

**MIDWIFERY ASSESSMENT OF THE PERINEUM AFTER
CHILDBIRTH: A MIXED METHODS EXPLORATION OF CONFIDENCE,
COMPETENCE AND CULTURE.**

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BACKGROUND

An estimated 70% of women giving birth vaginally in the UK will sustain perineal trauma that requires repair (Webb & Ismail 2014). Post childbirth perineal trauma is classified into 4 categories. First degree tears are small grazes or lacerations affecting only the skin, second degree tears affect the muscle of the perineum and the skin, while third and fourth degree tears extend deeper to affect the anal sphincter (Obstetric Anal Sphincter Injury - OASI) (RCOG 2017). The overall incidence of OASI in the UK ranges from 1.7% in multiparous mothers to 6.1% in first time mothers (RCOG 2017). With over 500,000 vaginal births in the UK per year, the incidence of severe trauma could impact 2000 to potentially 80,000 women. A meta-synthesis of the consequences of OASI in the lives of women charts experiences of sustained perineal pain, incontinence, psychological morbidity such as a sense of failure in one's identity as a woman and mother, and perceived stigma impacting on both intimate and wider social relations (MacLellan & Fourie 2019). There has been significant work in maternity services to minimize the impact of perineal trauma through the prediction of risk factors (Pergialiotis et al 2020), implementation of prevention interventions (Aasheim et al 2017, Jiang et al 2017, RCOG 2020), creation of best practice evidence for perineal repair (Elharmeel et al 2011, Kettle et al 2012) and dissemination of repair training (Wilson 2012). However, there is concern in the wide variation of midwives' confidence to accurately detect and *classify* perineal tears to then apply these guidelines (Byrd et al 2005, Andrews et al 2006, Bosanquet et al 2007, Webb et al 2019). Feeling confident to assess perineal trauma all of the time was reported by only 34% (116/338) of midwives in the survey by Bick et al (2012), while the study by East et al (2015) reported only 16% of midwife respondents (11/69) felt confident to diagnose anal sphincter injury.

Pre-registration training has been described as poor preparation for perineal assessment and repair in practice, with inconsistency across the country in the availability and content of preceptorship programmes to support skills training post qualification (RCM 2017, Hunter & Bick 2019). Lindberg et al (2012) found the 8 midwives of their qualitative study to express feelings of shame, guilt and failure towards the woman and her partner if the woman sustained a sphincter tear. The midwives in both Lindberg's analysis and Edqvist et al (2014)'s report, described feeling ashamed in front of colleagues and even singled out for criticism. They described how a busy labour ward did not always allow for a positive learning environment. As a result, some of the interview respondents suspected there could be colleagues who did not report the sphincter tear and did the suturing themselves. However, they emphasized that it can be difficult to identify a sphincter tear and so midwives did not necessarily deliberately hide the injury, but may genuinely miss the degree of damage. These findings emphasize the complexity of perineal assessment and repair that may not solely reflect a skills deficit.

METHOD

This study aimed to explore midwives' experiences of perineal assessment and repair through their training and practice, highlighting facilitators and constraints to competent practice. We used a mixed methods sequential explanatory design that originates from a philosophical standpoint of Critical Realism (Ivankova et al 2006). Critical Realism considers reality to exist and operate independently of our knowledge or awareness of it. This position is concerned with mapping the realities which produce the facts and events that we experience. This reality is not fully measurable by empirical survey or hermeneutic examination. By combining explanation and interpretation techniques, the critical realist seeks to understand the complex and layered processes and structures which cause those underlying facts and events (Gorski 2013).

Sample/Participants

We initially recruited a self-selecting sample of 91 midwives of more than one year qualified who are currently working in the UK, through social media recruitment to our online survey. The rationale for these inclusion criteria was to capture the UK context of training and update in perineal assessment and repair to inform the context of our results. Respondent details are summarized into table 1.

Table 1: Characteristics of Survey Respondents

The survey respondents interested in participating in an interview were invited to leave their email address for contact. All 60 interested respondents were contacted by the corresponding author and invited to participate in a single episode telephone interview. A participant information sheet and consent form was included at this contact. Following a maximum of two email reminders, 18 midwives proceeded to consent and interview. They shared a variety of experience from working in different Trusts and birth settings throughout their careers, as summarized in table 2:

Table 2: Characteristics of Interview Cohort

Data collection

We collected trend data through the survey, with the results determining which areas to explore through qualitative in-depth interviews (Ivankova et al 2006). The survey was formed of 10 open-ended questions under the three topic areas of competence, confidence and culture, identified from a detailed review of the literature. The questionnaire is available on request from

the authors. The survey was pilot tested locally before being circulated on the website of a national midwifery conference and popular midwifery journal from February 2019 to June 2019.

The survey findings were summarized and refined into themes of workplace culture after perineal trauma, experience of learning repair and decision making for episiotomy. They were used to structure the in-depth interviews. The 18 semi-structured in-depth interviews lasted between 23 and 80 minutes and were conducted with the principal researcher and colleague, who are experienced in qualitative interviewing.

