



Cue acquisition: A feature of Malawian midwives decision making process to support normality during the first stage of labour

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ABSTRACT

Objective: to explore Malawian midwives decision making when caring for women during the first stage of labour in the hospital setting.

Design and methods: this focused ethnographic study examined the decision making process of 9 nurse-midwives with varying years of clinical experience in the real world setting of an urban and semi urban hospital from October 2013 to May 2014. This was done using 27 participant observations and 27 post-observation in-depth interviews over a period of six months. Qualitative data analysis software, NVivo 10, was used to assist with data management for the analysis. All data was analysed using the principle of theme and category formation.

Findings: analysis revealed a six-stage process of decision making that include a baseline for labour, deciding to admit a woman to labour ward, ascertaining the normal physiological progress of labour, supporting the normal physiological progress of labour, embracing uncertainty: the midwives' construction of unusual labour as normal, dealing with uncertainty and deciding to intervene in unusual labour. This six-stage process of decision making is conceptualised as the 'role of cue acquisition', illustrating the ways in which midwives utilise their assessment of labouring women to reason and make decisions on how to care for them in labour. Cue acquisition involved the midwives piecing together segments of information they obtained from the women to formulate an understanding of the woman's birthing progress and inform the midwives decision making process. This understanding of cue acquisition by midwives is significant for supporting safe care in the labour setting. When there was uncertainty in a woman's progress of labour, midwives used deductive reasoning, for example, by cross-checking and analysing the information obtained during the span of labour. Supporting normal labour physiological processes was identified as an underlying principle that shaped the midwives clinical judgement and decision making when they cared for women in labour.

Key conclusions and implications for practice: the significance of this study is in the new understanding and insight into the process of midwifery decision making. Whilst the approach to decision making by the midwives requires further testing and refinement in order to explore implications for practice, the findings here provide new conceptual and practical clarity of midwifery decision making. The work contributes to the identified lack of knowledge of how midwives working clinically, in the 'real world setting. These findings therefore, contribute to this body of knowledge with regards to our understanding of decision making of midwives.

Introduction

Decision making is an everyday human activity. For midwives working in labour and delivery settings, decision making includes accurate identification of cues indicating deviation of labour progress

from the norm and ability to manage labour. "Cue acquisition", alongside correct cue interpretation, is closely associated with diagnostic accuracy (Elstein et al., 1978). Early diagnosis and appropriate treatment of slow labour progress are the strategies to prevent prolonged/obstructed labour and its sequelae and achievement of

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satisfactory foetal and maternal outcomes (WHO, 2006; Orhue, 2012). The significance of this study is the illumination into the process of midwifery decision making in the ‘real world’ of health care. The study provides conceptual and practical clarity of midwifery decision making elaborating on how midwives working clinically in a ‘real world’ setting employ the midwifery model of care that promotes desirable outcomes. This paper reports on the identified stages midwives followed to make decisions during the care of women in the first stage of labour in an urban and semi urban hospital setting in Malawi. The study findings are relevant to the Malawian and international midwifery community. The challenges of maternal and neonatal morbidity and mortality are identified global challenges (UN, 2015).

The burden of obstructed and prolonged labour

While the risk of dying during pregnancy, labour and birth is now very rare in economically more developed countries (EMDCs), women in economically less developed countries (ELDCs), such as Malawi, are still experiencing deaths due to childbirth-related complications (Ratsma et al., 2005; UN, 2015). Most EMDCs have considerably reduced maternal deaths related to childbirth complications. However, there are other international challenges that reflect the occurrence of serious incidents in maternity services provided, including deaths of mothers and babies. In the United Kingdom for instance, maternal deaths are also a concern as evidenced by the case reported by Kirkup (2015). Kirkup (2015) reported findings from an investigation into the University Hospitals of Morecambe Bay NHS Foundation Trust highlighting factors which led to unnecessary deaths of mothers and babies. These factors included substandard clinical competence, deficient skills and knowledge and poor working relationships between different staff groups.

