community midwives participating in her study, regarded the postnatal period as 'undisputed midwifery territory' (page 175) as there was no medical intervention or input unless requested by the midwives. The observational phase of my study demonstrated the lack of doctors within the postnatal ward environment. They would only attend the woman at the midwife's request, although, paediatricians were observed to undertake the one-off formal examination of the new-born infant. This examination aimed to assess the general well-being of the infant in detail and differed from the daily physical check undertaken by the midwife. Despite the observed absence of doctors within the ward environment, the midwives were still not able to control the structure of the interaction with the women. Ford and Walsh (1994) have offered a discussion on the acceptance by nurses of the medical profession and their influence within the ward and on the tasks carried out by nurses. As the midwives were not subjected to this influence by the medical profession, the data from my study, in common with Woodward's (2000) findings, indicated that midwives when left to their own devices adopted a theoretical framework which concentrated on undertaking the tasks required of them, thus aligning themselves with the organisation.

However, not all midwives appeared to experience conflict in caring for the women and their infants within the postnatal ward environment. One midwife proudly detailed *'I come to give value'* and how within a busy shift on duty she had been allocated *'thirteen patients ... I got them all processed'* (09). Another midwife described the antenatal ward as more demanding as *'on the postnatal ward you can see the women and get rid of them, send them home'*. This last comment certainly appeared harsh but must be viewed in the context of the organisational requirements imposed on the midwife. Similarly, the midwife who referred to having *'processed'* the women was, in essence, working within the organisational demands made of her as a practitioner, rather than a professional framework, and evidently felt comfortable within this organisational framework and hierarchy. Although clearly the ethos or culture of the organisation impacted on the midwives, for some midwives this offered a structure of practice with which they were comfortable as demonstrated by the midwife who valued the *'processing'* of the work possibly equating efficiency with *'good'* care. However, for some women this processing was important, Pauline described how the midwives *'were efficient, yeah, I got my forms on time'*.

4.2.7 Organisational issues and their impact on women.

In contrast to the observational data, the interview data did not (directly) convey a sense of the organisation impacting on the care provided to the women. The majority of the women did not voice an understanding or a concept of how the ward *'operated'*. Vicky offered the following comment:

' ... I can't understand if anybody wants to complain unless they had a real problem or an issue but like I said, my stay in hospital was fine ... yeah, cleanliness, from staff to everything, you know (pause) from start to finish, you know, everything went smoothly ... like the checks and everything was done like they have to ... '

Although a sense of *'busyness'* was conveyed, the majority of the women described their acceptance and understanding of this:

' ... I didn't feel like I had to rush home or anything and I thought it would be very much in one end and out the other, you know, (laughing) a bit like a production line because they were very busy and that but it wasn't like that at all, I was quite comfortable really and I felt quite welcome there ... ' (Helen, first baby)

' ... it's quite good how they manage to get round all the women and how quick in and out they are and remember who's been seen to and who's not (pause) the mothers were in and out of hospital, how they can actually remember who's been seen to and who has been given what information, it must be you know ... the ward I was in was cleared out and people were starting to come back in again, you know within twenty four hours ... ' (Vicky, fourth baby)

It is possible that women may not immediately wish to voice any concerns which would imply criticism of the care-givers. Pontin and Webb (1995), in assessing patient satisfaction, interviewed 40 patients in hospital on wards with differing specialities, about their experiences and the care that they were receiving. They described disclosure by the participants along a continuum where 'early termination' represented an unwillingness to elaborate further and when critical of their care the patients 'wrapped up' their concerns, thus avoiding directly criticising the nurses responsible for delivering that care. Pontin and Webb (1995) speculated that this indicated that the patients did not wish to criticise the nurses as care-givers; it should be noted that the interviews were carried out within the ward environment, which may possibly have made full disclosure by the patients less likely. However, a similar phenomenon had previously been described by Hall and Dornan (1988) who undertook a meta-analysis of quantitative studies on satisfaction with medical care. They reported the reluctance of patients to directly or overtly criticise those providing care. Vicky, above, alluded to the impact on her of the general busyness on the ward, whilst taking care not to imply open criticism of the midwives as care-givers.

The difficulties in assessing satisfaction with care have been highlighted (van Teijlingen et al., 2003). They surveyed 1659 women in Scotland who had given birth during a ten day period; a total of 1137 women responded (response rate of 69%)

completing a questionnaire. Broadly, the women described themselves to be satisfied with their care, irrespective of parity, and a preference for different care was not expressed. The authors concluded that satisfaction surveys are of limited use, as patients express a preference for what they know over aspects of care over of which they have had no previous experience. The women who participated in my study were not able to articulate any specific expectations, not knowing what to expect or what is available may well impact on the satisfaction reported.

However, in contrast to Vicky, Claire felt that the busy ward had impacted on her care:

' ... they told me it was a busy week because there are so many patients (sic) there so ... sometimes they, they had not time (voice raised) and like the end of their shift ... they cannot, they cannot stop for everybody ... '

' ... sometimes, especially in the morning ... maybe because they are so busy and there are so many emergencies coming or lack of money or too many patients ... they will start off and there are so many, you know, patients to be attended. That is what I observed and they told me all (voice raised) 'sorry, because we are lack of staff, that's why we sometimes ...' ... they are so slow in attending then sometimes when you ring the bell (pause) it's very understandable ... because we are all many ... ' (Claire, second baby, English not her first language, words in bold emphasised by Claire)

She concluded her thoughts with the following:

' ... I understand that they are busy, they are only human (laughing) ... that's why they cannot accommodate all the patients... '

Although Clare was describing how the busy ward impacted on her care, she was nevertheless guarded in her comments; her acceptance of a ‘standard package of care’ was thus implied.

A feeling of being caught up in the routine of the ward and, ultimately the organisation, despite the allocation of midwives to provide continuity of care and/or carer, was described by some women as the following vignette illustrates:

‘ ... I mean the only thing I found a bit irritating was the constant change in midwives, which is understandable because of the shift but it just seemed that each one that came in ... nobody knew what you’d been through or what had been done so far, it just seemed a bit like ‘here we go again’, having to say ‘well, this is what happened, I came in here ...’ and it seemed to be just constantly repeating (daughter crying, unsettled) about it all and that was a bit, a bit annoying but erm That was the only thing I found difficult and that, but it just felt like you were a new patient again when you had been there for twelve hours ... ’ (Helen, first baby)

Clearly, it is not possible to provide continuity of carer within a maternity service, throughout the twenty four hours. It was evident that Helen found it difficult having to repeat information to a new care-giver and possibly she expected each care-giver to be familiar with her individual needs and circumstances. The handover at the beginning of each shift provided the midwives and the health care assistants with information about each individual woman on the ward; this will be discussed in Chapter 5.

4.2.8 Midwives working within different levels.

The data suggested the impact of the organisation on midwives. The midwife was expected to conform to the cultural norms of the organisation as a whole, but equally she also had to operate in the ward environment as a practitioner. At ward level care was provided by individual midwives who aimed to deliver care and assistance which was sensitive and relevant to the needs of each individual woman. However, as has

been demonstrated by the data, this could possibly be described as a superficial description and in the table below I am offering a description of four levels which appear relevant to the findings:

Table 4.1 Four levels of operation within the postnatal ward

Four levels of operation within the postnatal ward, in descending order.

Maternity setting	Operational aspects
Organisation - represented by the ward	Key facet of organisation - throughput Midwives to execute main targets
Multiple bays	Divided into production units or blocks
Bay with women	Individual block with women
Each individual woman and her infant	Smallest operational unit

(Adapted from Goffman 1961, Handy 1993)

The organisation constituted the uppermost level of operation and midwives were then expected to adhere to the ethos of the organisation within which they practiced. The ward itself was subdivided into bays representing units to be managed, to which midwives were allocated. At the third level, each individual bay comprised six separate areas, corresponding to the women's bed area allocated to them during their stay on the ward. The women occupied the lowest level, and it was within this level that midwives as care-givers were expected to interact with the women. Thus a hierarchical structure was created within which the lowest level was unable to impact on the higher and overarching level(s).

Goffman (1961:18) described the distinction between the 'large managed group', referred to by him as 'inmates', and the smaller group of 'supervisory staff'. Here, the larger group represented the women 'inmates' who were placed within the ward environment, albeit temporarily, and the 'supervisory staff' are represented by the care-givers who were placed on the ward for operational purposes.

Halford and Leonard (2003) examined the meaning of hospital spaces and how these were used in the construction of nursing workplace identities. The data were collected through non-participant observation and in-depth interviews with doctors and nurses within two hospitals; a district general hospital and a cottage hospital. They described how overall the doctors had more access to the whole hospital, in contrast to the nurses who were less able to command space and were subjected to organisational 'confinement' and how this then impacted on the nurses and their construction of workplace identities. Furthermore, this spatial confinement led the nurses to construct a 'territoriality' (page 204) of spaces where nurses were able to have a personal interaction and engagement with their patients. The data from my study have demonstrated how the midwives were confined within the ward environment. In order to achieve their own spatial identity, the midwives created their personal territory within each individual bay. However, as referred to by Halford and Leonard (2003), this space or territory only belonged to them whilst on duty and, as such, midwives had to construct a new and different workplace identity at the beginning of each shift on duty. The need to create such an identity was evident and, in essence, as the midwife assumed ownership of the bay during her time on the ward during the day she created this identity for herself. The lack of allocation of bays to the midwives on night duty has been referred to above. As the ward 'functioned' differently during the night, it is possible that whilst on night duty, midwives constructed a personal identity with the ward as one 'territory'. There would appear to be little knowledge and understanding of how midwives view spaces in hospital, particularly within the ward environment, and their connection with the same; anecdotally the ward 'belongs' to the postnatal ward sister and is regarded as 'her ward'.

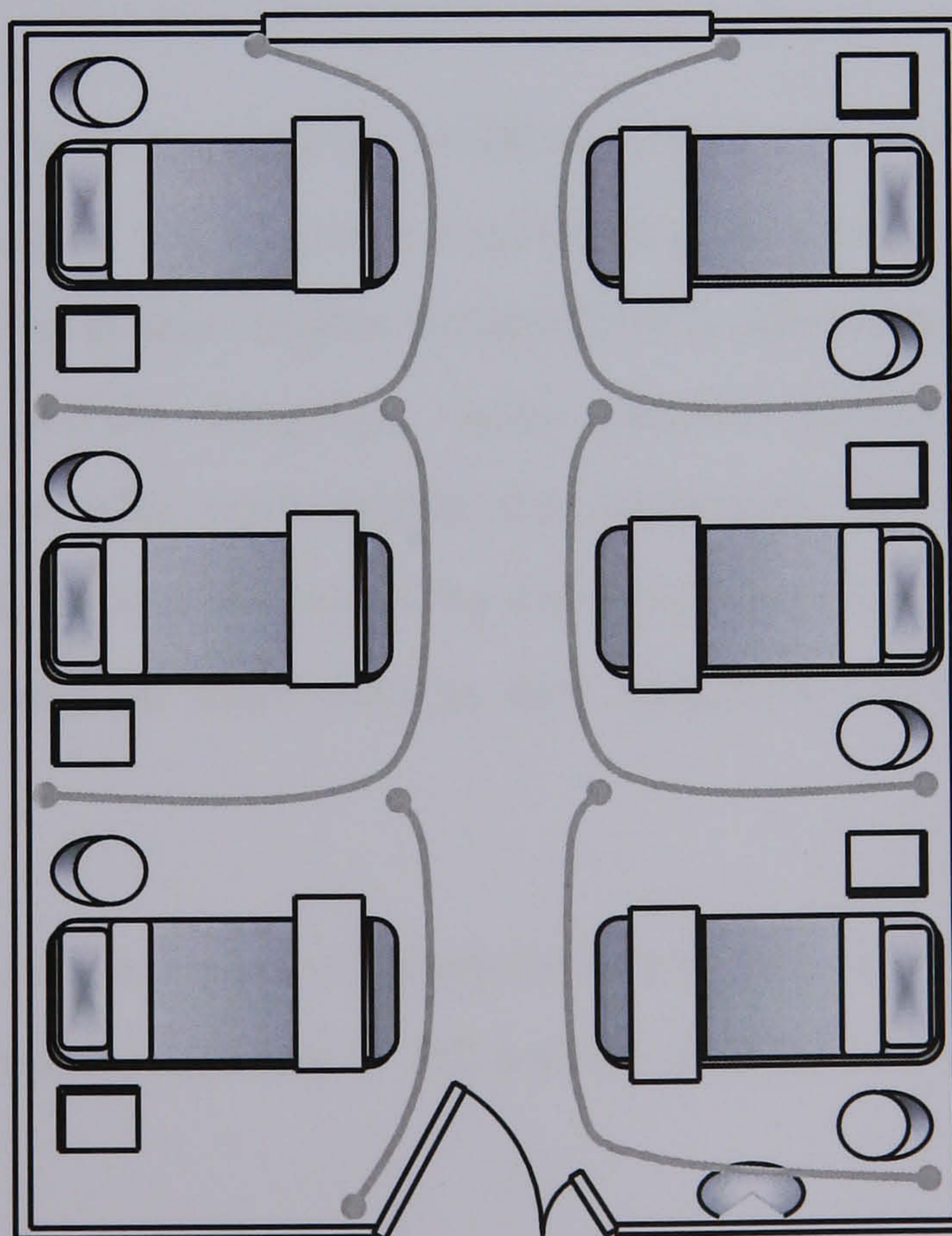
An historical review of research into the dynamic between nursing, space and place, referred to as 'geography of nursing' was undertaken by Andrews (2003) tracing the theoretical roots of geography from Aristotle to current times. Andrews (2003)

demonstrated that the movement of the main place of provision of health care to the community has changed the conceptualisation of place and space within nursing, as have the changes in the responsibilities and roles of nurses. Hunter (2002) detailed how community midwives, when in the clinical environment of an antenatal clinic at the GP surgery, abandoned the 'with woman' ideology, reverting to an allegiance with the institution and controlling the interaction with the woman. Halford and Leonard (2003) concluded that nurses were both subject to the space controlled by the organisation, but equally they were also agents of power within the organisational space. Similarly, midwives were subject to the operational setting as defined by the organisation but they controlled their local space, that of the bay. The women in the bay did not control it.

4.3. Loss of identity; becoming a number and conforming.

The new mother arriving on the postnatal ward after the birth of her baby was allocated to a bed space as illustrated in the figure below:

Figure 4.2 Layout of bay



This area consisted of the bed, a locker, a bed side table and armchair with a high back. Each bed space had a television suspended above the bed. The bed space was further defined by the bed curtains. There was a window at one end of the bay with a door out to the main corridor at the other end. Near the door was a hand basin and waste bins for the use of the women in the bay. There were normally a number of spare chairs in the bay for visitors.

The organisation was at liberty to define the personal space available to the woman by allocating her a bed for the duration of her stay, this defined her immediate environment. Women were rarely observed to move out of their bed space. Administrative purposes on the ward required each bed to be coded; the woman was thus identified with that code and was referred to in a terminology consistent with the language of production:

'As C4 is still busy, we'll do you'

'C6 wants to go home today'

'B5 wants some analgesia'

'the woman in A2'

It was evident that the midwives and the health care assistants were comfortable with this terminology, the use of the language emphasising the components of production was referred to earlier on in this chapter. Handy (1993) referred to how organisations fostered their own private language, with phrases having a meaning and understanding for those who work within the institution. The naturalness of the terminology to care-givers was illustrated by the following short interaction between two health care assistants on night duty as they sought to establish and undertake outstanding tasks:

'First health care assistant – 'which ones have you done?'

Second health care assistant – 'B2 and B5, just B3 and B4 to do.'

(16)

The women, as real people, in this bay were invisible, referred to as a number and not by name. The efficiency displayed by the health care assistants, may also be viewed

in relation to the findings by Halford and Leonard (2003) who described the movement of staff within the ward environment in 'spatial patterns', snatching conversations for the purpose of checking progress, thus confirming busyness and activity, whilst on the move.

4.3.1 Defining the woman's physical space.

The layout of the ward was obviously familiar to the care-givers within that environment, but clearly not to the women, although the data from the in-depth interviews indicated that some women had been on the tour of the unit in the antenatal period and would thus have been shown round the postnatal ward with a group of other women and their partners. The observational data suggested that women were rarely or only poorly orientated to the ward on their arrival following the birth of the baby; the labour ward was located in a different part of the hospital. This was reinforced by the interview data:

' ... when you were in the hospital they say to you 'do you know where to go to the feeding room?', well they mentioned it on the tour but I couldn't tell you where it was. I didn't even know where the toilet was when I was in there because I couldn't remember, we'd been whizzed round so quickly (referring to the tour) ...'
(Lizzie, first baby)

' ... they put me in a side room (pause) erm ... it was just that they sort of put you in there and forgot about you. They didn't show me the toilet as well, so by the time I needed the toilet, I went out and was sort of wandering round and someone then, one of the midwives came up to me and sort of 'do you need any help?' and showed me to the toilet, you know ...' (Denise, first baby)

It appeared that by not orientating the women to the ward, basic physical care or comfort was not provided. A lack of knowledge of the geography of the ward produced a sense of disorientation in the women, as is illustrated by the following vignette from the observational phase of the study:

This new mother had been on the ward for three days, the health care assistant had taken her baby to the nursery for a bath while the midwife carried out the maternal physical examination check. The woman was clearly anxious to find her baby and once the midwife had left she asked me as the observer – ‘Where is the nursery? I don’t know where the nursery is’. I answered her question. (1)

McGuire (2001) examined the introduction of woman-centred care in the community in the postnatal period. The women participating in focus groups in her study described feeling bewildered and disorientated through not being familiar with the layout of the postnatal ward, Wray (2002) described similar findings. This raises the issue of the need for care-givers to orientate the new mother to the ward on her arrival. That this should happen was in fact laid down in the guidelines for the unit where the current study was undertaken; it is acknowledged that during the observational phase transfer of women in from the labour ward was not observed.

Lock and Gibb (2003) in a study in Australia using phenomenology sought to understand women’s experience of early discharge home from hospital, prompted by an increase in the number of mothers who opted for early transfer home. Five women, of differing parity, participated in their study through what the researchers referred to as ‘extended conversations’, these conversations took place just prior to and after the birth and at about six weeks postnatally. They identified four main constructs, of which one was ‘spatiality’ with subsections of ‘physical environment, control, confidence, safety, time, talk and the heart of the matter’. In essence, the hospital was regarded as a foreign and unfamiliar place which rendered the women powerless. In contrast home, as a place, offered safety and comfort. The authors described how the institutional setting compromised the mother’s ability for self-caring, but also, importantly, that care-givers were equally affected by the social milieu of the hospital and must therefore recognise the impact of this environment on their interactions with the women. The limitations of their study must be acknowledged, such as the small sample, but its strength was that the women’s own experiences were sought.

4.3.2 Remaining within the defined space.

The interview data added to the understanding of women's views of the ward environment and the bed space they were allocated to during their stay, as Rose illustrated:

' ... it's still a bit like that in hospital sometimes, you're a spare part, aren't you, because you are restricted, you know (pause)'

Interviewer - 'can you explain what you mean by 'a spare part'?'

' ... well, at home I can just wander around (voice rising) and I can make myself a cup of tea (pause) and I think you sit at hospital and you are restricted, because you've got a bed and a chair, or your little nursery to go and feed your child, I never saw a television room or lounge (voice trailing) I never saw anything ...'

She went on to explain that: *' ... you could have a communal place, if the nursery was less formal, you know if it was a bit more relaxed ...'*

Interviewer - 'what would make it a bit more relaxed?'

' well, I only went in there once (the nursery), something a bit more cosy I would have thought, the room ... it was just a room with chairs and bright lights, you know, if you're in hospital and you've got to be in there for a while then it would be quite nice to have something like a comfy chair, I think ...' (Rose, second baby)

Vicky offered the following:

' ... [name of another local hospital] had one as well, they had tea and coffee, a place where you could actually sit, they got you up for breakfast, you went to a separate room, it wasn't far away from your children (sic) but I know [name of hospital where study took place] run things differently, they have big bay wards, they could have somewhere there (pause) so you could go and have a cup of coffee and then you could, that would get you talking to people as well. I mean it may be health and hygiene issues with toast and

bread sort of sitting around but it was just somewhere were you could actually go and sit for five minutes ... maybe talk to some of the other mums if you weren't sure and you got to talk to other women ... ' (Vicky, fourth baby)

The reference to how hospitals 'run things' allowed an insight into how women viewed or understood the ward environment.

In contrast to the two mothers above, Helen offered a different view. She had been allocated a bed within the antenatal ward area, as the postnatal ward area was fully occupied on her arrival. She described feeling comfortable and at ease within her bed space:

' ... I'd sort of made a little home for myself there (laughing), you know, in my quiet little corner, which was just me and my baby and that so ... my little place ... ' (Helen, first baby)

It would appear then that for Helen the bed area itself provided her with a place of security and comfort. She described how later when a bed became available on the postnatal ward itself and she was offered the possibility of moving, she elected to remain within '*my little place*'. Clearly, women have different needs as individuals. Helen felt that she exercised a degree of control over her physical space.

It is necessary to reflect that there were few data from either of the two phases of the study, to suggest that the individual mother was able to influence her own immediate environment within the postnatal ward. The framework created through the constraints of the organisation, furthermore created spatial boundaries which separated the care-givers and the new mothers from each other. Women were not observed to approach the desk area or the staff room, unless they required assistance for themselves or their baby. Generally, women were not expected to need to approach these 'official areas'; they were regarded as areas from which women were excluded and thus their presence there was not encouraged. Conversely, care-givers assumed that they had a right to approach and enter the woman's own bed space. In a sense, this added to the women's invisibility and passive status on the ward. Lock and

Gibb (2003:135) referred to the private aspect of personal bed space at home and how the allocation of a bed on arriving on the ward removed the woman's control of her 'physical world'.

The majority of the women appeared to conform to these assumed rules. The observational data suggested that women remained predominantly by their bedside within the bay area during their stay on the ward, only leaving the bay to attend to personal hygiene, to say good bye to their visitors or to use the feeding room. Women were not observed to move any of the furniture within their allocated bed space but were observed to use the bed curtains, and this will be discussed fully in Chapter 8. The feeding room could be used by women to feed their baby, this included breast or artificial feeding, or to express breast milk. Use of the feeding room was dependent on the woman being informed about its existence, as described by Lizzie above. One mother explained that another woman in the bay had told her about the availability of the feeding room; she had changed her baby's nappy in the toilet the previous night in order not to disturb the other mothers in the bay. There was also a nursery available for the women to use, although use of this by mothers was not observed. This might have related to the location of the nursery at the desk area, away from the bays. The nursery was also used by the care-givers for the handover at report time during which time it became the care-givers' territory (Halford & Leonard 2003), which would further have restricted the women's access.

The women were not encouraged or expected to leave the ward; it was assumed that they would remain within the ward area. Midwives referred to the postnatal ward not providing an 'hotel service' and they did not regard that the women should have the ability to 'come and go', although women whose babies were cared for on SCBU, were exempt from this rule. Arguably, the women's movements on the ward were restricted by the absence of communal areas specifically for the women; there was a small sitting room off the main ward and one mother was observed to see her visitors here during non-visiting time. The midwife said that she had 'allowed' the mother to go to the sitting room; again the midwife's language described the apparent mind set of the staff on the ward which here impacted on the women's movements. Midwives constructed actions and beliefs commensurate with their working environment,

findings which were also demonstrated by Halford and Leonard (2003) and Lock and Gibb (2003).

On entering into the maternity unit and, consequently, the hospital environment, the woman was required to relinquish her individuality, she was moulded into the sick role or helpless role, denied her dignity and thus became dependent on the care-givers (Hunt & Symonds 1995, Williams 1997). In this current study the ward environment and its layout offered a functionality which primarily benefited the care-giver rather than the new mother who was actively socialised into the routine and social culture of the ward. A failure to orientate the women to the ward layout, also served to define and restrict the woman's physical environment and ensured that she was available for the midwife to provide routine clinical care, as deemed necessary by the organisation. The lack of orientation to the ward did not appear deliberate however, rather an oversight. It is not possible to deduce why the women were not orientated to the ward environment, other than that it might have interrupted the flow of the midwife's work or tasks and was of low priority in that this was a familiar place to them.

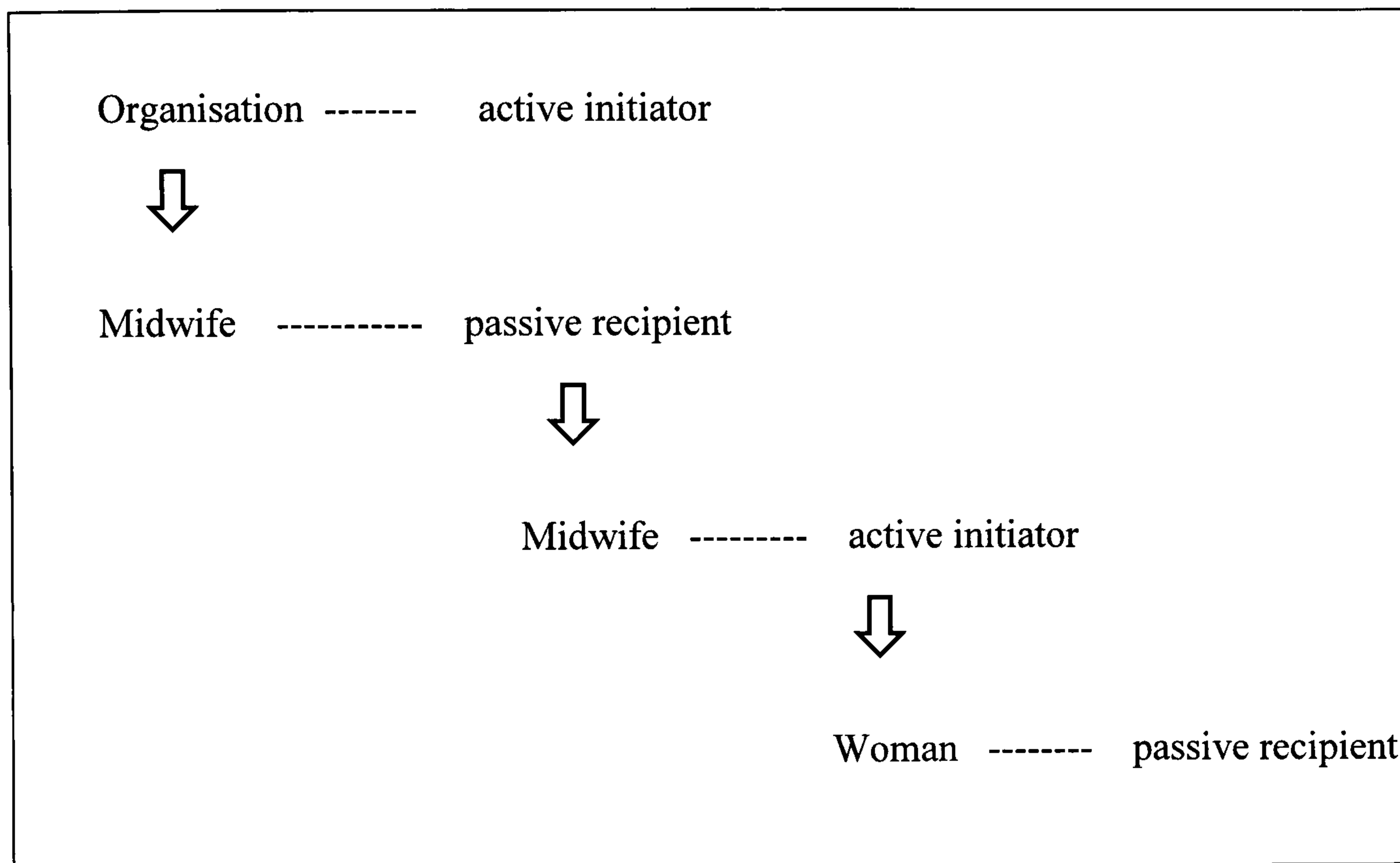
4.3.3 Moving away from the designated area.

The majority of the women were observed not to leave their bed area, possibly because of the lack of communal areas, as referred to by Rose above. However, one mother, after having fed her baby by her bedside, then left for the feeding room, explaining that she '*wanted somewhere different*' (11). One woman was observed to leave the bay for long periods with her baby in the cot, watching television by an empty bed in the bay, talking to another mother in the nursery, returning to her bedside late in the evening once the night shift had commenced. The first mother had given birth to her first baby and the second mother to her second son. These women, observed during separate episodes of observation, appeared united but unusual in their ability to move outside of their designated bay; the majority of the women remained within their bed space.

4.4 Placing midwives and the new mother within the organisation.

Activities by midwives closely matched the expectations of the organisation. The discussion above has also demonstrated the low status of the woman. The relationship between the organisation, the midwife as the care-giver and the woman herself is represented in the figure below:

Figure 4.3 Relationship between the organisation, the midwife and the woman.



The midwife, as demonstrated by the data, appeared not to challenge her role of passive recipient of organisational demands, instead converting this role to active initiation in the interaction with the new mother who was thus assigned the role of passive recipient obliged to receive the standard package of care. Midwives and women coexisted within the organisation and the culture on the postnatal ward, where the woman was managed for the purpose of fitting in with the needs of the organisation.

Kirkham (1989) referred to how the medical influence and institutional milieu within the consultant setting which rendered the midwives powerless to respond to each individual woman's needs. It is interesting that the data from my study revealed that, despite the lack of medical influence on the ward, the women were nevertheless

'passive work objects' (Kirkham 1989:131), clearly the ethos of the organisation alone was sufficient to achieve this.

Walby and Greenwell (1994) examined the relationship between doctors and nurses in relation to changing working practices and professional boundaries; they were interested in the collaboration between nurses and doctors on acute hospital wards. They interviewed a total of 127 doctors and 135 nurses in five hospitals across the UK. One aspect of their research focused on the relevance of 'Fordist' and 'post-Fordist' ideas of management (page 6); these concepts are based on Henry Ford and the automated production line in order to be able to use less skilled workers, therefore reducing the wage bill and the production cost. In 'Fordism', the management controls the workforce for the purpose of improving the throughput of the finished product. In contrast, 'post-Fordism' affords the worker a degree of autonomy who is thus encouraged to exercise flexibility and skill in their working practices. It is interesting that Walby and Greenwell (1994) on the very first page of their book, refer to the responsibility of health professionals in producing 'the product' as part of the work required to be undertaken within the ward area; my data reflect this statement. They lamented that health professionals, although generally regarded as autonomous practitioners, nevertheless, required to be managed and that in the process of being managed they might lose their autonomy. In undertaking the study, Walby and Greenwell wished to examine if the two groups of nurses and doctors had been able to move from a 'Fordism' to a 'post-Fordism' approach.

Based on their findings, they were able to describe a changing relationship between the two professions, possibly influenced by changes in the education of nurses and the extended role of nurses as practitioners. However, doctors still sought to exercise influence over the nursing profession and in particular the responsibilities of nurses, whereas nurses themselves attempted to resist a medical extension of their role. In their study nurses described not wanting to undertake the giving of intravenous medication, describing how this would take them away from caring for the patients and how they felt that the ward was not always adequately staffed to allow for the nurses to provide this aspect of care. The nurses emphasised the importance of technical care and knowing exactly what needed to be done.

Walby and Greenwell (1994) described how, over a period of time, the medical profession had lost control over the immediate ward environment and how this was now managed by a ward manager, although the medical staff were able to retain control over the patients. Their findings indicated both cooperation and conflict, however while the doctors sought to control the clinical activities of the nurses so as to protect their professional agenda, the nurses attempted to resist an extension of medical control over their responsibilities. The authors suggested that although nurses had advanced their own professional standing, an emphasis on rules and routines is limiting autonomy within the nursing profession whilst the medical profession had been able to move towards 'post-Fordism' more readily than the nursing profession. The tight control by the management of the nursing staff had further limited the nursing profession's ability to move towards 'post-Fordism'. Walby and Greenwell (1994), in common with Ford and Walsh (1994), argued that the low standing of female professions, such as nursing, is a legacy which must be viewed in its historical context. More specifically, Walby and Greenwell (1994) concluded that the nursing profession is not a fully developed profession as others control their work, that nurses practise within a rule-bound hierarchy and have limited control over their interaction with patients as these are considered to 'belong' to the consultant.

Rapport (2004), an anthropologist, immersed himself in a voluntary capacity, in the life of a porter at a large district hospital, describing the 'coercive nature' (page 104) of the hospital as an institution and an hierarchical structure with the doctors at the top of that structure. He further commented on the distance between the top of the hierarchy and the bottom, and how the porters were regarded as insignificant. However, in constructing their own existence within the hierarchy and their relationship with the doctors the porters were able to demonstrate that both groups in their day-to-day activities were affected by the institution, thus achieving some commonality.

The impact of the organisation was evident in my study too. However, as medical practitioners were not observed to directly deliver care or interact with the women on the ward (although paediatricians were observed to undertake the examination of the newborn infant) the influence of medical practitioners is not immediately understood. In this sense, the postnatal ward could be regarded as the 'territory' of the midwives

(Kirkham 1989) which should enable and empower midwives to act autonomously and independently of the medical profession in order to deliver care focused on the needs of the women. Essentially, midwives appeared powerless to grasp fully the concept of autonomous practice in delivering care in relationship with each individual woman. The allocation of midwives to a group of women at the beginning of the shift, as demonstrated by the observational data, appeared to have presented an opportunity for consideration of the needs of individual women. However, with the emphasis on structure and allocating the perceived workload rather than considering the needs of each individual woman, the midwives prioritised the routinisation and production component of care (Handy 1993).

Kirkham and Stapleton (2000) carried out in-depth interviews concerning the support needs of midwives as part of a larger study on the supervision of midwives. A total of 168 midwives were interviewed, the majority of whom practised within the NHS. The findings identified a diverse need for support by the midwives. The midwives explained how the culture of the NHS appeared not to value the caring work undertaken by them and how this lack of value on caring prevented them from receiving support for themselves; as a result the midwives felt powerless. A worrying finding from their study was the identification of midwives who described a lack of trust in their managers, supervisors and their colleagues. The authors concluded that the powerlessness experienced by the midwives inhibited them from developing and advancing midwifery practice.

It would appear then that midwives were socialised into the ethos of the organisation or the institutional milieu within which they provided care. Ford and Walsh (1994) have written extensively about this process and the effect of rituals on the nursing profession, with attitudes and beliefs handed down to junior staff. They offered several reasons for ritualistic nursing: training/ education, gender (most nurses are female), a reluctance to consider findings from research studies, as a coping mechanism for stress and, finally, attitudes and beliefs. With relevance to stress, they recounted how nurses adhered to ritualistic practice as a coping strategy, often undertaking unnecessary tasks, in order to manage and feel in control of their work. It must be remembered that whereas nurses care for ill patients, midwives care for women who are generally well, but it is acknowledged that some women will have

different needs because of an operative birth or because they are unwell following the birth of their baby. It is possible that the midwives' current working pattern, as dictated by the organisation, contributed to any stress which they might have experienced.

Colliere (1986) described how with the training of women by male obstetricians at the end of the 1700s, the women (midwives) were taught to emphasise the pathological aspects of pregnancy and, hence, lost their ability to respond to the expectant mother within her own environment. She argued that from then on, midwives became institutionalised care-givers and over a period of time, this led to midwives and nurses becoming 'invisible'. Reverby (1987) similarly charted the historical perspectives of nursing and caring as a 'woman's duty', as they were often passed down as a female apprenticeship from mother to daughter. As training for nurses was formalised, Reverby argued that the duty of care by the nurse became synonymous with following doctors' orders and that the nursing profession had yet to recover from this loss of autonomy and the hierarchical structure.

An understanding of the midwife within the context of the organisation may be found using the work of Lipsky (1980). Lipsky observed workers within public organisations in order to understand how an organisation impacted on the individual worker or, more importantly, how the individual experienced their position within the organisation. He argued that individuals, whom he referred to as 'street-level bureaucrats', assumed the ethos of the organisation within which they operated. He further argued that the concentration on the organisation itself, rather than the individual, had led to a lack of understanding of that individual's position; I would argue that my data have demonstrated a lack of knowledge of the midwife's place within the organisation. Lipsky (1980) described how over a period of time 'street-level bureaucrats' perfected their techniques for interfacing with their clients, and in so doing lowered their expectations of themselves and, ultimately, their clients. Furthermore, 'street-level bureaucrats' were encouraged to deal with the public en masse and were actively discouraged from interaction on an individual basis, instead proactively managing any interactions with clients. This was evident from my data, which demonstrated the needs of midwives to manage and control their interaction with the new mother.

With reference to the data from the current study, care-givers were expected by the organisation, and the postnatal ward manager, to respond to individual women but in reality they were required to develop techniques to respond to a group of women. These clients (new mothers) would have been regarded by Lipsky (1980) as non-voluntary as the services which they sought (care in hospital following the birth of their baby) could not generally be obtained elsewhere.

The findings illustrated that this social process within the ward environment contributed to the delivery of a standard package of care regardless of individual needs or preferences. This process was understood by the midwife to constitute compliance with the expectations of the organisation and the setting but was also considered by her to provide care to the new mother and her infant. Equally, the milieu in which the mothers were cared for, encouraged them to conform to a predetermined behaviour.

4.5 Conclusion.

In this chapter I have discussed the organisation and how organisational demands created a framework for practice within which care-givers operated. The expected 'workload' was assessed at the beginning of each shift and bays were allocated to individual midwives, for the purpose of delivering continuity of care and carer during the predetermined period of time of each individual shift. Midwives identified primarily with the bays rather than the women within them and as a result were not able to reflect on their practice but adhered to the ethos of the organisation of progressing and processing the work and by implication the women themselves. Different levels of operations were created with midwives responding functionally within each level; essentially the woman constituted the lowest and least important operational unit. The midwife's need to identify with each bay as her territory was evident and could be seen as a method of managing the tasks expected of her. The women were largely constrained to remain within the recognised and official area of their bed space, thus making it easy for the midwives to manage and control their workload efficiently by responding to the women as a group, rather than as individuals.

In the next chapter I will discuss how the operational demands impacted on the provision of 'care' to the women and their infants. Essentially, this fostered an emphasis on task-orientated care managed by the midwife as the main care-giver with the women passively receiving 'care'. A discussion on the concept of 'care' is offered in Chapter 6.

CHAPTER 5: TASK-BASED CARE.

In the previous chapter I discussed the organisation and its impact on the midwives and the women. This created a culture which influenced the interaction between midwives and women; neither midwives nor women were able to control the impact of the culture. Although Handy (1993) in his description of organisations referred to the difficulties in defining culture within an organisation, he nevertheless described how:

‘Strong pervasive cultures turn organizations into cohesive tribes with distinctly clannish feelings. ... The way of life is enshrined in rituals so that rule books and manuals are almost unnecessary; custom and tradition provide the answers.’ (page 183)

Davies et al., (2000) in discussing and tracing the roots of the concept ‘organisational culture’ within the NHS in relation to quality of health care, acknowledged the problems with defining ‘culture’ and offered the notion that ‘characteristics of that culture may be defined and assessed in terms of their functionality vis-à-vis the organisation’s goals’ (page 112). They also described how the people within the organisation share a core value and judgement of aspects within the organisation leading to ‘the way things are done around here’ (page 112). This phrase was often used by practitioners to indicate the norm as well as the possible futility perceived by them of attempting to change practice and, as will be discussed, the data from my study have indicated an apparent apathy or inability of midwives to change or challenge established or customary practice.

5.1 Midwives within the clinical area.

The postnatal ward was generally regarded as a busy clinical area and, as referred to earlier, the allocation of the workload in itself contributed to a rhythm of the ward which resulted in busy periods during the day. The women who participated in the in-depth interviews in the second phase of the study, referred to the busyness of the ward. This activity appeared to be accepted by the care-givers and the mothers alike, and not challenged and led to a task-initiated culture of providing care, as was evident

in both sets of the data. Arguably, the task-based care, based on the care-givers' need to undertake prescribed tasks, is understood and valued by practitioners as it provides a framework on which to base clinical practice (Stockwell 1972, Kirkham 1993, Ford & Walsh 1994). As will be seen, it enabled the midwives to feel that they were 'needed' and 'doing a good job', thus offering a sense of satisfaction.

5.1.1 'Passing by'.

The interaction between care-givers and the women was dependent on the midwives' need to undertake prescribed tasks. The provision of task-based care was managed by the midwife on behalf of the organisation, possibly leading to a disparity between tasks as required by the organisation and the needs of the individual woman. The data (see below) indicated that the completion of a list of tasks, and official documentation of the completion of those tasks, was perceived to legitimately relieve the midwife or care-giver of the need for further immediate contact with the women within the bay; this was possibly part of assumed practice and custom (Ford & Walsh 1994). However, Ford and Walsh (1994) in writing about nursing, argued that an adherence to rituals would not benefit the patients. Ford and Walsh (1994) as well as Kirkham and Stapleton (2000) have respectively argued that nurses and midwives need to value themselves and in this sense, rituals with tasks being completed to the satisfaction and requirement of the organisation, represented a tangible and visual aspect of work which could be used to demonstrate the worth of each individual care-giver. It also appeared to offer continuity for the midwives.