Ethical considerations

The participants' anonymity has been maintained through assignment of a participant ID number and de-identification of transcripts. All participants reviewed and approved the draft manuscript before submission.

Data analysis

The interview transcripts were analyzed using thematic analysis (Braun & Clarke 2006). The foundation of this study lies in the critical realist perspective that reality exists independently of our knowledge or awareness of it. Thematic analysis supports this epistemology as it goes beyond the words of the data to explore underlying assumptions and ideologies credited with shaping the words of the data (Braun & Clarke 2006). This theorizing of the socio-cultural context giving rise to individual accounts supports the critical realist approach of seeking to understand the complex and layered processes and structures responsible for those underlying facts and events. Thematic analysis of the survey data was conducted by the corresponding author before design of the interview transcript and submission for second stage ethical approval.

The interview transcripts were analyzed by each member of the wider research team (JM, JG,

SL-T) independently reading and manually coding them. We came together in a consultative workshop to refine our coding trees and generate inductive interpretive themes.

Validity and reliability

The corresponding author took an inductive approach to the thematic analysis of the discursive answers in the survey. To improve methodological rigour and applicability, two midwife colleagues were invited into the research team to contribute insider experience of practice in the interview stage. This insider experience brought different perspectives to the data interpretation and stimulated interesting analytical discussions surrounding philosophies of care and practical management of the birth process.

RESULTS

The interview schedule was designed from the thematic framework of the survey responses; workplace culture after perineal trauma, experience of learning perineal assessment and repair and decision making for episiotomy. It was piloted with 2 midwives outside the research team. Following re-ordering of the questions for better flow, the study telephone interviews were conducted. They lasted between 23 and 80 minutes (average 56 minutes) reaching data saturation after 16 interviews though 18 interviews were fully transcribed, analyzed and reported. The participant in the 23 minute interview was on maternity leave and requested the interview be cut short as her baby required attention.

The single episode telephone interviews commenced with the idea that examples of a supportive training model may come out of the data that could offer a template for a national approach. However, as the interviews proceeded inductively, participants concentrated primarily on their feelings and lived experiences of perineal assessment and repair within their work. The

episiotomy data is reported elsewhere as the density of data generated supported stand alone reporting (MacLellan et al 2020 in press).

How midwives gain confidence and confirm competence in assessment and repair, exposed a vital modality of learning largely neglected in the literature with regards to this area of practice. We felt perineal assessment and repair to be complex, embodied and irreducible to solely a trainable task. The value of experiential learning, of an intuitive knowledge base built up through talking with and learning from each other about the whole birth journey, was foregrounded in the interview responses. Rather than concluding with a reproducible ‘sign off sheet’ and competence assessment model, we have named the learning system underpinning the journey to competence and confidence in perineal assessment and repair that would do well to be formally recognized and incorporated into any training model. The three principle themes were extracted from the data that appear to constitute this learning system and were named as Confirming Decision-Making, Justifying to self and others and Space for Birth.

Confirming Decision-Making

A commonly identified barrier to undertaking confident perineal assessment and repair was the ‘theory-practice gap’. Many of the respondents cited difficulty in reconciling education and skills training undertaken using ‘simulated’ methods, with face-to-face assessment and repair of a woman’s perineum.

“It’s really difficult because they give you models . . . it is a practical session obviously but it is quite difficult to simulate human flesh and skin . . . try and do this you know when you’re faced with a perineum that’s falling apart.” (P1)

The relative complexity of ‘real-life’ perineal assessment and repair described by participants (compared to using simulated methods), seemed to be linked to a need to discuss cases with colleagues to ‘confirm’ decision-making. The benefits of working in close contact with an experienced colleague or mentor to develop expertise is central to midwifery practice where intuitive, embodied knowledge is developed through practical, hands-on experience. Validation or confirmation of decision-making is often achieved through corroboration with colleagues. Participants discussed referring to midwifery mentors, peers, seniors and obstetric colleagues for opinions on assessments in particular. This was a dominant theme across almost all the interviews:

“most of our births would have a second MW so you always have somebody even to compare what do you think about this or would you do this here.” (P3)

Although the need to confirm decision-making was identified by several less experienced participants, it was by no means limited to them, suggesting that confirmation was not just a tool for developing competence. A very experienced midwife, practicing for over twenty years remarked:

“if in doubt you’re always gonna ask a colleague or always gonna ask the coordinator or the registrar or the consultant . . . you know if you’ve got any doubts at all you’re gonna seek a second opinion.” (P5)

One participant identified the wider maternity team as central to decision-making on perineal assessment and repair:

“and as a team we rely on each other a little bit and support each other in the decisions that we make.” (P6)