Prolonged and obstructed labour remains a significant childbirth complication causing maternal mortality and morbidity in ELDCs (Fenton et al., 2003; Mathai, 2009). In 2013, approximately five percent of obstructed labour occurred worldwide (Kassebaum et al., 2014). In Africa and Asia, obstructed labour affects between two and five percent of deliveries (Usha and Krishna, 2004). Obstructed labour was responsible for 22% of all maternal deaths due to direct causes in Uganda (Mbonye et al., 2006). Similarly, 19% of 350 deaths related to obstructed labour were identified in a prospective study in Guinea-Bissau (Høj et al., 1999). In Malawi, these complications accounted for four percent of maternal deaths (Ministry of Health (MoH), 2010). In addition, 63% and 45% of indications for caesarean delivery in 2003 and 2010 respectively were obstructed/prolonged labour (Fenton et al., 2003; MoH, 2010).

These figures are said to be an underestimation of the problem; majority of maternal deaths due to obstructed labour as primary cause of death are rarely documented. Instead, documentation pertaining to the terminal cause of death are classified as sepsis, ruptured uterus or haemorrhage rather than the underlying cause (WHO, 2008). Furthermore, for those women who survive prolonged/obstructed labour, the sequelae of difficult labour (anaemia, infertility and obstetric fistula) may be devastating (Fenton et al., 2003; WHO, 2006; Mathai, 2009). Nonetheless, various reports (Sullivan, 2000; Raynor and Bluff, 2005; WHO, 2006; Hussein et al., 2007; Orhue et al., 2012) suggest that efficient and effective clinical decision making regarding progress of labour during first stage of labour is key to prevention and treatment of prolonged and obstructed labour and other complications caused by long labour. The decision making process therefore is a significant aspect to consider when looking at how midwives care for women during first stage of labour. However, decision making is also a complex and contextual phenomena. A range of decision making approaches that clearly illustrate different ways in which clinical decisions can be made exist and are reviewed here.

Decision making theories

Information processing theory

Clinical decision-making is conceptualised in different ways with various models and theories illustrating how decisions can be made. One such theory, the information processing theory, suggests a four-staged linear, logical and rational process. This involves cue acquisition, hypothesis generation, data interpretation, and hypothesis testing (Jefford et al., 2011). The theory provides explicit and systematic approaches to decision making. In addition, the steps can be tested, taught and provide a consensual decision to be made that is justified by data (Standing, 2010; Jefford et al., 2011). However, these linear steps may not reflect the iterative nature of the processes that midwives use during decision making in the ‘real world’ setting.

Intuition

In contrast, the notion of intuition is primarily linked with nursing and notably attributed to the work of Benner (1984) in her study investigating decision-making approaches by novices and experts in clinical settings. The main thrust of intuition is that decision making is based on an almost unconscious level of judgment and that practical wisdom and intuitive thinking, obtained through experience, play an important role in decision making (Benner, 1984; Thompson, 1999; Traynor et al., 2010). Intuition is viewed as an important element of midwifery knowledge and has been given legitimacy as a sound approach to decision making (Orme and Maggs, 1993; Davis-Floyd and Davis, 1996; Mok and Stevens, 2005; Walsh, 2010; Jefford and Fahy, in press). However, it is argued that using intuition, where reasons for action cannot be consensually validated, could undermine the status of midwifery as a profession (Jefford and Fahy, in press). Therefore, questions remain unanswered concerning how intuition is used in midwifery practice and how midwives can develop and improve its use in care of women in labour.

Cognitive continuum theory

Alternatively, the cognitive continuum theory includes both analytic and intuitive cognition along a continuum (Hamm, 1988). The model specifies both surface and depth task characteristics that are likely to induce cognitive modes at different points along the continuum (Hamm, 1988; Standing, 2010). However, the theory provides a general framework and not specific instructions. It does not give instructions on how to make sure that practitioners can navigate appropriately between intuition and analysis modes of thinking to accomplish precise clinical decisions (Hamm, 1988). The review of the most commonly cited theories from the literature can contribute to current thinking of the significant features of clinical decision making. Nevertheless, these theories are inadequate in themselves if we wish to elucidate the broad range of thought processes required in midwifery practice settings.

Decision making in midwifery

Decision making in midwifery has been studied less extensively and the way in which midwives make decisions during care of women in labour is not well known (Jefford et al., 2010; Masterson, 2010; Young, 2012). Within the few studies on midwifery decision making during labour and childbirth, it has been shown that midwives’ decision making is mainly based on linear collection of cues to generate one or more hypotheses from data. This process draws from their theoretical knowledge and experiences in the interpretation of cues (Danerek and Dykes, 2001; Cheyne et al., 2006). However, in a recent qualitative

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