The women who participated in the in-depth interviews never referred to a constant or prolonged presence of the midwife in the bay; instead describing how they would wait for the midwife to enter the bay, often in preference to using the bell or buzzer to ask for assistance. The women further described how, when asking the midwife for assistance, she would not necessarily be able to attend at that time but would return later. The busyness of the midwives was assumed. The midwives appeared to be expected to 'come and go' within the bay; women were accepting of this and did not question the midwives' need for leaving the bay at frequent intervals. This often created a busy environment in which the women and their babies were cared for, as the following reflection describes:

'During an episode of observation during an early shift, which lasted for four hours, I became aware of the high level of activity within the bay. On examining my field notes and reflecting back on what had been observed I realised that this level of activity or busyness could be attributed to the number of health professionals and non-health professionals who entered and exited the bay during the observation; in excess of 35 entrances into the bay were recorded. This included several different midwives (core midwives and a team midwife), a student midwife, two health care assistants, two housekeepers, a community clerk, a paediatrician and another doctor, a medical student as well as other persons delivering services on behalf of the ward or organisation (a photographer, personnel providing the rental for individual televisions (suspended above each bed), another person for cleaning the televisions and a woman who provided promotional samples and leaflets to the women). The majority of these entries were of a short duration and with the apparent aim of attending an individual woman, either for the purpose of providing care or seeking information from the mother. In contrast, there was limited movement in the bay by the women themselves or their partners who remained by the bedside, only leaving their bed area to observe a show bath or attend to their own personal hygiene. During this same period of observing, two women were observed to use the buzzer to request assistance and one mother informed the midwife while she was in the bay that her infant was now awake (the midwife had previously requested to be informed of when the infant woke), for the purpose of the infant 'check'' (8)

This observation was undertaken during an early shift and care-givers were focused on the tasks ahead during their shift of duty. Essentially, this created a busy environment in which the individual mother appeared peripheral to the operation with care-givers 'passing by' ostensibly for the purpose of providing care to the women. Wray (2006), reflecting on her initial period of observation within a postnatal ward,

described the busyness created by the main doors into the ward itself being locked for security purposes, with people constantly seeking or needing access to the ward. She described how this impacted on the time available to the midwife who was required to make an assessment for the need for entry into the ward by all callers. This was applicable to the ward where my observations were carried out; clerical support was limited to 'office hours' thus leaving midwives to monitor visitors to the ward for a significant period during the day.

The literature review revealed the women's desire to rest and recuperate in hospital following the birth of the baby (Kenny et al., 1993, Brown & Lumley 1997); it is difficult to see how this could be achieved given the level of activity within a bay. However, and perhaps more importantly, the midwife responsible for care to the women in that bay was not immediately available to the women; her presence in the bay was for short periods only.

5.1.2 'Purpose of entry'.

As the midwife entered the bay it was evident that she had a specific purpose for entering. The midwife entering with equipment such as the drug trolley, sphygmomanometer, equipment for investigations or administration of medication or a linen skip, effectively conveyed to the women the task or contact required. Midwives were primarily observed to enter the bay to provide physical care and rarely for social interaction alone:

'The midwife enters the bay, she proceeds to the woman in the bed by the window (B3) and closes the bed curtains, she does not address the woman prior to drawing the curtains. She does not talk to any of the other women nor indicate her availability to them.'

(06)

Stockwell (1972), in her now classic study, using non-participant observation on four general hospital wards, was able to demonstrate the direct relationship between task-related care and contact between nurses and patients. She sought to establish whether some patients were more popular than other patients and described how the patient's

personality influenced their popularity with the nurses; from her data she concluded that the reasons given for a patient's popularity rarely related to the need for nursing care required by the patient. In the second phase of her study, Stockwell examined the interaction between the nurses and the patients; interaction was initiated by the nurse only when required to undertake some form of treatment or if the nurse needed specific information from the patient. This prompted Stockwell (1972:54) to describe 'the singleness of purpose' in the interaction between the nurses and the patients and how in the absence of a task no interaction occurred. Stockwell (1972) further documented how the patients themselves would not approach the nurses, even when visibly available in the ward area, unless they had a specific need; she attributed this to the difficulty in attracting the attention of the nurse who was engaged in the completion of tasks. Furthermore, both patients and the nurses described that merely engaging in conversation was not considered part of nursing tasks; it should be noted that the nurses themselves regarded interaction prompted by the need for undertaking a task to provide an adequate opportunity for verbal interaction with the patients. This aspect was identified in the findings from the present study which indicated that midwives would rarely enter the bay unless they were required to undertake a task or offer prescribed care.

5.2 Activities.

The observational data clearly indicated the importance placed by midwives on the daily physical examination of the mother and her baby. How this activity was managed by the midwives is discussed within this section.

5.2.1 The importance of 'doing'.

The midwife's need to be physically active and 'doing' emerged as a strong concept; midwives conveyed the act of 'doing' as part of the cultural requirement of the organisation. Ultimately, contact with the women resulted from the need for activity to undertake a task; this ethos was illustrated by the midwives in informal conversations. In the absence of a task the midwife appeared bereft of the purpose for her being on the ward:

' ... I've been into the bay, they're alright, there's only so much that you can talk to them about ... nothing to do for the women ... '
(18)

The emphasis by midwives on completing physical care to the mother and infant within the early shift appeared to imply that it was not acceptable for tasks to be undertaken on a late shift or night duty, as is illustrated by the following entry in my field work diary:

' I arrive on the ward at 18.00 hrs. Two midwives are sitting by the desk area, they are chatting to each other. We exchange 'hellos' and I then seek out the co-ordinator who is a newly qualified midwife. She explains that she has been given the 'job' of co-ordinating as it is 'quiet' on the ward. I tell her that I am wanting to carry out an episode of observation; she says that is 'fine'. There are four midwives on duty, who are now all gathered by the desk area, one of whom had worked in the bay during a previous observation. I therefore approach another midwife asking her about observing in the bay which she has been allocated to – 'No problems'. She offers the comment – 'It's quiet, you should have phoned first, there is nothing to see'. The observation concluded several hours later and provided plentiful data ... ' (18)

Midwives clearly valued the act of 'doing' and performing tasks; this was their reasons for being on the ward or coming to work; arguably the organisation had socialised the midwives into such a performance. If the ward was 'quiet' they were temporarily deprived of their purpose. Curiously, they sought to confirm with each other that there was *'nothing to do for the women'*; joint agreement would thus appear to legitimise immediate withdrawal from the bay, away from the women. Midwives were observed to withdraw from the bay(s) and the women they were responsible for; there were periods, some prolonged, during the collection of the observation data when a care-giver was not present in the bay. However, some ambivalence was also evident as 'the tasks', described as 'work', were seen to prohibit the midwives from

caring for the women and being with the women. This demonstrated the complexity in the relationship between midwives and the women.

The care-giver's withdrawal from the bay in the absence of a task to be carried out may be viewed using Goffman's (1959) description of how individuals in their work situation actively regulate and control the contact with the people they are obliged to interact with. He compared this to a dramatic (theatrical) performance. Referring to Goffman's (1959) analogy in relation to the findings presented here, with particular reference to the observational data, the midwife as 'the performer' undertook activities within a defined setting, that of the ward environment generally and the bay specifically, with the women acting as 'the audience'. Throughout 'the performance' the values and norms of the setting were acted out and thus reinforced. Having completed 'the performance' (the tasks) the performer was entitled to retreat to 'the back stage' (the desk area or staff room) where he or she might expect to be free from intrusion from the individuals who 'the performer' was required to interact with.

This theatrical performance was indeed confirmed by the observational data where care-givers, predominantly the midwives, were observed to only enter the bay to interact with the women for the purpose of fulfilling a task, hence displaying what I have called a 'purpose of entry'. Having completed the required task(s) midwives would leave the bay immediately and were generally not observed to linger, thus possibly not indicating their availability to the women for further interaction.

In the previous chapter I referred to the findings from the observational data detailing the allocation of work to each individual midwife and how it was possible for a midwife to occasionally care for women at opposite ends of the ward. This would have contributed to the midwife's need to spend time moving between different areas and ultimately between the women as the following brief extract illustrates:

'The midwife has been assisting a new mother with feeding, the baby is not attaching but the midwife is reassuring the mother that the baby is well and will probably feed later. She then leaves the bay after telling the mother – 'I'll just go and see how the woman down the road is getting on ...' (14)

Here the midwife is dividing her time between mothers in two different localities which on this occasion contributed to her need to leave the bay; however, this observation was an isolated occurrence.

The reasons for midwives leaving the bay upon completion of a task would appear complex, as ultimately by this action they seemed to distance themselves from the very women who were expectant of care and assistance. The number of midwives rostered for each shift on duty varied, with a higher number of midwives during the early shift, as this was regarded by the organisation, and consequently also by the midwives, as the 'busiest' shift over the 24 hours.

Goffman (1959) sought to explore or describe the 'idealization' (page 45) or the way in which an individual presents himself for the purpose of adhering to and fostering the values espoused by the society in which that individual is operating. In this sense, withdrawing to the 'back stage' or the staff room enabled the midwife to adhere to the collegiate ethos; Goffman (1959) referred to how a group of individuals or colleagues are 'accomplices' (page 72) in maintaining the status quo. However the observational data demonstrated that midwives would also remove themselves or withdraw to the staff area in order to protect themselves from working on the postnatal ward; this aspect will be discussed more fully in section 5.6.

5.2.2 'Doing' but absent.

Certain tasks required the midwife to be away from the women and the bay to which she had been assigned. For instance, the requirement to complete administrative tasks, such as discharge letters might involve the midwife, as the main care-giver, being removed from the women for a period of time:

' ... the midwife leaves the bay at 10.25 hrs ... it is now 11.15 hrs, and the midwife has just 'poked' her head into the bay, she is holding some notes. She does not speak to the women in the bay. She does not enter but walks away up the corridor; a health care assistant is in the bay assisting a woman, she also leaves soon afterwards. The women remain in the bay. The midwife re-enters

the bay at 12.05 hrs when she heads for the bed space of one woman by the door, she pulls the bed curtains back but does not ask permission to do this. She does not interact with the women. She then walks around the bay, asking each woman and the partners present if they are 'okay?'. The reply from the women indicates that they are 'okay'. She informs one woman that the paediatrician is on his way to see her baby. She then leaves the bay again; she has been in the bay for five minutes. At the end of the period of observation I ask the midwife about the period away from the bay, she had been completing discharge letters for the women who were wanting to go home that day.' (07)

Thus, the midwife was absent from the bay but 'doing'. Administrative tasks involved the midwife withdrawing from the bay in order to complete her responsibilities towards the organisation and the woman herself. The presence of a central desk area meant that the midwife would return to the 'centre of operations' (the desk) where she would complete the paperwork required before the mother could transfer home or undertake other administrative tasks. At the time of the observational phase of the study, this paperwork was completed manually and could therefore, arguably, have been completed in the presence of the mother by her bed: however, this was never observed, midwives always returned to the desk area. (The discharge procedure was later computerised, but as the computers were sited centrally by the desk area, the midwife was still required to leave the bay in order to complete the required documentation.) The organisation thus retained its emphasis of a central area of operation, again consistent with an efficient and smooth running of the services (Handy 1993).

Hunt and Symonds (1995) described how the midwife, following the birth of the baby, would retire to the office in order to complete the notes; during this time she was not available for any immediate interaction with the newly delivered woman or a labouring woman newly arrived on the labour ward. Thus, they argued that, the writing of notes assumed a ritual of considerable worth to the midwives and enabled the midwife to remove herself from immediate contact with women; in essence she was working and completing tasks.

5.3. Prioritising the ‘work’.

The tasks required to be undertaken by the midwives were predetermined by the organisation and this reflected on the interaction with the women. However, the midwives were afforded a degree of autonomy, albeit limited, in that interaction.

5.3.1 Maintaining organisational priorities.

Midwives demonstrated a purpose when they were in contact with the women. The data demonstrated the impact of the ‘task culture’ within the ward environment (Handy 1993:187) and the need for the midwife to comply with this culture of organisational restraints, as a result of which she was unable to exercise **direct** control over her work. In contrast to the ‘task culture’, at the clinical level the midwife was able to operate and function within the ‘role culture’; Handy (1993:185) described how within the ‘role culture’, the job or role description is more important than the individual. However, the observational data from the current study indicated that the distinction between ‘task culture’ and ‘role culture’ was not absolute. As the role or job was more important than the individual, the midwife, as an individual, sought to exercise a degree of control over her work through her interaction with the women by deciding on the order in which the women were seen, as discussed below. The organisational milieu did not allow for the midwife to be heard, instead transforming her into an efficient operator within the institutional framework for the purpose of actively managing the women, the ‘passive work object(s)’ (Kirkham 1989:131).

The culture of the organisation controlled the midwife, who in turn exerted her control within the bay to which she had been allocated. Routine components of care, such as the daily physical examination of the mother and her infant, enabled the midwife to enact her role or job description. Carrying out the daily maternal and infant physical check fulfilled the midwife’s professional responsibilities (NMC 2004) but the organisation nevertheless controlled the actual assessment of needs through prescriptive documentation (see Appendices 13 and 14) which ensured that the midwife was able to ‘tick the list’ thus ensuring efficient use of the midwife’s time.

Thus, the central priority within the day focused on the undertaking of maternal and infant examinations – ‘the checks’. These checks were almost exclusively undertaken

in the morning within the early shift, giving the midwife a purpose for her presence in the bay. The midwife actively managed (controlled) when the examination took place, with the majority of midwives anxious to complete physical care for the women before they handed over to the next shift on duty. This midwife explained her normal activities on an early shift:

'I generally go round in the morning when they are having breakfast, to see if they are alright. If they are not eating you can go through a check. I like to have most things done by half past eleven, so if they want to go home I can get drugs etc. done. You don't have to get everything done in the morning, we offer a twenty four hour service here. You can leave things for the afternoon, although that is frowned upon.'

When I asked who disapproved, the midwife replied – 'managers and colleagues'. During the observation episode and as the morning progressed, the midwife was observed to meet her personal target, 'the checks' were indeed completed within the time frame set by her. She then retreated to the desk area. It was evident that the contact with the women related entirely to the need for the midwife to complete these 'checks''. (12)

By using the word 'service' (see bold above) the midwife identified with the organisation and its purpose and provided an indication of how she viewed her role within the postnatal ward environment. Furthermore, giving a time-limit for when the 'work' should be completed provided a target for individual practitioners but, nevertheless complied with the ethos of the institution. It is also interesting to note the midwife's expectation of disapproval by colleagues and managers of 'stepping out of line', in this sense the intra-collegiate relationship impacted on the midwife and her practice, causing disharmony between clinical practitioners. Hunter (2002) in her work on emotion work in midwifery, detailed the conflict between different levels of staff, where hospital based junior midwives described problems in working with senior midwives whose ideology for practice impacted on these junior midwives and differed from that which the junior midwives had been encouraged to strive for as students. Hunter (2002) described this as an unexpected finding, describing how

previous studies had identified tension between midwives and doctors but not between midwives. In my own study, midwives did not refer to a possible conflict with the medical profession but, as described above, they conveyed a feeling of needing to manage their work in order not to be judged as non-compliant by their colleagues.

There appeared to be some data supporting the value of prioritising the ‘checks’ and maternal observations in the morning as at other times this might impact on the women’s privacy or time with their visitors; Pauline described the midwife attending to her during visiting time:

‘ ... It was just that, I don’t know, I wouldn’t have minded if they did it before or after the visiting, it wasn’t just my blood pressure and ... erm like they wanted to ask questions, you know ... they are going to ask you in front of people and you really don’t want to talk about these things at that time ... the blood pressure thing wasn’t that bad but ... I don’t know how the others feel about it but I thought it was important (voice trailing) ... it was your time with your family ... it wasn’t convenient ... ’ (Pauline, first baby, normal delivery, in hospital for five days)

Another midwife explained her pride and personal need to have the ‘work’ completed before the end of the early shift. She acknowledged the ‘24 hour service’ but explained that *‘in reality, that is not how it works out’* (07). Midwives also described a need to undertake the physical care, the ‘discharge check’, for the women transferring home first and reasoned that *‘it just makes more sense, doesn’t it’* (08); possibly an example of socialisation into the goals of the organisation (Davies et al., 2000). The midwife perceived that this was also important for the women themselves, however, in reality it was the rhythm of the ward, influenced by the culture of the organisation, which dictated that the completion of discharge letters should be managed within the early shift. Women, who participated in the in-depth interview, did not themselves refer to their need for the midwife to prioritise the order in which women within a bay were attended to. However, Rose referred to the prioritising by the midwife:

' ... there was a woman next to me and she said to me that she would like to go home, but she needed to sort out transport and the midwife said to me - 'how long will it take your husband to get here?' and I said 'twenty minutes', so I think she did me first because my husband was going to be here sooner ...' (Rose, second baby, normal birth)

By undertaking the 'discharge checks' first the midwives were essentially able to 'tick off' those women from their list of 'tasks' to be carried out. This in turn enabled the community clerk to provide the woman with her letter or paperwork required for her to transfer home. It was evident that the midwife regarded the giving of the paperwork to the mother as constituting the end of the episode of care on the postnatal ward and the midwife was thus relieved of her duty of care to the mother and her infant. This was understood by the midwife as part of the organisation of the ward, however it may not always have been understood by the mother as the following extract illustrates:

' ... erm, there's one thing that was strange when we left the hospital is that we were being discharged and we'd had all our notes and everything and everything was fine. We were given them and then we just left ... so nobody actually checked us (pause) to see that we were leaving with the right baby or ... erm that we were actually checked out or something. I think we should have seen someone before we left, we should actually have seen someone at the desk, or something like that. I don't know, nobody actually said 'oh, you need to do this before you leave'. We were literally, she'd just had a bath, we'd got all our paperwork together and we got her dressed, got me dressed, got our stuff together and then we just left ... and, it was afterwards I thought 'oh, were we supposed to tell someone that we are leaving', you know or ... were they not supposed to check ... that we've left with the right child or whatever. It just seemed a bit strange that we just upped and left, so maybe, you know, that was a bit of an oversight.

I think erm were we supposed to see someone before we left? (pause) we didn't know ... because we didn't know if we had all the right paperwork with us then because they had given us an envelope erm to take, to give to the midwife ... but I didn't know what was in the envelope ... erm your pregnancy record, your white book erm, that was in the envelope because then afterwards I was thinking 'where is that book, didn't we need to have that?' and then it was only when the midwife came the next day that we realised that the white book was actually in the envelope but ... so yeah, maybe the discharging part of it might need to be looked at a little more ... ' (Gill, first baby, emergency caesarean section)

It would appear then that the mothers were not always informed about the procedures so familiar to the midwives and that therefore, possibly, they could not make sense of what was happening. In contrast, Vicky who had given birth to her fourth child using her previous knowledge of procedures described – *'you have to sort of be passed'*.

5.3.2 The need to retain control.

Clinical practice comprises an ethos which reinforces the assumption of a shared social norm of 'we have always done it this way' (Ford & Walsh 1994, Davies et al., 2000). Davies et al., (2000) detailed how shared beliefs and attitudes ensured that the organisational culture was judged positively and was valued by the health care professionals within the culture. This allowed the midwife to determine, despite the frequent reference to *'a 24 hour service'*, when women received routine clinical care, illustrated by the midwife's emphasis on the daily examination within the early shift on duty at the convenience of the midwife:

'I prioritise the checks, but if a woman is in the bath she decides', adding ruefully 'I'm set in my ways'. The entry in my field work diary reads – She has been qualified for a few years only, what has shaped her practice?. (07)

Davies et al., (2000) argued that health professionals are influenced by the culture of the organisation within which they practise; this socialisation is both implicit and explicit. The midwife above would appear to have settled into the culture of the postnatal ward environment with its value on progressing the women through it but, equally, she also acknowledged a degree of non-reflective practice. The women appeared to have no choice in when 'the check' was carried out; having a bath does not constitute a choice as to when 'the check' will be carried out and may be viewed by the midwife as unavailability whereby she is not able to control the interaction and the workload. The need to 'move on' with the checks was evident and midwives were observed to comment on the availability of women – '*as C4 is still busy, we'll do you*' (01). In the following vignette the midwife is accompanied by a student nurse who is spending the morning on the postnatal ward:

'...we'll do [name] as she (pointing to another woman in the bay who was talking on the telephone) is on the telephone'. *Turning to the first woman the midwife asks – 'can we do your check, is that alright?', the woman nods to indicate her agreement. This midwife on entering the bay at 09.45 hours with another midwife and the student nurse, had commented to her colleague on the number of checks she was expecting to undertake that morning – 'I've got seven postnatal checks to do', her colleague replied – 'I've got to go to theatre, I've finished my checks'*'. (01).

Although this midwife asked the woman's consent for undertaking the maternal check, this was rarely observed and may have been influenced by having a student with her; an assumption of instant access to the women was conveyed. Furthermore, in commenting on the number of checks, the midwives as colleagues shared and supported each other in the 'tasks' ahead. Hunt and Symonds (1995) had previously described how midwives would get through the work as part of loyalty to colleagues. Essentially the midwife determined or prioritised the order in which the 'checks' were carried out; this was not observed to be challenged by the women nor were the women observed to indicate their desire to be 'next', thus emphasising an automated component of care and how the women submitted to their place in the queue. The interview data confirmed this apparent acceptance and submission by the women.

Although Vicky (fourth baby) appeared to commend the midwives on their ability to *'manage to get round all the women'*, she also referred to the movement of the midwife from woman to woman:

' ... when they are going from people, from check to check ... you've got your routine checks, just checking and asking ... I know they have their routines ... '

The apparent pressure that the midwives felt to progress the women through the ward (and thus towards transfer home) may have added to the difficulties for midwives in acknowledging the women as individuals. The observational data conveyed the notion that the midwives were caring for a group of women rather than individual women within the bay, illustrated by the midwife who 'popped' her head into the doorway of the bay and in addressing all of the women inquired *'Anything for pain?'* which resulted in four out of the six women in the bay requesting pain relief (04). Lipsky (1980) argued that 'street-level bureaucrats' are instructed to care for the individual, however, in reality the requirements of the work situation means that they have to deal with clients en masse; as observed with the midwives who, in effect, managed a workload of women. Lipsky (1980) further detailed how workers were constantly criticised because of their inability to provide a service which was responsive and appropriate to the needs of their clients. The observational data confirmed that the midwives did not provide such a service, instead emphasising the aspect of progressing the women through the ward.

It is interesting to note that although midwives spoke about 'tasks' and 'work', they never referred to task-based care; consequently there was no reference to the orientation of 'tasks' related to care of the women. Shortly after the observational study had been concluded, midwives and health care assistants were invited by the senior midwife on the ward, to offer ideas towards 'the smooth running of the ward'. Several midwives suggested introducing 'task-based' care as they perceived that this would aid the work of the midwives in particular. This would suggest that midwives' views or understanding of 'tasks' and 'task-based' care is an area which merits further exploration.

Olsson and Jansson (2001) explored the way midwives related to women and their partners during the antenatal and postnatal period; five couples participated in the study, each couple were seen by the same midwife during the consultations. The consultations were video-taped and the data were analysed using content analysis. The researchers identified three main patterns of relating to the women and their partner where 'the respectful gardener' involved the midwife as a listener and offering an open exchange of information. In contrast, in the category 'the propagandist teacher' the midwife was distant and discouraged participation by the couple. In the third category, that of 'the steering inspector', the midwife displayed an impersonal manner, emphasising the technical aspect of care. However, the researchers described how the midwives, irrespective of their pattern of relating to the couple, nevertheless dominated and led the interaction, appearing to manoeuvre the consultation and how the expectant parents were largely accepting of this domination. This was a small study, involving five couples and five midwives only, but a total of 58 consultations were recorded, predominantly in the antenatal period with one consultation only in the postnatal period. My data have suggested the need for midwives to lead and manage the contact with the women in order to maintain their control.

5.4 'Ticking the list'.

Informal conversation with the midwives during the observational stage revealed the importance placed by them on undertaking the daily physical examinations of the mother and her infant. The observational data further revealed the extent to which midwives led or controlled the interaction. They were heard to ask predominantly closed questions which corresponded to the documentation which they needed to complete, and the women would respond to the questions asked. A few midwives invited questions from the women at the end of the examination but generally the women did not have any.

Lock and Gibb (2003) identified the negative experience described by the women in hospital of sharing the time available from the midwife with other women on the ward. The interview data similarly indicated that the women displayed some understanding of the midwives' need to '*get round all the women*' (Vicky, fourth

baby) and this may have prohibited women from interacting with the midwife. Arguably, it was difficult for women, in the current study, to make themselves heard within the midwife's pattern of undertaking the daily examinations but also the findings indicated that the midwives were influenced by the ethos and constraints of the organisation within which they worked and consequently it was probably not surprising that they felt the need to control and manage any interaction with the women. This reinforced the aspect of 'time' belonging to the midwife who ultimately responded to the institution's ethos of time management. Lomax and Robinson (1996), using video taping, observed the interaction between the midwife and the woman in the postnatal period both in hospital and in the woman's home. They described the asymmetry which was created with the midwife initiating the communication and how this served the midwife's purpose and enabled her to retain control. Lomax and Robinson (1996) also described how 'conversational turns' were not of equal length as the midwife controlled the conversation, women were rarely observed to participate in the conversation. It is interesting to note that even when removed from the immediate effect of the organisation by being in the woman's home, the midwives maintained the asymmetrical interaction. The midwives were also able to sustain a degree of detachment. The women in their study were not observed to challenge the midwife's domination of the interaction, leading Lomax and Robinson (1996) to conclude that interaction dominated by the midwife does not allow for empowerment of the woman. Lipsky (1980:120) similarly described how street-level bureaucrats actively controlled the 'content, timing and pace' in their interactions with their clients. My study has demonstrated similar findings.

5.4.1 Official lists.

The midwives in the current study were required to complete official documentation. The women carried their own personal handheld notes throughout the childbirth experience in which health professionals documented care in the antenatal and postnatal period; intrapartum care was documented in the woman's main notes which were held by the hospital and thus not accessible to the women. The section relating to the postnatal period comprised separate tables detailing maternal and infant physical adaptation (see Appendices 13 and 14). This check list was completed daily by the midwife and signed by each midwife during her shift on duty, thus indicating

that the care deemed necessary by the organisation had been provided. It provided a signed record that the midwife had delivered care and that some interaction between the midwife and the mother had taken place. The descriptors for the assessment of maternal and/or infant adaptation in the early postnatal period were determined by the organisation. The midwife's assessment that this adaptation was within normal limits required a tick only; if a need for further care or assessment were identified by either party then the midwife would be expected to make appropriate documentation of this.

Completion of the check list took place by the woman's bedside with the bed curtains closed to ensure privacy during the examination. It was evident from the observational data that midwives regarded completing and signing the official documentation to signify the completion of an episode of care for the woman. Signing off indicated the completion of the 'check' and represented progress for the midwife, a task which could be ticked off; in essence, a unit of work had been completed. If the midwife was not able to complete the maternal 'checks' soon after starting her shift on duty, a sense of falling behind was experienced – *'It's now eleven o'clock and I've not done any checks'* (14). Midwives described how 'too much work' prevented them from progressing with the 'checks' and how the unpredictability of the workload presented them with an unsettled feeling as women were transferred from the labour ward at any time adding to the midwife's sense of a lack of control over the work to be carried out. Similar feelings were described by the midwives who participated in Woodward's (2000) study. This led Woodward to describe how midwives were therefore only able to respond to the needs of the organisation, leaving them unresponsive to the needs of the women. This may have suited the organisation who regarded the worker, here the midwives, as 'resource units to be applied to a task' (Lipsky 1980:31) and an emphasis on 'productivity' was thus maintained.

Reference is made above to the midwives' description of an automated process in their interaction with the women, such as *'the work'*, *'the checks'*, *'A3 and A5'* rather than talking about 'caring' for the women. However, when discussing 'care' or the 'provision of care', they were making a direct reference to the daily physical examination of the mother and her infant. The organisation deemed that this was the purpose for the midwife's presence on the ward and thus it contributed to the midwife feeling needed and having a role. Paradoxically the need to conduct the physical

examination removed the midwife from the immediate effect of the organisational restraint and thus removed, the midwife was free to be present by the woman's bedside. However, the institution nevertheless still impacted on the relationship between the midwife and mother, as the midwife was expected to adhere to the 'tick list'. Thus, in effect, the midwife's action remained controlled by the organisation. This encouraged the midwife to adhere to a familiar format, essentially a format which did not discriminate between routine care and the needs of each individual woman. The existence of a list does not encourage the women to make themselves heard or enable them to participate in the examination itself. Furthermore, the use of a tick list assumed a set of predetermined parameters to be met by the women; going home from the ward depended on the 'tick list' being completed to the satisfaction of the organisation. In Chapter 3, I referred to the initial use of an observation schedule in observing within a bay and how the use of this schedule prohibited genuine observation. The use of the 'tick list' could similarly be argued to represent a barrier to establishing what really matters to the woman. Rose, described her interpretation of being '*checked out*':

' ... well, when they are looking at my stitches erm ... just giving me medical attention, sitting down talking to me you know, have I done this?, have I done that? that sort of thing ... ' (Rose, second baby, normal birth)

Although Rose concluded with the comment of the midwife – '*just having time out with me*', she nevertheless detailed an interaction managed and manoeuvred by the midwife as referred to by Lomax and Robinson (1996), Olsson and Jansson (2001).

The 'routine checks' that midwives referred to consisted of daily maternal and infant physical examinations. Much has been written about the content of the physical examination of the mother and her infant (Rush et al., 1989, Ball 1994, Garcia & Marchant 1996, 1999, WHO 1998). There appears to be no consensus on whether the format or documentation for the examination should be formal, through the use of a list detailing predetermined descriptors, or informal, inviting documentation negotiated between the midwife and the mother. Gilmour and Twining (2002) discussed the process of redesigning a new 'clinical pathway' for use in the postnatal

period. The authors were concerned that postnatal care was continuing to evolve in a routine and mechanistic fashion which did not allow for individualised care, nor did it adhere to the evidence available as to effective care. A radically different 'clinical pathway' from the one currently in use within the maternity unit was proposed, however, this met with resistance by the midwifery staff and therefore a modified 'clinical pathway' was introduced. Although a written description of the eventual changes is given, an example of the 'clinical pathway' is not included, making it difficult for the reader to assess the proposed changes. However, one of them removed the necessity to record the mother's temperature daily, but the midwives regarded this as unsafe; in essence they described how recording the mother's vital signs provided them with a reason for approaching and attending to the mother. This reinforced the notion of task-initiated care and needing a 'valid' reason for seeking the mother out; namely that of providing 'care'.

Marchant and Garcia (1995) in examining which aspects midwives thought were important in the daily postnatal check, were able to describe variations in the practice of the recording of vital signs, between the midwives in the two hospitals surveyed. The results indicated that midwives were undertaking aspects of care, such as recording maternal temperature, even though they had not reported this aspect as important. Indeed, Enkin et al., (2000) detailed the routine recording of maternal observations, such as recording of maternal temperature, as an aspect of care which is unlikely to be beneficial for the new mother. It would therefore appear that midwives undertake care or observations for which they can provide no rationale if they are instructed to do so by the organisation. Routine recordings or observations are not generally based on the needs of the women themselves but respond to the expectations of the organisation; ultimately this reinforces the passive role of the new mother. It is not argued that 'tick lists' are necessarily detrimental in the provision of care to the women, merely that the lack of involvement of the woman marginalises her and the aspects which may be important to her and her new infant.

Moreover, it could be argued that using words such as 'lochia' and 'involution of the uterus', terminology familiar to the midwife but not to the new mother, prevented the mother from fully participating in her care but enabled the midwife to comply with the routine of the organisation. Arguably, the use of medical language not only

deliberately excludes but also controls the woman (Kirkham 1989, Williams 1997). Gilmour and Twining (2002) in redesigning clinical pathways advocated woman friendly language, for instance talking about 'blood loss' as opposed to 'lochia', in order to include the women in their care. Women who were interviewed in the second phase of the current study, referred to 'bleeding' and 'blood loss'; they also described that these were aspects which were of concern to them and that they needed the midwife to confirm the normality of their experience.

5.4.2 Ownership of official documentation.

The mother's handheld notes contained a separate postnatal care plan inviting the mother and the midwife to discuss the individual mother's needs in relation to caring for herself and her baby, however, this care plan was never observed to be completed by the midwife or referred to by the midwife or the woman. Engaging in an open dialogue with the woman would have meant the midwife having less control over her interaction with the mother and, ultimately, not being able to respond to the task culture (Stockwell 1972, Handy 1993) as required by the organisation. Referring to the care plan would have empowered the women to have a voice and offer their perspective of their needs. Clearly, women had a need for such a discussion, as the data from both phases of the study strongly indicated, but as the midwives appeared to regard such a discussion as an additional option to the daily routine care, any possible exchange was prohibited.

Symon et al., (2003) piloted a tool – the Mother-Generated Index (MGI), which aimed to enable mothers to self-identify areas of concerns to them in the postnatal period; the researchers were interested in assessing the quality of life for new mothers. They highlighted the strength of the tool as being that mothers were able to undertake this assessment themselves, although completed in collaboration with a health visitor, as opposed to health professionals assuming the needs of the women. However, as the questionnaire is intended to be used initially at six to eight weeks and then again at eight months after the birth of the baby, it would not allow for new mothers to indicate their concerns in the early postnatal period. NICE (2006) advised that a postnatal care plan should be developed with each woman in order to provide her and her infant with individualised care. Referring back to the lack of use of the care plan

by midwives in my study, it would appear then that care-givers are 'missing' an opportunity for dialogue with the women about aspects which matter to them in caring for themselves and their infant.

Lack of reference to the care plan by the midwives indicated that they did not perceive the care plan as part of 'the work' and it must therefore be concluded that they regarded the daily examination itself as providing women with the opportunity to have their concerns heard. Although the documentation in respect of the provision of physical care contained a heading of 'general well-being', this required a tick only and may thus not have facilitated the midwife or the mother to discuss any concerns fully. Moreover, a tick on its own does not indicate the quality of the interaction between the midwife and the mother, only that care was apparently delivered according to the standards set by the organisation, but not whether what was provided by the midwife met with the needs of the woman. This is consistent with Stockwell's (1972) findings where the completion of task-based care alone was regarded by the nurses to equate to communication between the patients and themselves.

Webb and Hope (1995) carried out structured interviews with 103 patients of mixed age and gender on surgical and medical wards, in order to discover what aspects of nursing mattered most to them. The patients reported 'listening' to patients' worries as most important, rating this aspect of nursing as more important than the nurse undertaking physical activities. They also wanted nurses who were open, friendly and sympathetic to the needs of the patients. It is often argued that women receiving care in childbirth are not 'ill'. It is therefore interesting to note that in Webb and Hope's study the patients, who could be regarded as being 'ill', nevertheless rated 'listening' over actual physical care. The findings, as described by Webb and Hope (1995), would appear to be highly relevant to the findings from my study; arguably the relationship between women and midwives is dependent on midwives being able and willing to 'listen' to the women. The need for women to be listened to was evident and this will be discussed later.

Very few women were observed to read their handheld notes while they were on the postnatal ward and would therefore not have been aware of the midwives' entry in the notes. The women had had the responsibility for carrying their own handheld notes

throughout the pregnancy and would have been able to read them at any time. Entry into the hospital, which entailed handing their notes over to the staff, had therefore changed the ownership of the notes and resulted in women appearing to perceive that they were now not able to access their own notes despite the fact that the notes were kept at the end of the bed. Pauline (first baby) who stayed in hospital for five days after the birth to be monitored for herself, described reading her handheld notes after coming home – ‘... I read, when I got home and read through ... that it (recording of blood pressure) should be every four hours ...’. She had not read her notes while in hospital nor been told the intended frequency of the observations. It would appear then that keeping the notes at the end of the bed ensured their immediate availability to the midwives but not to the women; the notes became the property of the hospital/organisation. Furthermore, the handheld notes were often removed to the desk area by the midwives, thus making them even less accessible to the mother herself and reinforcing the one-sided aspect of ownership of them. It has previously been suggested that entry into hospital alters the status of the woman transferring her to the category of ‘patient’ with the resulting loss of identity and individuality, as lamented by Williams (1997). She argued that medical jargon and a lack of information by the care-givers enabled the controlling of the woman by the organisation.

5.4.3 Alternative lists?

However, not all midwives appeared comfortable with the emphasis of ‘ticking the list’, as one midwife explained during an informal discussion. She was critical of midwives who used lists to ‘*tick off the mother, baby, medication, discharge letter etc. and then sit down by the desk. They just complete the postnatal check list and do not ask the woman how she feels*’. Although she acknowledged that this could be regarded as ‘efficient’, she expressed a personal preference for being in the bay in the morning during which time she would invite the women to talk about breastfeeding. She described how in her judgement ‘*a uterus will involute, it does not need a hand on it*’ and she therefore preferred to assist women with infant feeding as ‘*the postnatal check can wait*’. She proudly detailed how ‘*all babies have fed at least twice when I’m on*’ (06). The comments offered by this midwife are interesting; Ford and Walsh (1994) described the potential for conflict with other colleagues as a result of

'deviating' from the known and expected practice and routines. This midwife appeared at ease with her ideology of practice and did not feel the need to withdraw to the staff room or 'the back stage' (Goffman 1959), but equally she had her own agenda for what she regarded as important or expected the women to discuss during her time in the bay. The women who participated in the studies undertaken by Bondas-Salonen (1998) and Lock and Gibb (2003) identified the need for the midwife to be willing to listen and be with the mother. However, in essence, the midwife above remained faithful to the organisational culture as the women were not encouraged, nor given the opportunity, to set their own agenda for what was important to them. As a consequence the women remained marginalised and in receipt of mechanistic care.

Handy (1993) offered the notion that pervasive cultures shape organisations to apply a common (private) language which make rituals and guidelines unnecessary. Saliently, he warned that cultures are predominantly fostered by a dominant group within the organisation and consequently, over a period of time, not all cultures suit all purposes or the people working for or being cared for within the culture.

5.4.4 Working lists.

The observational data demonstrated the existence of 'unofficial' lists in addition to the official requirement to complete the standard documentation in relation to the daily physical check of the mother and her infant. Each shift commenced with a handover or report from the co-ordinator of the previous shift. During this report time the midwives and health care assistants would all gather in the nursery and make detailed notes about all of the women on the ward. The handover report would include information on observations required for the mother and/or infant, possible concerns with feeding and who would be likely to go home that day. This information would generally only be provided for the early shift, as has been seen, women were generally expected to transfer home in the morning or early afternoon. Each midwife or health care assistant would refer to her list throughout her shift on duty:

'The health care assistant is by the door leading into the bay, she is pulling the linen skip and the linen trolley of clean linen. She

comments to me on the 'chore of bed making' and then pulls a list out of her pocket. She unfolds the piece of paper and checking it moves on with the linen skip and trolley to a different location ...'
(07)

In essence, the handover offered the midwives and health care assistants, a projection of 'units of work' which they were required to complete, or more specifically the 'number of checks' which would be part of their workload on their shift of duty – *'I've got seven postnatal checks to do'* (01). The number of checks related solely to the number of women, the infants were not included in the numbers; this aspect will be discussed in the next section.

Holland (1993), in an ethnographic study using participant observation, examined the culture of nursing and the existence of rituals within a surgical ward. She identified the report time as a cultural event which all nurses were expected to participate in. The handover reinforced the social cohesion of the group of nurses on duty and ensured that order was maintained, consistent with the ethos of the organisation. In my study observational data confirmed the routine of the handover or report to be part of the culture of the ward; in essence the report provided the midwife or health care assistant with an overview of her responsibilities for her shift on duty and 'mapped' her forthcoming 'tasks'. This ensured that the organisation controlled the midwife's time and her availability to individual women. Furthermore, the language used during report time emphasised the clinical component of the care with midwives predominantly referring to women as *'normal delivery, day two, breastfeeding'*. The co-ordinator was responsible for giving the report and would have received feedback from the relevant midwives prior to report time; midwives were therefore not able to hand care or information over personally about the women for whom they had been responsible.

In completing the tasks the midwife fulfilled a role as decreed by the organisation and this allowed her to function and process expected work. As the main care-giver, as laid down by statute (NMC 2004), the midwife could reasonably be expected to have a prominent profile within the ward environment and the bay to which she had been allocated. The vast majority of the interactions observed during the first phase of the

study or referred to by the women in the in-depth interviews were with the midwives. However, the midwives were assisted within the ward environment by health care assistants. The health care assistants were included in the handover report, but they were not required to complete official paper work or discharge letters and thus they had the freedom to offer the possibility of a different interaction with the women. The combined data indicated that health care assistants interacted differently with the women, on occasions making themselves accessible through lingering in the bay but not necessarily indicating their availability verbally. They assisted with what were regarded as non-midwifery tasks, such as providing baby linen, replenishing water jugs, assisting women with personal hygiene and also offered assistance with breastfeeding; arguably these tasks constituted a 'working list' for the health care assistants. The health care assistants were responsible for the daily 'show bath' (showing parents how to bath their baby) thus offering an opportunity for a one-to-one interaction between the mother and a care-giver. They appeared to act in the role similar to that of a lay-carer, offering basic but nonetheless important care (Kitson 2003), and would refer to the midwife as appropriate. In this sense the health care assistants acted in a 'caring' capacity, as they appeared less constrained by the organisation, whilst the midwife acted in a 'processing' capacity.

The participation of health care assistants within maternity care is a relatively recent introduction, initially aiming to relieve the midwife of non-midwifery tasks (Kaufmann 1999, RCM 1999, Ladyman 2005). The attempt to formalise the role of health care assistants as maternity carers with a view to integrate them further within the provision of maternity care has been subject to further discussion (Francomb 1997, Kaufmann 1999, McKenna et al., 2003, Keeney et al., 2005).

McKenna et al., (2003) sought to identify the training needs of midwifery assistants. A total of 100 midwives and 58 student midwives at a large teaching hospital in Ireland participated through completing a questionnaire; 20 midwives were subsequently interviewed. No student midwives volunteered to participate in the interviews, which the researchers acknowledged as a limitation of the study, especially as these student midwives would have undertaken duties similar to those of health care assistants. As the research was carried out within the work environment it is possible that the student midwives were more comfortable with completing an

anonymous questionnaire as opposed to being interviewed. The findings indicated three levels of training of health care assistants which the participants regarded as important. At level 1 they wished for the health care assistants to understand the organisation and the ward environment, level 2 involved training on basic core competencies and their role as a support worker. Level 3 would provide them with more in-depth knowledge relevant to midwifery skills. The participants also identified the need for mentorship within the clinical area, with ongoing training and education similarly regarded as important. Whereas the midwives were broadly supportive of increasing the role of health care assistants it should, nevertheless, be noted that they were wary of possible long term implications if the health care assistants were to become increasingly more involved with direct care and thus undermining the role of the midwife.

Similar caution had previously been expressed by the midwives who participated in Francomb's (1997) study. She sought to explore the view of midwives and their perceptions of the role of support workers in a maternity unit prior to the introduction of formal training of support workers. Francomb (1997) collected the data using a self administered questionnaire distributed to a total of 80 midwives; the response rate was 70%. In her sample of midwives, only 36% had experience of working with health care assistants. Of those with no experience, 56% expressed reservations about any proposed training of health care assistants. Generally, concerns related to the statutory duties of midwives (NMC 2004) and midwives were anxious that health care assistants in relieving them of non-midwifery duties, must not replace the midwife. Although broadly the midwives cautiously accepted the support workers, they were nevertheless anxious in respect of any erosion of their own role, indicating at that time some reluctance to embrace such a move.

There are differences in the results from the two studies by Francomb (1997) and McKenna et al., (2003), possibly relating to the studies being undertaken in different maternity units and the time lapse between the two studies. Undoubtedly, health care assistants or support workers within maternity care will have an impact and input into the care for the new mother (DoH 2004). Furthermore, it was evident from both sets of data in the current study that the women themselves greatly appreciated and valued

the interactions with the health care assistants, consistent with the findings detailed by Keeney et al., (2005), as will be referred to below.

5.5 The separateness of the infant.

The midwife was also required to undertake a daily physical examination of the infant. However, in contrast to the examination of the mother, the daily examination of the infant was managed differently and appeared to be slotted in as an appendage. In essence, the daily physical check of the infant was ‘fitted in’ during the midwife’s presence in the bay – *‘now that I’m here’*. Thus, there appeared to be little recognition of providing care for the mother and infant together and acknowledging them as a family unit. The request by the midwife to the mother to carry out the check was often observed to be identified with *‘looking at the baby’s cord’*:

‘ ... can I just have a look at the baby’s cord? ... now that I’m here ’(10)

Essentially, the midwife was thus able to convey and emphasise the importance of her time by deciding when it was more efficient and convenient to her – the midwife- to undertake the examination of the infant. The woman may have perceived that it would be undesirable or difficult to ask the midwife to carry out the ‘check’ of her baby at some other time or that she might have to forfeit the midwife’s assessment of her baby. Some midwives spoke about not wanting to wake a baby, preferring to wait for the baby to be awake as the mother might only just have got her baby off to sleep:

*‘ ... I’ll just have a look at the cord ... now that she is awake ... ’
(07)*

Here the midwife had regard for the mother and the sleeping pattern of her infant and responded in accordance with the needs of the individual mother. They also appeared more relaxed to ask a colleague on the next shift to undertake the examination of the infant than they were to ask them to ‘check’ a mother. The physical examination of the infant was described as ‘less work’:

'... I've done all of my checks ... just one baby to do ...' (09)

Clearly the conflict described by some midwives in wanting to complete the 'checks' relating to the women, for which they were responsible during an early shift on duty was less evident when compared to the examination of the infant. However, there was also a notion that the infant added to the workload, with care for the mother regarded as the real and important work. The perspective of the midwife of the infant being separate from the mother is further illustrated with the following account of a conversation between two midwives, one of whom is a senior midwife:

Midwife – 'How can it take so long to look after eleven patients?'

Senior midwife – 'But you don't have eleven patients, do you?, there are twenty two of them – mothers and babies'.

Midwife – 'Yes, that's half the problem'. (10)

Separateness of the baby from the mother was also observed on occasions which did not relate to the daily examination of the infant, as described below:

'The midwife and a student nurse are with a new mother who has had her second baby, having completed the check for both of them. The health care assistant enters the bay to discuss bathing the baby. The midwife tells the health care assistant that the woman cannot bath the baby herself as 'she is post section' and 'the baby is big'. The mother offers no comment, consent is not given by her, and the health care assistant wheels the baby away in its cot. The midwife proceeds to take a sample of blood from the woman and discusses with her when she can go home, the midwife decides that tomorrow is appropriate. The woman offers no comment, nodding in agreement. The midwife and the student leave the bay – 'right, we've finished'. The woman immediately turns to me and asks 'where is the nursery? I don't know where the nursery is'. There is a slight anxiety in her voice. I tell her where to find the nursery. She returns shortly afterward, commenting to the other women in the room – 'I forgot the towel'. One of the other women tells her

that 'they will have one'. The mother later returns wheeling her baby in the cot, she looks pleased telling the woman in the next bed – 'she loved it'. (01)

Here the mother and her infant were separated without the mother's consent. The apparent need to bath the baby overrode, on this occasion, the ethos of not separating the mother and her infant. However, the midwife did show concern for the woman having had an operative delivery. The woman was clearly anxious about having her baby removed and not knowing exactly where the baby had been taken. The asymmetry of the interaction (Lomax & Robinson 1996) where the midwife led or manoeuvred the interaction (Olsson & Jansson 2001), clearly inhibited the woman from asking the midwife where her baby had been taken to. The care-givers were familiar with what was happening but were mistaken in assuming that the women shared that familiarity or understanding.

The policy of the unit emphasised the need for the infant to be cared for by its mother, by her bedside and for them not to be separated unless for medical reasons. It was therefore strange that the midwives separated the infant from the mother, rather than considering them as a unit, requiring care and assistance together. It was evident from the interview data that women did not wish to be physically separated from their infants, Gill described her experience:

' ... I had buzzed for the midwife to come ... basically because I couldn't lift her back into the cot ... so the midwife came along and put her down and said that she could take her back to where they all sit ...if I wanted them, let me have some rest and take her away. So they wheeled her away and I had become so upset by the fact that she wasn't next to me anymore or I couldn't see her ... I felt that I had abandoned her ... I became really, really upset ... so I ended up getting out of bed ... I felt so overwhelmed by the fact that they had taken her away from me and I had become very anxious then. Gill described how she went to the desk and brought her daughter back ... and finally went back to sleep with (name of

daughter) back by the side of me ... and I felt a lot better ... (Gill, first baby, emergency caesarean section)

5.5.1 Involvement of the new mother in the examination of her infant.

It was evident that not all babies were examined when the mother (or father) was present; a mother was heard to ask the midwife *'is my baby okay?'* to which the midwife replied *'yes'* explaining *'I had a look at him earlier when you were in the toilet'* (06). The observational data indicated that this mother was concerned about her son, she had requested and received assistance with feeding throughout the morning. However, assisting with feeding and examining the baby were considered two separate activities by the midwives and may therefore not have reassured the mother about her infant; this will be discussed later. This would indicate a low priority in involving the mother in the examination of the infant and/or in the physical care provided to her infant. This mother was not provided with an opportunity to observe the midwife's examination of her baby and to discuss any concerns that she had in relation to the health of her infant; the infant 'check' had been 'signed off' by the midwife for that day and was hence regarded to be complete.

In the following vignette the midwife is instructing a student nurse; the maternal check has been completed by the midwife and here the infant check is 'tagged on' to the maternal examination:

'The midwife tells the mother (this is the woman's second baby) – 'now we need to do the baby' followed by 'is it alright if we look at the baby?'. No reply is heard from the mother, the midwife suggests 'let's draw the curtains back'. The midwife and the student nurse draw back the curtains. The midwife asks the student nurse – 'what do you observe when looking at the baby?'. I can see that the midwife and student are facing each other over the infant's cot, the midwife has her back to the mother who therefore cannot see her baby. The student nurse says that she thinks the baby's face is slightly jaundiced. The midwife replies – 'Excellent!' and proceeds to ask the mother about the frequency of

feeds and the amount the baby is taking (the baby is artificially fed), the mother answers the midwife's questions. There then follows a discussion between the midwife and the student nurse while they complete the examination of the baby; the mother is not included in the discussion. ' (01)

Here, the student is praised for her clinical observation of the infant and the midwife provided a teaching session for the student. However, and more importantly, the mother could have been afforded the same attention and been helped to understand her infant's condition. The midwife, in questioning the mother about the feeding made an assessment of the infant, but again, as this was not discussed with the mother, she may not have understood the relevance of this. However, the mother did not appear concerned, and the midwife may have assumed that as this was the mother's second baby that no further information was required.

The daily physical examination of babies involved a comprehensive assessment of the general well-being of the infant as well as an assessment of feeding as set out in the mother's individual handheld notes (see Appendix 14). The midwives appeared to concentrate on checking the infant's cord and it is difficult to assess what the women understood from the examination or its relevance to their baby.

Lomoro et al., (2002) described how the women who participated in their study felt reassured by the medical examination of their infant. However, the observational data from my study indicated that parents requested for a paediatrician to review their infant only if they had specific concerns or a family history of concern to them.

Reference was made in Chapter 1, when discussing the aims of postnatal care, to the requirement for the health professionals to enable the mother to feel confident in caring, not only for herself, but also in caring for her infant (Rush et al., 1989, Ball 1994, Garcia & Marchant 1999). In separating out the provision of care for the mother and her infant, concentrating predominantly on the mother, it would appear that an opportunity for providing information or education to the new mother (and the father) on caring for the infant was lost. Using focus groups involving women and midwives separately, Proctor (1998) explored the concept of quality in maternity care.

She identified the women's need for advice and assistance on infant care before returning home however, this aspect was not raised as a possible issue by the midwives. The findings from my study have also demonstrated that the midwives, as care-givers, did not always appear aware of this need by the women. The interview data further indicated that women felt that they had to ask for this information as it was not generally given freely:

'... they should give you information ... general information, you know, with the baby and stuff like that ... how to care for your baby, you know ... and we had to go, you know on the last day we had to ask the midwife 'how do we bath him?, do you get a demonstration?', my other half, he asked that and they said 'oh, yeah we've got one at eleven o'clock this morning going on'. That would have been ideal information to be told (pause), (name of partner) had to ask for them to then say, they could have said that themselves ... (voice trailing)' (Denise, first baby)

Discussing the care plan in the women's handheld notes would have provided the women with an opportunity to discuss any concerns about caring for themselves or their infant.

The women who participated in the in-depth interviews made little or no reference to the midwives undertaking the daily examination of their baby, possibly indicating a lack of understanding of the purpose of the 'check' or, indeed, whether it had been carried out as described above. Clearly, if the examination of the infant was undertaken when the mother was not by her bedside and she was not informed, the mother would not be aware of the check having been carried out or the relevance of the check to the health of her baby.

In contrast, Gill (first baby, emergency caesarean section) expressed a different view on several occasions during the interview:

' ... I can't remember really discussing anything to do with the operation with any of the midwives, everything is focusing on the

baby (pause) they would actually be helping you more with caring for the baby rather than looking at the mothers themselves but I don't think that was such a bad thing. I think the focus ... everything is focused on the newborn. I think the new mothers are focusing on, on the baby as well ...'

She went on to explain later during the interview: *'I think even now, like the health visitor comes to visit you and, again to see the baby, they're not really coming to see you at all ...'*

However, the comments offered by Gill are in stark contrast with those of the majority of the women and illustrate the need for care tailored to the needs of the individual woman.

5.6 Being there for the woman and keeping a distance.

The need for the midwife to withdraw from the bay was evident and referred to earlier in this chapter. This need to remove herself from further immediate contact with the woman was demonstrated at a superficial level which primarily involved physical distancing, but midwives also demonstrated their need to withdraw at a deeper level. At a deeper level this involved emotional as well as physical distancing, and this is discussed in the section below.

5.6.1 Ambivalence about withdrawing from the women.

Completing the examinations of the mother and her infant concluded the interaction and conveyed to the midwives that there was *'nothing to do for the women'* (18); the absence of a 'task' to be completed was a recognised and acceptable reason for withdrawing to 'the back stage' (Goffman 1959). However, on occasions, the midwives themselves demonstrated ambivalence about not spending 'free' time with the women:

'...why is it that on a day when it's quiet, like today, we don't want to be in the bays with the women?...' (09)

It was evident that the midwives regarded this as a dilemma; midwives are, ultimately, required to be available to the women. This requirement was both a professional one (UKCC 1998, NMC 2004) and an expectation by the organisation, as demonstrated in this chapter as well as the previous chapter. In exercising their option of physical and emotional distance from the women the midwives justified their position through reasoning that:

'...women should take responsibility for themselves and their babies...' (18)

In referring to 'responsibility' the midwives implied that the women were 'not sick' and were therefore capable of requesting assistance as required. However, in reality and as discussed above, the women frequently found this difficult. Paradoxically, the midwives lamented that:

'... they (women) don't call us, they don't use us ...' (18)

'... they don't want to disturb us, they don't want to be a nuisance ... and when they do call it's for trivial things like water ...' (18)

'... some women don't ask for help ... others ask too much ... you know what I mean ...' (09)

Women expected what could arguably be described as basic care, such as a jug of water, they knew that this would be provided within a hospital environment. When this basic care, above regarded by the midwife as 'trivial', was not provided, women felt let down. Denise (first baby, normal birth) described how she would have appreciated the midwife coming into her room *'coming in asking really, even for a jug of water ... the fact that I had to ask ...'* . Two opposing views were thus evident.

Quiet periods were rare on the postnatal ward, however, they were valued as they provided an opportunity for the care-givers to gather by the desk area or in the staff room with their colleagues. The 'back stage' offered sanctuary and collegiate relationship (Goffman 1959). Tea would be taken and personal, less often professional, experiences would be shared; the social and cultural importance of tea was evident. Curiously, the ritual of tea varied according to the time of day. Midwives

would comment, following the customary partaking of tea after having received the handover report in the morning – *'must start some work'* (9) and in this sense the tea served as an encouragement to move out into the area and to the women to whom they had been allocated. In contrast, tea was not taken at the beginning of the late or night duty shift. In the afternoon, the tea would be taken during visiting time as *'they (the women) don't want us during visiting'*. Following completion of maternal observations and the drug round at the beginning of the night shift the care-givers would gather for tea, as the midwives expected the mothers to have settled for the night by this time.

Hunt and Symonds (1995) described the custom of the midwives having tea following attending a woman during birth; tea was taken as a reward, 'unofficial therapy' (page 104), for work undertaken and while completing notes. Tea was thus an important aspect of the culture of the ward and integral to the work. Furthermore, in the current study, the midwives controlled the tea break; they were able to take a tea break at their convenience, informing the women of their need for tea - *'I'm gasping'* (04). Tea drinking was regularly observed during the observational phase and if a cake (baked by a colleague) or biscuits (a 'thank you' from a woman going home) were available, this was indeed a treat! Essentially, tea served as a celebration of a 'job well done'.

5.6.2 The need for keeping a distance from the women.

For midwives delivering the care and being available to the woman required 'an investment of self' by the midwife; a personal commitment of giving which the midwife as the main care-giver perhaps found it difficult to undertake or sustain indefinitely. In informal conversations, midwives appeared in agreement of their own needs - *'I need support as well'* (09), describing the workload as *'too heavy'* preventing them from *'caring for the women'* (09). The feeling was expressed that - *'... women have too many expectations ...'* (09) and that these expectations represented an unrealistic situation for the midwife as the main care-giver.

Hunter (2002) explored emotion work in midwifery, conducting focus groups with student midwives and qualified midwives, previously discussed in Chapter 2. Two main occupational ideologies were identified; the hospital based midwives identified

with 'being with the institution' whilst the midwives working in the community were able to adhere to the 'with woman' ideology. The midwives in integrated practice who moved between the two practice settings experienced conflict when working in the hospital as this compromised their ideology of being 'with woman'. The conflict experienced by the midwives in particular in my study, was evident from the observational data; midwives were not able to practise an ideology compatible with an ethos of providing woman-centred care. Women were able to 'opt out' of the situation by going home, as will be seen in a subsequent chapter, however, midwives were not able to exercise this option; they were contractually obliged to the organisation, although they had a choice of working within the hospital setting or in the community.

Reference was made earlier in this chapter to midwives conveying the sense of caring for a group of women and thus not acknowledging the individual woman; in essence an efficient method for the midwife to process her responsibilities (Lipsky 1980). It was further noticeable in conversation with care-givers, both midwives and health care assistants, that they referred to women in the plural as opposed to woman in the singular. Hunter (2002:129-130), in detailing the background to her study and having reviewed the relevant literature, offered the distinction based on the literature identified between 'with woman' (singular) and 'with women' (plural). 'With woman' comprised individualised practice which involved caring for the woman as an individual and was provided by the midwives in the community setting. In contrast, 'with women' referred to a routine approach to caring for the women, consistent with the organisational setting.

The observational data revealed the cost to individual midwives in responding to the demands of the organisation and the institutional setting. This appeared to lead to the midwife's need to remove herself from additional contact with the woman, over and above the required routine care, in order for the midwife to protect herself from the effect of the organisational routine of the postnatal ward. In the words of one midwife:

'...working on the postnatal ward is a downer ... an emotional let-down ...' (09).

Clearly, the data indicated that there were unresolved issues for the midwives in providing care to the new mother on the postnatal ward, leading to a sense of powerlessness. Cattrell et al., (2005) sought to explore aspects of postnatal care which mattered to midwives; this included delivering care in hospital and the community. Focus groups were used in the collection of the data. The 26 participants detailed the importance of being able to deliver individualised care to the women and how this provided them with job satisfaction. They were critical of the time needed for administrative duties, describing how this removed them from contact with the women and they acknowledged that at times the provision of care to the women was fragmented. Positive feedback from the women was appreciated, reassuring them that their contact with the women was appreciated. Clearly, there is a dichotomy between what midwives wish to provide in respect of postnatal care and what they are actually able, or enabled, to deliver.

The purpose of my study was to seek to understand the women's perspectives of care on the postnatal ward and information gained in relation to the midwives' views was additional to the data gathered in relation to the women's views. The views of the midwives have not been sought in detail; however, the findings from the observational phase in particular, indicated the urgent need and importance of seeking to understand the midwives' perspectives of being a midwife on the postnatal ward. As midwives spontaneously approached me during the observational phase, to engage in conversation about working on the postnatal ward, it appeared evident that midwives, as the main providers of care within the postnatal ward, were anxious to have their views heard.

It appeared then that midwives withdrew from the women on the postnatal ward; at a superficial level and a deeper level. This can be viewed as a coping mechanism through which the midwives managed the dissonance experienced as a result of task-initiated care. Argyris (1964:59) had described the concept of 'adaptive activities' which are used by individuals to manage conflict with and within an organisation. Conflict is manifested when an individual, the employee, is unable to adjust to or meet the demands of the organisation. Thus, the aspect of withdrawal which valued a sense of disconnectedness in relationships (Goffman 1959), allowed the midwife to attain and maintain a distance or barrier, both emotional and physical, between herself

and the woman. Connecting with the woman is congruent with midwifery practice which purports to foster a relationship or partnership between the midwife and the woman (Kirkham 2000). Withdrawal from this relationship can be viewed as a psychological response (Argyris 1964, Lipsky 1980) as well as 'alienation' by the midwife from the woman with whom she is expected to interact.

Helplessness and a sense of lack of power are dimensions of alienation. Equally, electing not to get involved or withdrawing from the work, such as absenteeism, is an additional coping strategy (Argyris 1964:60). The need to leave the bay has been demonstrated by the data, but other forms of coping were evident, such as the ritual of tea drinking which also served to maintain the collegiate cohesion. (At the time of the data collection, the absenteeism caused by sickness and the frequency for request for annual leave was higher on the postnatal ward than on the antenatal or labour ward or community setting)

The new mother had expectations of care and support which were appropriate to her individual needs and the needs of her infant. Equally, midwives themselves were in need of support, but might not feel that as practitioners they had an automatic right to support or to express a need for this support (Kirkham & Stapleton 2000). Hence, midwives were not heard, and consequently, on a deeper level they were not able to voice their concerns, leading Kirkham (1999) to describe the midwife as 'muted'. It is possible to suggest that in order to assist the mother, the midwife must herself feel supported, valued and have a voice.

It was evident from both sets of data that the midwives' absence affected the interaction with the women. Buber (1957) offered a philosophical perspective on 'distance and relation', where 'distance' referred to the 'human situation' (women in need and requesting assistance) and 'relation' described man as 'confirmed for what he is, what he can become, not as a detached context but in his reality' (women acknowledged as individuals). He further argued that:

'Relation is fulfilled in a full making present, when I think of the experience belonging to him the other become a self for me, and the making independent of his being ...' (pages 103-104)

To achieve this level of understanding of the woman's concerns would necessitate a different investment by the midwife in her interactions with the women. Denise detailed waiting for the midwife to come and see her:

' ... so I waited for someone to come in and, you know, the midwife would be in two hours later and sort of, you know, fluttered in and fluttered out again ... ' (Denise, first baby, normal birth, allocated a single room)

This raised issues for Denise about the availability of the midwives to her and the purpose of the midwives but equally the purpose of her being on the ward. The midwives appeared to understand their role, Denise was less clear as to her reasons for staying on the ward.

The socialisation of student nurses had been explored by Mackintosh (2006). She conducted semi-structured interviews with 16 student nurses, six to nine months into their training and again prior to completing their training. The interview data obtained by Mackintosh (2006) indicated a change in the view of the student nurses over a period of time; the student nurses detailed personal disillusionment in not being able to provide care in a way which they had expected to and this resulted in a loss of idealism. Furthermore, Mackintosh (2006) commented on the decline of the use of the word 'care' in the second interviews by the student nurses, instead referring to negative aspects of care. She concluded that they were experiencing an inability to cope with the nursing role and that the process of socialisation affected how they cared for the patients.

My data suggested that the organisation valued the task culture with its emphasis on 'getting the job done'; a task culture is entirely job or project focused and prescribed objectives have to be met (Handy 1993, Ford & Walsh 1994). However, whereas Handy (1993) described how within the task culture individuals had a high degree of autonomy over the work or tasks, the findings indicated that midwives were not able to control their work. Midwives based within the hospital perceived that their colleagues based in the community setting enjoyed more control and greater freedom over their work. Midwives described how community midwives were able to be *'with*

one woman only', implying that community midwives did not appreciate the difficulties of working on the postnatal ward with the responsibility for a group of women. In contrast, midwives in the community described, in informal conversations, having '*escaped*' from the postnatal ward. In essence, midwives whether hospital or community based, have the same duty of care to the new mother and her infant (NMC 2004), the only difference being where that care is provided. 'Escaping' from the postnatal ward does not relieve the midwife of her duty of care but it appeared to alter the midwife's autonomy of her practice and offered the possibility of 'with woman' ideology, as described by Hunter (2002).

The emphasis on the task culture and processing the 'work', and by implication the women, was largely incongruent with the wishes and the needs of the women and this will be discussed later. Price (1993), using grounded theory approach, interviewed parents about their perceptions of the quality of nursing care provided to their hospitalised children. Quality of care was associated with an active presence by the nurse, described as relationship-based care, however, the parents reported receiving mainly technical care, such as clinical observations and monitoring of equipment conveying a functional and efficient manner. This was a small study, involving four parents only and it should be noted that one child was hospitalised seven years prior to the study, which must raise the issue of accuracy of recall of events. However, there are similarities between Price's data and the data from my study.

5.7 Conclusion.

In this chapter I have examined the influence of the culture of the ward which resulted in the provision of a task-orientated care practice. A description of how midwives managed this care whilst adhering to and remaining within the ethos of the organisation was offered. The need for midwives to be able to exercise a degree of control over their interaction with the women was evident. The 'back stage' provided midwives with refuge and sanctuary and they exercised withdrawal at several levels. Women appeared silent and compliant with the controlled contact offered by the midwives.

The care that midwives provided for the women on the postnatal ward, primarily consisted of routine clinical observations – the daily physical examinations. They appeared unable or unwilling to form an emotional relationship with the women. However, such a relationship was perceived as important by the women and appeared to override their need or desire for clinical care. This will be discussed in the next chapter.

CHAPTER 6: THE CONCEPT OF ‘CARE’.

In the two previous chapters I have discussed the organisation and the resulting task-based care. I have demonstrated how the organisation influenced the interactions between the midwives and the women, as the midwives were primarily only able to respond to the needs of the organisation. The aim of the study was to observe what activities occurred within the ward environment and the interactions that occurred between women and health professionals as well as to seek the women’s perspectives of care on the postnatal ward; I wished to portray the women centrally within that environment. However, as illustrated by the data, the women were in fact peripheral within the organisation. Essentially, whilst on the ward the women expected to receive assistance and support for themselves to enable them to recover from the birth and to aid them in caring for themselves and their baby. The purpose of a woman’s stay on the postnatal ward was to receive this care.

6.1 Reflecting on ‘care’ and the needs of the women.

It is therefore necessary to reflect on the meaning of the word ‘care’ and to seek a definition of ‘care’ for the purpose of the study and the combined findings from the study. The Nursing and Midwifery Council (NMC) (2002) in their Code of Professional Conduct define ‘care’ as the provision of ‘help and comfort’. Although this might be regarded as a basic definition, nevertheless assistance and support by the midwife must be considered as a fundamental premise of care and also of the relationship between the midwife and the woman.

The data demonstrated that the women had needs and the interview data in particular indicated that the women wished for their needs to be acknowledged and met. The women demonstrated and expressed a variety of needs, as represented in Figure 6.1, as well as their wish to be acknowledged as an individual; it should be noted that the descriptions of needs offered within this figure are not exhaustive. Arguably, in order for each individual woman to have her needs recognised, the midwife would be required to respond to the individual nature of these needs by providing assistance and support. This may include the provision of information, advice, physical assistance, observation and listening in relation to the woman’s health or that of her baby.

Figure 6.1 Needs of the woman

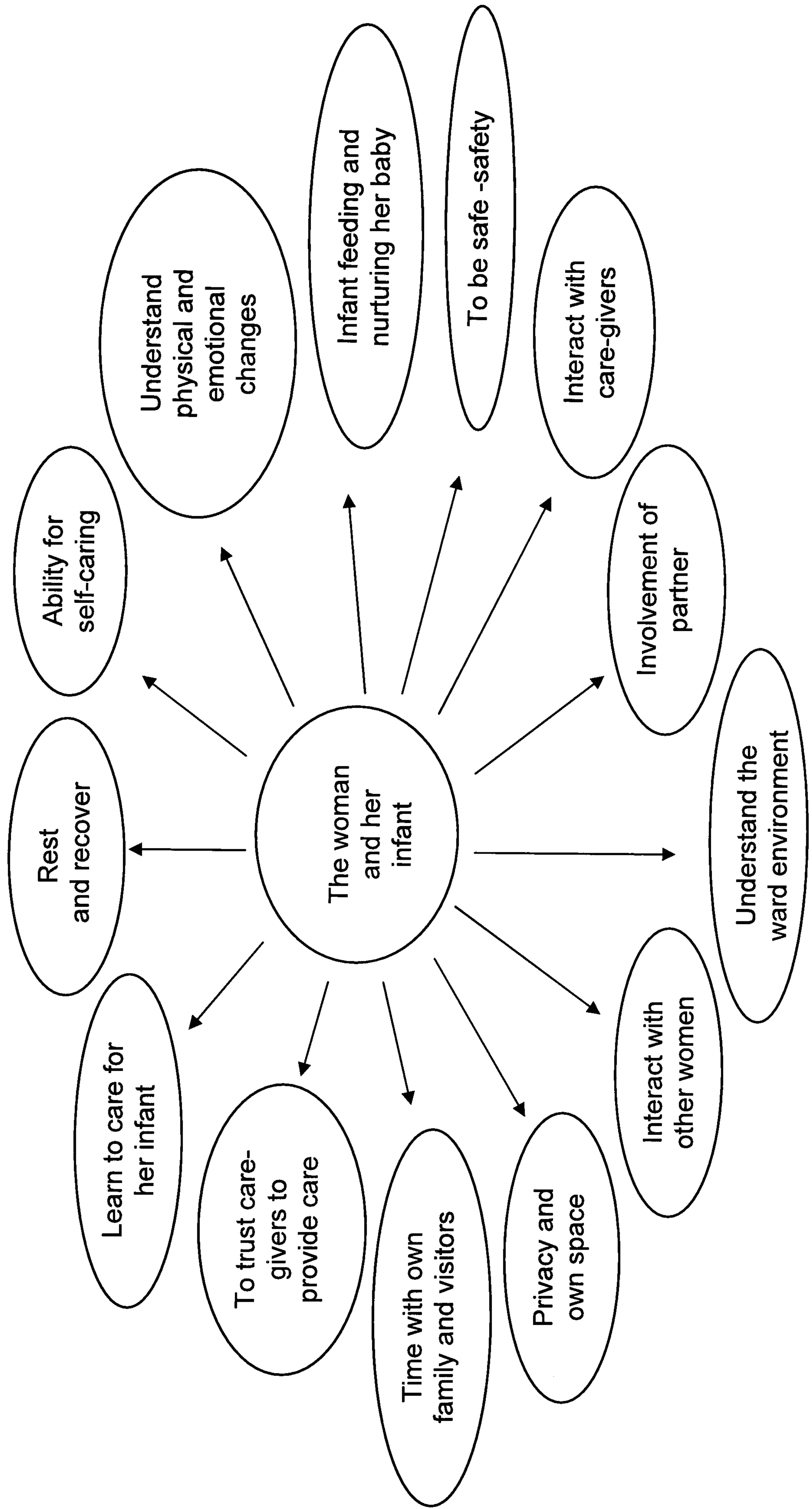


Figure 6.1 Needs of the Woman

It would therefore appear relevant to include the needs and requirements as expressed by individual women in a discussion on 'care'. However, in reviewing the literature on 'care' it was not possible to find a definition of 'care' which related specifically to the data; there would not appear to be an exact fit.

Swanson (1991), using a phenomenological approach, explored the views of 20 women who had recently suffered a miscarriage and eight women who suffered mental health problems during pregnancy as well as 19 care-providers, which included five mothers and two fathers, on providing care in a neonatal unit. The findings led Swanson to define caring as:

'a nurturing way of relating to the other toward whom one feels a personal sense of commitment and responsibility' (page 165)

and that the caring process comprised five discrete categories:

- 'knowing' – striving to understand the meaning of an event to the other
- 'being with' – emotionally present, sharing feelings, 'being there'
- 'doing for' – protective of the other's needs, doing for the other what they would do themselves if possible, providing physical care
- 'enabling' – facilitating, using one's expert knowledge for the benefit of the other
- 'maintaining belief' – sustaining faith in the other's capacity to get through an event or transition

(modified from Swanson 1991:165)

Based on the findings from the observational phase the theoretical concept of care developed by Swanson (1991) appeared relevant. As the study progressed and with the data analysis, the combined observation and interview data demonstrated the women's need for the midwife and other care-givers to relate and respond to them as individuals. They wanted the midwife to be available, offering assistance and 'enabling' when required. Women also wished to be supported in any decisions they made for themselves and their infants, 'maintaining belief', as the following data extract illustrated:

' ... one of the midwives kept telling me off for letting her sleep with me (laughing) ... yeah, she said 'I think you should put her down' and I actually, 'well, whatever' and as soon as she'd gone I thought 'oh, she can stay with me'. Well, I felt, just felt (voice rising), you know, that she needed a little bit of comfort and security because she did have a very traumatic birth and a very traumatic entrance into the world so to just be put in a plastic box over there somewhere ...quite harsh, you should be allowed to do, I mean she said it was all because of health and safety, concrete floor and all the rest of it, you know. I understand the reasoning behind it but ... my reasons behind it were just as valid, I should be allowed these sort of things if I really want to (quiet, reflective voice), so I did (laughing), I just got her back out again after she'd gone out of the room (laughing heartily) ... ' (Lizzie, first baby)

The language used by Lizzie is interesting. She made a reference to the midwife's attention to health and safety, but nevertheless regarded this as 'harsh'. Lizzie's natural need to mother and care for her baby overrode what was 'allowed' by the midwife; a degree of defiance was demonstrated but also a belief that she had a right to self-care for her daughter.

6.2 Providing personal or professional care?

However, whereas Swanson (1991) described the need for a personal commitment by the care-giver, who in her study were nurses, the midwives in my study did not appear able or chose not to offer a meaningful personal commitment to or take responsibility for the woman's care. In the two previous chapters I have discussed how the findings illustrated that midwives were primarily only able to respond to the needs of the organisation; they demonstrated commitment to the institution and other colleagues and found it difficult to offer genuine interest and personal availability for each new mother.

The differences between personal and professional commitment by the midwife to each individual woman must be reflected upon. The findings from the data indicated the midwife's demonstration of professional commitment to and responsibility for the woman, essentially manifested by the dominance of task-based care. Arguably the midwife has a professional duty to interact with the woman and provide care (NMC 2004), furthermore the midwife has a contractual responsibility by virtue of her employment within the NHS; the data demonstrated that the midwives were able to meet these professional requirements through adhering to the ethos of the organisation. Swanson (1991) however, puts a personal sense of commitment and responsibility by the nurse to the woman as central to her definition of care; such a level of personal commitment was rarely demonstrated within my data, instead the midwives indicated the need to withdraw from immediate contact with the women upon completion of the required tasks. The clinical element of caring, 'doing for' (Swanson 1991), was demonstrated by my data and referred to in the previous chapter which reported on the task-orientated aspects of care provided by the midwives; thus evidence of physical assistance was plentiful, but there was little evidence of psychological and emotional support.

Reference was made above to the findings of Hunter (2002), who detailed how the midwives based in hospital found it difficult to identify with the women and how, in contrast, community based midwives were more able to form a relationship with them. The women who participated in the in-depth interviews in the current study, often indicated a warm and strong relationship with their community or team midwife, describing her as '*my midwife*'. In comparison, the midwife in hospital was not referred to with the same familiarity or warmth and was rarely referred to by her name; women referred to '*they*'. Midwives in my study spoke of the ability of the team and community midwife to be with '*one woman only*'; suggesting they envied their colleagues' opportunity to adhere to a woman-centred ethos or framework. Based on my findings it would appear then that the individual woman's requirements for assistance for herself and her infant were marginalised and not always recognised. Figure 6.1 illustrates the variety of aspects of care and assistance which the women sought for themselves as derived from the interview data however, despite this, it would appear that the women as individuals represented a small component only within a much larger unit, that of the organisation. Therefore it might be concluded

that the needs of individual women were not compatible with the needs of the organisation itself. This is clearly in conflict with Government initiatives which have emphasised the importance for care being focused on the needs of the individual woman and how this should underpin the services for women and infants (DoH 1993, DoH 2004, NICE 2006).

6.3 Providing physical and emotional care.

It must be emphasised that the provision of professional ‘care’ by the midwives and health care assistants is not disputed; a range of caring activities were offered and delivered to the women. Physical care, described by Swanson (1991) as ‘doing for’, was provided to the women, essentially as an organisational demand but equally, and importantly, at the request of the women. Such interactions were documented in the women’s handheld notes which provided the organisation with proof that ‘care’ as deemed necessary or requested had been delivered. Swanson (1991) also referred to the category of offering emotional presence to the women - ‘being with’. However, it was evident that the midwives felt the need, to remove themselves from a relationship with the women which would have offered emotional care or support; emotional support was clearly requested by the women, as will be described below, but rarely provided by the midwives.

The data from the in-depth interviews indicated that the women sought a presence from or a connecting relationship with the midwife; this necessitated a further review of the literature to seek a deeper understanding of the importance of care and caring in relation to this need expressed by the women. In order to be responsive to the needs of individual women, the midwives would be required to respond to an individual woman in a way which was relevant to her and her circumstances. Mayeroff (1971), using a philosophical stance, described the process of caring itself as:

‘...in caring for another person we can be said to be basically with him in his world, in contrast to simply knowing him from outside.’

(page 43)

As observed, the midwives were generally not able to be with the woman in such a way; essentially they appeared more familiar with a broad ethos of surveillance as an institutional demand (Goffman 1961). In describing surveillance, Goffman described how this involved personnel doing what was required of them; the data indicated the importance to the midwives of carrying out tasks required by the organisation and they knew the women mainly distantly from the 'outside'.

Attempting to be aware of the woman's needs from her perspective would seem to be crucial to the relationship between women and midwives. This level of caring would involve the midwives making themselves available to the women, possibly unconditionally; however, the midwives were in reality managing the women remotely from the desk area at the request of the organisation. The midwives were rarely able to offer a personal commitment or responsibility to the women. This was reflected in the narratives of the women:

*' ... they didn't come to say 'are you okay?', are you coping?' ... they're nice enough staff, when they **did** call (slight rise in voice to emphasise the word 'did'), you know when I rang for help ... they were always willing to help when you asked for help (pause) ... no one was asking if I was okay, it was **me** asking the midwife 'can you help me?' ... (Denise, first baby)*

Denise clearly felt that the midwives or health care assistants were not always there for her; she described how this had affected her experience on the ward and contributed to her going home early. The view held by some of the midwives that the women needed to learn to take responsibility for themselves and their infants was evident – *'...women should take responsibility for themselves and their babies...'* (18). Although Denise explained that the care-givers would provide assistance when this was requested by her, it would appear that, on occasions, the care-givers distanced themselves from the women in order to encourage self-caring in addition to the need to maintain their own emotional distance. The midwife's desire to promote self-caring was not observed to be explained to the women who may therefore not have been aware of this expectation.

Kitson (2003), in offering an analysis of a lay-caring and a professional caring relationship, described how caring assumes a commitment by the carer 'to provide a sustained and beneficial service to the recipient of care'. She argued that this commitment was essential in the caring relationship. She surmised that lay-carers, such as family members or personal friends, were able to support the person in need of assistance and support because of their knowledge of that person. Dependency was not created, rather the person required care due to a developmental stage, such as recovering after the birth of the baby. Kitson (2003) argued that it is only when the care provided by the lay-carer is inadequate for the person requiring care, that the role of the professional carer is appropriate. The importance to the women of their partner being able to assist and support them on the postnatal ward was evident and will be discussed in Chapter 8.

6.4 Purpose of providing care.

According to Mayeroff (1971) the essence of caring is in helping the person in need of care to grow, but caring also allows for personal growth of the carer. Clearly, women have needs and wish for these needs to be heard and met. As suggested above, care may be required because of illness or a need for personal development during a particular event (Kitson 2003), such as recovering from childbirth or a mother learning to care for her infant; women in my study appeared to indicate their desire to be assisted in adjusting to the role of mothering, irrespective of parity. However, the provision of care must not create dependence on the care-giver (McCourt et al., 2000) as this is likely to benefit the care-giver rather than the person in need of care, although a degree of reciprocity in the caring relationship may be desirable, as argued by Mayeroff (1971). It appeared that both women and midwives valued a reciprocal relationship, but the value put by the organisation on the production component of progressing women through the ward militated against achieving such a relationship.

Mayeroff (1971) further described the need for devotion and how 'when devotion breaks down, caring breaks down' (page 8). However, Morrison (1992) argued that Mayeroff's view of caring is inappropriate in nursing, as his discussion on caring lacks an understanding of the clinical element, regarded by Morrison to be integral to nursing care. Hence, Morrison (1992) urged the nurse to refrain from forming an

intimate relationship with patients; a degree of professional detachment was advocated. In contrast, Brykczyńska (1992) considered the inclusion of Mayeroff's analysis on caring to be essential in an understanding of the theoretical development of care and caring. For Brykczyńska (1992) the 'committed presence' by the nurse with the patient was vital in the caring relationship. The data from my study demonstrated how physical care, as a functional and measurable element, was esteemed by the organisation as it demonstrated the activities of the midwives but a 'committed presence' did not appear to be of the same importance.

Swanson's (1991) and Mayeroff's (1971) discussions on care and caring are both included because of their resonance with the data from my study. The midwife caring and being 'with woman', has been discussed in the midwifery literature, [see for instance Hunt & Symonds 1995, Davies & Wickham 2000, Kirkham 2000, Marchant 2006], although within the context of midwifery a lack of definition of these concepts remains. Mayeroff's (1971) description of 'caring' and the importance of being 'with (her) in (her) world' (page 43), would seem to be congruent with the philosophy of being 'with woman'. In 'being with' the woman the midwife was required to relate to the woman and respond to her individual needs. However, in my study it was apparent that the personal sense of commitment by the midwives had been replaced by a professional obligation. Equally, as discussed previously, the midwives' constant description of and reference to 'women', in the plural, may illustrate the difficulties experienced by them in responding to each woman as an individual and suggest the inability of midwives to directly influence the environment within which they practised.

Woodward (1997), in a review on professional caring, discussed the two terms of 'care' (to have regard for, to provide physical help or comfort) and 'caring' (showing care and compassion) to highlight the differences between them and their relevance to the theory of midwifery practice. However, in reality both terms are used interchangeably in the literature and by health professionals, and often without a formal definition of what we, as health care providers, actually mean when using them. Lipsky (1980:72) described the grammatical change which has taken place in the use of the word 'care' from a verb to a noun, this he argued changed the emphasis of the human interaction between the people providing a service and those in receipt

of such services. It appears that the term to offer or provide 'care' is thus used without a consensus of what care means to those in a caring capacity or to those in receipt of that care (Harrison 1990, Woodward 1997, Davies & Wickham 2000). Furthermore, Marchant (2006) has argued against the use of the term 'routine care' in postnatal care, describing how the word 'routine' might negate the need for care to be flexible and appropriate to the needs of individual women. The data from my study have demonstrated that women sought to have their concerns heard as individuals and that 'routine care' as provided by the midwives did not always meet with their expectations of care for themselves.

Women who have given birth are not regarded as ill, and indeed women are generally well following the birth of their baby. It is possible that for midwives this shifts the emphasis of 'care' and may bring an expectation of self-care or independence by the women as was indicated by the midwives. This may present a dilemma for a caregiver who has been a general nurse prior to undertaking a midwifery qualification. It is possible that the nurse will be more used to a level of expressed dependence by patients. Davies (1996) has detailed the ambiguity felt by student midwives in moving from general nursing, where they were expected to care for ill and dependent patients, to a caring situation with, essentially, well women. Midwives are socialised into providing care within a medical model of care (Williams 1997); women, by virtue of being in what claims to be a caring environment, expect to receive care appropriate to them. The data suggested that women required assistance whilst in hospital, commenting if this was not forthcoming - '*nobody has been to see me*' (06) even when their observations had been carried out.

6.5 Being offered a 'disconnected presence' but wishing for a 'connected presence'.

In summary, in being cared for, the woman reasonably expected the midwife to relate to her and acknowledge her concerns as an individual. Caring could thus be regarded as involving the midwife and the health care assistant responding to the woman and recognising her individual needs through their 'presence' with her. This would involve an awareness of the woman's potential need or wish to receive care in all of

Swanson's (1991) five categories (see above); the data have however demonstrated the midwives' emphasis on 'doing for'.

The emphasis by midwives on delivering or providing task-based care has been demonstrated, and was described by the midwives as 'the work' or 'the checks' but rarely referred to as 'care'. The interview data similarly suggested the lack of use of the word 'care' by the women themselves; instead they articulated a desire for the midwife to be available to recognise them as an individual with requirements relevant to them and to provide assistance in recognition of those individual needs. Vicky (fourth baby, normal birth) described the importance to her of:

*'...[being] treated as an individual, for who and what you are ...
you know, for your own needs'.*

In essence, the women were asking for recognition on different levels, by requesting assistance with physical care and, importantly, a meaningful interaction with the midwife, where the midwife responded directly to the woman and her needs at any given time. The midwives were able to respond to the request for physical or clinical care but often failed to recognise the need for the personal commitment sought by the women. The overarching aims of the organisation prevented a more meaningful way of relating with the women and, as a result, midwives were not able to offer the personal commitment desired by the women. It would appear then that care which was responsive to the needs of the women was dependent on a personal commitment by the midwives, as identified by Swanson (1991); the data demonstrated the inability of the midwives to offer such a personal commitment. In contrast, the professional commitment as demanded and expected by the organisation was readily provided. Personal commitment to each woman would arguably require a deeper investment by the midwives in their relationship with the woman. It therefore appeared that women sought a meaningful and what I have chosen to call a personal or 'unconditional presence' from the midwives but the midwives were predominantly only able to respond to the women through a 'functional presence'. In Chapter 4 I described how the midwives adhered to organisational functionality and how this impacted on their interactions with the women, a 'functional presence' was thus demonstrated by the midwives in their interaction with the women.

Kralik et al., (1997), using phenomenology, interviewed nine women following total hip replacement about the nursing care they received on the ward. Two major themes emerged: 'engagement' and 'detachment'. In 'engagement' the nurses engaged themselves emotionally and physically with the women, offering availability and assistance acknowledging the women's 'humanness'. In contrast, the detached nurse avoided personal contact and was perceived to offer a negative experience. In 'detachment' the nurse demonstrated efficiency to the organisation but failed to recognise the individual concerns of the women. It is recognised that women recovering from orthopaedic surgery may require a different and enhanced level of care when compared to women following the birth of their baby, however, the data from my study suggested the need for care-givers to 'engage' with the women and this was often lacking.

The differences between what was offered and what was expected are summarised and represented in Table 6.1 below. A degree of discord, primarily for the women, resulted as women and midwives were not always able to achieve a meaningful connection. In this table, I have sought to offer an illustration of the interactions between the midwives and the women, portraying what was offered by the midwives and what the women desired in these interactions. Dykes (2005) described the theme of 'disconnected encounters' in which the time available to midwives prevented a meaningful interaction with the women (a further discussion of the work by Dykes (2005) will be given in Chapter 7).

Table 6.1 The interaction between the midwives and the women.

Disconnected presence – offered by the midwives	Connected presence – requested by the women
<ul style="list-style-type: none"> • outside knowledge • functional • tasks – ‘doing’ • processing • identifying with the organisation and colleagues • organisational values • efficiency • service orientation • measurable output • detachment • known ‘territory’ • professional commitment • contractual • transiency <p style="text-align: center;">↓</p>	<ul style="list-style-type: none"> • inside knowledge • unconditional support • emotional support • personal commitment • trust in the care-givers • availability • understanding individual needs - ‘normality’ • non-judgemental assistance • offer of extended care • trust in the process/ passing through the ward • inclusion of partners • not always able to articulate untold needs • temporarily displaced • nurturing <p style="text-align: center;">↓</p>
<p>Leading to difficulties, therefore needing to ‘protect self’</p>	<p>Leading to difficulties therefore needing to ‘protect self’</p>
<ul style="list-style-type: none"> • limited physical and emotional presence in the bay • withdrawing - emotional refuge with colleagues • physical refuge in administrative tasks and ‘desk area’ 	<ul style="list-style-type: none"> • withdrawing to own bed space • ‘opting out’ – going home • seeking support from immediate family

Seeking to understand patient’s perspectives of therapeutic and non-therapeutic interpersonal interactions led Williams and Irurita (2004) to undertake a study using the grounded theory approach; the study was carried out in Australia. Forty patients, from both surgical and medical wards, were interviewed and a total of 78 hours of participant observation was carried out of six patients who were followed over several days. The participant observation also included informal conversations with patients

and nurses. They were able to identify three categories: a 'perceived level of security' which involved the relationship with staff and availability of assistance, 'level of knowing' within which access to information and knowledge was important. In the third category of 'level of personal value' patients indicated that a lack of interaction with the nurses led them to feeling devalued. However, the 'level of personal value' rose on interactions such as kindness, positive comments and active listening, with the nurses or non-nursing staff. Williams and Irurita (2004) concluded that the quality of the interaction experienced by the patients aided their emotional comfort; they therefore urged nurses to have regard for the 'psychosocial' care or interpersonal interactions. My data similarly indicate the importance of this element of care.

6.6 Conclusion.

Having explored the general concept of 'care', I will now go on to describe the range of the women's care needs, their perspective on the care and assistance they received on the postnatal ward and how they managed or reacted to the interactions with the care-givers. This will be discussed in relation to the findings already presented about the organisational needs and the emphasis on task-initiated care. Aspects which appeared of importance to the women will be discussed in order to assist care-givers in understanding the women's needs for care on the postnatal ward.

CHAPTER 7: HAVING (CARE) NEEDS ACKNOWLEDGED ON THE POSTNATAL WARD.

In Chapters 4 and 5, I described the organisation with a task-based culture and its impact on the midwives and the women. Although the midwives and the women appeared to coexist within the organisation, the data nevertheless suggested that the women were marginalised (see Table 4.1) and that the organisational needs took priority. In this section I wish to describe the women's encounters with the care-givers, primarily the midwives, and how they managed and responded to these interactions. I have chosen the examples of pain relief, transfer out from the post-operative bay and infant feeding to illustrate how the women steered their passage through their stay on the postnatal ward. I conclude by discussing the importance of care-givers providing a 'connected presence'.

7.1 Expressing uncertainty.

The combined data demonstrated that the women wanted to receive assistance and support for themselves as well as in caring for their baby. The women who participated in the in-depth interviews did not refer to any specific expectations of care or what the period on the postnatal ward might involve, possibly because of an overwhelming preoccupation with the birth:

' ... I didn't have any [expectations] ... I wasn't looking forward to the whole birthing thing anyway ... I just hoped it would be over quickly and that it wouldn't hurt ... ' (Helen, first baby, vaginal birth)

' ... I didn't know any of the midwives and didn't know any ... erm of the procedures that were going to happen there ... ' (Gill, first baby, emergency caesarean section)

It could be argued that with no previous experience women could not be expected to describe possible expectations, in contrast to women with previous experience - *'but I expect to have the care and anything else or whatever'* (Vicky, fourth baby). Rose

similarly described how *'first time round you wait for the midwives, don't you? this time round I did it myself, I knew it would be there for me'*. Although there was a sense of women with previous experience implying a degree of knowledge of what they could expect to receive, neither Vicky nor Rose, were able to describe that 'expected care' or what would 'be there'. However, women referred to their needs and the interaction which they wished for with the care-givers whilst on the postnatal ward (see Figure 6.1).

Irrespective of previous experience it appeared that the women needed the midwife for assistance and guidance during their stay on the postnatal ward. The woman's passage through the postnatal ward was linked to the interactions with the care-givers on the ward. Using a phenomenological approach, Halldórsdóttir and Karlsdóttir (1996) explored women's experiences of interactions with the midwives during labour and the birth. Ten women of differing parity participated, the inclusion criteria being that they should have experienced both a caring and an uncaring encounter with the midwives and these encounters were then explored in detail. The results indicated that during a caring encounter, the midwife appeared as an 'indispensable companion'; this contributed to the women experiencing empowerment as they were able to connect to the midwife. An uncaring encounter had the opposite effect; here the women detailed insensitive care from the midwives who were often in a hurry and adhered to routines rather than listening to the women. These women described feeling discouraged and disempowered. Their study related to women's experiences during labour, as did McCrea et al's., (1998) study as described below, but arguably the interaction between the midwife and the women is relatively similar at any stage during the childbirth experience.

The analysis of the combined data in the current study, suggested that the issues receiving assistance with pain relief and breastfeeding and as well as care following a caesarean section were of especial importance to the women; these aspects will therefore be described in this chapter.

7. 2 Managing the need for pain relief.

The need to receive relief of pain was evident from both the observational and interview data. Women who participated in the in-depth interviews vocalised their requirement to have access to pain relief.

7.2.1 The women's needs for pain relief assessed and managed by the midwife.

Access to analgesia appeared largely dependent on the midwives as the following vignette from the observational data illustrates:

'The midwife on night duty is undertaking a drug round with the drug trolley. It is late in the evening. The mother is asking for pain relief and makes her request - 'can I have some painkillers?'

Midwife - 'yes (pause as midwife studies the prescription chart) ... already had eight co-dydramols ... was it a normal delivery?'

Woman replies - 'yes'

Midwife - 'is it the stitches?'

Woman - 'no, backache'

Midwife, pausing - 'I'll give you voltarol, you're not asthmatic?'

Woman - 'no'

This mother was clear in her need for pain relief, the midwife perhaps less so. The entry in the field diary reads - 'the midwife has regard for the safety of the administration of analgesia as part of her professional responsibility. In order for the woman to receive pain relief she is asked to justify that need'. (18)

This mother was able to negotiate a satisfactory outcome to her need for analgesia. However, not all mothers were successful in having their request heard and met:

'This mother who had given birth to her second daughter earlier that day, requested pain relief; the midwife replied -

'for a normal delivery you should not need anything else than paracetamol ... if afterpains are bad you might need co-dydramol and we can send that home with you'. The woman offered no

comment and the midwife left the bay shortly afterwards. An entry into the field work diary reflected on a comment made by the woman earlier, where she described the value to her of sharing concerns with other women because 'from midwives you get the textbook stuff'. This was her second daughter; her movements around the bed indicated a need for analgesia. The woman was not observed to receive any.' (18)

Clearly, the midwife must adhere to safe practice in the administration of medication, but equally, the individual woman's concerns must be acknowledged; here the midwife appeared to assume that following a normal birth the woman would not be in need of analgesia. The woman's reference to and her perception of receiving care according to official guidance, the '*textbook stuff*', may possibly have related to previous experience with the birth of her first daughter. It appeared that this mother resigned herself to receiving care or management according to official regulation or guidelines available to midwives. Although the two illustrations above related to the same period of observation, they involved two different midwives, and thus illustrate differences in individual midwives' approach and control in providing care or offering choice.

McCrea et al., (1998) examined the influence of the midwife's approach to care when providing pain relief for women in the first stage of labour. Non-participant observation was undertaken of interactions between midwives and women in relation to pain relief; 11 midwives caring for 15 women were observed. Content analysis of the data yielded three discrete categories of approach by the midwives: the 'cold professional', the 'disorganised carer' and the 'warm professional'. Essentially, the 'cold professional' maintained a mechanistic approach to the provision of information or giving of pain relief and remained distant from the mother; she did not assist the mother in making a decision about pain relief. The 'disorganised carer' provided limited information only, based on her own opinions and personal experience. She appeared not to listen to the woman and would leave the labour room at frequent intervals. McCrea et al., (1998) described this midwife as nice to the women but unprofessional in her manner. In the third category of 'warm professional' the midwife offered explanations and provided information in order to enable the woman

to make her own decisions. She encouraged the woman to ask questions and offered physical and emotional support to the mother. The authors advised caution in interpreting the results, due to the small scale of the study and not being able to follow the women up after the birth to hear their views on the interactions. However, their findings illustrated the possible relationship between the personal qualities of the midwife and the impact of those qualities on the woman and the care she received. This may also have been true of the midwives I observed.

7.2.2 Learning to manage the care provided to ensure own needs for pain relief were met.

Extracts from the interview data also demonstrated in some detail how the women themselves managed and secured the pain relief which they required. This sometimes involved the woman negotiating with the midwife.

Thorne and Robinson (1988) described the conceptualisation of the development of a (three stage) theory developed from the views of those receiving care within a hospital environment. The researchers initially carried out two separate research projects, both using a phenomenological approach with in-depth interviews for the data collection. One study involved family members where an adult member was receiving treatment for cancer, the second consisted of members of families with a child with chronic illness. A total of 26 family members participated from 14 families; the care-givers were not included in the study. Independent analysis of the two studies by the researchers revealed the common theme of the relationship between those in receipt of care and their care providers, which prompted a re-analysis of the combined data in order to understand the participants' experience of being involved with an adult family member or child receiving care for chronic illness. This re-analysis yielded a three stage theory of health care relationships, referred to by the authors as a 'relationship evolution' (page 299).

Three discrete levels of relationships were identified within this three stage theory: 'naïve trusting', 'disenchantment' and 'guarded alliance'. Thorne and Robinson (1988) described how at the basic level of 'naïve trusting', the patients and family members expected to have a relationship with the health care professionals based on

common core principles of care and mutuality. When this trust was unrealised the patients entered the ‘disenchantment’ phase. The researchers described this stage as a period of frustration where they had to re-evaluate their interactions with the care providers. Having achieved this they passed into the stage of ‘guarded alliance’, where both parties shared an understanding of each other’s perspectives. The researchers described how some of the patients or family members never achieved this ‘guarded alliance’ but opted out of having further contact with the care-providers; this will be discussed below in relation to my data.

Due to the small sample of 26 participants only, Thorne and Robinson (1988) advised caution in interpreting the results but they offer their findings in the belief that the conceptualisation of the three stage theory, provided health care providers with an insight into the relationship with patients and their dissatisfaction with health care. Caution must be exercised as their data related to the views of family members of chronically ill patients, who are likely to interact with care-givers over a longer and sometimes extended period of time. Essentially, new mothers are well following the birth of their baby and elect to transfer home early on in the postnatal period. However, whilst on the postnatal ward they seek to develop a relationship with their care-givers and through this to receive care which is appropriate to their needs. It is possible that the women, although not having any specific expectations of care on the postnatal ward, entered the hospital with a ‘naïve trusting’ that care would be provided.

Gill described how she learnt and understood how to manage her need for analgesia, moving through the three stages of relationships, as described by Thorne and Robinson (1988):

‘ ... because after a caesarean section (pause) at the beginning the midwives would come round and say ‘okay, it’s time for this, it’s time for that’ and they would actually give you your medicine, your medication ... (‘naïve trusting’)

↓

*... and then, when you, when you moved on to the other ward it was up to **you** to tell them, the midwives, ‘it’s time for me to have*

something' (pause) so for the first day we kind of left the pain relief a bit too long...('disenchantment')

↓

... but then, once we got that organised it was fine (voice trailing)
... (pause) no, it was fine, every time I needed pain relief they were there, very quickly, they either came round to do their rounds or go and get some ...' ('guarded alliance')
(Gill, first baby, emergency caesarean section)

However, Gill concluded with the following advice for care-givers:

' ... I think they must tell the ladies that the pain relief now is up to themselves, they (the mothers) must, you know, keep an eye on the time and call for ... when they need their medication ...they (the midwives) wouldn't necessarily come and see you ... '

This 'informed level' (Thorne & Robinson 1988:298) represented information understood by the mother on reaching the final stage of 'guarded alliance', and the advice appeared to be offered in an effort to ensure that other mothers were able to have their needs met. In offering her advice, Gill expressed concern for other mothers.

Where the request for analgesia was not heard or not effective, the woman used a variety of strategies in order to receive pain relief; as was described by Lizzie who referred to not receiving pain relief when she needed it:

' ... the first time I didn't (voice raised) and that was because whoever it was that was giving out the tablets said that you were only supposed to have them every six hours, and I had asked for them too early but I've had co-dydramol before and I had always had them every four hours (laughing) and I actually said to the midwife 'I can have them every four hours' (pause) ...and it was just pure chance that somebody else walked in like five minutes later and I asked again and that was the midwife (name) who did

examine me when I very first went into hospital, I think she was one of the senior midwives, who said 'of course you can have some, I'll go and get you some straight away' and she did, she got me them straight away ... ' (Lizzie, first baby, forceps birth)

Thorne and Robison (1988) described how successfully progressing through the stage of 'disenchantment' may involve a degree of assertiveness, here Lizzie informed the midwife about frequency of self administration. Trust or 'guarded alliance' was re-established by the second midwife who complied with the Lizzie's request. On transferring home, Lizzie was again able to negotiate a successful outcome:

' ... when I came home from hospital they said to me 'do you want some pain killers to go home with?' and I said 'yes please'. They went off and got me my co-dydramol and I put them in my bag and when I got home I had only been given ten and I thought 'well, that's not going to see me very far with all these stitches that I have actually got' so (name of community midwife) the midwife, bless her, she followed up a prescription for me and got me another forty (laughing) so I did have enough in the end ... ' (Lizzie, first baby, forceps birth)

Clearly, there was no discussion on the number of tablets that the woman required to ensure continued adequate pain relief; rather an easily administered standard discharge pack of medication was provided. Arguably, a discussion between Lizzie and the midwife would have established Lizzie's needs. Kirkham (1989) found that organisational culture prevented meaningful interaction between care-givers and women as indeed my own data have illustrated. On this occasion Lizzie only reached a 'guarded alliance' once she had returned home and the community midwife organised a further prescription.

A different approach to self-care and ensuring adequate pain relief was also described:

' ... they were really good about that, I got ... I mean I clicked (using the call bell) them every four hours anyway, to make sure I was topped up and that ... it wasn't something they took on, to look after me, I looked after myself, do you know what I mean, I made sure that I got it so ... '

Interviewer - 'how did you make sure you got it, did you refer to your medication chart?'

' ... I timed it every four hours basically (laughing) because I mean I knew they wouldn't give me anything until it had been four hours and that and they did check the chart of what I was having, I never looked at it myself but I did time it so ... to keep myself straight anyway because I wasn't sleeping and that without it ... ' (Helen, first baby, vaginal birth)

Although Helen requested analgesia regularly whilst on the ward she was not asked, in contrast to Lizzie above, if she required pain killers to take home with her. This led her to reflect:

' ... I would have liked taking some home ... that would have been a better option (voice trailing) ... ' (Helen, first baby, vaginal birth)

It is possible that the differences in the type of birth may have contributed to Helen not being offered analgesia to take home, as she had had a vaginal birth, whereas Lizzie had an instrumental vaginal birth. The policy of the unit was to provide analgesia on going home for women following an operative or instrumental birth only and not for women following a normal vaginal birth. This again illustrated a lack of individualised approach where the mode of birth determined the provision of pain relief.

In passing through the postnatal ward, women sought to understand the options available to them there. Both Helen and Lizzie had to use their ingenuity in order to receive medication appropriate to their needs. Previous experience of postnatal care enabled some women to enter at the 'naïve trusting' stage assuming that the care that they required would be there for them, as the following vignette illustrates:

' ... because I knew in (name of previous hospital) they knew what time I'm going to take my medicine (voice raised) and like here you have to ring to have your medicine (sounding surprised) (pause) we are so many and maybe they don't know what time you are going to take your medicine ... but I have to ring for my pain killer ... I told them I need my pain reliever 'actually it's time to take my medicine' ... so they were 'okay'...' (Claire, elective caesarean section, second baby, English not first language)

Having arrived at the 'disenchantment' stage Claire was not able to achieve a 'guarded alliance' as:

' ... they still don't know what time ... are you going to take your medicine ... sometimes, all of the time (voice rising) I usually ring for my medicine (pause) and we know that medicine is very important during this time, it's your recovery time ...' (Claire, elective caesarean section, second baby, English not first language)

A sense of disillusion was thus experienced; the midwife was not present to seek to understand the woman's needs, or to understand the woman from her 'world' (Mayeroff 1971). The oft quoted meaning of the midwife, that of being 'with woman' was not realised.

The positive relationship between the woman and the midwife experienced with a planned homebirth has been highlighted by Munday (2003a, 2003b). She carried out a study of women's experiences of the postnatal period following a planned homebirth, using a phenomenological approach. Ten women of differing parity participated, two women were having their first baby; none of the women had previous experience of homebirth. Five women were cared for by an independent midwife and the remaining five were booked with their community midwife. The women were interviewed postnatally between six weeks of the birth and 18 months. Although a small study, carried out in Canada, it is reasonable to assume that the needs of women in Canada would not be too dissimilar from those giving birth in the UK. Munday (2003a) acknowledged that as the women had elected to give birth at home, partly because of

dissatisfaction with the system of birth in hospital and this may have lessened the objectivity with which they reported their experiences. Conversely, being interviewed at home may have contributed to the richness of disclosure. Women in her study described the relationship with the midwife as one in which the woman felt able to voice and discuss her concerns or issues at all times, thus giving a sense of a partnership with equality, knowing that her concerns would be recognised (Munday 2003b). It is possible that a different relationship or partnership with the care-giver may be experienced by the woman receiving care in hospital by virtue of the fact that she is unlikely to have met the midwife before arriving on the postnatal ward but a positive relationship such as that described by Munday needs to be aimed for. The data from my study suggested that women wished for a meaningful interaction with the midwives.

7.2.3 Importance to the women in deciding on their need for pain relief.

Recognition as an individual was important and the data from the in-depth interviews demonstrated that the woman wanted to be heard without a feeling of being judged because of individual needs expressed:

' ... certainly on the first ward, you know. It was offered to you when you needed it erm and you do, if you're in any pain, because you're constantly topping up on what you have and that's why the second day it was so much more painful for me, one it was only tablets and two ... I had to wait that bit longer. It felt like ... I would say double the length of time, I mean, I couldn't really remember on the first ward but it was certainly enough readily available you know and I felt that I was asking 'cos I was frightened of the pain coming in, I wouldn't necessarily be ready for it, I thought I'll ask anyway and if I'm allowed then I'll be given it and I was ... whereas on the second ward, you know, it was checked a bit more disciplined 'no, no, you've got another hour to wait' ... you know, so I did feel that was a bit harsh especially when it was only tablets as well and I thought 'how come I was allowed it so much more frequently on the other

ward?’ *and it was an injection, you know, why and only one day later, you know, am I supposed to be that much better that I can only have sort of half the pain relief? ...*’ (Jane, second baby, elective caesarean section, receiving care initially on the post-operative bay before moving to the main postnatal ward)

Jane described a sense of disapproval from the midwives for asking for analgesia, giving her a ‘*bad*’ feeling as if she was a ‘*drug junkie*’ or a ‘*wimp*’ and this had made her reticent to ask. On her return home she managed her analgesia according to her own requirements:

‘ ... I did take them every four hours, not six which is what it said on the packet and there could have been a bit more of them, in the end I just took one of the pain killers ... erm rather than two and end that much sooner ... ’ (Jane, second baby, elective caesarean section)

In essence, Jane trusted that she would have her needs recognised and experienced bewilderment when this trust broke down (‘disenchantment’), leaving her unable to resolve this breakdown of trust whilst on the ward. The midwife and the woman are both dependent on communicating with each other; clearly on this occasion, Jane did not understand the rationale for the midwife’s actions which then led to her expressing a feeling of being deprived of adequate analgesia. As the care provided did not meet with her expectations, she experienced a shortfall in her care.

Clearly, the midwife was required to have regard for the safe and appropriate administration of medication. Evidently, some midwives were more able to respond to the women’s needs for relief of pain, but equally for some women their requirements were underestimated and therefore some requests were not realised. Maternal morbidity following childbirth would appear extensive and underreported with many women experiencing discomfort whilst in hospital (MacArthur et al., 1991, Glazener et al., 1995); the management by the midwives in relation to analgesia for relief of pain indicated that this was not always understood; the observation had indicated that the midwives sometimes ignored the woman’s requirements.

The women did not refer to the midwife asking about pain or the need for pain relief at the time of the daily physical examination. The observational data indicated that the midwives would undertake drug rounds at set intervals as required by the organisation, thus not only separating out the daily check and the provision of analgesia but also failing to recognise the importance of acknowledging the needs of each individual woman. One midwife was observed to return to 'her' bay on completion of the checks asking all six women simultaneously if they needed something for pain. Thus the need for analgesia was considered as a group rather than an individual need.

The women who were cared for in the post-operative bay initially (as in Jane's case), reported better access to analgesia whilst in that bay and they regarded this as a positive aspect of their care. Pellino and Ward (1998) examined the satisfaction with pain relief by patients undergoing elective orthopaedic surgery; they wished to examine the relationship between pain severity and satisfaction by patients. A total of 137 patients participated, completing a questionnaire in the post-operative period whilst still on the ward, which assessed 'perceived control', 'pain severity' and 'control'. Statistical analysis of the data revealed a significant association between perceived control and satisfaction ($p < 0.05$). The authors concluded that patients who perceived that they had more control over their pain expressed greater satisfaction with the level of pain relief provided. As a result they argued that patients should be encouraged to recognise and report their need for pain relief. The data from my study indicated that women experienced greater satisfaction with the pain relief available when they were able to control this for themselves. Back in 1989 Rush et al., questioned the rationality of non-prescription medication remaining under the control of the care-givers rather than encouraging self-care by the women themselves. Recent initiatives would appear to suggest a trend towards self administration of drugs (Grantham et al., 2006). Such an initiative may impact positively on the midwife's time by allowing her to spend more time with the women but, and more importantly, enable each woman to manage her relief of pain and discomfort associated with the birth of the baby and their individual requirements.

7.3 Receiving care in the post-operative bay and then being moved to the 'general' bay.

A description of the ward was given earlier, with a diagram to illustrate the layout of the ward at the time of the observation (see Figure 4.1). The observation was undertaken within the postnatal bays only and not within the post-operative care bay; the intention was to observe women on the postnatal ward and not specifically within a post-operative ward environment. However, with the policy of moving women out of the post-operative bay to another bay within 12-24 hours, women who had an operative birth were inevitably included in the observation and were therefore included in the in-depth interviews. The in-depth interviews highlighted the aspect of receiving care within the two bays and it was evident that women who had received care within the post-operative care bay regarded this as a 'special' and positive experience and different from the bay which they were subsequently moved to. Several aspects were identified by the women, such as assistance with personal and physical care:

' ... I don't quite know what it was, I think the first night you're looked after really well, because you're on a different ward ... as soon as you move, they are there ... erm they are washing you and just taking real care of you and then I think it was when I was moved to the normal maternity ward, ... and the care there wasn't ... as prompt ... ' (Jane, elective caesarean section, second baby)

'...eh, afterwards, actually because I still had my catheter during the first night and ... they always ... eh talk to me or ask me if I need something or if the baby cried, what she wants or sometimes they ... take my daughter away to, you know, to take care for a while so that I can have my rest ... during the night and they also asked me about my wound ... and how the pain ... and yeah, you know and ... how my blood loss and everything ... ' (Claire, elective caesarean section, second baby, English not first language)

' ... the special ward where they put you after a caesarean, all the ladies in there have had caesareans, special care unit or whatever,

where the midwives come round and see you regularly with your pain control and make sure you are not bleeding too much and change your dressing and things like that (voice trailing) ... (Gill, emergency caesarean section, first baby)

Although women were aware of the policy of moving from the post-operative bay to a postnatal bay, Jane described how she did not feel ready for the move to the 'normal' maternity ward:

*' ... I'm not sure they (referring to the staff in the bay into which she had been moved) specifically know why you're there, you could just have had your baby naturally or whatever ... the different types of ward, the care there was certainly different, between the caesarean ward to the general maternity ward ... and I found that just particularly difficult because I couldn't physically move ... and I didn't feel that, when I was in the caesarean ward you felt that you **could** ask for help, you know, even if it was just to get up, because everybody else was in the same boat as you erm whereas on the other ward people were managing to move around on their own, ... so ... erm you kind of reach the conclusion that 'well, I think I'd better just get up and about and go really' ...'* (Jane, elective caesarean section, second baby)

In moving the woman out of the post-operative bay, the staff spoke about the aim to encourage mobility and self-caring, arguably an important aspect of care following an operative procedure. However, as the move was essentially initiated by the rules of the organisation and not driven by the needs of each individual woman, the timing of the move may therefore not have suited the woman as she did not feel 'ready' to move to the next bay. Her experience led Jane to question the care-givers' knowledge of her needs and individual circumstances:

' ... we were moved straight to the other ward, it was only a matter of a day, within twenty four hours, but I didn't feel any better, in fact I felt worse the second day ...I don't know if the nurses (sic)

there didn't really know, you know, that you'd had a caesarean, you might just sort of come in from a normal birth in the delivery room, erm but it wasn't as 'are you okay?' sort of every hour ...'

Jane referred to feeling '*completely on my own here*' and how this had contributed to her decision to transfer home the following day:

' ... you go from being cared for on one ward and then on the next, you're cared for but nowhere near to the extent that you were ... you just feel that you want to get home ... to your own home ...'
(speaking quietly)

By virtue of being in a care setting 'designed' to deliver care to the new mother, she may, reasonably, have had expectations of a certain level of care or at least to have been involved in a discussion about her needs.

The findings of Thorne and Robinson (1988) offer an understanding of the views provided by the women in the current study, as illustrated by Jane above. She described receiving physical care and assistance on the post-operative ward comparable with what she felt she needed and was able to remain in a state of 'naïve trusting'. On transferring to the main postnatal ward however the care fell short of her requirements and expectations and she experienced 'disenchantment'. In contrast to the participants in Thorne and Robinson's (1988) study Jane felt that she did not need to continue receiving care from this group of care-givers (she had nothing specific to gain from them) and therefore did not need to achieve a 'guarded alliance'. In essence, Jane 'opted out' from receiving further care within the ward environment and transferred home. At the time of the interview Jane reflected back on her care:

' ... you know when you asked me about doing the survey, I thought 'overall I'm quite happy about my stay' and then I started thinking yesterday about my whole experience (pause) ... at the time I didn't actually think 'this is really bad', you know, I just thought 'well, now I'm on a different ward, I've got to get on with it myself' ...'

Thorne and Robinson (1988) referred to the need for the relationship between carers and those receiving care to evolve over a period of time. The families who participated in their study were caring for a family member with chronic illness or cancer which is likely to involve or necessitate a long-term relationship in hospital. In contrast the woman's stay on the postnatal ward is normally of a short duration and this may impact on the relationship or the interaction with the midwife. Postnatal women may view their position as different as they do not generally need to receive highly specialised or specific services from the care-givers in hospital (as those in Thorne and Robinson's study had to) and have the option of returning home to receive care from their team or community midwife and their own families.

Woodward (2000) described how midwives failed to recognise women's discomfort following birth by caesarean section and the impact this might have on caring for themselves and their infant. She detailed their needs as being similar to that of a sick role. However, she concluded that as the sick role was not always acknowledged, their needs were not met. Clearly, Jane did not feel ready or prepared to move to the general bay and would have wanted to continue to receive that 'special' care available within the post-operative bay, however, official protocol overrode her wishes. The maternity unit did not have a policy of different or separate staff for the post-operative bay and the midwives were allocated to either the post-operative bay or the main postnatal ward. As a result the woman could be cared for whilst in the post-operative bay and subsequently on the main postnatal ward, by the same midwife who thus appeared to tailor the provision of care to the placing of the woman on the ward rather than her needs and individual requirements.

Not feeling different from the other women was also important and being on the post-operative bay appeared to confirm the normality to the women of their own birth. Stockwell (1972) described how patients were aware and sensitive in detecting the concerns and needs of other patients, especially in the absence of a nurse to offer support. Gill's description appeared to validate what Jane had said:

' ... the special ward ... I think that was actually (voice rising) the nicest part of being in hospital because all the people that were in that same ward as you had been through the same thing ... a lot of

them, some of them had had elective caesareans, some of them had had emergency caesareans as well ...so it was nice to talk to them and find out about what they had been through ... that it wasn't just you that was there ... we were there for twenty four hours and ... the next day they move you into another ward, they spread you around ... with other ladies (voice trailing) and that was very hard (voice rising) because then we were split up and so again, you are just with new people who haven't had a caesarean, have just had a normal birth ...' (Gill, emergency caesarean section, first baby)

Gill reasoned:

' ... that they split up all the caesarean care, the caesarean ladies because obviously they need more care than ladies who have had a natural birth, so therefore, you don't want to have them all in one ward, because then the poor midwife who is looking after that ward would be rushed off her feet all the time ...'

Although Gill was critical of having been separated from the other women in the post-operative bay and felt that women who had had an operative birth needed 'more care', she rationalised that her individual needs had to be balanced with an expectation of what the midwife could reasonably be able to undertake. In essence, Gill appeared reluctant to criticise the care-givers and such reluctance has also been identified by Pontin and Webb (1995).

Fenwick (2005) conducted a grounded theory study exploring women's experience of birth by caesarean section. The women who were interviewed in her study, identified a feeling of missing out on a normal birth; in the present study Gill voiced such a feeling. The women in Fenwick's study also described that their physical and emotional needs were not acknowledged on the postnatal ward; they regarded their stay there as a negative experience. Similar findings were reported by Singh and Newburn (2000) who described how women who had had an operative birth reported inadequate care in hospital.

The women in the current study described how the move from the caring environment of the post-operative bay had denied them the level of support and interaction with the care-giver that they felt they needed. Jane detailed '*almost too much care*' in the post-operative bay but a feeling of '*they don't even know I'm here*' on moving to the other ward. Gill similarly described how on having moved - '*the only time that I was seeing the midwives really was when they were helping me*'. This contrasted with the women's descriptions of staff, both midwives and health care assistants, being more available within the post-operative bay ready to respond to the needs of the women or assisting with care of the infant. As evident from the observational data, midwives were not observed to offer or provide additional or different care to the women within the general postnatal bay who had had an operative birth, possibly based on the assumption that care provided initially on the post-operative bay would have prepared the women for at least a degree of self-care or the expectation that all women recover within the same time frame.

The purpose of the post-operative bay was to provide care as appropriate to the needs of the women who had had an operative birth in the immediate postnatal period, such as monitoring of vital signs, ensuring adequate analgesia and wound care. Baxter and Macfarlane (2005) conducted a study seeking women's views on their care following a change in practice which involved nurses and nursery nurses providing care to women who had had a caesarean section rather than midwives. A total of 146 women who had received care before the change in practice and 142 who received care following the change, returned a questionnaire at between five and 18 weeks postnatally. This represented a response rate of 65% in the post-change group and 68% in the pre-change group. The women's case notes were also reviewed to estimate the level of intervention by the staff. Statistical analysis of the data demonstrated that the women who received care following the change in practice were more satisfied with their care, with 53% of the women in this group describing their care during the day as excellent or very good, compared to 35% in the pre-change group. It is interesting to note that the differences were greater still when the women evaluated their care at night; 59% in the post-change group described their care as very good or excellent, compared with 28% in the pre-change group. Similarly the women in the post-change group reported higher satisfaction with physical care and practical assistance offered. It is not known whether the women were cared for separately from

women who had had a vaginal birth or were moved during their period of recovery on the postnatal ward; it is therefore possible that the women in their study did not experience a different and reduced level of care after their first post-operative day and this may have contributed to the high ratings offered by the women following the change in practice. Baxter and Macfarlane (2005) concluded that the change in practice appeared to have improved care to the women who had had a caesarean birth; the authors referred to a significant improvement in the satisfaction with care reported by the women. As the nurses and nursery nurses appeared to be in addition to the current staffing level, it is possible that the change in the type of staffing expertise contributed to the satisfaction expressed by the women. An economic evaluation of the change in practice was not reported with the findings, but following the study the unit had increased their establishment of nurses and nursery nurses. It is evident from my study that the women rated the care in the post-operative bay as better suited to their needs when compared to the general postnatal bay. The rate for caesarean section for 2004-2005 for England was given at 23% (The Information Centre 2006) and it is therefore important that these women receive care appropriate to them and their needs throughout their stay on the postnatal ward. The current study has demonstrated the importance attached by the women of receiving care of the level and type provided in the post-operative bay and that midwives were able to provide this type of care.

7.3.1 Progressing from the post-operative bay.

Jane and Gill both described the value to them of being cared for in the post-operative bay and the sense of loss they experienced on moving out of that bay. In contrast, Claire described being aware of the policy of being moved from the post-operative care bay and when this did not happen as expected she described her feelings of mild disappointment:

' ... actually, I was supposed to move that day (voice raised) but they told me the ward is full so then I haven't a bed, I don't have a place to sit in ... so I stuck on the post-operative bay for I think a whole day and I told them 'that's okay, just remove my catheter so I can move' and they removed my catheter and they helped me to

clean up, to have shower and then I remember I rang because the second shift is coming and I told them that I am supposed to transfer to the postnatal ward and then they told me 'oh, I will check and see if there is a place because it's so busy'. They check and that midwife, she is nice also and 'there's a place for you, you can move' and then they moved me to the postnatal ward ...'

For Claire, the move from the post-operative bay appeared to represent progress.

In providing physical care to the women in the post-operative bay as described by the women themselves, the midwives were adhering to the aspect of 'doing for', as advocated by Swanson (1991). Although the provision of care or the pattern of care in the post-operative bay was essentially driven by the requirement of the organisation, this met with the expectations and the needs of the women, but for the majority of the women led to them feeling bereft when that level of care was no longer available on the main postnatal ward.

It would appear then that in requesting pain relief and receiving care on the post-operative, but less so on the main postnatal ward, women were able to use different strategies to secure care appropriate to their caring needs.

7.4 Needing to be reassured about feeding their infant.

Early observational data indicated that women wished to receive assistance with feeding their baby; women had a need to be reassured about their ability to feed their baby. One new mother declined the invitation to participate in the observational phase describing how she felt '*pressured with the breastfeeding*'. Similarly, a mother participating in the in-depth interviews detailed how with her first daughter she had closed the bed curtains when feeding, describing this as a '*confidence thing*' and a way of avoiding being '*judged*'; this time with her second baby she '*hardly used*' the bed curtains.

7.4.1 Nurturing their baby.

Women frequently expressed concerns about feeding, predominantly in respect of breastfeeding but occasionally about artificial feeding. A new mother was heard to voice her anxiety about breastfeeding to a health care assistant:

'...that's what I'm worried about, he's not had anything'. The health care assistant offered no reply, however later the mother repeated her concern - 'what happens if he doesn't feed?' to which the health care assistant replied - 'I'll get the midwife and she'll sort something out'. No further assistance was offered by the health care assistant. This mother was later heard to tell her visitor - 'I can ring the bell for help' and she did. (14)

Mothers were also observed to share their concerns with visitors or a caller on the telephone:

'She took thirty five ml which I think is alright'. (16)

'I'll be alright if I can get the feeding sorted'. (18)

The second mother was talking to her visitors, the midwife had indicated previously that she would provide assistance with feeding at the end of visiting. Informal conversations with the midwives revealed that they perceived that the women did not want or need them during visiting hours. Visiting times for the woman's family and/or her friends was restricted to two hours in the afternoon and one hour in the evening. Visiting times for the partner will be discussed in the Chapter 8.

One new mother offered the following comment to her partner on his arrival on the ward in the morning:

'...we had a go last night, we're kind of getting there'. The midwife was observed to provide assistance with the breastfeeding. The paediatrician carried out the newborn examination and on assessing the sucking reflex commented – 'He can suck', to which

the woman responded – ‘It’s me really, I’m not very good at it’. The woman’s comment prompted the paediatrician to inquire about the feeding but having established that the baby had fed at the breast since birth, no further advice was given, instead ending the examination – ‘Alright, well done, congratulations’. The woman and her partner both replied – ‘Thank you’. Later when asked by the midwife allocated to the bay – ‘Are you going home tomorrow?’, the woman replied – ‘... depends on the feeding, the midwife at home can’t help me in the same way, she’s only calling once a day’. (10)

This new mother repeatedly expressed her uncertainty, seeking reassurance and guidance with breastfeeding. She was observed to receive assistance from the care-givers, and she expressed confidence in knowing that the care-givers were there to provide assistance if required.

Helen (first baby) whose baby was born at term with a low birth weight, described a fear of her body not being able to nourish her baby *‘as it let me down in labour’* and how *‘the placenta had not been functioning for weeks’*. She experienced a sense of *‘failure’* and feeling that it was her *‘fault’* and how on discussing this with her midwife once home, she had received no practical assistance. She described *‘sticking with it for two weeks’* and the *‘huge relief’* she felt on changing to bottle feeding. Having made the change she felt that she then understood that her body would have been capable of nourishing and sustaining her baby. Helen’s doubt in her body’s ability to nourish her baby was striking. This information was offered by Helen soon after I had arrived at her house and before I had the opportunity to start recording the conversation. Although Helen later mentioned aspects of breastfeeding whilst on the ward and receiving assistance from the midwives, she did not offer further details during the interview on her reasons for changing to bottle feeding. Helen perceived the assistance provided by the midwives on the ward as negative, as described below, and this may have contributed to her not asking for assistance once home.

The national survey of infant feeding (DoH 2002) revealed that nine out of ten women, who gave up breastfeeding in the first six weeks after the birth of the baby,

would have liked to have breastfed for longer. This was also evident from my interview data. Five women who were breastfeeding when they agreed to participate in the in-depth interviews had changed to bottle feeding by the time of the interview. For all of these women this was their first breastfeeding experience and they unanimously expressed regret about not having been able to continue to breastfeed.

Dykes and Williams (1999) in a study using a phenomenological approach, explored women's perception of the adequacy of their milk in relation to nourishing their babies. Ten women, who had all given birth to their first baby, participated in in-depth interviews on three occasions up to 18 weeks after the birth of the baby. Four major themes emerged; briefly, these related to - a need to visualise the quantity of breast milk, maternal dietary concerns, the challenging journey of breastfeeding and the need for support. The theme of breastfeeding as a challenging journey was referred to as 'falling by the wayside' and was associated with a lack of involvement by the midwife and poor advice in relation to breastfeeding. Their findings revealed that six out of the ten women expressed anxiety about the adequacy of their breast milk. Although a small study, it nevertheless provides an understanding of women's concerns in relation to nourishing their baby by offering an alternative perspective to the available quantitative data, such as the national survey on infant feeding. Dykes and Williams (1999) described the negative impact of a medicalisation of infant feeding and of the marketing of infant formulae, which they described as having contributed to women's lack of confidence in feeding their baby. They further argued that this lack of confidence is culturally induced and that any physiological insufficiency of breast milk can be attributed to poor management of breastfeeding. The findings from Dykes and William's study are important as they identified areas of concern to the women and offered guidance on how midwives could assist women in their breastfeeding journey. However, as demonstrated by the data from the current study, this assistance or support was not always available to the breastfeeding mother resulting in the woman experiencing a feeling of losing her way.

7.4.2 Women in need of assistance with their feeding.

Women's persistent requests for assistance with breastfeeding were evident in both sets of data. They exhibited a longing to be assisted with their priority of nourishing

their baby and for the midwife to confirm that they were 'managing'; a sense of fragility was palpable. Lizzie described receiving help whilst on the ward:

' ... she was the first lady that tried to help me with the feeding in the middle of the night as well and she was very patient ... she was really nice, I mean it didn't work in the long run but she did show the compassion and the time even though it was in the middle of the night ... ' (Lizzie, first baby)

It was apparent that Lizzie appreciated this assistance offered to her in feeding her baby. By providing the 'compassion' and 'time' the care-giver essentially offered her commitment, identified by Swanson (1991) as being central to caring. The interaction with the care-giver took place during the night shift and this may have contributed to the care-giver's ability to assist Lizzie; I have previously referred to the difference in expectations by the organisation of activities over the twenty four hours.

Pauline who had had given birth to her first baby (normal birth), described her experience:

' ... I wanted to breastfeed (voice raised) but you don't know how much you're giving them ... and if you have given any ... so ... they would like help me and erm tell me what I should do, put me on the pump (voice trailing) ... you know, just helpful that way... '

However, it was evident that the practical support provided did not always suit the needs of the individual woman, as the following vignette illustrates:

*' ... the only bad thing that I found with one midwife, because they're so many, changing all the time erm ... was when she was showing me how to breastfeed, she was really hurting me (voice rising) she was putting my nipple in her (the baby's) mouth but ... you know they try and bring the milk out of it first and she was doing that and I just felt it was really **painful** and we were trying to do it lying down and I said to her 'you're going to have to stop'*

and I said 'you're really hurting me' and she was quite surprised so again it's probably not them, it's me. I should have said something before you know, you're probably sort of not yourself, put yourself in their hands and hope they'll do what's right for you and the baby so ... that's the only thing that I did find was very uncomfortable because (pause) but it does depend on how you feel about your breasts I suppose and it was just that I hadn't had a chance to really try it and I felt with her that she was like forcing it in her mouth and things and hurting me and things (pause) ... when I had a bit of a quiet time erm I just tried it myself then, I just, just me and her and she latched on then and everything was fine, so it was just more about being relaxed (sounding happy) instead of forcing things were they weren't going to go and then it was alright, we took off from there so ...' (Helen, first baby, breastfeeding in hospital but subsequently changed to formula feeding)

The assistance offered to Helen and her daughter was largely managed by the midwife and clearly did not meet Helen's needs as a new first time mother.

Dykes (2005) described how midwives 'invaded' the woman's space in order to actively attach the baby, using a 'hands on' approach. In assisting Helen, the midwife led the interaction, thus creating an asymmetrical relationship (Lomax & Robinson 1996). However, Helen felt able to end the interaction. It is interesting to note that Helen assumed that the pain experienced was 'her fault'; the subsequent success and joy in succeeding on her own was evident. Clearly, Helen was critical of the assistance offered by the midwife but she nevertheless rationalised that *'it's probably not them, it's me'*, consistent with the findings detailed by Pontin and Webb (1995) where patients 'wrapped up' their concerns in order not to criticise the care-givers. The midwife in assisting Helen provided care through 'enabling', as described by Swanson (1991), in using her expert knowledge but her surprise at Helen's comment would indicate that she failed to understand the interaction from Helen's perspective and therefore, on this occasion, she was not able to care through 'knowing' (Swanson 1991).

Mahon-Daly and Andrews (2002) in an observational study of women who were breastfeeding and formula feeding, sought to understand women's experiences of breastfeeding from a geographical view, which the authors described as relating to space and place. The purpose of their study was to seek to understand the women's transition into a 'new world' (page 65) of breastfeeding. Participant observation was carried out of a group of mothers attending a mother and baby group over a period of five months; all the mothers had some experience of breastfeeding. A number of informal interviews were also conducted. Five themes were identified, which included 'space and breastfeeding'. In this category the women described breastfeeding as a private event; women were observed to position themselves away from the main group whilst breastfeeding. One of the authors was herself a breastfeeding mother, a fact known to the participants and an aspect which the authors regarded as allowing the researcher integration into the group. It is not known how she dealt methodologically with this prior knowledge.

Helen, above, confirmed the need of privacy in the act of breastfeeding as it belonged to her body, by withdrawing from the help available. In a sense the closed bed space offered the women a sanctuary where they were not observed and could withdraw from the ward environment and also from the other women.

Denise described her first night on the postnatal ward, feeling deprived of sleep and how when she needed assistance:

' ... I just rang the bell, she came in, she didn't come in off her own, I rang the bell, she came in and took over. I'd been crying, you know, she helped me to take him away and she said 'well, I think he is hungry, do you want to try and breastfeed him?', you know, sit in the chair at two o'clock in the morning that's the last thing I wanted to do. I was just like 'no, no', you know, so she said 'do you want to bottle feed him?' and I said 'yeah, okay' ... so she took him away. It was only because I asked her that she took him away, and after that I was a bit emotional, you know what I mean ... (pause) ... I think she sort of guessed that I couldn't cope with him and that I didn't want to breastfeed him at two o'clock in the

morning, so she sort of said to me, you know, 'do you want me to put him on the bottle and what milk do you want to give?' ... and I said 'oh, (name of milk) or anything', you know and she was like 'fine' and took him away ...' (Denise, first baby, breastfeeding in hospital but formula feeding at the time of the interview)

Here, the midwife clearly offered to assist Denise with breastfeeding and discussed the options available with her. At the time of the interview Denise described the assistance as having been positive and right for her at that time. Later she offered a scenario where the midwife had not responded to her needs:

' ... well, he was latching on okay and obviously, you know, trying to get the milk through and stuff like that but ... erm I just had him on the one breast and ... I wasn't swapping him over and once he'd finished on the left breast I should have put him on the right breast in case he wanted some more milk but I didn't know that then, so after he had finished on the one breast I thought he wasn't hungry anymore and I had given it to him and he'd still be crying and I thought 'what are you crying for?', and it didn't click then that I should put him on the other breast, try him again on that one. It wasn't until my mum said to me ... and the midwife could have said to me ... I don't know why she didn't sit down with me explaining and 'why don't you try him on that one?', you know. She didn't even explain to me that the milk had run out on this one and the other breast is full, try him again on the other breast you know. They sort of ... Sunday morning they asked me 'are you breastfeeding or not?' because I had another midwife then in the morning after handover and she said 'are you breastfeeding or not?' and I said 'I am' and that was it. I thought 'is that it then?', she didn't actually say ... it would have been nice if she'd sat down and said (pause) ... but it would have been nice for her to say or sit down with me to watch me do it, to make sure that I was doing it properly, that I didn't have any problems because I really struggled when I got home and that ... hard work, this

breastfeeding and they always, (slight rise in voice) you know, they push it so much 'oh, breastfeeding is the best' and all that lot, but the help I got was non-existent, you know ... a shame ...' (Denise, first baby, breastfeeding in hospital but formula feeding at time of interview)

Where the assistance provided did not meet the needs of the woman, a sense of loss was experienced. Denise who earlier described her need for support in the middle of the night, later attempted to understand the *'non-existent'* assistance.

Arguably, Denise expected to receive support by virtue of being in hospital, but described how that support was not always there when she needed it; rather the midwife appeared to challenge Denise on her method of feeding. Denise moved through *'naïve trusting'* to *'disenchantment'* (Thorne & Robinson 1988):

' ... the fact that I had no support, you know, and in the morning by seven o'clock I was like 'yeah, can I go home, send me home' (laughing) and I think, it was just that, I wanted to go home any way, sort of part of the family and everything, you know, a bit more support (voice quiet) ...' (Denise, first baby, breastfeeding in hospital but formula feeding at time of interview)

Having reached the stage of *'disenchantment'*, Denise *'opted out'* by going home, in the knowledge that this would increase her access to support, from her partner and her mother. Kitson (2003) described the importance of a lay-carer above that of a professional carer, who is regarded as being required only in the event of lay-caring being deficient. Arguably, the professional carer, the midwife, did not respond in a way which was meaningful to Denise and rather than seeking to enter a *'guarded alliance'* she opted out of hospital in favour of predominantly lay-care.

7.4.3 Assessing and sharing with the feeding.

The interaction between the midwife and the woman was dependent on assessment and sharing of concerns; Gill described the midwives assisting her:

' ... we tried to express using the electric pump to see if we could express something for her but it didn't work, nothing came out, so we tried to hand express and that didn't work either so ... in the end we just gave up, and ... I mean she had a little bit, very, very little ... and then I think the next day my milk had actually come in ... ' (Gill, first baby, emergency caesarean section)

The midwives regarded an assessment of *'feeding'* to require documentation of frequency, length of feeds and volume taken by the infant. Language used by the women themselves indicated a process of *'being done to'* – *'they put me on the pump'*. This may have reflected the midwife's need to manage the interaction with each woman:

' ... we'd a pretty good feed there, he's had a good ten minutes there ... I'm not saying that you're going to have problems each time but ... ' (voice trailing, sentence not completed by the midwife) (15)

Similar comments by the midwives were heard for women who had elected to formula feed:

'Midwife, looking at the bottle on the trolley, commented – 'he's had about thirty ml, that's alright'. This woman had given birth to her third child and was not observed to question the amount needed by the baby.' (18)

One woman described how she felt *'pressurised'* as the midwives continued to ask about her baby's feeding pattern (13). Midwives were observed to question women and make their own assessment about the feeding, but would not always share this information with the woman. As there was limited sharing with the women on why *'ten minutes'* or *'thirty ml'* was acceptable, it is possible that the midwife's reasons for the assessment were not understood by the mothers. The interactions between the midwife and the woman conveyed a *'functionality'* which was understood by the

midwife but may not have had a meaning for the woman. In maintaining this functionality the midwife continued to respond to the demands of surveillance by the organisation.

During the construction of the observation schedule (see Appendix 3) one midwife offered the comment that postnatal care was ‘80% breastfeeding’; the midwives present concurred with this statement. This would imply that the majority of their time whilst on duty was spent assisting women with breastfeeding, however, this was not observed nor was it referred to by the women in the in-depth interviews. The unwritten rules of the organisation ensured that maternal and infant checks were prioritised over other aspects of care and support; in essence, ‘feeding’ was represented by a box which had to be ticked off primarily based on the midwife’s assessment. Lists which the midwife was required to complete guided the physical daily care for the woman and her infant were discussed in Chapter 5 (see Appendices 13 and 14), but as ‘*breasts*’ and ‘*feeding*’ were separated out this appeared to physically disconnect the two aspects, with ‘*breasts*’ required to be monitored on a medical ‘illness’ model to ensure free from infection, similarly described by Dykes (2005). Reference was made earlier to the midwife who spoke about how she ensured that all babies had received a minimum of two feeds during her shift on duty. Although she adhered to the expectations of the organisation as her tasks were completed within the given time frame, she nevertheless sought to offer support to the women with infant feeding in addition to those tasks. In essence, she demonstrated creativity even though ensuring a minimum number of feeds introduced an element of regimentation. Denise referred above to the physical absence of the midwife and how she would have wanted the midwife to stay with her during the breastfeed. Dykes (2005) described how organisational constraints prevented the midwives from offering time to the women; the impact of the organisation was evident in my data and may have contributed to Denise’s unsatisfactory experience.

7.5 Offering a ‘connected presence’ to the woman.

In Chapter 6 I described to the women’s request for a meaningful interaction with the care-givers, offering aspects of such interactions in Table 6.1. The observational data included some rare social interactions which were shared between the midwife and the

woman, offering a glimpse of an alternative relationship which was not based on the midwife's immediate need to deliver physical care. For example this light-hearted comment by a midwife at the end of her late shift – *'I'm off, I don't do dirty nappies this time of the day'* (15) to which the women laughed, or congratulations to the women on their progress with baby care or feeding:

'Well done!' (10)

'... that lovely feed you gave her earlier...' (18)

'... I'll tell you what ... if you get into bed and get comfortable, I'll put her next to you..' (15)

Such interactions appeared unusual and predominantly of a fleeting duration. However, the following extract from the observational data illustrated a different perspective of a more prolonged presence by the midwife with the woman:

'There are four mothers in the bay. All of the bed curtains are drawn, leaving a small gap for entry or exit into the woman's bed space. There is a low level of activity in the bay, the midwife is with one of the mothers undertaking the maternal examination. This mother had had her first baby three days ago, her husband has just arrived and she greets him joyfully – 'I'm allowed to go home today'. The woman shares her concerns with the midwife – I don't feel prepared for motherhood'. The midwife talks about 'adjustment' and that 'it takes time'. The baby is now crying lustily, the mother expresses doubt about the breastfeeding, indicting her uncertainty in carrying on breastfeeding. The midwife comments –'you're only human', asking to feel 'her tummy', inquiring about clots, passing urine and bowels. General health advice is given as the midwife carries on with the postnatal check, the woman mentions formula - 'it's just nice to know that there is back-up there'. The midwife seeks to reassure her and her partner (present throughout the examination) that - 'you'll be able to make enough milk for your baby'. The midwife proceeds to explain the content of the pack of written information which she has given the

woman. She then leaves the woman's bed area. The infant is crying again, through the gap in the bed curtain the woman can be seen packing. She then asks her partner to close the curtains fully as she intends to feed her baby. The midwife is in the bay, washing her hands. The woman is heard to be in discomfort, the midwife attends immediately and offers assistance with feeding whilst informing the mother – 'feeding should get better'.' (03)

Although the midwife was essentially present for the purpose of completing physical care and delivering information to the woman, she nonetheless responded to the woman's concerns.

Where the midwife was able to offer a continued presence to the woman, this was commented on by the women as a positive experience, in essence describing how these encounters had enhanced their experience of receiving care on the postnatal ward. A personal quality of warmth and friendliness in individual care-givers was referred to by some of the women in the in-depth interviews. Lizzie, who asked the staff to look after her daughter for a couple of hours during the night, described the care given by health care assistant on returning her baby to her:

' ... When she did bring her back down to me, she remade my bed for me and she went and got me a cotton sheet because the blanket was just so hot that they had on there, there was no cotton sheet on the bed, top sheet, so she got rid of the big heavy blanket and so on 'I'll get you a nice cotton sheet, it will be a lot cooler', which she did and then she was the one that sort of 'I'll make it nice and comfy for her to lie with you'. I really liked her (voice rising, sounding positive). She was a really nice sort of approachable person, you could ask her something and ... she just sort of acted on it, she seemed to know her job really well, in fact I think she did more than her job's worth, you know, she probably went out of her way a bit to help people (voice trailing) ... yeah, I really liked her (pause) yeah, she was lovely ...I don't know her name (sounding regretful)' (Lizzie, first baby)

Jane similarly referred to her positive experience with one midwife on the ward:

' ... I was very pleased with the midwife actually we had erm ... not all the way through, I didn't see her for the two days that I was resident there, when she took me down for the operation and then brought me back to the bay and then I saw her on the last, on the discharge day erm, you know, she was fantastic, really funny as well, a short lady ... can't think of her name, it would have been on my paperwork (voice quiet) ...

Interviewer - 'what made her 'fantastic'?'

Jane - 'she was just funny, there was such a humour about it all, nothing was ... you know, you're in hospital, most miserable place in the world (laughing) with ill people and stuff and she just made the whole experience, like it was to be enjoyed, you know. The whole thing was done really well ... and she brought me back to the bed ... I had a drip in my hand (pause) and I think it slipped out of the vein and the water they attached to me, once I was back at the bed, puffed my hand up. It didn't go in the right place and I went 'oh, look at my hand!' and she sort of 'oh, crikey!' and with that she got somebody straight away, I think it was the surgeon, she said 'do we need to have this in?'. I didn't like them anyway and she knew that (pause) but the fact that she got it sorted really quickly because she knew that that would have bothered me anyway, let alone the fact that my hand was swelling and she said 'let's get that out, we don't need that', you know, and just took it out and took my mind off it, whereas she could have just said 'it's really got to stay in there until someone can come round' or 'we'll put it in again' which she knew I wouldn't have wanted. She just got it out and left it out. Everything was done sort of really in your best interest, rather than what you had to have ... erm so she was fantastic and then on discharge she was back (pause) and (name of partner) really got on well with her as well, you know, I just remember they were having a really good banter all the time. That

was nice ... (voice trailing)' (Jane, second baby, elective caesarean section)

Jane was describing the importance to her of the midwife listening to her, being aware of her preference and acting in accordance with her wishes; essentially the midwife responded to Jane's anxieties and offered a personal interaction similar to the 'respectful gardener' described by Olsson and Jansson (2001) (see Chapter 5). It is possible that for some women, such connecting experiences with the midwife or health care assistant, 'rescued' the woman's experience on the ward or ameliorated a negative or unsatisfactory experience; Jane's experience of moving from the post-operative bay to the general postnatal bay was referred to above and it would appear that on reflecting on her interaction with the 'fantastic' midwife, Jane was able to reach a 'guarded alliance' (Thorne & Robinson 1988). Meeting up with the midwife again before transferring home further enhanced this experience. The data from the in-depth interviews indicated that where women met the midwife on the postnatal ward who had provided care in labour, they commented positively on this reunion.

Gill similarly described her experience:

'... I had some very special treatment (voice raised, excited) when I was in hospital ... because the day after she was born erm ... was my partner's birthday and I hadn't, we hadn't planned to be in hospital (voice rising) I had gone in for Monday and she was born on Tuesday and his birthday was on Wednesday and erm ... I hadn't planned anything but I had already bought him a card which I had in the dresser at home but of course I couldn't get it because I was stuck in hospital so one of the midwives erm ... put me in a wheelchair and we went down to the shop at the hospital and allowed me to buy a card and a little balloon saying 'Happy Birthday', just to make him very special as well ... and ... that was very, very special, that was like ... extra special care which was not necessarily ...erm constituted what they were there for really, so that was really, really nice of them and I really appreciated that (pause) yeah very nice ... like I say it, that was something that they

didn't have to do, but it was just lovely that one of the midwives did that for me ... ' (Gill, first baby, emergency caesarean section)

It should be noted that in speaking about these individual midwives, who offered a 'connected presence', the women spoke freely and in some detail, possibly indicating the importance to them of these interactions. The women who participated in the study by Kralik et al., (1997) (see Chapter 6), described how 'kindness and consideration' where the nurses were generous with their time contributed to them feeling cared for and valued as the nurses engaged with their needs. My study had suggested that this investment by the midwives was clearly significant to the women. However, this 'kindness and consideration' was rarely demonstrated in the observational data, remaining a hidden and undiscovered aspect of care and the midwives' interaction with the women. Arguably, the general busyness of the ward with the ethos of progressing the women through it may in itself have masked this aspect of the relationship between the women and the midwives, subsequently discovered in the in-depth interviews. It is interesting to reflect on the fact that few of the women appeared to know the name of the care-giver providing care and how for some of them this was an aspect of regret.

The reasons for why some midwives or health care assistants were able to interact differently are unclear, but may reflect the personality or traits of each individual midwife. Britton (1985) described her personal encounters with nurses following surgery for malignancy. The nurses who were best able to meet her needs, were those who attempted 'honest communication', had regard for 'the whole person' and exhibited what she referred to as 'compassionate spirits'. She further described how nurses whom she described as professional often appeared cold and used medical language which alienated her, as a patient, from understanding her own condition or what was happening to her. Arguably, undergoing life saving surgery involves a longer period of recovery and need for specialised assistance from health care professionals. In contrast, midwives are not generally expected to provide such a prolonged period of assistance, however Britton's descriptions resonate with the experiences of postnatal women above who clearly wanted a meaningful interaction with the midwives.

7.5.1 Women 'rationalising' about their care.

The data appeared to indicate a need for a level of acknowledgment which recognised the individual mother and her presence on the ward. The interview data suggested that mothers voiced a degree of concern or criticism if their expectations were not met, but would often also present an explanation as to why this had not occurred, possibly in an attempt to ameliorate the experience.

Essentially, it was apparent that some women were clear that their care in general or a particular experience could have been better for them, but they still remained reluctant to criticise their care-givers or the care provided. Reference was made earlier to Helen who assumed the responsibility for the pain experienced in receiving assistance from the midwife with breastfeeding – *'my fault'*.

There were other instances when women offered similar comments but which did not relate to breastfeeding, in which they appeared to indicate that when the care had not met their expectations or their needs, that this was their *'fault'*. They appeared to reconsider their comments as they spoke; Gill described how she had requested assistance with her daughter during the night:

' ... I hadn't actually expected the midwife to take her away, so that's what it was ... a bit of a misunderstanding (speaking quietly)'

Similarly, Lizzie offered the following on having to walk down the main corridor of the hospital when transferring to the postnatal ward after the birth of her baby:

'but, you know, that wasn't to do with my care or anything like that, that's just me'

Women appeared to assume the blame for any shortcomings in their care. Reference was made above to the women being marginalised by the activities of the organisation and, possibly, this tendency to assume the blame may be as a result of their low position within the organisation.

7.5.2 The role of health care assistants.

The combined findings from my study suggested the importance to women of the care provided by health care assistants in addition to care delivered by the midwives. The following extract from the observational data illustrated the presence offered by a health care assistant to women in a bay:

'A health care assistant was observed to assist the women in one bay throughout the morning, helping to fill in menu cards, finding magazines for a mother who requested something to browse through, raising the cotside of the bed when the mother was resting in bed with her baby next to her, helping to arrange flowers. In the course of the morning she chatted to women and partners alike. The midwife allocated to the bay had completed routine maternal and infant examinations by 09.00 hours, only returning to the bay for administrative purposes or at the request of the women or the health care assistant. There were five women and their babies in the bay.' (05)

Here, the midwife maintained the organisational process whilst the health care assistant interacted and was there for the women in a caring capacity (Kitson 2003). By virtue of the fact that the midwife was the trained and designated health professional, the organisation could arguably expect a different level of participation or input from the midwife and this may explain the differences in interaction described between the two care-givers. The differences in the 'tasks' required to be undertaken by the midwife and the health care assistant would also need to be taken into consideration. However, as referred to in a previous section, health care assistants appeared to remain for longer out on the ward or in the bays, possibly as a result of the organisation having less influence on them than on the midwives. The positive interaction experienced by Lizzie on receiving care from the health care assistant was referred to above.

Keeney et al., (2005) surveyed theatre nurses as well as midwives and women in a maternity unit on their perception of the provision of care by trained health care assistants. Nine staff from the theatre unit and 16 midwives completed a self-

administered questionnaire. Six women from the maternity unit were interviewed. The nurses and midwives regarded that the health care assistants offered valuable assistance which allowed them to have more direct contact with the patients/ women. They also expressed satisfaction with the care provided by health care assistants. It is interesting to note that the women themselves regarded the health care assistants as providing more direct care, such as assistance with feeding or personal hygiene, than the qualified staff. Moreover, they reported the availability of the health care assistants to be greater than that of the midwives.

7.6 Conclusion.

This chapter has highlighted some of the needs expressed by the women and the importance to them of having those needs recognised. The stages that women moved through in order to have those needs realised have been discussed. Achieving a prolonged connectedness with the midwife or the health care assistants was valued by the women. I will now go on to describe further aspects of care important to the women.

CHAPTER 8: HAVING REGARD FOR SELF; RECEIVING SUPPORT ON THE POSTNATAL WARD.

The observational data demonstrated the midwives' central emphasis on providing physical care, predominantly through undertaking maternal and infant examinations daily and this was described in Chapter 5. However, the combined findings indicated that the women themselves, in addition to their need for physical care, had concerns which did not always relate to the clinical care provided by the midwives or the health care assistants. Such concerns or unresolved issues mainly related to the women's need to receive emotional or psychological support.

8.1 Importance of emotional concerns.

Women's need for emotional support, in addition to physical care, in the immediate postnatal period has been identified (Audit Commission 1997, Singh & Newburn 2000). This need for emotional support appeared not always to be met by the midwife, possibly due to the midwife's primary focus on undertaking the routine clinical care or 'tasks' as expected by the organisation. The adherence to the task-based culture led to physical distancing of the midwife to the woman. As a result, the routine daily physical examination was likely to be the woman's sole opportunity of a one-to-one interaction with the midwife. Closing the bed curtains, defined the woman's immediate space and offered privacy, providing an opportunity not only for the midwife to listen to and hear the woman's concerns but equally for the woman to let the midwife know of her specific concerns. The bed space was the woman's designated personal space or territory whilst on the ward and it could be argued that the midwife was a visitor within this space. However it is acknowledged that bed curtains are not sound proof.

8.1.1 Seeking emotional support from the midwife.

This opportunity for communication was lost to the woman if the midwife was not able to hear the woman's concerns. This was illustrated below where a mother following the birth of her first baby, actively sought emotional support from the midwife during the daily check:

'.. the woman tells the midwife - 'I'm going back to an empty house.'

Brief pause, followed by midwife asking the mother - 'have you had your bowels open?'

The woman confirmed this.

Further brief pause, following which the midwife said to the woman - 'it's a lovely time to have a baby.' (it is December and Christmas is coming up)

The midwife opened the bed curtains by the foot of the bed and then left the woman's bed space. As she passed the woman in the adjacent bed, she informed her - 'I'll come and see you shortly.'

The midwife left the bay. The first woman remained behind the partially opened bed curtains, at no time did she walk around or attempt to converse with any of the other women in the bay.

This mother was later heard to confide to a telephone caller - 'This week has been a bit tough ... a bit raw ... it's a bit tricky ...' (10)

Clearly this mother was in need of emotional support from the midwife, and wished to discuss aspects which would be relevant to her once she had transferred home. However, her attempt to engage the midwife in her immediate concerns was unsuccessful. Effectively the midwife had blocked the woman's comment and as a result her request for support was not heard as the midwife swiftly concluded the maternal examination; in essence a degree of detachment and control was maintained (Lomax & Robinson 1996, Olsson & Jansson 2001) and the concept of care as part of offering support thus appeared lacking.

By informing the second woman of her availability '*shortly*' the midwife indicated to the first woman that her own opportunity for further immediate interaction with the midwife had ended. The concept of 'time' is elusive and possibly interpreted differently by women and the midwives alike, the midwife in the extract above defined her time available to each woman. Hence, the time available to midwives, and the need to carry out the examination itself, impacted on the interaction between the midwife and the individual woman. The midwife's time has to be shared with other

women, and in this sense women were competing with each other for the midwife, as detailed by Lock and Gibb (2003). The women in their study also reported a sense of the midwives and the organisation assuming ownership of 'time' which made it difficult for the women to claim their time with the midwife. In contrast, once home, the women described how the midwife would offer her time to listen and support them. The ethos of 'time' to belonging to the hospital was evident from this current study with the resulting impact of the routine and culture of the organisation on both care-givers and women.

8.1.2 Women offering emotional support to each other.

Women's desire and need for emotional support was thus a strong element within the observational data. This was further confirmed by the findings from the in-depth interviews where women described the positive aspect of talking to other women and providing mutual support. The women interviewed referred to 'chatting' and how good it was to talk to other women in the same bay as the following narrative by Wendy who had had her second baby illustrated:

'... the girl next to me, her curtains were round and I heard the midwife talking to her ... erm. I didn't take much notice but ... erm I noticed she was crying and when she came, when the midwife had gone the lady came out, the baby was sort of on my side next to the bed and I just said to her 'are you okay?' and just talked to her and tried to be friendly and that, you know, and she said 'yeah, I think so' and sort of started from there really and I just said that as a first time mum you're a bit out of your depth but, yeah ... she actually had her baby the day before, so baby blues had kicked in, she said 'yes' and she said 'can't stop crying' so I said 'don't, just cry' I said, 'you need to get it out of your system', I said 'I've had one already' ... and then we just started chatting about different things and what have you and things, work and birth, all about this birth (laughing) because she'd had a ventouse as well, so we just sort of compared notes (laughing) ...'

Thus this mother's support for another woman within her bay is evident and resonates with other literature. Allen et al., (2002) in a study which used both qualitative and quantitative approaches, examined anxiety in patients undergoing gynaecological surgery. In the qualitative phase of the study 44 patients were interviewed on the telephone at home following discharge from hospital. Allen et al., (2002) described how in observing other patients experiencing distress, patients would try to help them cope with their anxieties. The patients who participated in their study detailed how talking to other patients and sharing their experiences, was used as a coping strategy in their own management of anxiety. The authors reported that whilst reading or listening to music was given as the most common coping strategy, talking to other patients on the ward was the second most common coping strategy used by the patients.

The data from the in-depth interviews, of women talking to each other was interesting; the observational data had revealed little or no communication between the women in the bay during the episodes of observation. The written information which was used to invite the women to participate in the observation clearly identified the investigator as a member of staff and may thus have muted the natural behaviour of the women and, consequently, altered what was being observed. The extent to which the women did interact was demonstrated by the data from the in-depth interviews:

'...but we just, sort of generally chatting, things ... not really to make friends, but just somebody to talk to ...' (Wendy, second baby)

' ... you sort of get up and you 'are you alright?' or whatever, you know ... or 'what did you have?', 'that's normal after your first' and it sort of strikes up ... or asking each other something like 'what time is lunch?' or whatever ... or we were just talking about all the babies who got jaundiced, you just sort of strike up a conversation talking about the baby ... just little things like that and then you just start talking. There is one lady that I am still in contact with when I had (name of toddler), we both called our

daughters the same, so we just happened to be in the bed next to each other, before and after, and we've stayed in contact so ... just the hospital thing ... but yeah, you'd be amazed, friendships can be made ...' (Vicky, fourth baby)

'... it was quite nice and we were up quite late and it was also nice because the lady who had her baby a few hours before me and we were actually in the bed next to each other and we sort of ... 'oh, let me see what you had' ... and then I had like a first time mum and her baby was not feeding very well you know, I think you sort of say 'oh, I had one, my baby ...' just to, I think it's quite nice for them to reassure themselves ... or it's nice to reassure each other but I feel even with being there twenty four hours you can, women can actually chat and get to know each other ...' (Vicky, fourth baby)

'... when all the visitors went and there were only the three of us left in that bay ... we were all alongside each other ... I was chatting to the lady in the bed next to me, only because her baby was very battered and bruised, she'd obviously had a really hard time having her and she was a bit bashed from the forceps as well, so we were just sort of comparing notes really and the lady next to her at the other end her baby had been on the special care so she had been in there for a couple of days because he'd had an infection. She was the one that sort of got everybody chatting, I think because she had been there for a couple of days she obviously needed the conversation more than me and the other lady did but the three of us just sort of sat together and had coffee and compared notes ... it was just somebody to talk to when there was nobody else there apart from her (laughing, referring to her daughter) ...' (Lizzie, first baby)

It appeared then that when the care-givers were not there, the women sought to extend their network of support by relating to the other mothers in the bay. In essence, the

women responded to each other through knowing the other mother within ‘her world’, described by Mayeroff (1971) as vital in caring.

8.1.3 Importance of being in a bay with other women.

The majority of the women interviewed had been in a bay with other women during their stay in hospital and it was evident from the data that they regarded this as beneficial to themselves and a sense of sharing was conveyed. It appeared that this peer support was an aspect of care which the midwife, as the main care-giver, was not able to provide. It is interesting to note that the two women, who were cared for away from the main postnatal bay areas, spontaneously identified this as a disadvantage to them. One mother spoke of a sense of having lost out through being in a single room, describing a feeling of ‘isolation’:

‘... they put me in a side room ... it was just they sort of put you in there and forgot about you ...if in a room with other women I would probably have stayed in for another night ... it would have been nice to get the support from other women, ask them for advice and see how they are handling their baby ... somebody in the same boat as me ... ’ (Denise, first baby)

This new mother went home having spent one night only in hospital, describing how she had then received support at home from her partner and her mother.

The maternity unit had a policy of using the beds on the antenatal ward as an ‘overflow’ bay if the postnatal ward was fully occupied; for the layout of the two wards and their proximity to each other, see Figure 4.1. The other woman, who was allocated a bed on the antenatal ward, described being ‘lonely’ and expressed a need to talk to other mothers:

‘... that’s the only thing ... it would have been nice to say to someone ‘that was awful’ or ‘God, I’m knackered’ or ‘didn’t like that at all’, even to sort of show each others babies ... I didn’t have

any of that which, probably, I needed that more ...' (voice trailing).

She went on to explain that – '... the only thing with the midwife and staff and that, it's there every day for them, you do feel that they will say what they are supposed to say to make you feel confident and comfortable about what's happening, but like there being other mums ... do you know what I mean? It's comforting to know that what my body is doing and what she (referring to her daughter) is doing is right, in a way ... just comparing notes and making myself better that way ... yeah I found the whole experience truly mind blowing any way and that so ... I don't know if it affects everyone like that ...' (Helen, first baby)

This implied a therapeutic value to the women in talking to each other and sharing their experiences. Johnston (1982) in a quantitative questionnaire based study within a surgical ward environment, examined whether patients were more aware of the worries of other patients than the nurses were; 20 patients and 17 nurses participated. She found that patients were more sensitive in detecting concerns than were the nurses who were caring for the individual patient and concluded that nurses were generally not good at identifying patients' worries or concerns. Johnston (1982) reported that patients were able to be responsive to the needs of 'patient colleagues' within the ward because they had the time and the necessary relationship. Arguably, patients within a surgical ward may remain in hospital for a longer period than a new mother, the majority of whom go home early if all is well with them and their baby (Audit Commission 1997), but the women's responsiveness and alertness to other women is evident within the interview data. Ultimately if midwives themselves are not aware of individual women's concerns then they will not be able to offer reassurance and emotional support.

8.1.4 Midwives providing emotional care.

The observational data demonstrated that midwives themselves were aware of the need to offer emotional support and not merely routine clinical care:

'It's not just the postnatal check that needs to be done' (17).

However, a degree of lack of clarity and purpose in respect of the provision of psychological or emotional support was expressed – *'I suppose we do this.'* (17). The midwife who offered this comment expressed uncertainty about the rationale for emotional care and whether such support was genuinely available to women within the ward environment. This uncertainty possibly reflected the assumption by midwives that any interaction between women and midwives should be driven by the need to carry out a task for the woman, the physical activity of 'doing' (Stockwell 1972, Ford & Walsh 1994, Woodward 1997), thus not legitimising other forms of care or interaction.

It appeared then that interacting with women, when active and supportive listening is given freely, possibly contributed to a sense of ambivalence for the midwife, as 'chatting' or simply being present is not understood nor valued as a caring activity by the midwife (Wiggins 2000). The way in which care is organised hinders two way communication (Kirkham 1993) and, as was described earlier, midwives are part of the task culture with its emphasis on getting through the work (Handy 1993). The routine of the organisation enforces non-reflective practice and, consequently, communication with women is not fostered (Woodward 2000). Women who participated in Bondas-Salonen's (1998) longitudinal study in Finland on the culture in which care was provided, described the importance to them of the midwife 'being there', unconditionally available and willing to listen and talk. They wanted the midwife to be present without having to complete notes or tick a list.

Where the midwife was available to listen to and be with an individual woman, this was appreciated and commented upon by the women, as the following vignette illustrates:

'... and there was this lovely lady (referring to the midwife) on duty in the ward and we had, I was having a few problems in my relationship, you know ... she didn't actually tell me what to do but she reassured me that she was listening ... she was there to listen (voice rising) and talk to me ... she just asked me, you know 'how

are you feeling?' ... *it was quite nice to talk to actually talk to someone after the birth which wasn't the family, which wasn't my friend ... somebody that was listening to you ...and I remember she was leaving at two o'clock (in the morning) and if she needed to stay, she actually made the offer 'if you need me to stay, I'll stay longer' ...* ' (Vicky, fourth baby)

This interaction happened during the night. Reference was made earlier to the rhythm of the postnatal ward where midwives would be busy undertaking 'the checks' of the mother and infant during the morning shift. In contrast, the night duty shift appeared to be a 'holding operation' until the next morning. The midwife in the extract above originally went to the woman for the purpose of undertaking observations of her baby, but made herself available to the woman by her presence and willingness to listen. It is possible that the absence of a 'tick list' to complete enabled the midwife to offer time and presence to the mother to hear her concerns.

Providing emotional support or assistance presented a dilemma to the midwives. James (1992) offered a discussion on women's domestic work and care provided within a hospice care setting, referred to as workplace health care; highlighting the problems in defining 'care'. Having previously identified aspects of care, referred to as carework, James (1992) offered the formula of 'care = organisation + physical labour + emotional labour' (page 488) as components of such carework. In referring to domestic care or family care, she described how this related to care and caring for, predominantly as part of women's activities and generally unpaid. James offered two different ideologies (page 491); firstly 'health service ideology' which encompassed training, scientific knowledge, doing and treating with physical interventions, highly specific and with a quantitative approach to illness. In contrast, the ideology of 'family care' offered familiarity and closeness, was unpaid and also unspecified.

Essentially, she offered the notion that the organisation assumed priority over the needs of the individuals and thus the organisation and its impact on care cannot be overlooked. Within the organisation she described the gender division of labour where the majority of carers are female. A further characteristic of the organisation was the imperative to organise care and she particularly examined the relationship between

physical and emotional labour. Physical labour involved the provision of care based on tasks which were required to be carried out; physical labour was highly visible. James (1992) argued that physical labour created a framework which impacted on the development of social relations within the hospice environment. Physical labour carried out by the nurses within the hospice setting was understood as paid work and 'doing' and the pressure to comply with the organisation was implied.

Emotional labour was similarly regarded as hard work, but in order to offer emotional care, the worker or carer was expected to respond to another person in a way which was meaningful to both of them. However, in contrast to physical labour, emotional labour was essentially invisible and therefore occupied an ambivalent status. However, when comparing domestic or family care and care in the health care setting, sharing or common expectations were absent between those providing care and those in the receipt of care, within the health care setting. James (1992) concluded that in the hospice and health care environment, physical care was regarded as a priority, whilst emotional labour remained largely – 'informal and grafted on to the dominant biomedical, physical system' (page 503).

The ambivalence experienced and described by the midwives in not always being able to offer emotional support was manifest and remains an aspect which is not well understood. It is however evident that women wish to receive emotional support.

8.1.5 Seeking support from other people.

In the absence of emotional support being offered by the midwife who was the prime care-giver, women would seek support from their existing network of family and friends and in the case that follows, a midwife with whom she had a pre-existing relationship.

'This new mother was having a conversation with a caller on the telephone. She was on her own, no visitors or ward staff were present – 'this morning I just wanted to cry, spoke to (name of team midwife) ... that made me feel better, just wanted to cry ... I don't know why ...' (12)

The woman spoke to the team midwife who happened to be on the ward and although routine physical care was observed to be given by the midwife who had been allocated to the bay, no further assistance was offered by the core midwife. It is not known whether the team midwife fed back to the core midwife about the woman's concerns.

Lipsky (1980) described how clients seek benefits and services and have individual expectations for themselves. In contrast, the workers or 'street-level bureaucrats' seek to control the process of providing such services. It appeared that the midwives' need to comply with the organisation led them to manage the interaction with each individual woman according to her own agenda, and with an assumption by both the midwives and the organisation, that physical care equated to psychological care. Where an urgent need for emotional support was not met by midwives, women sought support for themselves from their partner or visitors or by interacting with other care-givers within the ward environment. The findings also indicated that this could lead to resentment by the midwife responsible for the woman's care if she herself was not approached by the woman:

'The housekeeper was observed by the midwife to talk with a woman and to return to her several times throughout the morning, the midwife commented to me – 'It's not on', regarding the conversation as covert as she herself did not know 'what's going on'. The midwife sought the housekeeper out in order to remind her of her housekeeping duties but was not observed to inquire about the woman's concerns. The midwife did not approach the woman in order to follow-up the woman's concerns and possible need to talk.'

It appeared that the conversations the woman had with the housekeeper possibly presented the woman's only opportunity to have her concerns heard. The opportunity to have her concerns heard must be regarded as an aspect of care. In contrast to housekeepers, health care assistants were regarded by midwives as having a legitimate, but limited, role in listening to women but would be expected to report back to the relevant midwife responsible for the woman's care. Reference was made

earlier to the increasing involvement of health care assistants or maternity care assistants in the care of women, but with the midwife retaining her role as the main care-giver (Francomb 1997, McKenna et al., 2003). The women interviewed were not always able to identify the official role of the member of staff available, referring to *'nurses'* or *'a different colour uniform'*. Uncertainty in identification of staff and roles may lead the women to have concerns over whom to approach to seek assistance. However, Williams and Irurita (2004) demonstrated that patients valued any contact with staff on the ward, irrespective of their role, describing how these interactions contributed to them feeling valued as a person.

Clerks interacting with the woman for administrative purposes such as confirming their address, were observed to receive requests for assistance from the women. These requests related mainly to wishes for support with breastfeeding, with women expressing uncertainty about the feeding, but were occasionally of a more intimate nature. The clerks reasoned that *'they'll ask anyone, won't they'* (09) and were always observed to feed back to the relevant midwife. However, the midwife decided on the possible need for follow-up which meant that, on occasions, the midwife would not return to the woman to follow up her concerns.

Clearly, the individual midwife's reaction to the woman expressing her concerns impacted on the midwife - mother relationship and conflict might be experienced. The comment by a midwife that *'women have too many expectations'* (09) was offered during a discussion amongst the midwives by the desk area away from the bays and those present concurred with their colleague's comment. This statement illustrated the tension experienced by the midwife when the new mother appeared to have expectations over and above what the individual practitioner felt that she realistically could or wished to meet.

It is interesting to note the midwives' collective use of the word *'women'* and the allocation of a midwife to a group of women was referred to above; the midwife was adapt at processing this group of women during her shift on duty and, indeed, this was valued by some midwives as their contribution to and within the organisation. In a sense, by referring to *'women'* the midwife may have distanced herself from the individual woman and, consequently, the midwife may have been less responsive in

hearing the concerns of each woman. The midwife cannot be expected to meet the expectations of all the women but arguably the midwife must strive to meet each individual woman's needs to the best of her abilities. The two different occupational ideologies adopted by the hospital based midwives and community based midwives: 'with institution' and 'with woman' respectively (Hunter 2002) was referred to above. The midwives in her study also referred to the need to protect themselves emotionally possibly because of the expectations of the women, the demands made on them by the organisation or attempting to balance work and personal lives.

The concept of the midwives needing to distance themselves from the women emerged from my data, but the reasons for this would appear unclear. However, it was evident that for some midwives this created conflict for them as practitioners. It would therefore appear that midwives wish to provide emotional support, but are prevented or perceive that they are prevented from providing such care. Similarly, Staden (1998) in her study, using a phenomenological approach, on the alertness of nurses to the needs of others, described the conflict experienced by the nurses when they were not able to respond to and meet all of the needs of the patients, whether physical or emotional. Although a small study, involving three practitioners only, the participants were united in the conflict that they experienced as care-givers from the lack of recognition by the organisation of their desire as nurses to provide emotional support.

8.2 Reflecting on the birth experience.

There was evidence from the observational data that women needed to talk about the birth itself, irrespective of parity:

'They didn't believe me because the machine didn't pick up the contractions and they couldn't feel my contractions, they thought I was only three to four centimetres ... I kept saying I wanted to push ...' (14)

This mother who had just given birth to her third baby was talking to a caller on the telephone; she was not observed to talk to the midwife about her experiences.

The need to talk about their birth experience was reinforced by the data from the in-depth interviews where the majority of the women spoke about their birth experience and their feelings in the immediate postnatal period:

' ... because I didn't have a fantastic birth, so I was trying to leave it all behind me ...yeah, it really blew me away and I just wasn't on this planet I don't think ...but I probably, but I don't know if I should have spoken to anybody about it anyway ... it wasn't anything to do with the hospital like I didn't enjoy it or ... it was just that my body didn't do what it was meant to do ...and things like that ... so ... I think I should've spoken about it to ... but I didn't ask, but at the same time neither was there anybody to talk to (voice trailing) ' (Helen, first baby)

Vicky, who had given birth to her fourth baby, similarly described her experience:

Vicky - '... I was having flash backs, because I felt a real grump because I didn't know how to take the gas and air, I got myself into a bit of a panic at the end when I was having her ... I felt it was my most painful and I was getting flash backs and I had actually mentioned that I was feeling like this (pause)...

Interviewer - 'do you mean in hospital?'

Vicky - '... no I didn't ... I mentioned it after (referring to going home) and they actually brought it up each day 'how are you feeling today?' ... they reassured me ... '

This mother did not approach the midwife in hospital to tell her of her concerns, the reason for this is not understood; the woman herself did not provide any further information during the interview about this aspect, possibly an example of what Pontin and Webb (1995) called 'early termination' and not wishing to criticise the care-givers.

Gill described how physical care alone was not adequate for her individual needs:

'...I mean they'd come round and check your scar ... and see how you're bleeding and things like that but we didn't actually talk very much about ... erm the operation itself ...

Interviewer - 'would that have been helpful to you?'

Gill - ' I think just because you, I was under general anaesthetic so, you know (voice rising) completely unaware about what was going on so it would have been nice just to ... know what happened, the chain of events and things that happened. I had a good two hours where I was completely ... she was born at five thirtyish in the morning and I think I came round at about half past seven, so ... a good two hours I kind of lost of whatever was going on before ... erm like throughout the labour and everything that happened before, you know, you're there and you're experiencing everything so I suppose in a way ... it would have been nice to ... erm just fill in the gap.'

At the start of the interview itself, Gill had detailed how:

' the thing that I remember most about it (referring to her stay on the postnatal ward) is that the surgeon, the person who did my caesarean came to see me, I think the doctors always come to see you afterwards ... and tell you how the operation went or whatever ... but I was still very, very dopy from my anaesthetic so I don't remember anything that she actually said (voice rising) but I remember her coming ... so I think that was a shame really because it would have been nicer if she would have come a bit later and then I could have, we could have asked some questions ... (voice trailing)'

This mother conveyed a feeling of not being able to make sense of what had happened to her in her birth experience and would appeared not to have been given an opportunity to discuss this experience; she had not asked for another opportunity to

speak to the surgeon. In emphasising the need to complete daily checks, adhering to a known format (see Appendix 13), the opportunity to understand the woman's concerns may have been lost. Here the aspect of caring, as described by Swanson (1991), of 'knowing' or understanding the meaning of an event (the caesarean operation) to the mother and, furthermore, the aspect of 'enabling' where the midwife would have been able to use her professional knowledge to explain the sequence of events which had led to Gill having given birth by caesarean section were not provided. Affonso (1977), in surveying a total of 150 women in relation to their childbirth experiences, described the need for women to be assisted to make sense of an event which related to their labour. She argued that where recall was vague ('missing pieces' page 159), the women should be assisted to reconstruct that experience in order to move forward. Gill had clearly 'lost' two hours.

It was thus evident that women needed to make sense of the experience of giving birth and a desire to talk about this experience was manifest. The value to women of talking through their birth experience has been acknowledged (Audit Commission 1997, Marchant & Garcia 2000, Singh & Newburn 2000). Marchant and Garcia (2000) raised the issue of how this component of care could best be made available to the women, according to each woman's needs. It should be noted that several mothers spoke about their previous birth experiences during the in-depth interviews, suggesting that their experience remained with them for some time after the event; the women who participated in the study by Halldórsdóttir and Karlsdóttir (1996) similarly referred to previous birth experiences.

In a recent study by Cattrell et al., (2005) midwives identified a need to offer emotional support to the new mother; they spoke of the need to debrief women following childbirth but detailed a lack of time as a barrier to offering emotional support. In a randomised controlled trial, Lavender and Walkinshaw (1998) examined the possible reduction of psychological morbidity through debriefing. A total of 114 women participated, with 56 women participating in an interactive interview discussing their labour (the intervention) and with the remainder of the women receiving standard care. Women in both groups completed a questionnaire at three weeks postnatally, assessing their emotional well-being. The results demonstrated that women in the intervention group were less likely to have high anxiety ($p < 0.0001$) and

depression scores ($p < 0.0001$); they were generally more satisfied with the information provided on the ward. Whilst on the ward, all the women were cared for in single rooms (Alexander 1999); the importance of chatting to other women (or patients) was evident in the current study and the study by Allen et al., (2002). However, Alexander (1998) has called for a clarification of the terms defusing and debriefing following birth and further research concerning their value.

Gamble et al., (2002) in their review of literature on debriefing or non-directive counselling identified that a single counselling session ('listening visits'), such as that offered by Lavender and Walkinshaw, was unlikely to reduce the prevalence of depression or lead to improvements in health. However, they acknowledged that a high proportion of the participants in the studies reviewed described the debriefing as helpful.

Undertaking an RCT in Australia, Gamble et al., (2005) examined the effectiveness of counselling for women at risk of developing psychological trauma symptoms following the birth of the baby. Women in the intervention group ($n=50$) received face-to-face counselling within 72 hours of the birth and again by telephone at four to six weeks postnatally; the counselling was offered by the same midwife who had received appropriate training. The women in the control group ($n=53$) received standard postnatal care. At the follow-up at three months, women in the intervention group reported decreased symptoms of post-traumatic disorder or trauma as well as in their feelings of stress and depression. The researchers concluded that the intervention had a positive effect in reducing trauma symptoms over a longer period although they acknowledged that the expectations of the participants may have affected the results. It is noted that of the women who were allocated to the intervention group, 86% ($n=43$) rated the counselling provided highly. Furthermore, 90% of the women ($n=45$), described that women should have an opportunity to talk about the birth within a few days of the event. The researchers therefore argued that this type of intervention could be part of the responsibilities of the midwife, following appropriate training; the data from my study identified that women wish to talk about their birth experience. The researchers do not define 'standard' postnatal care, a definition would have made it easier to understand the potential relevance of the study from a UK perspective.

Gamble et al., (2005) concluded that postnatal care should provide women with emotional support in the early postnatal period. The importance of offering emotional or psychological support has been highlighted with the publication of the NICE guideline (NICE 2006). It is worth noting that of the 348 women screened initially for inclusion in the study by Gamble et al., (2005), 29.6% (n=108) reported some trauma symptoms. In the current study women spontaneously referred back to the labour during the interview; Vicky (fourth baby, vaginal birth) described '*flash backs*' to the labour and how she had discussed this with the midwife once she had transferred home. Helen (first baby, vaginal birth) similarly described how she '*didn't have a fantastic birth*' and how there was '*nobody to talk to*' about it.

A more detailed discussion of the evidence concerning postnatal debriefing is beyond the scope of this thesis but it is worthy of note that the maternity unit where my study was carried out provided a 'Birth Afterthoughts' service for the women, who would be offered 'debriefing' with the Head of Midwifery or a midwifery manager. The details of this service were provided on a satisfaction survey which each woman was invited to complete when the midwife transferred the care to her health visitor. The availability of the 'Birth Afterthoughts' service was not displayed within the unit, possibly illustrating the midwives' ambivalence concerning their role in listening to the women.

8.2.1 The need for partners to talk about the birth experience.

My observational findings indicated that the partners also had a need to talk about their experience. They expressed a need to share their feelings and have their concerns acknowledged:

'I'm knackered ... was up all last night and only got three hours sleep' (13)

' ... the long labour ... everything that could go wrong did ... very emotional ... she didn't have any contractions ... ' (15)

This latter partner was talking to a caller on the telephone. The midwife was assisting the woman with breastfeeding and was present throughout the telephone conversation but she offered no comment or follow-up for the woman's partner. It is possible that the midwife did not regard it as her responsibility to support the partner as well as the new mother; midwives referred to the 'women' in informal conversations, but they rarely referred to the partner. By virtue of being the 'in-patient' it appeared that the woman was the person designated to request and receive care.

Gill who earlier described her sense of having lost some time and understanding of what had happened, expressed her concerns for her husband:

' ... I mean with (name of husband) being away as well because they're not allowed during a general anaesthetic, I think he was quite worried ... and ...he was given (name of daughter) straight away after she was born, so he spent some time with her, but he's a bit ... he was more worried about me, about, you know what was happening to me at the time ... just you know, you've got this daughter, this new baby (voice rising) ... but he was still very, very worried about what was actually happening to me ... (voice trailing) ...I don't understand (voice rising) why they have to leave if you're having a general anaesthetic, ... if you're having a caesarean with the epidural then they can stay (pause) yeah, I think that, that was when the detachment came in ...I think that's when (name of husband) was feeling very apprehensive and very worried ... because all of a sudden, you know, if he was there the whole way through the labour and I think all of a sudden to be told 'sorry you're going to have to step outside now' (voice trailing) ... (pause) the decision to go to, because it was an emergency caesarean but it wasn't like under extreme emergency, we still had time to decide and consent and all that sort stuff. I think he would have appreciated a little more information at the time ... '

The inclusion of the husband or partner would therefore appear to be important to the women and his well-being was of concern to them. However, the partner was not

included within the designated 'work' which the midwife was required to undertake and on occasions, as described above, he appeared to be treated as a bystander. Locock and Alexander (2006) examined the experiences of men in relation to their partner undergoing diagnostic screening in the antenatal period. They conducted a total of 41 in-depth interviews which included women, couples and two male partners; the majority of the participants were women (n=33). The participants were recruited through GP surgeries, antenatal clinics and voluntary organisations as well as support groups for fetal abnormalities. Half of the women had a normal pregnancy with the remainder having a baby with a disability or chronic condition. The authors were able to identify several roles for the men. The category of 'men as parents' described how the involvement of the man as the father was sometimes limited because of the organisational structure. Locock and Alexander (2006) further commented how some men assumed the role of 'bystander' and how in this role they did not feel able to support their partner. The authors acknowledged the limited number of partners (n=8) in their study, but also described the value of women offering their perspective of the inclusion and the importance to them of their partner in the procedures.

8.3 Participation by partners on the postnatal ward.

The importance to the new mother of being assisted and supported by her partner whilst on the ward and for the partner to be able to assume the role of the father, was apparent from the observational data. One mother was clear in her need for her partner's assistance, giving him specific instructions - *'If you put her in the cot, you can do the fetching and the carrying'* (16). The partner assisted as required, this mother had had an operative delivery and was using crutches because of a serious back problem.

The interview data added to this aspect and helped to clarify not only the women's desire for their partner's support but the new fathers' need(s) to be included in the care of the mother and the infant. The staff's acknowledgement of the partner was important to the new mother - *'they were nice to him'* (Claire, second baby).

8.3.1 Partners supporting the new mother.

However, the observational data also suggested the conflicting discourse between the woman's need for her partner to sustain her and the organisation's apparent inability to acknowledge his importance and presence. As a natural lay-carer (Kitson 2003) the partner was often able to cherish and support his family. It was evident from both sets of data that women would wait for their partner to arrive in the morning before they themselves headed off to the bathroom, leaving the father to care for the baby. The interview data also revealed that in the absence of their partner, women would ask another mother – *'also you take it in turns to mind each other other's babies while you go for a shower ...'* (Lizzie, first baby).

Lizzie also described her dependence on her husband on having first arrived on the postnatal ward:

'I was so unsteady on my feet, my mum and my dad were there and my sister was there the first time I needed to go to the toilet and they stayed by the bed with the baby and my husband came with me. He just sort of went out to find it and came back and got me and then he walked me there and sort of stood outside the door and waited for me to come out just because I was still sort of wobbly on my feet ... and it was just for his peace of mind, just to make sure that I was alright ... he did a little scout about, came back and said 'oh, it's only there', but I walked from there and it took me twenty minutes to get 'only there' (laughing) ...'

It was evident from Lizzie's description, and confirmed during the interview, that she was not orientated to the ward on her arrival and therefore not able to find her way. The importance to women of being orientated to the ward was highlighted by women in McGuire's (2001) study and discussed earlier in Chapter 4.

Sustained support from one partner was observed where a woman had been re-admitted to the ward from home for maternal observation. Here, her partner stayed with her throughout the morning assisting with personal hygiene and breastfeeding, bathing the baby, providing hot drinks. Interaction with the midwife was only

prompted by the midwife providing maternal medication. This level of participation by the partner was generally not observed. Possibly having been at home for a few days had given both the mother and father the confidence to care for their baby and he for her, independent of the care-givers on the ward.

Midwives expressed an expectation that the partner would participate in the care of his family, but also viewing him as someone who would assist the midwife. The role of the father as ‘supporter’ has also been discussed by Locock and Alexander (2006). One midwife shared her concern that a woman ‘*was quiet*’, she had been into the bay several times to ‘*ensure all is well*’ and expressed relief on the arrival of the partner – ‘*... the partner is there helping her, ... it’s nice isn’t it?*’ (13)

However, in reality, partners were only able to assist the mother, and the midwife, during ‘official’ visiting hours. The policy of the unit at the time of the study ‘allowed’ partners open visiting in the morning, but restricted visiting in the afternoon. They would be asked to leave during the official rest period, this included all women whether in a six bedded ward or in a single room. The organisation, enforced by health care professionals within the ward environment, curtailed the partners’ provision of care through ‘rules’ which ‘allowed’ their presence and therefore participation at prescribed times only; fathers were marginalised as ‘visitors’ and generally regarded as separate from the new mother. Inevitably, this limited the contact between the woman and her partner, such absence was felt and women described partners being ‘*chucked out*’ (Jane, second baby), ‘*he had to go off during that quiet time*’ (Felicity, first baby). Denise, who had had her first baby, offered the following comment:

‘*... you don’t get people coming to check throughout the day on you, especially when (partner) went home, you know, he left ... I really felt by myself then, you know. I’m sure many feel that when their partner goes home and they are left to fend for themselves then ... after visiting time, like when he had to go, I just thought ‘oh, this is it you know, I’m left by myself, what do I do if I anything goes wrong?’ ...*’

Claire, second baby following a caesarean section, described her loss on her husband going home at the end of the day:

' ... but the, the saddest part when he will go on the night, that's the saddest part because that's the night that I need him ... '

Although Denise and Claire both missed their partner once visiting had finished, the interview data indicated that generally the women and their partners viewed the visiting hours for partners, as set by the maternity unit, adequate:

' ... it was nice because, because he was working as well and when he got time off, when he could, he could just come in at any time, that was good. Because if there was a time limit there would have been a problem, you know, ... if they have the time off, say they have taken time off ... they also bond with the child as well ... she stayed with him on his stomach ... she stayed like that for ages ... it was wonderful ... ' (Pauline, first baby).

Not all the women were able to receive support from their partner; Vicky described her experience in the absence of a partner:

' ... I felt quite awkward not having a partner ... he wasn't able to be there ... I felt I should be allowed to have someone there (voice rising) ... my friend was not allowed in in the morning, she wasn't allowed to come onto the ward at all, had it been my mum, my mum was ill, she couldn't come to the hospital so the only available person, it's not just that that person wasn't to come to see the baby, it's a case that you have got children at home ... she was looking after my children, you know ... just someone to reassure you that the kids are fine, bring up anything that you need, you know ... I was allowed to meet with her ... like in a little sitting room, but the baby stayed where she was so ... (pause) It would have been nice if my friend could have just stopped for half an hour ... just to help me bag up my stuff and take things home for

me and sort out my bits and pieces, you know ... ' (Vicky, fourth baby)

Vicky felt that she was not able to receive appropriate support from her friend on the ward; she suggested during the interview that the policy of 'partners only' being able to visit in the morning should be changed to include the woman's 'nominated supporter'. At Vicky's request, her suggestion was forwarded to the midwife responsible for Audit and Quality for consideration.

However, one mother was observed to receive support from a female visitor in the morning, the visitor was seen to assist the new mother, looking after her baby so that the mother could get some much needed rest, secure in the knowledge that her baby was cared for (6). This mother clearly had a need for support, having called the midwife several times in order to be reassured about her infant. In the absence of her partner, this support was provided by a friend but only following negotiation with the midwife responsible for her care, who thus 'granted' the friend access. Mayeroff (1971) emphasised the importance of knowing the person for whom the care-giver is caring and of 'being' with him in 'his world' (page 43). Here, two different accounts have been offered; possibly indicating the individuality of the midwife.

The new mother was in an environment which purported to offer care and support, with care-givers available at all times. Despite this, women evidently relied on their partners to offer assistance with tasks such as baby care. The partner provided support as a lay-carer. In this role of a natural lay-carer, usually a friend, close relative or the woman's own mother, the partner was able to give sustained support and assistance. It has been argued that lay-carers can offer a continued presence, sharing in the responsibility of caring (Kitson 2003). However, in reality this sharing capacity was sometimes interrupted by the institution with the enforcement of visiting hours and restriction of visitors themselves; the women who participated in Singh and Newburn's (2000) study reported resenting the restriction placed on visitors by the maternity unit. Arguably, the woman's immediate support network, that of her family, are likely to understand and spontaneously respond to her needs.

Partners in the role of lay-carer fill a need for care or assistance which may not be met by the midwife or other care-givers within the ward. Proctor (1998) identified the need to involve the partners in the care of the mother and the infant; the importance of this to the new mother is supported by the evidence from this current study. Recent initiatives recognise the importance of the father, not only in caring for his family but equally for him to receive care as part of the new family (Practising Midwives 2002, RCM 2002a). The mother-infant interaction commences with the birth of the baby when they usually spend time together; in contrast the organisational setting prohibits unlimited father-infant interaction. This may ultimately adversely affect the father's ability to care for his infant (Niven 1992). The need for the new father to be involved in the care of the baby as the first step into fatherhood is acknowledged (RCM 2000a). Arguably, the midwife is responsible for enabling the father to initiate the development of his skills in caring for his family; regarding him merely as a visitor does not allow for early integration of the family unit. Brown and Lumley (1997) found that in the antenatal period women planned to return home early from hospital following the birth of the baby, as they did not wish to be separated from their family. A woman's family is her social support and her family will be intuitive to her needs.

A similar perspective was offered by Claire who had given birth to her second child. She described the joy and comfort offered to her with her first child in the country of her birth (non UK) when her husband and her mother had been able to stay with her on the ward and how they had provided support and assistance:

' ... single room, that's why we had the privacy ... I have my relatives so ... when the baby came to my room there is somebody look after with my baby ... and single room so he's always there, at night he can sleep there, yeah ... it's like a house, we have privacy ... just like my mum, she's there every day, every night for support ... ' (Claire, second baby, but here referring to the birth of her first baby)

Although Claire's view reflected a cultural, and possibly an organisational, difference in the provision of care, it was evident that this time she felt less supported on the ward.

In a study in the north of Sweden, Fredriksson et al., (2003), compared parents' satisfaction with postnatal care in a family room within a maternity setting for three days or early discharge within twenty four hours; the parents were able to decide on the type of care they wished to receive. A total of 23 parents were interviewed at home at about four months after the birth of the baby. Although the parents who participated were divided as to where care was best provided, the parents described the need to participate in decisions about their care as important. Another key finding was the importance for the family to be together, regardless of the place where the care was received. The authors conclude that the care environment should be designed to enable both parents to feel able to participate in their care. Swedish fathers are, in common with fathers in the UK, involved in the care throughout the childbirth experience, furthermore, they are generally offered the opportunity to stay with the new mother on the postnatal ward where self-caring by the parents is encouraged with the care-givers available to offer support and assistance as requested (Lindblom 2005, personal communication). Therefore a direct comparison with my data cannot be made, but the woman's need for her partner's support would appear to be evident within both cultures.

Nyberg and Bernerman Sternhufvud (2000) interviewed 20 couples in the postnatal period as part of a larger international study involving Australia, the United States of America, Canada and Sweden, about their concerns in the postnatal period. The interviews were undertaken with both parents at five to ten days after the birth and then at six to eight weeks later. The mother and father were both interviewed separately; a structured interview schedule was used. An unexpected outcome of the study was the fathers' keenness to be included in the study as they felt it important that their views should be heard and acknowledged; they described concerns about breastfeeding and general infant care. The authors advised that as this was a small study with well educated couples, generalisability should not be assumed, but the importance of the inclusion of fathers was demonstrated, similarly confirmed by the data from my study.

8.3.2 Partners participating in the care of their infant.

Partners were observed to participate in the care of their infant; many fathers actively sought to involve themselves and undertook practical tasks such as feeding and changing of nappies. In the words of a new father bottle feeding his baby – *'I'm besotted, I'm doing things I never thought I'd do'* (17). The observational data indicated that partners participated in the sessions where health care assistants provided instructions on how to bath the baby or in the making up of artificial feeds. A few fathers were observed to bath their baby themselves before transferring home, but this option was only available during visiting hours. However, the 'bath demonstration' only took place at certain times, as an official part of the routine of the ward and this did not always suit the needs of the women and their partners:

'... because he only got there at certain times, because the bath times were at certain times, so he couldn't make them ... we didn't actually think about asking them when we were there because I thought 'okay, maybe it's just those times ... they do it'(voice trailing)... he hasn't done it yet (laughing)t, he just watches, ... but he does help, like he holds the towel out ...' (Pauline, first baby, one month old at time of interview).

One father was observed, whilst putting some rubbish in the bin, to comment to the midwife as she entered the bay – ' ... something has just happened that has never happened to us before, he's gone on the breast, he's now feeding ... he's been there for ten minutes or so ... how long should he have?'. His delight was obvious. The midwife suggested leaving the baby to finish the feed and then offer the second side. He returned to his wife, telling her – 'offer the other breast, the more the merrier'. (15)

Pleasure was also demonstrated as the following extract illustrates:

This partner was talking to a caller on the telephone – ' ... she's just feeding ... it's taken an hour to get him on and now he won't stop, we gave him a little on the spoon and that seemed to get him

going'. *The midwife was present assisting with the feeding, this is the mother's second baby.* (15)

Fathers were seldom observed to be included in the daily examination of the infant by the midwife; an opportunity for education on caring for the infant or for fathers to ask questions may therefore have been lost. In the absence of receiving the information, partners would request assistance:

' ... (name of partner) had to ask, I tell you, I think he was worried that he would drop the baby in the bath because he thought at one stage that we were going to have to bath him ...' (Denise, first baby).

In the literature review I referred to the study by Moss et al., (1987) and how their findings demonstrated that whereas the fathers were allowed to be present during the birth of their baby, in the postnatal period they were not allowed into the nursery to participate in the changing and bathing of their infants. The researchers concluded that the fathers' role on the postnatal was marginal, the findings from my study nearly twenty years later suggest that fathers are not always included in the care of the mother and the infant.

The importance of inviting and allowing the new father to participate in the care of his infant on the postnatal ward is argued by Leahy Warren (2005), who examined social support for first time mothers and their confidence in caring for their infant; 99 mothers participated, completing a self-administered questionnaire at six weeks following the birth of the baby. Statistical analysis of the data showed that women regarded their partner and their own mother, as their main source of 'appraisal support', which related to the mother receiving positive feedback in caring for her infant. Health professionals and mothers were regarded as offering informational support. This was a relatively small quantitative study using a new scale, which was piloted prior to use to establish validity and reliability for the purpose of the study; the mother's own perceptions of social support were not explored and this is acknowledged by the author. Leahy Warren (2005) was able to demonstrate that 'appraisal support' had a statistically significant relationship ($p < 0.01$) with the

women's confidence in caring for their infant. She suggested that care settings need to recognise the partner's role in actively supporting the new mother in the postnatal period. Leahy Warren (2005) acknowledged the difficulty in defining 'social support' but suggested that this involved the two aspects of 'structural' element which involved the woman's close network of her family and, secondly, the 'functional' element which involved receiving appraisal and informational support. My data have demonstrated the women's need for their partner to support them during their stay on the postnatal ward.

8.4 Bed curtains – their ownership and role.

The bed space allocated to the woman on her arrival on the ward was referred to in Chapter 4; this was her designated space while on the ward. The relative lack of movement by the women within and out of the bay has been demonstrated. Bed curtains were part of her bed space within the ward area and defined the immediate area available or designated to the woman. The observational phase of my study explored the context of care within the ward environment and interactions between the women and care-givers. Early observational data indicated that the use of the bed curtains by the women and the care-givers was important and appeared to influence the interactions between them. The data from the in-depth interviews supported what had been observed.

The combined data demonstrated that women felt confident enough to open and close the curtains to suit their needs. Equally, midwives appeared to exercise an assumed right to open the bed curtains to suit their requirements. The data suggested that each party had their own definition of the use and need for curtains; in a sense, creating conflict concerning the 'ownership' of the bed curtains. This section will discuss the use of bed curtains by the women and the midwives, offering the women's perspectives first.

8.4.1 The use of bed curtains by women to create privacy.

The women described a variety of reason for their use of the bed curtains; the data from the in-depth interviews enabled a construction of the importance of the bed

curtains to them. It appeared that the women were using the bed curtains to create privacy, not only when they were on their own but also when they were with their partner and immediate family during visiting times; this was supported by the findings from the interviews:

'... I had mine round if I wanted to have some sleep ... or get myself changed, maybe five minutes with the baby, you know like you have that little bit of time ...it's good to know that you've got them there to give yourself a bit of privacy' (Vicky, fourth baby).

'I was feeling really tired as well and, I don't know, I just felt that I needed a bit of a quiet time away from, even like the people around me ... we'd got chatting and everything, I didn't even want to chat to them, just wanted to sort of take stock a bit so I did draw them then ...' (Lizzie, first baby)

In drawing the curtains to create privacy, the women created their own micro unit; thus, six separate and private units were created within the bay. However, as indicated by the interview data, this construction of private units did not suit all of the women, as the following vignette illustrates:

'... the ward I moved onto, everyone had their curtains closed, so everyone was very insular ...erm. It was actually one of the midwives that came in and said to the ladies – 'come on, let's open all this up and get the windows open and get some air' ... it was terrible because you open up ... erm your curtains and there was nothing there apart from curtains, you know, there was nothing there and ... it was just dreadful ...' (Gill, first baby)

This woman was describing a palpable sense of isolation despite being in a bay with other women, describing relief when the midwife drew the curtains back and thus opened the ward up. Lizzie, who used her bed curtains to ensure a restful environment for herself and her baby, also described how she felt on seeing another mother's bed curtains permanently closed:

'... the woman in the bed opposite me had never had those curtains drawn back so I may as well have drawn mine across because I couldn't see anything at the side anyway ...'

The need for interaction with other women or just being aware of their presence was referred to by women:

'... once I was up or if I was reading I would open them up because obviously you feel quite secluded ...' (Vicky, fourth baby)

'... I had them open, I didn't like the feeling of being closed in, I felt very isolated...' (Rose, second baby)

Burden (1998) had described how fully closed curtains appeared to indicate a need to withdraw completely, semi-closed curtains (small opening only) indicated a need for support and assistance, whereas partially closed bed curtains (half way along the bed) provided a restful and private environment; she referred to the bed curtain positioning as 'signalling'.

In the current study I aimed to explore care within the postnatal ward environment rather than a specific aspect, such as privacy, as explored by Burden, or the specific use of bed curtains by the women. Furthermore, I observed exclusively within the postnatal ward environment. However, the findings from the observational phase of my study indicated a need to explore further into women's use of and thoughts about the bed curtains and this aspect was therefore explored in the in-depth interviews.

Burden (1998) concluded that there is a lack of knowledge of how midwives view the positioning of bed curtains and the women's use of them; my data helped to provide more insight. The midwives in my study generally reported a dislike for closed bed curtains and this is discussed in section 8.4.4.

The use of bed curtains by the women in my study to achieve privacy has been discussed. The respect and understanding of the need for privacy of the other women

within the bay was evident, a finding which was similarly reported by Burden (1998). Wendy described during the in-depth interview how:

'... the lady who had a caesarean she had her curtains round most of the time, she was really tired, she was dozing off ... I didn't really speak to her ...' (Wendy, second baby).

The women's use of the bed curtains to achieve privacy was evident and their need for this seclusion was indicated.

Leino-Kilpi et al., (2002) explored the maintenance of privacy within the postnatal ward from the perspectives of the women and the care-givers, in five European countries: Finland, Germany, Greece, Scotland and Spain. The data were collected using a questionnaire and explored physical dimensions of privacy, such as dressing and personal hygiene as well as social and informational privacy which included asking questions, meeting visitors and entering the mothers' room. Mothers in Scotland, Germany and Finland reported higher levels of satisfaction with physical and social aspects of privacy. There was no reference to bed curtains in the text but an acknowledgment that the women in Scotland were sharing the room with other mothers, possibly indicating that the women in the other countries were cared for in single rooms. The care-givers in Scotland, Finland and Germany scored higher in their perceptions of how the women's privacy was maintained than their colleagues in Spain and Greece. The care-givers in Greece and Spain reported higher levels of satisfaction with the maintenance of privacy when compared to the mothers in those countries. The authors acknowledged the possibility of cultural differences between the countries and different educational issues for the care-givers. They also speculated on different cultural interpretations of privacy, which could account for the differences found.

The high number of health professionals moving through the bay was referred to in Chapter 5, therefore it may not be surprising that women feel a need to protect themselves or withdraw from the general busyness of the bay.

8.4.2 The use of bed curtains to indicate a need for assistance.

Women were observed to leave the bed curtains semi-closed, leaving a small opening or 'a door way', into the space created; this was explained by several women as being '*in case I need some assistance*' (10). This finding was in contrast to the findings reported by Burden (1998) who assumed that semi-closed position indicated a current, rather than a possible future need for reassurance.

Leaving a small opening enabled the woman to see out into the bay but equally the midwife could see into the woman's bed space. Gill who had had her first baby, detailed how she would '*leave the curtains open a little so that I could see what was going on*'.

Closing the curtains fully indicated a need for recuperation, as described above, or a lack of confidence. Although Pauline explained how she used the bed curtains for privacy, she also referred to the need not to be directly observed or overlooked by the other mothers in the bay:

' ... like shut yourself off on your own. When you've got them open ... everyone, you feel as if everyone is looking at you ... I had mine closed ... ' (Pauline, first baby).

Similar findings were reported by Burden (1998); the women on the postnatal ward in her study described a feeling of being judged on their 'performance' as a new mother, although she did not indicate whether this was relevant to all women irrespective of parity. The interview data from my study suggested a relationship between the use of bed curtains and women's need to feel confident in caring for themselves and their baby:

' ... I can remember when (name of first daughter) was born, I had like the corner, I had the window down the end ... I didn't feel very confident ... and I always kept my curtains closed and I think it's a confidence thing ... [this time] I kept mine open because I was that much more confident ... I think one, two, three, four women were all new mums (indicating that these women had their curtains

closed) whereas the lady next to me she was a second time mum, she had her curtains open so it must just be a confidence thing, they must feel that they are being watched...'

Interviewer - 'who would be watching?'

'...I don't' know (laughing) but it could be someone like me that, because I didn't say anything if someone was ... I wouldn't criticise and I wouldn't give any advice unless someone asked, I don't know ...' (Rose, second baby).

Rose described a feeling of lack of confidence when she had with her first daughter, but this time round she felt confident and had therefore used the bed curtains differently.

8.4.3 Ownership of bed curtains.

Women and midwives appeared equally at ease with their respective use of the bed curtains with each using them for their own purposes. In essence, the curtains therefore belonged to the person at the point of usage; this created a shared ownership but with some potential for conflict. This sense of ownership of the bed curtains was observed as the following vignette illustrates:

'On the midwife's entry into the bay most of the bed curtains were partially closed; the midwife opened all of the bed curtains fully without consulting the women in that bay or providing a reason for drawing them back. The midwife remained in the bay, and carried out maternal and infant checks, with the midwife inquiring – 'Who's next?'. The women were not observed to talk to each other. As the midwife left the bay for her tea break, having informed the women that she was 'gaspings', it remained quiet, the women were not talking to each other. Three of the women closed their curtains shortly after the midwife's departure. When the midwife returned after her tea break, she did not open bed curtains that were closed, but carried on with the examinations.' (04)

Following this observation the midwife was approached, with a view to seeking clarification on what had been observed. She readily provided her reasons for opening the bed curtains on entering the bay explaining that women did not talk to each other if the curtains were closed, and that the women by the doorway, and therefore furthest away from the window, would have limited day light. She also wanted to be able to see and ask *'if everybody is alright'* and *'if the baby is sick I can say to all of the women what to do'*. A personal preference was also given - *'I can't stand the curtains closed, can you?'* (04)

Several reasons were thus given. Opening the curtains for teaching purposes appeared effective as the midwife was observed to refer to all the women simultaneously, using written material covering aspects such as infant feeding and postnatal exercises, which she had previously provided the women with. Essentially this created a group teaching session and may therefore not have been appropriate for the needs of each individual woman; the women were not observed to ask questions of the midwife. Arguably, as the material given out consisted of information which the care-givers were required to provide the women with, the midwife observed appeared to use an efficient strategy in the provision and dissemination of that information. However, the communication could be regarded as managed by the midwife, thus creating asymmetry in the interaction (Lomax & Robinson 1996). This is also consistent with Kirkham's (1993) reflections that the organisational milieu prevented meaningful communication. Hence, the midwife was able to maintain the organisational emphasis on the 'checks' and her need to manage the bay and the group of women to which she had been allocated, thus fulfilling the notion of 'getting through the work' (Hunt & Symonds 1995). The impact of the task culture on the midwife's interaction with the woman has been referred to above (Handy 1993) which resulted in a need to control and manage the interaction with the woman (Lipsky 1980). The midwife's assumption of the right to control the bed curtains in order for her to undertake those tasks was evident and any consideration of the women's preferences possibly given a low priority.

8.4.4 The use of bed curtains by midwives.

Care-givers were observed always to close the curtains for examinations or care which required privacy for the mother. The women reported that this was important to them:

'...because I had stitches and everything like that and they weren't going to let me go home until they were happy with those plus you've got to lie on your side and you've got somebody looking at your most intimate area ... you're not going to get me to show you my most private parts while somebody's husband is sitting alongside ...' (Lizzie, first baby).

Although the midwife demonstrated regard for the woman's privacy by closing the curtains for the daily physical check, she assumed the right to draw the curtains without asking permission. Women were not observed to be consulted about the opening and closing of their bed curtains.

As described earlier, midwives were also observed to open the bed curtains without seeking permission; there was evidence from the interview data that some women found this helpful:

'... there was nothing else apart from curtains ... there was nothing there and ... that was just dreadful and it was so hot as well ...and the midwife definitely helped with that as well, by encouraging them to draw back their curtains and, you know, keep getting some light in the place, to get some air in the place' (Gill, first baby)

'...it is good that the midwives actually do pull them back because some of the girls would probably tend to leave them [closed] ...' (Vicky, fourth baby)

'... and I remember this midwife saying 'shall we make it a bit light and airy in here and have all the curtains open' and I think once the

curtains were open everyone thought 'oh, this is nice' ... ' (Rose, second baby).

Although the women described a need to draw the curtains to suit their needs, such as for resting or maintaining privacy or to achieve *'quiet time away'* as described earlier by Lizzie, they nevertheless appeared to appreciate the midwife or the health care assistant drawing the curtains back and in so doing opening up the bay.

The data indicated that the midwives did not always draw closed curtains back on their entry into the bay as the following data extract demonstrates (although it must be acknowledged that this was a night shift):

'At the beginning of the night shift one of the midwives entered the bay wheeling a sphygmomanometer. As she entered the bay she sighed and raised her eye brows, ?at the sight of the closed curtains. There were four women in the bay and three of them had their curtains fully closed. She pointed at the curtains exclaiming – 'it's so hot in here!'. She headed for a bed space, looking behind the curtain – 'who have we got behind here?, oh hello'. There is recognition in the midwife's voice on seeing the mother. As she came out of the woman's bed space, she found a window pole and opened the louver windows exclaiming – 'it's so hot in here, we need some air!'. The women were not consulted on the opening of the windows. It was winter and cold outside.' (17)

Here the midwife appeared to comment on the closed curtains by her remark on the heat in the room but she did not open the curtains, instead electing to open the louver windows to let in some air.

8.4.5 Bed curtains as a barrier.

Bed curtains were also perceived by the midwives to prevent women from communicating with each other. This midwife described how bed curtains when drawn back enabled the women to:

'when they are having breakfast they can talk to each other and be chummy' (6)

The midwives appeared united in their belief that women needed and should be encouraged to talk to each other:

'first time mothers need to interact with each other' (7).

They described a need for women to learn from each other, for instance a mother breastfeeding her baby with her curtains fully open, would provide a role model for the other women in the bay. The midwives clearly regarded closed bed curtains to inhibit communication between the women. The observational data provided little evidence that the women were talking to each other as desired by the midwives. However, the interview data indicated that the women did in fact talk to each other, and this 'chatting' was important to them whilst on the postnatal ward as it enabled them to seek support from each other, as discussed above.

The bed curtains were seen as a physical barrier by the midwives - *'You can't get to the women' (09)*. They described how the bed curtains physically prevented them from accessing the women as they wanted or needed to; thus indicating the midwife's assumption of her right of instant access to the woman at all times. At no time were midwives observed to ask for permission to enter behind closed curtains or to announce her intention to enter the woman's bed space before doing so. Women were not observed to object to the midwife's use of the curtains without their consent; however, it is possible that in opening the curtains the midwife would have minimised the individual woman's need for privacy. The creation of the bay (which included the bed curtains) as the nurses' personal space (Halford & Leonard 2003) was referred to in Chapter 4 and may explain the midwives' use of the bed curtains. The reasons for the midwives' dislike of the bed curtains appeared unclear and this aspect would thus require further investigation.

In conversation, the midwives also mentioned the aspect of safety, explaining how when the curtains were fully closed they were not able to observe the women in order

to ensure that everything was well. This demonstrated regard for the safety of the mother and her infant. However the data had indicated that the midwives left the bay upon completion of the tasks, hence there were periods when there were no health care professional in the bay.

The guidelines of the maternity unit where the study was undertaken indicated that the purpose of the postnatal ward was to provide care and rest to the new mother and her infant, in common with guidance offered elsewhere (RCM 2000a). By allocating the woman to a bed space on her arrival on the ward, the woman was provided with her own space; the bed curtains were part of the woman's space and she exercised her right to operate the curtains to suit her purposes and need. My data suggested that using the bed curtains to screen herself from others enabled the woman to exercise a degree of control over her immediate environment, providing physical and emotional safety; closing the curtains also removed the obligation to talk to the other women in the bay. Women respected the privacy of other women; they were never observed to enter another woman's bed space when that woman's curtains were closed although this could lead to a sense of 'isolation' as described by Gill. Vicky (fourth baby) offered the following comment during the interview – *'you have people around you but you're in hospital amongst strangers'*. Lock and Gibb (2003) in examining the importance of place reported that women did not identify with the hospital as their place, regarding it as an unsafe environment which suggests that closing the curtains creates only a partial feeling of safety.

The findings from my study indicated that whilst the women valued their privacy, they also appreciated interaction with the other women within the bay.

8.5 Sharing with other women.

Women described the impact on them of sharing the bay and the midwife with other new mothers.

8.5.1 Coexisting in a bay with other new mothers.

Although women valued the interaction with other women and sought support from them, sharing the physical environment with other women occasionally created ambivalence. The impact of other women within the ward environment on the individual woman was evident from the interview data. The women who participated in the second phase of the study referred to not wanting to be disturbed by the crying of babies of other mothers at night:

' ... when they (referring to health care assistants) came on, it was with the night shift and (pause) they actually came into the room where the ladies are and they said erm 'if your babies are crying at night please take them out so that others can sleep' which was good (voice raised) because the night before, these babies were screaming and no one was caring for them ... you felt like getting up and getting a bottle and feeding her yourself, you know, so that was good (affirmative voice) because (pause) once one baby starts crying it seems to be a chain reaction, they get that one quiet and then another one starts so you don't really get much sleep ...'
(Pauline, first baby)

Equally, they did not want their baby to disturb the other mothers within the bay:

' ...I think at night, because if your baby is making a lot of noise you, you don't want to disturb the rest of the women in the ward so therefore you tend to get up and then go somewhere ... a lot of babies that didn't settle during the night, they would keep all the other ladies awake, you know, ... (name of daughter) was actually very good, because she was actually a very quiet baby in hospital because she didn't cry very much at all or need very much comforting ...' (Gill, first baby)

Gill described a sense of fitting in with the ward and commented on her baby fitting in by being 'very good'.

However, a different and deeper perspective also emerged from the interview data and this provided an understanding of some of the difficulties experienced because of co-existence with the other women in the bay and their resulting emotions. Women who referred to this aspect did so in some detail:

' ... in the middle of the night ... it must have been about three o'clock in the morning, there was a lady that moved in, the bed in the middle opposite me and she was just, she was just annoying because this baby cried all night long on and off, and every time her baby cried she put her light on really bright which sort of lit up the whole room almost and then she'd buzz the midwife and the midwife, you know, was in and out all night and she said to her, you know, 'he's been sick' and I felt like saying to her 'he's your baby, you deal with it', you know, 'the rest of us are all being woken up by your light and then people traipsing in just to be told that your baby's been sick', so alright, fair enough she might need a clean sheet or something but she just needed him lifted out of his bed. She was expecting somebody else to come along and to clean up all the sick and put the baby back to sleep for her so that she could go back to sleep and it just carried on like that all the way through the night until about six o'clock in the morning and I just got up in the end, I thought 'it's pointless trying to sleep now', because I was so hung up, so I just got up. She was really irritating, she couldn't keep her light on the dim light, she kept putting it on really bright and just one of those spotlights really bright in the middle of the night, it does light up the whole of those rooms ... she was just annoying ... ' (Lizzie, first baby)

' ... the baby next to me was constantly crying because she couldn't feed it erm ...yes, that baby I actually heard from the other ward. When I moved I said to them 'wherever you put me, please don't put me next to that baby'. I said 'I don't mind anywhere else, even in the corridor, but not that bay' (laughing) and she (referring to the member of staff) said 'oh, alright'. So I

had the shower and I came back and I was in this bed so I didn't know what bay was what and all of a sudden this crying started and I thought, and it was next to me, and I thought 'oh, no' and I mean the baby was really frantic and it was over a week old, good strong lungs on it and erm ...' (Jane, second baby)

In contrast to Lizzie, Jane described a belief that the staff, the care-givers, should intervene and manage the situation:

' ... I kind of thought, with that circumstance when the baby is constantly crying like that, that something is wrong, maybe the mum and the baby should go into a private room erm ... but it was constant [crying] and then she'd be feeding it and ten minutes later ... just all the time and she was crying and in quite a state as well and erm she just said 'look, you take the baby', it was about eight o'clock at night 'just take it way from me' so they took her, they said 'give her a really good feed and we'll bring her back to you at four o'clock in the morning, we promise'. She gave it a good feed, the baby went off at nine o'clock and by eleven the baby was back and because the baby had such a massive cry, got in such a state that the poor nurses, you know, couldn't possibly keep her until four o'clock so they brought her back at eleven, and just sort of 'we're really sorry but she needs another feed' and this just went on through the night and the mother was getting distraught as well because she'd get stressed out because all the other mums that were in there or were arriving in were thinking 'what on earth ... what is going on here?' and she felt that. She was getting more and more stressed, she was only young as well erm, so I felt that, that sort of circumstance she should've been given a private room maybe and maybe they should look out for that ...'

The views of the women concerning the difficulties of sharing a bay with other women remain unclear and poorly understood. Two contrasting themes emerged with women needing to support each other but also a strong desire for the other women in

the ward not to impact directly on them; the importance of 'self' was evident. The views offered above contrast strongly with the other data relating to women interacting with each other. Clearly, women have needs on different levels which they expect to be met whilst on the postnatal ward.

The expectation to be able to rest and recuperate after the birth of their baby is given by women as a reason for not transferring home soon after the birth (Kenny et al., 1993, Brown & Lumley 1997). The results from the current study demonstrated that this expectation may not be realised, leaving women with an unsatisfactory experience. Lizzie, who above described her annoyance at being disturbed by another mother in the bay, detailed how she herself had sought assistance to minimise her daughter disturbing the other women:

' ... at midnight, she was wide awake and not sleeping at all and I was absolutely dead beat ... and I was really, really aware that other people being in that room with you whose babies were asleep and the fact that you got one baby in the corner that won't settle and go to sleep, and everybody is so totally shattered and really need their sleep. I wheeled her down to the station, and one of them, she wasn't a midwife, she was one of the assistants, care assistants or whatever you call them, she just took her ... ' (Lizzie, first baby)

The partner of a new mother, who had had her first baby following a caesarean section commented during a period of observation that *'she can't wait to go home and relax'* (07).

Ball (1994) in a study which examined the emotional needs and well-being of women and satisfaction with motherhood, interviewed 320 women within 24-36 hours after the birth, of whom 297 completed a questionnaire at six weeks postnatally. She found that 41% of the women reported low satisfaction with their ability to rest in hospital, primarily due to lack of sleep at night. Ball reported that lack of sleep adversely affected the mother's emotional well-being. On examining the results further she was able to demonstrate that the mothers who were cared for in the two hospitals in her

study which practised 'rooming-in' of babies over the twenty four hours, were more likely to report lack of sleep, when compared to the mothers at the hospital where the babies were cared for in the nursery at night. The lack of sleep and its impact on the psychological well-being of the mother has also been described by Niven (1992) in her book which aimed to offer advice to health care professionals on psychological care to the mother and her immediate family. She argued that the new mother may be physically and emotionally exhausted, as well as having a sense of exhilaration from the birth, and as result she may find it difficult to rest and sleep. Niven (1992) questioned the assumption that mothers and babies benefit from a twenty four hour policy of 'rooming-in' and urged the midwife to be sensitive to the needs of the individual mother. Of the women who participated in Woollett and Dosanjh-Matwala's (1990) study, 44% described the need for rest and recuperation and the importance to them of the care-givers assisting them by looking after their baby if requested; a need confirmed in the current study.

Arguably, the ward environment must facilitate the women to rest and recover.

8.5.2 'Sharing' the midwife.

In coexisting with other mothers within the bay, women were required to share the time available from the midwife to interact with each individual woman. The observational data revealed that midwives or care-givers would indicate their availability to the women whom they were caring for:

'The midwife tells the woman - ' ... now, I'll just go and check on someone at the other end of the ward, who is supposed to be feeding ... keep trying ... '

This mother was experiencing problems in breastfeeding her son and had been receiving assistance throughout the late shift by the midwife. The midwife returned shortly afterwards and continued to offer support. ' (14)

'I'll come and see you shortly' (10)

A degree of availability was also indicated with midwives being present in the bay in order to undertake routine physical maternal and infant examinations. However, as the midwife progressed from 'check to check', with the order largely being determined by the midwife, each mother had to wait the turn allocated to her. This was never observed to be challenged by the women, who appeared to accept this 'rule' as part of the routine of the ward. However, the women participating in Lock and Gibb's (2003) study described the negative aspects of competing for care with other women within the ward environment, describing the 'ghosts' of other mothers impacting on their interaction with the midwife. Felicity having had her first baby spoke about how:

'some women are more demanding than others, aren't they?'
describing how *'those that demand get, don't they?'*.

It is possible that a lack of knowledge of the role of the midwife within the postnatal ward contributed to the women's reluctance or inability to request assistance for themselves, as described by Denise who had given birth to her first baby - *'what is their line of work?'*. Denise spoke about *'my antenatal midwife'* whom she knew and how 'her' team midwife had brought her over to the postnatal ward but she was evidently unsure about the role of the midwife on the postnatal ward. This lack of clarity, although perhaps surprising, has been reported previously. Leach et al., (1998) interviewed 247 women of different parity during the antenatal period on their perception of maternity carers, including midwives, obstetricians and general practitioners (GPs). The women considered the obstetrician to be responsible for specialised care, but were unsure of the role of GPs. The majority of the women were clear about the role of the midwife, however 7.3% (n=18) of the women interviewed were not able to describe what a midwife does or tasks which she is likely to carry out. Only 48% of the women referred to the midwife's role in providing postnatal care.

Sharing the midwife or health care assistant with other women may lead to a negative and unsatisfactory experience:

' ... and they spent a lot of time with certain people that were struggling with the feeding side of it, they didn't really think erm anyone who is bottle feeding and yes that's easy. I was finding it awkward too, you know, get up and about and move and that wasn't really a priority I suppose, I think from their perspective, yeah ... ' (Jane, second baby, elective caesarean section, artificially feeding)

In contrast, Claire who had had her second baby, appeared to accept the impact of the other women and the delay in time for her to be attended to when she sought assistance, reasoning that *'it's very understandable ... because we are all many'*. Bondas-Salonen (1998) found that when the women referred to care as being lacking, they rationalised that this was because the care-givers were busy and therefore not able to attend or assist them and their baby. Essentially, the mothers 'excused' the midwives, ensuring that direct criticism was not given (Pontin & Webb 1995). However, the participants in Price's (1993) study (see Chapter 5, section 5.6.2) commented that they were aware of the busyness of the nurses, but nevertheless lamented the fact that they were busy with other patients and not themselves.

8.6 Conclusion.

In this chapter I have discussed further aspects of concern and importance to the women, particularly those relating to receiving support. The different facets of care which women required have been explored, such as women wishing to talk about their birth experience. The need for partners to be included in the care, further highlighted the women's desire to be supported. The paradox of needing to draw support from other women whilst at the same time ensuring that a distance was maintained, lest their own needs were compromised by having to share both their environment and the attention of the health care professionals has been revealed.

It was evidently important to the women to receive support which was appropriate to them and their needs. The midwives' desire to provide sensitive and supportive care is not in doubt and no indictment of care is intended, rather to highlight that the

organisation appeared to militate against the wishes and desires of midwives and women alike.

In the final chapter I discuss further aspects of the organisation which may impact on the midwives' need to protect themselves by identifying with the organisation in their interactions with the women. I conclude by referring to implications for practice and further research.

CHAPTER 9: DISCUSSION AND CONCLUSIONS.

9.1 In summary.

In this study I observed activities that occurred within the postnatal ward environment and interactions between women and health professionals as well as exploring through interviews the women's perspectives of care on the postnatal ward.

The all pervasive influence of the organisation with the resulting marginalisation of not only the midwives but, most importantly, the women has been demonstrated. When 'passing through the postnatal ward' women sought to make themselves heard. The care and assistance provided to them was heavily influenced by the need for the midwives to adhere to the task culture (Handy 1993) and care was not generally individualised according to the needs of the women.

This resulted in a rhetoric of 'care' as opposed to a reality of 'care'; the findings suggested a relationship or interaction based predominantly on the expectations of the organisation to which the midwives subscribed (Lipsky 1980). As a consequence, the midwives were only able to offer a functional and 'disconnected presence' to the women who wished for a connected interaction and presence from them. Such a functional relationship appeared to benefit the midwives but not the women, thus making it an unequal and, at times, an unsatisfactory relationship.

Where the midwives were able to offer a 'connected presence' to the women this was achieved through 'creativity' where midwives worked outside, although sometimes simultaneously within, the constraints of the organisation. In the absence of a committed and 'connected presence' from the midwives or the development of a 'guarded alliance' (Thorne & Robinson 1988), women 'opted out' by withdrawing to their bed space or ultimately by transferring home.

My findings suggest an urgent need to ensure that care is appropriate for each individual woman and her infant and this cannot be achieved if the provision of postnatal care continues to be viewed as 'standard' with one format suiting all women (Bick 2006). The women interviewed were articulate in their descriptions of wanting

to be treated and acknowledged as individuals. However, as described in detail above, the impact of the organisation largely prevented this from happening.

9.2 Further considerations of organisational aspects.

The ambivalence felt and experienced by the midwives was evident; they wished to provide care but did not feel empowered to challenge the current organisational provision of care which emphasised the completion of tasks and records as an expected standard. In contrast the health care assistants appeared to be protected from this dissatisfaction; the reason for this was not clear although it could be argued that in the absence of having to complete tick lists they were able to form a relationship, albeit fleeting, with the women.

The allocation of midwives to different clinical areas, in order to maintain and extend their clinical skills, essentially made the midwives themselves visitors, thus in common with the women 'passing through the postnatal ward'. They may therefore not have been given the opportunity, nor felt the need, to invest in an attachment to the postnatal ward environment other than to develop a workplace identity within each shift on duty (Halford & Leonard 2003). Although the midwives did not appear to identify with the postnatal ward as a setting, they nevertheless had a need to identify with the bay to which they had been allocated as this represented both security and spatial identity (Halford & Leonard 2003). In a sense, the attachment existed at a lower level, within the physical space of the bay, but this attachment did not extend to the women. It appeared that the midwives had a need to protect themselves and this will be discussed below.

The expectation that they might be moved to the labour ward at any time, in addition to the unpredictability of the number of women being transferred from the labour ward, often at short notice, further impacted on the work pattern of the midwives. Additional midwives were not allocated to the postnatal ward as the workload increased. Ball et al., (2002) undertaking research into reasons why midwives decided to leave midwifery, surveyed those who had not renewed their intention to practise. In phase one of the study 250 midwives were sent a postal survey; 139 midwives (56%) responded and of those 28 midwives were interviewed, using an ethnographic

approach. As part of the findings, the researchers described midwives' dissatisfaction with rotation through shifts, describing how such 'dislocations at work' impacted on their relationship with the women as well as colleagues; the need by midwives to identify with their colleagues has been referred to earlier in this thesis. Arguably, such 'dislocations' devalue the midwife and negate her need for defining her own territory (Halford & Leonard 2003) but, equally, they reinforce postnatal care in hospital as being the 'Cinderella' component of the woman's childbirth experience, as midwives can be removed from this setting and 'redistributed' at short notice.

Although there was no physical barrier which separated the antenatal and postnatal areas of the ward, it is interesting to note that generally the two areas 'operated' independently of each other. The ward sister would work either within the antenatal or postnatal ward area and although the senior midwife, she also had a 'workload' to manage and, possibly, did not feel able to respond to concerns outside of her immediate responsibilities. In common with her colleagues she would concentrate on the tasks which she was required to complete. It was manifest that midwives accepted the value placed by the organisation on 'processing women through' and the efficiency with which they effected the women's transfer home. The efficiency demonstrated by the midwives in undertaking the tasks and managing their workload, also served to protect them. Ball et al., (2002) detailed how managers, although aware of the dissatisfaction felt by midwives, at times felt unable to intervene in order to support them. The midwives in the current study did not express any expectation of managerial support and the ward manager was not observed to provide clinical care on the ward.

9.3 Understanding the midwives' need to protect themselves by identifying with the organisation.

The midwives reported that the 'workload' prevented them from caring for the women. In essence the midwives described not having the time to 'care' for the women; this was discussed in Chapters 4 and 5. The inability of midwives to directly influence their immediate work culture or working practices was demonstrated. I would argue that the 'dislocations at work', as described by Ball et al., (2002), reduced the midwives' autonomy and their ability to challenge current organisational

practice. Furthermore, a lack of time, as a resource, to both examine and reflect on current practice not only impacted on the midwives' interaction with the women but possibly contributed to the 'disconnected presence' offered by the midwives (see Table 6.1).

Essentially, midwives perceived it easier and preferable to identify with the organisation and its emphasis on a task culture as the organisation appeared to place little value on midwives developing a relationship with the women. Remaining within the known and familiar practices provided both safety and valuing (Ford & Walsh 1994) and therefore, if they are to succeed, midwifery leaders and clinical practitioners will need to plan and implement changes together. During the time span of this study, two documents on postnatal care were published by the RCM (2000a, 2000b) but neither of these were referred to or disseminated within the maternity unit. In 2007 the DoH stated that:

'Innovation and service development is strongly associated with positive leadership and an organisational culture supportive of people developing their ideas for improvement'. (DoH 2007, page 39)

As the ward sister was expected to carry a 'workload' whilst on duty, an immediate opportunity for her to provide leadership or to discuss organisational issues may not have been available. Conversely, it could have been seen as an opportunity to review the provision of care and allocation of overall staff resources of which she was part. It was evident that the shift co-ordinators did not feel the need to provide such leadership.

In order to further understand the midwives' position and relationship with the organisation a brief discussion will be offered on the work by Menzies Lyth (1988) who in the late 1950s undertook observation of nurses working within clinical areas and held interviews with approximately seventy nurses. She discovered high levels of anxiety and distress amongst the nurses and subsequently went on to describe the causes and the effects of this level of anxiety. The nurses developed a 'socially structured defence mechanism' (page 50) in order to protect themselves. It is striking

to note that the midwives in my study demonstrated the same need to protect themselves from the women for whom they were expected to provide care. Withdrawal from the bay upon completion of their tasks constituted an example of the defence mechanism described by Menzies Lyth (1988). Deflecting questions while remaining in the bay also effectively protected the midwife from offering a personal or enhanced investment in any interaction with the women.

Menzies Lyth (1988) described how the 'nursing service' (page 51) attempted to protect the nurses from anxiety by constructing the workload into tasks. In my study the organisation provided task-based care and one of the reasons that the midwives did not challenge this may have been that they found it helped to protect them from anxiety. Menzies Lyth argued that by performing the tasks, the nurses were thus relieved of the responsibility of caring for the patients. She further described the importance to the nurses of adhering to the tasks as set, which she referred to as 'a matter of life and death' (page 55) thus emphasising their importance to care-givers. This resonates with my findings where midwives described the need to complete required tasks within their shift on duty and how the completion of tasks essentially confirmed the midwife's ability to manage her workload and thus assured her significance within the organisation. The advice by NICE (2006), as set out in their postnatal guideline, therefore represents a significant challenge to current working patterns.

Worryingly, Menzies Lyth (1988) described how ultimately the defence mechanism used by the care-givers to protect themselves actively inhibited them from realising their potential and ability for providing care and support. The data from my study suggest that the midwives were not seeking an alternative working pattern, nor was there a conscious attempt to provide care differently with the exception of a few midwives who aimed to be 'creative' in their interaction with the women. Thus the desire of the women for a 'connected presence' (see Table 6.1) from the midwives remained largely unfulfilled.

Reference was made in Chapter 5 to the midwives emphasising the need for women to take responsibility for themselves and their infant, although women were not assisted to achieve self-caring. Clearly, encouraging self-caring by the women would have

involved an investment by the midwife beyond designated tasks. The wish by the women for an 'unconditional presence' with the midwife in order to be seen as an individual has been demonstrated and how the midwife was primarily only able to respond to the women through a 'functional presence'. The aim by the midwives to offer a 'functional presence' only should be viewed in relation to the discussion offered by Menzies Lyth (1988), as discussed above, and the midwives' need to protect themselves.

Postnatal care is an area of clinical practice where the influence of the medical staff is minimal and yet the midwives still experienced difficulties with practising autonomously. The reason for this is not fully apparent but the constraining influence of the organisation within the hospital setting must be acknowledged. Williams (1997) documented how midwives were simultaneously compliant with and affected by the emphasis of medical surveillance and dominance within maternity care. Although she was referring primarily to aspects surrounding the birth, there appears to be a dichotomy in providing postnatal care. Midwives were essentially powerless in how care on the postnatal ward was organised, responding only to their own placing within the organisation. Engaging in a relationship with the women might be regarded as an essential part of any interaction with them (Kirkham 2000). The reluctance or inability of the hospital based midwives to form a relationship, particularly an emotional relationship, with the women has been referred to earlier in the thesis. This is in contrast with the team midwives who were observed to 'drop in' and seek the women out on the postnatal ward and who perhaps could be seen as removed from the organisation.

9.4 Using policy framework to support care.

During the progress of my study, documents were published which aim to offer guidance to midwives and support workers on the provision of woman-focused care (DoH 2004, NICE 2006, DoH 2007). A common thread within these documents is the concept that women should be involved in their care and have a choice in how and where that care is offered and provided to them, thus aiming to place women at the centre of the available services. Local guideline for the maternity unit where the study was conducted expressed the need to provide a safe and supportive environment for

women and their infants as well as appropriate communication and liaison between members of staff. However, the main aspect of the document was formatted to offer specific guidance to midwives on clinical care and observations and this was reflected in the task-based care they offered to the women. My data have demonstrated the apparent mismatch between the care women expected to receive and what was actually provided, which was not woman-focused.

Although the midwives described the need for women to take 'responsibility' for themselves and their infants, the women were not observed to be supported in achieving self-caring. There was little evidence of this aspect of care being actively encouraged by the midwives. Persson and Dykes (2002) interviewed six Swedish women and their partners who had transferred home early, within twenty six hours of the birth, and were receiving home visits by a midwife. Normally transfer home was later than this but within 72 hours. Using the grounded theory approach, the researchers were able to identify the main category as 'a sense of security'. Within this category the parents described the need for an empowering attitude from the midwife which led to parental 'self-determination'. Parents also detailed the importance of being able to support each other, to take control and assume responsibility for their baby. The researchers acknowledged that it was not possible to seek the views of the women and their partners who remained in hospital for the normal length of stay. The DoH (2004) advocated the need for parents to receive assistance in the postnatal period to adjust to parenthood, regarding this of equal importance to receiving clinical care. The DoH also considered the inclusion of the baby's father essential in the provision of care to the woman and her infant. Arguably, involving the partner enables both parents to assume joint responsibility for their family. My data demonstrated the importance to the women of receiving support from their partner but that this was not always possible within the ward environment. Furthermore, my study also identified the value to women of self-determination, as expressed by Lizzie who described her decision to have her daughter in the bed with her after the midwife had told her to put the baby back in the cot – '*my reasons behind it were just as valid*' and how she '*should be allowed these sort of things if I really want to*'. Involving women in the planning of their care, as advocated by DoH (2004), will enable them to better ensure that care meets their needs and expectations. The

recommendation of encouraging each woman to actively participate in the planning of her care was further reinforced within the NICE guideline (NICE 2006).

The report 'Maternity Matters' (DoH 2007), described how women should have a choice in where care is provided throughout the childbirth experience. The document acknowledged women's dissatisfaction with postnatal care within the hospital setting and stated that this aspect should be addressed urgently in order to provide women with a better experience. The framework proposed in the report described choice in postnatal care, mainly following transfer home from hospital, outlining how women should be able to access care either at home or in a community setting, such as a Sure Start Children's Centre. Moreover, the document detailed how, irrespective of the place where postnatal care was provided, the care should be co-ordinated, based on relevant guidelines and, most importantly, that care must be personalised for each individual woman and her infant.

The NICE guideline described the importance of a documented, individualised postnatal care plan and how this should be developed and reviewed with the woman at each postnatal contact (NICE 2006). The construction of an individualised care plan, in consultation with the mother, would offer midwives the opportunity to interact with women as individuals in a caring capacity, as apparently desired by the midwives in my study. However, it would appear that midwives will need to be assisted in the transition from task-based care to individualised care; the impact of the organisation was absolute. The embracing by the maternity services and by midwives of recent guidelines and frameworks has the potential to increase their caring interaction with the women and shift the allegiance from those associated with the organisation to those related to the individual.

Essentially, the recommendation by NICE (2006) for midwives to engage with the individual woman, constructing a care plan which is relevant and specific to her alone represents a change in current working practice. Given the findings of my study of the adherence by the midwives to a generic 'tick list' created by the organisation, publication alone of such documents or guidance may not be enough. Unless midwives are actively encouraged to discuss the context of care being proposed by the relevant publications as these become available, they will fail to impact on the care

provided to women and their infants. Midwives need to be aware of the need for open debate and dialogue as a result of these publications and to be assisted through protected time for discussion. Such discussions must be tailored not only to the needs of the women and the local population but, equally, to consider the needs of the midwives as care-givers within a hierarchically structured organisation. A failure to use relevant documents to guide practice is likely to impact negatively on the options of care available to the women.

The publications by DoH (2004, 2007) and NICE (2006) have emphasised the importance of the period of care postnatally extending for up to six to eight weeks after the birth of the baby. During the part of this time that the woman spends in the community she should have access to professional support. In comparison, the period in hospital is of short duration and this may result in the emphasis of care being on immediate recuperation whilst ensuring the well-being and safety of the new mother and her infant; this may not promote the acquisition of parenting skills. Ockleford et al., (2003) referred to the transient nature of care in hospital in the early postnatal period as being a period of observation, suggesting that the majority of care should be provided by the community midwife once the woman has returned home. However the current study has demonstrated that women wish to receive care (and not simply observation) in hospital after the birth of their baby and therefore that such care must meet their needs and expectations. An increased understanding of the views of midwives about the practical aspects of the provision of care on the postnatal ward would appear important. It was evident from my findings that both midwives and women wished for a meaningful interaction; midwives wished to 'care' and women wanted to be accepted *'for [their] own needs'* (Vicky).

9.5 Reflections on undertaking research as an 'insider'.

Undertaking research within my own area of practice presented me with the challenge of attempting to 'detach' myself from that area, thus essentially entering into the unknown. The decision to undertake the observation prior to the in-depth interviews assisted me in seeking to understand the postnatal ward environment from the perspective of an outsider. I strove not to feel complacent about what was arguably familiar; instead I wished to acknowledge my limited understanding of the culture

which I sought to explore. Abandoning the observation schedule (see section 3.3.3.1) liberated me to observe aspects which I, as a midwife, might have overlooked and therefore would have failed to realise the importance of. I similarly sought to reflect on the midwives' assumption that I would share their perceptions and views of the provision of postnatal care.

The observations 'exposed' the ward to me and revealed aspects which I initially found disconcerting, such as the midwives removing themselves from the bay and retreating back to the staff area, thus creating a distance between themselves and the women. Their concentration on the performance of tasks with their strict adherence to the tick list was similarly disturbing. I did not recognise this as commensurate with providing care to women. The request by one of the midwives that I should count the number of times care-givers entered into the bay, thus ostensibly confirming their busyness and worth, was heartfelt. It would appear that 'counting' the busyness was important; there was little or no reflection on the possible effect of the midwives' busyness on the women. It became clear that midwives experienced difficulties in providing care within the ward environment. Hunt and Symonds (1995), in a study based on observational data, described the dilemma experienced by one of them in having to resist the instinct to take over the care for a woman who appeared not to be reassured by the actions of the midwife; instead the researcher withdrew to make notes about the observation. I did not observe instances where I wished to intervene, but as my study progressed I was aware of a deep desire to share the findings so that care for postnatal women can be improved.

Listening to the women detailing their perspectives of care on the postnatal ward was equally disquieting. I feel that my 'new' perspective of the postnatal ward enabled me to make much greater sense of the women's views of that environment. The accounts offered by the women also provided me with a different awareness of the postnatal ward and aspects of receiving care within that environment. I was surprised by how earnestly individual women revealed issues of specific concern, often returning to them more than once. The willingness with which women participated, sharing their experiences, was humbling and I hope that I was sensitive to the importance attached by them to their revelations; they genuinely wished 'to help' other mothers. This has further strengthened my desire to share my findings.

In undertaking this study, I have explored my own expectations and assumptions as a practitioner and as an investigator (Kirkham 1989, Hunt & Symonds 1995), and in this sense this study has been a personal journey. I am aware that, as an individual, I have occupied a part within the study as I probed and attempted to make sense of what I observed and what the women were telling me (Wolcott 2001). I am conscious that I now view the postnatal ward environment differently and that nuances, previously hidden, have been revealed. This may be reflected in my own clinical practice subsequent to the study; Lofland and Lofland (1984) described how investigations may change the researcher. I was not prepared for how midwives or other care-givers would unconsciously shape their practice, and hence the provision of their care, in order to fit in with the organisation. This has challenged my own understanding of care in the hospital environment as a practitioner, as I strive to ensure that my contact with women is set within my understanding of woman-focused care.

In conclusion, being a midwife was both a strength and a limitation in undertaking this study. Sensitive issues such as the midwives describing feeling emotionally drained and needing to 'escape' from the postnatal ward were painful to hear and record here but documenting this has facilitated a reflection on the position of midwives within the caring process. This does not imply judgement of my colleagues and their interaction with the women, but rather a need to offer my findings, in the hope that they will contribute to an understanding of the provision of care in the future. I am committed to feeding back to the maternity unit and my colleagues and will be offering an oral presentation of the findings upon completion of my studies.

9.6 Limitations of the study.

As the study was conducted within one site only, generalisability of the findings should not necessarily be presumed. However, the literature review had revealed that women, irrespective of country of residence in the developed world, appeared united in their dissatisfaction with postnatal care in hospital. It is possible that the women who elected to give birth at the maternity unit where the study took place have similar expectations and views of care as women giving birth at neighbouring maternity units and therefore, their views may resonate with the views of women receiving care

elsewhere. Despite the data collection being limited to one site only, the findings nevertheless have the potential for wider impact by providing midwives with a better understanding of women's experiences. The nature of an ethnographic study is to increase the knowledge of the phenomenon of interest (Hammersley & Atkinson 1995) and this was achieved in this study.

The full complement of staff enjoyed by the maternity unit, in comparison to neighbouring units, at the time of the study was referred to in Chapter 4 and this may have impacted on the perspectives of the women. It is feasible that women receiving care in a unit experiencing problems with the recruitment and retention of midwives may have reported different and even greater levels of concern.

Arguably, the views of the women themselves from the in-depth interviews, in addition to the observational data (Grant 2001), can add to care-givers' understanding of what is important to women when receiving care on the postnatal ward. Women's recall of events on the postnatal ward may have diminished with time but, in the absence of sound evidence on the best time to undertake in-depth interviews, an effort was made to ensure that the time span between going home and the interviews was of a reasonable interval so that women would be able to recall their stay on the postnatal ward.

I acknowledge that the accounts and descriptions offered within this thesis are the result of my interpretations of what was observed or told to me by the women; total objectivity is not possible (Eisner 1991, Kingdon 2005). Kingdon (2005) described how both professional and personal experiences will impact on where the investigator places him or herself within the debate of the study. I have explained above (see section 3.8) how I wished to place the women at the centre of my findings and yet how the all pervading influence of the organisation dictated the order in which the data were presented. My aim was to seek the women's perspectives of their care and I hope that I have been able to reflect the voices of the women, particularly in Chapters 7 and 8.

9.7 Implications for practice.

Midwives need to be supported to provide care which is tailored to meet the needs of individual women and to consider the purpose of their interaction with women. Redshaw et al., (2007) in their national postal survey which used a random sample of 4800 women during one week in March 2006, achieving a response rate of 63%, highlighted that there remains dissatisfaction with postnatal services. They described a flexible approach to care during the antenatal period and the birth, but found this less obvious in relation to postnatal care in hospital. Hence, it would appear that there has been little change in the provision of postnatal care in hospital since the last national survey reported by the Audit Commission (1997) and Garcia et al., (1998).

I hope that midwives will be able to use the findings from my study to engage in a debate about the nature of postnatal care in hospital and why there is so much feedback that demonstrates dissatisfaction with the provision of this care. Such a dialogue has the potential to assist midwives in examining the current provision of postnatal care for the purpose of informing their practice. It would appear that presently consultant midwives have a high profile nationally in supporting 'normal birth'. However, there are a small number of consultant midwives who within their remit of Public Health also have a responsibility for postnatal care, but not exclusively postnatal care in hospital, as part of the continuum of the childbirth experience (Jokinen 2007, personal communication). In the absence of a consultant midwife with a remit for postnatal care in hospital, the possibility of identifying a midwife with the specific responsibility for providing leadership and clinical guidance on the postnatal ward may be a way forward in offering support to care-givers (Allen 2006, personal communication).

The current emphasis on task-based care, with an ethos of getting through the work, appeared to militate against care-givers offering the women time to talk and their concerns appeared lost. The findings have indicated the desire of women to talk with the midwives; this must be recognised as an important component of care and facilitated. In the unit where the study was undertaken, this could be achieved by using the postnatal care plan in the woman's handheld notes, thus providing women with an opportunity to raise issues of concern to them. The implementation of the NICE guideline (2006) will enable midwives to engage with women with the aim of

providing woman-focused care. It was evident that the format of a 'tick list', although serving the organisation's requirements, did not facilitate communication with the women. The procedural language of 'checks' and 'work' reinforced the 'standard' nature of postnatal care, however, it was manifest that the women did not regard care as 'standard'.

Inclusion of the woman's partner in such a discussion would enable him to support his family. I discussed the separateness of the infant in section 5.5 in relation to the daily checks. The DoH (2004, 2007) urged care-givers to ensure that parents have the skills and support to become confident parents. Encouraging the midwife to examine the mother and her infant at the same time, and including both parents in the examination of their baby, would aid them in self-caring as they move forward into parenthood.

There is also a need to recognise the specific needs of women who have had a caesarean section and an acknowledgment that on transfer to the main postnatal bay many of these women felt that they did not receive adequate assistance. The organisation of care on the postnatal ward must therefore reflect this need, possibly through them receiving care in the post-operative bay for a longer period or ensuring continued assistance on transfer to the general postnatal bay.

The requirement for care to be driven by the needs of the women is paramount; and this study revealed that the organisation of care at times would override the wishes and needs of the women. Essentially, women wanted information and support so that they could understand what was happening to them and how they could help themselves. This could be facilitated by informing women about local support groups, relevant support telephone numbers as well as information available through the internet. Assistance offered by midwives must reflect the need by women and their partners to assume responsibility for themselves.

The study indicated that women wished to receive care in hospital after the birth of the baby and viewed it as important, although they had no clear idea as to what they could expect from their stay on the ward. Strong leadership, involving service managers and senior midwives, is required to shape the future pattern of postnatal care in hospital; the provision of care which is sensitive to the requirements of the

new mother and her infant must become a reality and priority, not merely an afterthought added on to the main event. There is an urgent need to consider restructuring its provision and organisation. This could include encouraging a longer period of rotation onto the postnatal ward for midwives with a particular interest in postnatal care, thus promoting a coherent approach through providing continuity on the ward from a specific cohort of care-givers. This could further be encouraged through self-rostering or development of a team approach offering increased autonomy to the midwives. Such initiatives would have the potential to highlight the importance of postnatal care and to move it away from its 'Cinderella' status. Woodward (2000) described how, unlike the palliative setting, the midwifery setting lacked a reflective approach which perpetuated the 'doing' aspect of care. It is possible that visible and purposeful clinical leadership could support the midwives to reflect on their practice. Midwives were also clear that 'paper work' prevented them from giving time to the women; it would therefore seem practical to ensure administrative support for indirect care such as the electronic entry of routine data. Releasing midwives from administrative tasks would ensure that they are able to offer the time and meaningful presence which the women sought.

In any proposed organisational changes it would appear imperative to ensure that midwives are facilitated to achieve a connectedness, thus enabling them to offer a presence to the women which is meaningful both to women and to the midwives themselves. The recent publication by NICE (2006) presents an opportunity for midwives to not only include the woman more fully in her care but also to engage with her and her concerns. Where tick lists are commonly used as an indicator that care has been provided, midwives may need to be assisted to make the transition to a greater emphasis on involving the women in their care.

If the role of the health care assistants is further increased to include tasks or duties currently seen as the responsibility of the midwife, this may well impact on the health care assistants' ability to make themselves available to the women. In the light of data from my study, this would be regrettable. It is important that new initiatives are evaluated from the perspectives of the women and not merely against organisational priorities. As health care assistants assume the responsibility for further tasks,

midwives may find that they have increased time to spend listening and talking with the women.

The emphasis by midwives on women assuming responsibility for themselves whilst simultaneously continuing to stress the importance of remaining within the 'rules' of the organisation, for instance the restrictions of visiting time for partners, must be reflected upon. For example, a description was offered above how early transfer home might better facilitate women and their partners to engage in self-care for themselves and the infant (Persson & Dykes 2002). Although there was some evidence of self-caring being undertaken by the women and their partners, there was little evidence of this aspect of care being actively encouraged by the midwives. In this sense, the emphasis on self-caring appeared as a rhetoric as opposed to a real and actual option of care within the postnatal ward environment. This may have implications for clinical practice as well as women's views of assistance offered within the ward environment.

9.8 Implications for further research.

In the previous section I discussed possible implications for practice in relation to the findings. The findings have also demonstrated aspects where further research would enhance midwives' understanding of care within the postnatal ward environment.

The aim of the study was to seek the women's views of receiving care within the postnatal ward environment. The observation highlighted that the views of midwives, responsible for delivering care, was an aspect which is not well understood. It was not possible within the time frame of my study to seek the views of the midwives and their views are under represented in this study; the PinC report (Forster et al., 2005) which sought the views of the midwives, was undertaken in Australia. However, the information gathered during informal conversations with the midwives demonstrated their desire to have their views heard. As midwives are responsible for delivering the majority of the care on the postnatal ward, although increasingly assisted by health care assistants or maternity support workers, there is an urgent need to understand the midwives' views on practising within the postnatal ward. The findings from the observational phase in particular, suggest the importance of seeking to explore why some midwives appeared more able to be 'creative' in their interaction with the

women. The midwives appeared 'trapped' and their apparent passivity within the organisation has been referred to. Future research in particular may include seeking their views on rostering and periods of allocation to the postnatal ward as this relates to organisational issues.

Furthermore, the data suggested that the midwives' views about and understanding of 'tasks' and 'task-based' care is an area which merits further exploration; midwives did not refer directly to providing 'care' to the women. A formal definition of 'care' appears lacking, as demonstrated by the literature review undertaken for this study, and further research should seek to understand midwives' views of 'care' and their priorities in relation to 'care' in their interactions with the women.

The findings suggest that women supported each other within the bay but nevertheless had a need to maintain their own privacy. There may therefore be a need to explore women's preferences for receiving care in a single room compared to a communal bay. The differences described by women on receiving care on post-operative bay and the general postnatal ward have been discussed and this may require further investigation in order to understand how women can best be supported following an operative birth.

9.9 Conclusion.

This ethnographic study sought to explore care on the postnatal ward from the women's perspectives. The women's need to receive a 'connected presence' from the midwives has been referred to. The impact of the organisation, with an emphasis on the provision of physical care, on the midwives' interaction with the women was highlighted. Ultimately, this led to a lack of a formal definition and acknowledgement of the emotional aspects 'care'. As a result midwives must consider how care, as desired by the women, can best be provided. It is recognised that midwives themselves need to be supported in this task.

APPENDICES

Appendix 1 Letter available in the antenatal period

Date:

Dear

I am a midwife with a special interest in the care provided by health professionals in hospital for new mothers over the first few days after the birth.

The purpose of this letter is to inform you of a study which will be undertaken at (name of hospital), on the ward where you will be cared for after you have given birth to your baby. The project will look at care for new mothers and their babies in hospital, with the aim of understanding how health professionals can best help and support women and their babies in the first few days while in hospital. The project is a part of my PhD studies and my findings will be included in my thesis.

As the researcher I will visit the ward at different times over a period of weeks which may coincide with your stay in hospital. I will give out written information about the study on the days when I am on the ward.

Permission for the study has been given by the Head of Midwifery and the Local Research Ethics Committee. Taking part in the study is entirely **voluntary**. If you do not wish to take part this will not affect you or your baby's care or treatment.

If you are willing to be included in the study, your written consent will be requested by me at the time of the study. You can of course change your mind at any time. If you have any questions, you can write to me care of the address below and your letter will be forwarded to my home address in Sandhurst, Berkshire. This letter is printed on Bournemouth University headed paper as this is where I am undertaking my higher degree. If you prefer you can contact Professor J Alexander, who is acting as supervisor to the study, at the address below or on 01202 504360.

Thank you for reading this letter.

Yours sincerely

Irene Ridgers (Mrs)
Midwife and PhD student

Appendix 2 Leaflet for women seeking consent for the non-participant observation

Congratulations on the birth of your baby!

I am a midwife with a special interest in the care provided by health professionals for new mothers in the hospital setting over the first days after the birth. I would like to know more about what happens on the postnatal ward by undertaking observation of what happens there. To do this I plan to visit the postnatal ward at different times during the day over the next few weeks.

Prior to starting my observation it is important to me that everyone in the ward is comfortable with my presence there. Therefore, I would like to ask whether you consent to your care being observed by me for short periods of the time during the day.

If you agree to participate, I would like to reassure you that all the information obtained will be treated as confidential and kept in a secure place. You will not be identified as an individual.

If you feel unable to participate at this time this is quite understandable and your wishes will be respected. It will not affect the care or treatment you and your baby receive.

Thank you for reading this, I hope that this research will enable midwives to learn more about how the best care can be provided for new mothers and their babies.

Please indicate whether you do or do not agree to your care on the postnatal ward being observed by me, by signing the appropriate section below.

Best wishes for your future.

Yours sincerely

Irene Ridgers
Midwife and researcher.

If you need to contact me at any time you can reach me on the postnatal ward on 01276 604194, if I am not available you may leave a message.

I agree to the observation

I do not agree to the observation

Name: _____

Signature: _____

Date: _____

If you would like to receive a short summary of my findings, these are likely to be available in 2002, please give your name and address below:

I agree to the observation

I do not agree to the observation

Name: _____

Signature: _____

Date: _____

If you would like to receive a short summary of my findings, these are likely to be available in 2002, please give your name and address below:

Appendix 3 Observation schedule

Observation Episode Number: _____ Date: _____ Ward area: _____
 Time comm: _____ Number of women: _____
 Time fin: _____ Number of infants: _____
 Number of m/WS allocated to ward area: _____ Number of m/WS on duty: _____

		M/W	HCA	Other	Comments
Mother PN Exam	daily				
Mat Obs	TP BP				
Medication	PRN				
	drug round				
Ass.	bath/shower				
Care of	IVI				
	catheter				
	redivac				
	stitches				
	abdo. wound				
Infant Exam	daily				
	weight				
	cord				
	NBC				
	baby unwell				
Infant Obs	TP				
	SBR				
	BM				
Ass.	top & tail				
	nappy changing				
Ass.	Br/f				
	A/f				
	meals/tea				
Verbal comm.	handover from LW				
	call bell				
	PN reflection				
	emotional support				
	'chatting'				
	show bath				
	A/f demo				
Non verbal comm.	standing				
	sitting bed/chair				

Appendix 4 Trigger question

Trigger question:

Please tell me about the care you and your baby received on the postnatal ward.

Appendix 5 Information for women for the in-depth interviews.

Congratulations on the birth of your baby!

This letter has been given to you by the community clerk at my request. My name is Irene Ridgers and I am a midwife at (name of hospital). I am studying at Bournemouth University for a PhD. I have a special interest in women's views of the care provided for new mothers in hospital following the birth of the baby. This is to inform you about a study which I am undertaking. I wish to ask new mothers about aspects of care in hospital which are important to them.

To do this I would like to interview mothers when their baby is about two weeks old. The conversation would be held at your convenience and in a place of your choice, this could be your home. It should last no longer than 1 hour at the most. In order for me to listen carefully to your views I would like, with your agreement, to tape record the conversation. I would like to reassure you that all information obtained would be treated as confidential and kept in a secure place and the tape will be destroyed on completion of the study; your identity would not be revealed. My study has been approved by the local ethics committee, the obstetricians and the Head of Midwifery.

If you are interested in participating, please let the community clerk know and I will provide further information today before you go home. If you decide to take part you are of course free to change your mind and withdraw from the study at any time. If you decide not to take part you need do nothing; not taking part will not affect the care you and your baby receive.

Thank you for reading this letter and for considering taking part in the study. I hope this research will enable midwives to understand better about aspects of care in hospital which are important to women after the arrival of the baby. The results from my study will be reported in a formal thesis and I will also seek to publish them in a professional journal. I will be offering a report to women who have taken part and given me their views. If you wish for further information, please contact me on the postnatal ward on 01276 604194.

Best wishes to you and your new baby!

Irene Ridgers
Midwife and research student.

Appendix 7 Profile of the women participating in the in-depth interviews

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Gill	First baby	Emergency caesarean section	Breastfeeding	Home on day 4	Three weeks	60 minutes	Gill described how she wanted to <i>'help and give something back'</i> and she spoke freely and easily. Gill spoke about <i>'other women who just had a normal birth'</i> and the comfort she had derived from being cared for in the post-operative bay with other women who had also had a caesarean section. Her husband was at home and brought the daughter to her for feeding. We sat at a table in the conservatory.
Pauline	First baby	Normal birth	Breastfeeding initially, changed to artificial feeding in hospital	Home on day 5	Three weeks	30 minutes	Pauline was quiet and appeared reserved, sentences were short and often required further prompting. She was keen to talk about the recordings of her blood pressure which she felt had led to a longer stay in hospital as they were infrequent. Her husband worked long hours. She had her daughter on the sofa with her and also fed her during the interview. I was invited to sit on the sofa opposite.

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Wendy	Second baby	Ventouse birth	Breastfeeding	Home on day 2	Five weeks	40 minutes	Wendy was contacted several times, 'out and about' with her first daughter, I therefore offered to come in the evening but she preferred the day time as time with her husband in the evening was important to her. Wendy seemed at ease and spoke freely; aspects of self-initiated care and about the need for women to talk to each other. She also referred briefly to her previous experience with her first daughter. Toddler active, playing during the interview. Baby changed and fed during the interview. I sat on the sofa opposite her.
Claire	Second baby	Elective caesarean section	Breastfeeding	Home on day 4	Three weeks	35 minutes	Claire had given birth to her first baby in her country of birth and offered comparisons of her care then and on this occasion. The ward clerk had commented on approaching her about participating in the study ' <i>she's got a nice smile</i> '. She spoke easily and was keen to share her experience. She commented on how she understood that the staff were busy and ' <i>there were so many women</i> '. Her toddler was playing with his toys, the video was playing. Claire had a decorator in who was painting the external window frames of the room in which we sat. Her daughter was asleep upstairs. I sat in an armchair opposite her.

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Lizzie	First baby	Forceps birth	Breastfeeding initially, artificial feeding at time of interview	Home on day 2	Three weeks	60 minutes	Lizzie spoke easily and freely described aspects of her care; she laughed easily. She referred to seeking out the midwife whom she knew would respond to her concerns and requests, on occasion this meant challenging the midwife. Lizzie had 'sorted' her need for analgesia herself while in hospital and then with the help of the community midwife whom she referred to as ' <i>I love her to bits</i> '. She held her daughter on her chest throughout. We sat at her dining room table. Her parents arrived at the end of the interview. She concluded the interview with the comment ' <i>she's now three weeks, I feel that I have made a decent recovery</i> '.
Jane	Second baby	Elective caesarean section	Artificially feeding	Home on day 3	Three weeks	60 minutes	Jane spoke quickly and easily, she described her care in the post-operative bay and feeling let down on transferring to the main postnatal ward and how this had led to her going home. She wanted to know if other women were describing experiences similar to hers. Her toddler was playing, watching a video and eating his lunch. Jane had groceries delivered and engineer called to inspect the burglar alarm. Her son was asleep upstairs. We sat on the same sofa.

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Denise	First baby	Normal birth	Breastfeeding initially, artificial feeding at time of interview	Home on day 2	Three weeks	35 minutes	Denise spoke quietly and slowly, difficult to hear at times. She described a sense of 'abandonment' due to being in a single room and the midwives not coming to see her. She described care as self-initiated and going home to receive support from her partner and her mother. Denise concluded the interview with the comment – <i>'they were good, they were really good when they helped me ... I'd go there again just as long as I got the help, as long as they are helpful, you know them coming in asking really'</i> . I was invited to sit on the sofa opposite her. Her baby was asleep in a bouncing chair by her feet. Her telephone rang but she did not answer it. Her washing machine was on and we temporarily suspended the interview during the spinning cycle!

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Helen	First baby	Normal birth	Breastfeeding initially, artificial feeding at time of interview	Home on day 3	Nearly six weeks	30 minutes	Contacted several times, husband (in the forces) away and she had been staying with her mother up north; she was keen for me to come. Helen was quiet and reserved although she laughed readily, she referred to several issues before I was able to switch the tape recorder on. Although, she referred to her 'trust' in the midwives and how 'somebody would be there' and 'you really felt like you were a priority at all time' she nevertheless described a sense of not being able to understand why the midwives with each new shift did not appear to know about her and her needs. Helen, whose husband was due to leave the Army shortly, described how she was looking forward to her imminent move up north to her family. Her daughter was unsettled throughout the interview and the interview ended fairly quickly as Helen indicated her need to be able to concentrate on her daughter. I was invited to sit on sofa opposite her. Helen walked around whilst trying to comfort her daughter.

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Vicky	Fourth baby	Normal birth	Artificial feeding	Home on day 2	Just over two weeks	60 minutes and a lengthy chat post interview during which time notes were made	<p>Vicky was talkative and spoke freely and confidently about her care. Vicky was a single mother and she described how her female friend had not been able to support her on the ward as the policy stated 'partners only', describing how 'the midwives can only be there for so much so it would also help the midwives'. She concluded with the comment - 'treated quite well, leave you to your own devices, don't they?'</p> <p>There was some activity in the house during the interview with people coming and going independently of Vicky. Her female friend was there to care for her toddler and her toddler would be in to the room frequently so see her mother. The baby daughter was asleep in a Moses basket and Vicky fed her during the interview. I sat on the sofa opposite her.</p>

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Rose	Second baby	Normal birth	Artificial feeding	Home on day 2	Three weeks	60 minutes	<p>Rose was keen to participate detailing – <i>'I would like to help'</i>. Rose spoke freely and indicated that she had thought about what she wanted to tell me prior to us meeting. She described the need for written information, <i>'a manual'</i>, on the ward to assist women during their stay by knowing where to find equipment and how she had helped herself to a bottle of formula for her baby, using her previous experience of the ward. She felt that breastfeeding mothers received more assistance. Rose drew on her previous stay with her first daughter and how <i>'this time round I wasn't afraid to ask, I made it better'</i>.</p> <p>I was invited to sit on the sofa opposite to Rose, she settled on her sofa and curled her feet up underneath her. Her toddler was at the playgroup. The baby was in the Moses basket and was fed during the interview.</p>

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Felicity	First baby	Emergency caesarean section	Breastfeeding initially, artificial feeding at time of interview	Home on day 4	Just under three weeks	30 minutes	<p>Felicity spoke easily before the interview but seemed less at ease once the tape recorder was switched on. She described having 'tried' breastfeeding and that she received no instructions on the making up of formula before going home and that women who were breastfeeding were given more assistance. She would have liked to stay longer on the ward but had been told that she could go home. She was concerned that she had been sent home and expected to give herself her anti-coagulant injections without prior instruction, so she asked the team midwife on the first morning home. She appreciated the support from the health care assistants who were asking 'are you alright?'. Felicity described 'fantastic care in labour' with 'one-to-one support' but as 'there were not enough midwives' on the postnatal ward this led to 'those that demand get, don't they?'; however, she did not feel that she had missed out on care for herself. I was invited to sit on the sofa opposite her, her son was asleep upstairs. Her mother rang during the interview, Felicity answered the telephone and her mother arrived a couple of minutes later, she waited in the kitchen until the end of the interview.</p>

Name	Birth number	Birth type	Method of feeding	Day of going home	Age of baby at interview	Approximate length of interview	Comments
Anne	Second baby	Elective caesarean section	Breastfeeding and artificial feeding	Home on day 5	Three weeks	60 minutes	<p>Anne chatted easily and freely. She referred to her care as 'good' and the need for the staff of 'turning the beds round'. She also detailed having met midwives who had cared for her with her first baby and being able to catch up with them, referring to a midwife who had been pregnant at that time. Anne referred to finding the ring tone of the telephones disturbing and not enabling her to rest. I was invited to sit on the sofa opposite Anne, her toddler was playing in the room and the baby was also in the room and bottle fed during the interview.</p>

Appendix 8 Written consent for health professionals

Dear Colleague

This leaflet is to request your participation in a study which I am currently undertaking.

You may be aware that I am studying at Bournemouth University for a PhD, looking at aspects of postnatal care and I am particularly interested to find out more about care in hospital in the immediate postpartum period. I wish to examine what activities take place within the ward environment and to describe what activities health professionals undertake with and for women. I have searched the literature available and have not been able to identify any previous relevant work.

My study is designed as an observational study which means that I wish to observe what happens on the ward in the immediate postnatal period. I will not be collecting names or personal details and you will not be identified as an individual. The findings will be reported in a formal thesis; the maternity unit or staff within the unit will not be named.

The research to be carried out has been reviewed by (name), Head of Midwifery, who has given her approval and support. The study has also been reviewed by the Local Research Ethics Committee. As a health professional conducting research I still have to abide by the supervisory process, in the unlikely circumstance of observing unsafe practice; this is clearly defined in the UKCC's publication of 1996- 'Guidelines for Professional Practice'. The process is no different from that in normal clinical practice. A copy of the main protocol for my study will be available in the Midwifery Resource room throughout my study, I will be running information sessions and will be happy to answer questions at any time. I can be contacted through Mat A; should you wish to speak to one of my research supervisors you can contact Prof. Jo Alexander at Bournemouth University on 01202 504360.

I hope that you will feel able to participate in my study and your written consent is requested. You are of course free to refuse. It is my belief that the findings from this study will add to midwifery knowledge as well as offer a new perspective on postnatal care in hospital.

Thanking you for considering taking part.
Yours sincerely

Irene Ridgers

If you would be happy to take part, please sign and date this form to indicate same.

Signature:

Date:

Appendix 9 When to intervene

When to intervene.

The need to have regard for the safety and well-being of the mother and infant is acknowledged to be of paramount importance. The observer would therefore expect to intervene in situations when maternal and/or infant health is seriously compromised, possibly presenting a life-threatening situation. Hence, the observer would abandon the role of researcher and undertake midwifery practice in the situation of postpartum haemorrhage and/or collapse of the mother and asphyxiation of the infant, and in any other sudden and unexpected emergency situation.

Equally, it is recognised that there may be situations when the observer will not offer direct assistance to the mother, such as support with infant feeding or obtaining pain relief for the mother, as such intervention may alter the situation observed. However, a member of staff would be informed within a reasonable time. Issues of when to assist or intervene in non-emergency situations will be discussed with the midwifery staff prior to the start of an observation episode.

References

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Appendix 10 Letter to women on feedback from the non-participant observation

Dear

I am a midwife at (name of hospital) and a PhD student at Bournemouth University. You may remember participating in an observational study on the postnatal ward in 2002 when I observed within the bay where you were. At the time you requested a short report of the findings. Examining the findings has taken time but I am now pleased to send you this letter outlining some of them. Due to the limited space available here the findings reflect the experience of the majority of the mothers and do not necessarily represent the experience of each individual mother.

New mothers.

I observed that confidence in feeding the baby was of central importance to mothers and they would ask for assistance and advice if they had concerns or were unsure about feeding or if the baby should be woken for a feed. It was evident that this is an aspect of caring for a new baby which is important to all mothers, not just first time mothers.

New mothers also wanted to know that they and their baby were recovering well following the birth. They would seek to be reassured by the midwife or health care assistant in respect of their own health or that of their baby. Parents would appear to find the routine examination of their baby by a paediatrician reassuring. Whilst on the postnatal ward, mothers were cared for by the hospital midwife, but a visit by their own team or community midwife seemed to be appreciated.

Mothers were observed to make frequent use of the telephone by the bed side. They would have conversations with callers but would also discuss issues related to their personal care or well-being. It would therefore appear that keeping in touch with her family and friends is important to the mother. The bed curtains would frequently be closed around a mother's bed, especially at visiting time, possibly indicating that privacy is important. Mothers were rarely observed to talk to each other within the bay but would occasionally offer support to one other.

Women expressed a wish to be involved in the care offered to them by the midwife, such as deciding when to return home to be with their family.

Mothers were only occasionally observed to use the feeding room or nursery available on the ward, instead remaining within the bay.

Partners and family.

The woman's partner would appear to be important to her and his arrival in the morning was eagerly awaited. Mothers would often wait to have their shower or bath until after their partner had arrived so that he could look after the baby. It was evident that new fathers enjoyed participating in caring for their family and used every opportunity available to them to participate in the care of their new baby such as the baby bath demonstrations. Fathers would offer encouragement with feeding. Evidently, mothers appreciated their partner being on the postnatal ward, offering assistance and support to them, and some mothers would appear to miss his support during non-visiting hours. Visiting by other members of her immediate family and own children was also important to the mothers.

Midwives.

The findings show that midwives are concerned to ensure that the ward offers an environment which is suitable for the provision of care for the new mother and her baby. Generally, the midwife would be in the bay in the morning undertaking postnatal checks and examining the baby with the mother. Midwives and health care assistants were available to offer assistance with feeding and this included both breast and bottle feeding.

I am grateful for your participation in my study. The findings are exciting and will add to midwives' understanding of the importance of care to the new mother on the postnatal ward in the first few days following the birth of the baby. The findings have also demonstrated aspects of care which we as midwives have not fully appreciated or understood and I will now be following this up in interviews with a group of new mothers when I will be seeking to understand the mother's experience of care on the postnatal ward in more depth.

If you have any questions or comments as a result of this letter please feel free to contact me on the postnatal ward MAT A on 01276 604194 and a message will be left for me.

Best wishes to you and your family and thank you again for your participation.

Yours sincerely

Irene Ridgers
Midwife and PhD student.

Appendix 11 Letter to women on feedback from the in-depth interviews

Dear

I am a midwife at (name of hospital) and a PhD student at Bournemouth University. You may remember participating in my research looking at women's views of their care on the postnatal ward after the birth of the baby. We met at your home and you spoke to me about your care whilst on the ward. At the time you requested a short report of the findings. Examining the findings has taken some time but I am now pleased to be able to send out this letter outlining some of them. Due to the limited space available here, the findings reflect the experience of the majority of the mothers and do not necessarily represent the experience of each individual mother.

Midwives and other staff on the ward.

Mothers were generally appreciative of the care provided by the midwives and expected the midwife to provide care which was appropriate to them, this included observations of themselves and their baby. Women commented on how, during their stay, the staff often appeared busy but were nevertheless able to make themselves available to the women, although on a few occasions this meant that they had to wait to receive care from the midwife or have the information, such as the paperwork required before going home. Women particularly commented on the helpfulness of the health care assistants in relation to personal care and assistance with the baby, such as a baby bath.

Where a midwife or health care assistant had provided 'extra special' care this was greatly appreciated and commented on by women. Often this health professional was remembered by name. Mothers spoke about the reassurance of seeing and being cared for by a known midwife, describing how this midwife would be familiar with your individual needs.

Mothers also spoke of the need to talk about their birth experience with the midwife. It was generally regarded as important that the midwife or other health professional was willing to and had the time to listen to concerns raised. Women described how the midwife would endeavour to find the time to attend to all of the women she was responsible for during her shift on duty.

Information provided on the ward.

Being informed about the care available for yourself and your baby was important; women needed to feel involved in the care provided. Women were, in the main, happy with the information offered by the midwife although there were occasions when women described not receiving enough information and how this had prevented them from understanding what was happening and making decisions about their own care.

Receiving information also included understanding how and when mothers could request pain relief for themselves and manage this need themselves. Women also wanted to be informed about what would happen on the day that they went home and the subsequent follow-up visits by the midwife at home. Mothers spoke of the importance of being able to decide for themselves when to go home, when they felt ready. For some women it was clearly important to go home and receive support from their immediate family.

On arriving on the ward, women wanted to be told about the layout of the ward, so that they were able to find the bathroom and the feeding room independently and knew where to obtain a bottle of milk for the baby if they were artificially feeding. Some women spoke about needing to know the 'routine' of the ward.

Assistance with own care and caring for the baby.

Women who had had a caesarean section greatly appreciated the care provided within the first twenty-four hours in the post operative bay on the ward. Mothers described the staff on this ward as particularly attentive to their personal needs and how this included help and assistance with their new baby. However, in moving to another bay on the ward women described not being able to receive the same level of support and how this may have left them feeling less able to care for themselves and their baby. When this was the case the woman wanted to receive care from her partner or may decide to go home.

Receiving medication on time to ensure adequate pain relief was important. Women also described the reassurance of knowing that the midwives and health care assistance were available to offer support and advise with feeding the baby, this included both breast and bottle feeding mothers. For some women staying in for an extra day in order to receive assistance with feeding was described as positive and helpful.

Being in a bay with other women.

Women spoke of the importance of communicating with other women in the bay. It was evident that women supported each other and mothers with previous experience would 'assist' other mothers. This was greatly appreciated, especially by mothers who had had their first baby; observing other mothers changing and feeding assisted those women in caring for themselves and their baby.

However, women's own space was equally important and women appreciated being able to rest and recover with the bed curtains closed; this included private time with their own family and visitors. Partners and visitors coming to the ward to support the mother were important but the need to have respect for each others privacy was expressed. The majority of the women who participated in the study were cared for in a six bedded ward; being in a single room was sometimes perceived as lonely.

Mothers spoke of the need for safety for the baby and the cot alarm system was seen as meeting that need. Women wanted the baby cared for by their bedside, although when the midwife or health care assistant offered to care for the baby by the desk area in order to enable the mother to rest this was appreciated.

I am most grateful for your participation in my study and I feel that I have learnt a great deal about what matters to mothers on the postnatal ward following the birth of the baby. The findings are exciting and will add to midwives' understanding of the importance of that care to the new mother on the postnatal ward. As a result of the findings I have been able to make suggestions on certain aspects of care which I hope will be implemented within the maternity unit. I am currently completing the writing up of my thesis and following on from this I hope to be able to have aspects of my research published in journals for midwives, thereby making my findings available to a wider audience. I wish to reassure you that your anonymity will be protected in any publications.

If you have any questions or comments as a result of this letter please feel free to contact me on the postnatal ward, MAT A on 01276 604194 and a message will be left for me to ring you back.

Best wishes to you and your family and thank you again for your participation.

Yours sincerely

Irene Ridgers
Midwife and PhD student.

Appendix 12 Copy of transcript from in-depth interview

Please tell me about the care you and your baby received on the postnatal ward.

I – as we were saying, care for you and Mark on the postnatal ward, how you felt you were looked after on the postnatal ward

M – on the maternity ward?

I – yes, on the maternity ward after you'd had Mark

M – erm, I thought it was okay (laughing). I think because when I was still in Central Delivery Suite, they sort of rang the maternity ward and they put me in a side room, so I felt like a bit isolated and frightened, most people like to be with other people, and ... I just felt a bit, you know, they just put me in there and then sort of left me to do it by myself, I felt a bit lonely. Is it okay to say this? (stopping abruptly, looking somewhat apologetic and hesitant)

I – yes, of course

M - so I sort of felt they left me to do it by myself, they didn't tell me about the bell and that I had to ring the bell if I needed any help, so I wanted to know ... so I rang the bell, it was about ten o'clock at night and he had weed everywhere (laughing) [1:05] so and then they came and helped me but throughout the whole day they sort of didn't attend to me at all, didn't speak to me, I was quite disappointed, they didn't check that I could change a nappy, you know, they didn't come through to make sure that I could do it. And obviously the next day when I decided to go home then so that my partner could give me a bit more support at home, and they sort of came in, the midwife came in, she knew that I was breastfeeding but she didn't tell me how to breastfeed properly, so she just wanted to see Mark latching on to the breast and that was it, so I sort felt that I could have done with that really

I – mm

M – because then when I took, you know, Mark home, I didn't know about alternating on the breast. So I thought I just had to feed on one breast and that was it, so Mark was still hungry, because no one told me, it took my mum a few days later to say to me about alternating sides ... and that was it really.

I – mm ... so was there any particular reason why you went into a side room? [2:22]

M – no (sounding hesitant) ... I think because of the bed shortage ... they put me in a side room, but I didn't mind (slight rise in voice), it was nice having your own room, you got your peace and quiet and stuff like that but ... erm ... it was just they sort of put you in there and forgot about you. They didn't show me the toilet as well, so by the time I needed the toilet, I went out and was sort of wandering round and someone then, one of the midwives came up to me and sort of '*do you need help?*' and showed me to the toilet, you know, just like how to put him down and by two o'clock by that morning, you know, Saturday morning, no Sunday morning two o'clock in the morning and ... I'd had no sleep since Friday and I was tired ... so it was good, I rang the bell, they came and they took him away for a while, because I thought '*oh, no, I'm going to try and calm him down and sort him out*' [3:28]. I was so tired after the labour and stuff that I thought '*oh no*', that I couldn't handle it so they came in and took him away in his cot and they kept him for a while which was quite nice. That was a good point (laughing) ...

I – mm

M – and that was it really. I can't really think of anything else.

.....

I – how did that make you feel, being as you said 'isolated' in a single room and the midwives not coming in to see you?

M – erm, well, pretty bad. I just ... I did have my partner there during the day which was nice because he managed to support me, he helped me out with Mark as well. I just thought if I was a single mum in a side room, I wouldn't cope, because I still wouldn't have clue what to do. I just, you know, think it's important that I've got the midwife, you know, just keep checking on me, making sure '*are you okay?*' and stuff like that ... I know they are busy and have other mothers to deal with as well but they didn't come to say '*are you okay?, are you coping?*' ... they're nice enough staff (voice raised slightly) [4:57] when they **did** call, you know when I rang for help and they were always willing to help when you asked for help. It's just nice to have a little reassurance, you know, just pop their head round the door and say, you know, '*are you okay?*' [5:12]

I – mm

M - ... ask any questions, that's why I was so anxious to get home that day because I thought I'm not going to get any help if I'm staying, you know, so I thought '*I've got to get home*' (voice slightly raised, hint of laughter) [5:30]

I – so the fact that the midwife didn't pop in to see that you were okay, was that part of your reason for going home?

M – yeah, yes I just thought, you know, at night time as well when I was struggling with him, no one popped in. The light was still on, they knew I was still awake and they must have heard Mark cry, but, you know, no one popped in and I thought if I had been at home ... I'd just had enough really, those people must have known that I was just absolutely exhausted and you know, no one was asking if I was okay, it was me asking the midwife '*can you help me, can you take him away for a bit* [6:17] *I can't cope on my own*' ...

I – how did you ask the midwife then?

M – how did I ask her?

I – yeah, it was two o'clock in the morning

M – yeah, I just rang the bell. She came in, she didn't come in of her own, I rang the bell, she came in and took over, I'd been crying, you know, she helped me to take him away and she said '*well, I think he is hungry, do you want to try and breastfeed him?*', you know, sit in the chair at two o'clock in the morning that's the last thing I wanted to do. I was just like '*no, no*', you know, so she said '*do you want to bottle feed him?*' and I said '*yeah, okay*' ... so she took him away. It was only because I asked her that she took him away, and after that I was a bit emotional, you know what I mean,

I – mm

M - the hormones were kicking in, plus the fact that I had no support, you know, and in the morning by seven o'clock I was like '*yeah, can I go home, send me home*' [7:27] (laughing) and I think, it was just, I wanted to go home anyway, sort of part of the family and everything, you know, a bit more support (voice quiet) ... just me ...

I – you mentioned the midwife offering a bottle, how did you feel about that?

M – yeah, that was fine because she, I think she sort of guessed that I couldn't cope with him and that I didn't want to breastfeed him at two o'clock in the morning, so she sort of said to me, you know, '*do you want me to put him on the bottle and what milk do you want to give?*'

I – mm

M – and I just said '*oh, SMA or anything*', you know (laughing) [8:20] and she was like '*fine*' and she took him away ... you know, to help to try and calm him down just so I could get some sleep for a couple of hours ...

I – you said you'd had no sleep since Friday

M – yeah, it was Friday and I'd had him Saturday morning and had no sleep through Saturday, it was like twenty four hours coming on for two days that I'd had no sleep, I was really starting to feel that, you know and when you don't get the sleep and you don't get people coming to check throughout the day on you especially when John went home, you know, he left ... I really felt by myself then, you know. I'm sure many feel that when their partner goes home and they are left to fend for themselves then ... [9:13]

I – do you mean when you came over to the ward or after visiting time?

M – after visiting time, like when he had to go home I just thought '*oh no, this is it you know, I'm left by myself, what do I do if anything goes wrong or?*', you know I just felt I'd had no support throughout the day. I was as too scared to ask anything. I thought it was just normal that they don't check on you. [9:41] and that was probably why I was a bit wary of asking, especially to ask them to take him in the morning. I was a bit worried that they wouldn't, should I ask them?, would they do it for me? ... Didn't have the courage to ask ...

I - why was that do you think?

M - ... erm, I don't know ... I just, because no one had been with me through the day [10:22] to check that I was okay, I thought, I thought it was just normal for the midwives to check with you after you'd had the baby and when it came down to it, I was too scared to just sort of ... ask them, I don't know why ... scary .. yeah, you know, what is their line of work? How will they help me? You know, I thought, well, nappy changing will they sort of help with that so that I could get some rest, I didn't know how they, know how much help they would be willing to give to me ... so I was too scared to ask them. [11:07] they might look at me and think '*cheeky*', you know (laughing) ...

I – what time did you arrive on the postnatal ward? [11:23]

M – about half ten, eleven?

I – in the morning

M – in the morning

I – and did somebody come with you from the labour ward?

M – yeah (interrupting) my antenatal midwife, she was there in the ward with me, she took me across to the ward with John and Mark and ... and then she showed me to the side room [11:50] and said '*the midwife will be with you in a minute*' ... and she said that they, because I'd had the epidural, she said they would give me blood pressure

check and things like that. because I was quite willing to go home after I had given birth to be quite honest, but she said *'oh no, you've had the epidural you need to go to the maternity ward over night and get your blood pressure checked and things like that'* and it wasn't until Sunday morning that I actually had my blood pressure checked and I thought I have to have a blood pressure check, that's why I had to stay the night, that's what I thought, you know and I didn't get a check until the next morning. [12:28] and it took about an hour and a half, two hours for the midwife to actually come in to see me after she'd brought me round and then sort of introduced herself, you know, *'if you need anything come and ask us'* ... you know, *'just give us a shout'*, and that was it, do you know what I mean? She didn't tell me about the toilet and stuff like that and within a minute she walked out. She actually said to me *'is there a reason why are you here?'* and I, you know, said because of blood pressure checks, I would have liked to gone home but because I'd had an epidural and she said *'oh, the epidural won't keep you in here'* and I was then confused because one midwife said I should stay because of the epidural, you're saying I don't have to stay and then ... because I had meconium in my waters, I then just thought that must be the reason and I said *'I had meconium in the waters'* and she said *'oh right, just stay overnight to be on the safe side'* [13:41] so it was a bit bitty, you know, the information ... (voice trailing) ...

I – so with the meconium in the water how did they check?

M – well, no they didn't check Mark until Sunday morning, I had the paediatrician came round and I just wanted to go home and they checked him out and he was fine and they checked my blood pressure and just made sure that I was okay, you know that I was fit to go home

...

I – did you ask them on the Saturday to check you blood pressure, as the midwife had suggested it needed checking

M – no because the midwife said to me *'oh, because you've had the epidural, they will come and check your blood pressure'* so I waited for someone to come in [14:48] and, you know, the midwife would be in two hours later and sort of, you know, fluttered in and fluttered out again, you know and then on Sunday morning about ten o'clock they finally checked it and it was fine but I thought that's what I was staying for, to have my blood pressure checked, you know, I had not long had the epidural, you know, not long gave birth and I was taken to maternity which was so

unnecessary, no reason for me being there, you know, and then I thought well it was a bit like, you know, and then I thought what's the point in me being here, I might as well go home, I'll get more support at home [15:35] so I decided to go home the next day ... it wasn't all bad

I – mm

M – you know what I mean, they were very helpful when I asked for the help. It's just that they didn't sort of check on you, you know, make sure you were okay and still alive (laughing) [15:56] ...

I – did you get more support at home

M – yeah I did, you know, because ... I came home on Sunday and I was absolutely shattered and John was carrying Mark around happily and he sort of took him for me while I had a rest which was nice and then he woke up and then I woke up and sort of came downstairs ... and he was off for the two weeks which was nice, so I had support for the whole two weeks ... even crying for the first couple of days trying to figure out '*why are you crying?*', '*what are you crying for?*' and stuff like that and I was breastfeeding and it was quite hard, it didn't work. I'm not doing it any more (laughing), I gave that up four days after I came home so but, just the extra support for that ... you know ... the breastfeeding was really difficult and I wasn't doing it properly because no one had really explained to me what to do ... Mark wasn't getting the right amount, he was crying I'd be thinking he was wet and his nappy needed changing and I'd just fed him a minute ago [17:34]

I – so how could the midwife have helped you on the postnatal ward with the breastfeeding?

M – well, he was latching on okay and obviously, you know, trying to get the milk through and stuff like that but ... erm I just had him on the one breast and ... I wasn't swapping him over and once he'd finished on the left breast I should have put him on the right breast in case he wanted some more milk but I didn't know that then, so after he had finished on the one breast I thought he wasn't hungry anymore and I had given it to him and he still be crying and I thought '*what are you crying for?*' and it didn't click then that I should put him on the other breast, try him again on that one. It wasn't until my mum said to me ... and the midwife could have said to me ... I don't know why she didn't sit down with me explaining and '*why don't you try him on that one?*', you know. She didn't even explain to me that the milk had run out on this one and the other breast is full, try him on the other breast you know. They sort of ...

Sunday morning they asked me '*are you breastfeeding or not?*' because I had another midwife then in the morning [19:11] after handover and she said '*are you breastfeeding or not?*' and I said '*I am*' (telephone ringing) and that was it. I thought '*is that it then?*', she didn't actually say ... it would have been nice if she'd sat down and said ...

I – do you need to answer that?

M – no, it's probably my mum, but it would have been nice for her to say or sit down with me to watch me do it, to make sure that I was doing it properly, that I didn't have any problems because I really struggled when I got home and that ... hard work, this breastfeeding. [19:54]

I – mm

M – and they always, you know, they push it so much '*oh, breastfeeding is the best*' and all that lot, but the help I got with it was non-existent, you know ... a shame [20:11]

(pause)

I – you mentioned information and having the information

M – yeah

I – as a general aspect what's important with information, what was important for you?

M – well ... erm just giving me advice really, on like how to ... you know, even how to change a nappy. They should give you information or ask you if you know how to, just the help really or, and the breastfeeding as well [21:02] the information on that, you know, just give you a bit of advice on how they can help with the breastfeeding ... general information you know, with the baby and stuff like that ...

I – mm

M – how to care for your baby, you know ... and we had to go, you know on the last day we had to ask the midwife '*how do we bath him?*', '*do you get a demonstration?*', my other half, he asked that and they said '*oh, yeah we've got one at eleven o'clock this morning going on*'. That would have been ideal information to be told, that I was due for this baby bath this morning, you know, stuff like that, John had to ask for them to then say, they could have said that themselves ... so it was a bit ... as you can imagine, and yet the alarm, it was very good and they were very helpful with that and it was nice to know, you know when the baby was getting off to sleep, you know how to clean their faces and stuff, for something so simple, it would have been nice to have

the information, to have been told about it so that we had the choice to go and watch [22:30]

.....

I – what made John ask about the baby bath demonstration?

M – I don't know (voice rising), I tell you, I think he was worried that he would drop the baby in the bath because he thought at one stage that we were going to have to bath him. He wasn't, he was wiped down obviously after the birth ... erm but the next day John was like '*have you washed him or anything?*'. We had just given him wet wipes, you know, and things like that. I think John thought that we were going to bath him some time, I mean he was panicking probably how to do it [23:05], so I wasn't too bothered, I thought we'd learn but it was nice that John asked, but I don't know what made him ask, but it was nice that he asked so that we knew how to get him washed, you know, I wouldn't have had a clue that you have to put cotton wool on his face, not putting bubbles in the bath, I would probably have used a flannel for his face (laughing) that sort of thing, you know so it was nice to do that ... [23:43]

.....

.....

M – he thought, you know the staff were nice ... when you asked for advice but you've had a baby, that's it you're the one that's had the baby, just do it yourself sort of thing ... I'd go there again though (voice raised, laughing) sounds really bad doesn't it?.

I – no

M - I feel like I'm being horrible but [24:31], I'd go there again just as long as I got the help, as long as they are helpful, you know them coming in asking really ... even for a jug of water (laughing)

I – did you have to ask for a jug of water?

M – yeah, yeah ... [24:53] ... because I was thirsty and I was in labour and I was thinking ... '*can I have a drink of water please?*' so ... the fact that I had to ask ...

.....

I – you said they were helpful when you asked

M – yeah

I – can you talk a bit more about how they were helpful?

M – well ... he'd weed in his cot, just weed in his cot and then I put him on the bed and he'd weed on my bed, because the cot was wet, so and this was like twelve

o'clock at night and I'm panicking, having a big frenzy, thinking *'I've got no clean sheets, what do I do?'*, so I rang the bell and the midwife came in and she was very helpful. She helped me put the nappy on before he weed again, everywhere and she got another person to help her to change my bed so I got new clean sheets, clean cot sheets, helped me tidy up the room a bit, because I'd panicked, everything was everywhere and she said *'are you okay?'* and you know, *'I've got a bed now to sleep in as well'* [26:23] and also the midwife who came in at two in the morning, she was very ... helpful, suggesting things (pause) she suggested *'I reckon that he his hungry, do you want to give a bottle?'*, you know she was giving good advice, she was nice ... calling in (pause) ... it would have been nice if they had popped their head round the corner, *'are you okay?'* but when they did come, they were very, very helpful [27:04] you know, suggesting ... it's just the little suggestions that, I had the choice, she didn't say *'why don't you sit on a chair for breastfeeding?'* or also *'sit in the chair and breastfeeding'* ... and *'if not, do you want me to get some milk?'*. You know, it was nice to have the choice. [27:27] *'get the milk down, take him away, I can't put up with him anymore'* (laughing)

I – so was that important, the midwife not telling you what to do but a few suggestions so that

M – yeah, it was nice the way she put it [27:51] I didn't then feel under pressure to sit in the chair and breastfeed him and I didn't feel guilty either about him being taken away, you know, I had a bit of a cry and stuff like that *'oh no, he's gone, you know, what am I going to do?'* but I soon fell asleep afterwards because I was so tired but it was nice, you know the suggestion she made [28:15] her sort of saying about the breastfeeding ... it's not very good if you put them on normal milk, I thought that's what she might say if I suggested it myself to take him away for some milk ... but because she suggested it for me I didn't mind ... she was suggesting it was quite normal to do that so ... that was nice

I – mm

M – you know when they gave me the support it was really good, you know one minute the midwife came in and helped me with Mark after he'd weed and stuff like that was quite nice [29:09] (At this point the washing machine is starting to spin in the kitchen, the mother is laughing trying to make herself heard over the noise commenting that she 'over loaded it in the hope that if it breaks down I can have a

new machine', we both laugh and I suggest 'shall we stop it there for a minute while the machine finishes?', M – yeah.) Tape switched off. [29:23]

.....

Tape restarted

M – yeah, when they came in ... it was very good, the help they gave me ... and that was it (laughing)

.....

I – can I ask you about when they took Mark away and you fell asleep, did they bring him back or did you go to find him after you woke up?

M – well, I got up at six o'clock, so I'd had about four hours and I then went and got some stuff together, I thought '*I'll grab a quick shower*' so I went out to the desk to see where he was and he was obviously there by the desk and I asked how he had been and she said he had calmed down after a proper feed and stuff like that, and I thought '*oh, that's good*' and I said '*is it okay if I have a shower?*' and she said '*do you want us to keep him here or bring him with you?*'. I didn't know that I could take him into the shower, a simple thing like that, I thought '*what do I do with the baby?*' and she said '*oh no, keep him here*' (end of the first side, the mother stops talking)

(second side)

I – the shower

M – yeah, the shower and then she said '*then come and collect him*'. So I had my shower and then got some clothes on and went and collected him and brought him back in the room again ...

I – how did you find where the shower was?

M – well, when I asked for the toilet the midwife said '*oh, by the way the showers are here*' ... so I knew then anyway ... so then I took Mark and we went back into the room again. I don't know, she didn't explain to me what would happen, you know, was she coming back with him at the end of the night ... and I said '*I was up anyway*' [31:43] to see how he was and he was bottle fed with proper milk (laughing) ... yeah

.....

M – can't remember anything else (very quiet)

.....

M – they were good

.....

M – they were really good when they helped me (very quiet) [32:26]. If I had been in the other ward with the other babies crying, I did like the idea of the side room, because I would have found it, with Mark crying a two in the morning, it was peaceful, I did feel that in the main ward with the babies kept there at night you may not get a lot of sleep. A side room was nice but I still didn't get a lot of help

I – do you think you might have chatted to the other mothers then?

M – yeah, and maybe got some advice from them even, you know, just so that you have some idea how they treat their baby, maybe they would know and the woman who was in the side room next to me, she didn't have her baby with her, you know and so ... so she kept herself to herself. It would have been nice if the midwife had come round, just to ask about the nappy changing ... I could have done with a bit more information really, it would have been nice ... to find out a bit more, to have the midwife come into the room ...

.....

.....

(at this point the baby is starting to wake and the mother's attention turns towards her son, she is still quietly spoken and indicates that there is nothing else that she wishes to add or talk about)

Total length 34 minutes and 50 seconds.

This mother has had her first baby, she had brief stay on the postnatal ward of just over twenty four hours. She readily agreed to participate in my study. She started off breastfeeding but when we met she was bottle feeding. In hospital I was aware she was in a single room when on the postnatal ward and I wanted to ask her about this, but I did not need to as she brought this up herself right at the beginning. This mother spoke very quietly throughout the interview, despite my encouragement for her to speak up. There was little variation in her voice. Her son is sleeping peacefully during the interview, he is in the same room and within her sight.

3/52 PN

Appendix 13 Assessment of maternal adaptation

ASSESSMENT OF MATERNAL ADAPTATION

Type of delivery/Date/Time

 Perineum
 Blood loss Parity after delivery

Last Hb RH Factor
 Anti D Required Yes/No Consent/Explanation
 Date Given Signature
 Rubella required Yes/No Consent/Explanation
 Date Given Signature
 Post Natal Hb (taken Day 2)

Tick = Within normal limits X = Need * = must enter details

Day	Admission					
Day/Date						
Temp/Pulse *						
B.P. *						
General Well being						
Breast						
Involution of Uterus						
Lochia						
Perineum/ Wound						
Bowels						
Legs						
Signature						

Print Name

An assessment has been made within agreed standards

Name AM						
Name PM						
Name ND						

Appendix 14 Assessment of baby's adaptation

Assessment of baby's Adaptation

Baby's name Feeding Breast/Bottle

Male/Female Hospital Number Vit K IM/Oral Yes/No Consent/Explanation

D.O.B Time Date and time given Signature

Print Name

Day	Admission					
Day/Date						
Feeding						
General Well being						
Mouth/Eyes						
Skin Colour						
Cord						
Urine/Bowels						
Weight						
I.d. Labels						
Signature						

Print Name

Name AM						
Name PM						
Name ND						

GLOSSARY

Antenatal – period before the birth of the infant

Bed space – area with bed, locker and chair provided for the woman during her stay on the ward

Care-giver – midwife or health care assistant providing care on the postnatal ward

Core midwife – midwife working exclusively within the maternity unit, rotating between different clinical areas

Early shift – hours worked between 07.10-14.40 hours.

Haemorrhage – excessive bleeding, potential life threatening loss of blood

Intrapartum – period covering labour and the birth of the baby

Involution – uterus returning to pre-pregnant size following the birth of the baby

Late shift – hours worked between 14.20-21.50 hours.

Lochia – blood loss from the uterus following the birth of the baby

Maternal morbidity – disease or illness in the mother

Meconium – infant's first stool(s) passed in the first few days after the birth

Multipara - woman who has given birth to her second or subsequent infant

Night duty – hours worked between 21.30-07.30 hours.

Operative delivery – delivery by forceps, ventouse or caesarean section

Paediatrician – doctor specialising in the care of infants and children

Parity – total number of previous live births and stillbirths

Perineum – pelvic floor between the vagina and the anus

Postnatal or postpartum – period after the birth of the infant

Primipara – woman who has given birth to her first infant

Puerperal sepsis – infection of the genital tract in the first six to eight weeks following the birth of the baby

Team midwife – working predominantly in the community in a team, sometimes providing intrapartum care to known women or women within the team

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