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395 That support and dependability of colleagues appears to be an important component in
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397 confirming decision-making, of getting decisions right for women. Several discussed this in very
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399 empathic terms:
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402 *“It doesn’t matter if you’re a band 5 or top of band 6 or you’re a band 7, if there’s*
403 *something that you think I’m not really sure, always, always get somebody to come and*
404 *have a look or come and support you, come and help you because you’re dealing with*
405 *people’s lives you know. It’s not just kind of thinking you know shall I put this tyre on the*
406 *car.” (P1)*
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414 Several participants described the systems for assessing competence in their practice areas. There
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416 was significant variation in the accounts given. Despite recognition of the critical importance of
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418 experiential learning opportunities,
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421 *“Yeah yeah that’s like 90% of it I’d say, or 99%, as that’s how we learn.”(P7)*
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424 there was a consistent requirement for some kind of formal confirmation of competence:
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427 *“you know you go to the perineal repair training and then I think it was 3 supervised*
428 *perineal repairs and then you would be signed off as competent.” (P10)*
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432 The judgement that competence is achieved through a formal ‘sign-off’ process, after certain
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434 number of repairs have been completed, was identified as problematic:
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437 *“We had to suture 3 pairs, no 5 pairs before you could be signed off as being competent.*
438 *It doesn’t necessarily mean you feel confident and so I’d still get someone to look over*
439 *my shoulder.” (P11)*
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This suggests that the need to confirm decision-making with colleagues is an ongoing phenomenon, central to the development of competent and confident practice. Theoretical knowledge and technical skills developed via simulated teaching reinforce the notion of ‘taskifying’ the perineum; reducing it to a disembodied fragment of a woman’s anatomy. This is problematic for midwives, as a reductionist approach to assessment and repair does not truly reflect what they need in order to develop competence.

Justifying to self and others

Popularity of the OASI Care Bundle was felt by some respondents to have emphasized a culture of culpability in midwifery practice. Across the interviews participants felt they must justify their practice and deviation from guidelines to themselves and colleagues or risk blame.

“... there was an obstetrician who came in to talk to us and he said ‘what, did you do the finnish grip?’ and of course on the birthing stool its almost impossible ...it was well you should have done that and this could have been avoided and so its your fault. There’s a lot of blame culture I think.” (P12)

“...I do feel like I was trying to explain myself a little bit” (P6)

While defending the unpredictability of birth, participants expressed guilt, as if betraying their colleagues and the woman by crossing the boundaries of practice out of normal birth to interventional. There was also a sense of solidarity with birthing women originating from an embodied position of understanding:

“because the perineum is something important and you only have one for the rest of your life” (P13)

This awareness conferred a sense of responsibility on the attending midwife and either led to motivation for training and support to do the best job in repair, or avoidance. Avoidance was framed in a context of fear:

"I mean everybody has their thing that they are scared about doing haven't they... ive heard from colleagues that suturing is their 'bete noir'." (P8)

The cultural split between technocratic labour ward practice and 'low-tech' community practice was very apparent in respondents, and raised an interesting challenge to institutional birth practice. Some experienced community midwives justified their lack of suturing as a conscious decision,

"The perineum is designed to accommodate a baby's head...that must mean that some kind of trauma is normal then the body surely must be equipped to deal with it. People do heal nicely without sutures." (P14)

A young midwife who had moved into community practice spoke of anxiety after her hospital based training, but after 3 years of practice feels confident in her decisions not to suture a tear. The feedback loop of reviewing women postnatally increased confidence in future perineal assessment and decision making.

"there has been a few times when I have ... thought 'oh that definitely needs something' and having an experienced eye coming in and saying 'do you know what that will actually come together really well itself'" (P4)

While this was seen as a gap in learning from the institutional setting:

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"I wouldn't know how many would come back with problems after that, you don't find out as a MW." (P3)

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A number of midwives wished to convey the complexity of perineal care, while championing the art of midwifery in optimizing a woman's physiology for birth. Participants tried to justify the importance of relationships, trust and birth support as a significant contributor to perineal care, quoting from the intuitive knowledge base of midwifery.

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"I've been a MW for 20 years and I don't know who will tear until I know." (P14)

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"the most important intervention for the woman is the MW herself...the mother MW relationship." (P9)

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While the theme of justification sits as a defence to perceived challenges to decision-making in the unpredictability of birth, it also reinforces decision-making to the self and others by verbalising the experiential and intuitive evidence base of clinical judgement in practice. Until the clinical judgement of a midwife is captured in the language of 'evidence', midwives will have to justify their perineal care decision making and practice to themselves, their colleagues and birthing women.

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The birthing space was felt to define action of the attending midwife in relation to the use of her skills toolbox and the influence of time. Within a community setting, the sense of responsibility was felt very strongly as transfer to the hospital would disrupt the context the midwife was trying to protect. Practise proceeded with this in mind, optimising physiology and allowing the time to facilitate birth without judgement or challenge.

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619 *“in community settings.....it’s a very different environment that requires very different*
620 *skills and competencies.” (P9)*
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624 *“Its that trust that women have in our skills so protecting them during labour and birth.”*
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629 However, if the woman sustained a tear, many community midwives felt deskilled in suturing
630 and would not hesitate to transfer in to the labour ward for repair. Some cited a lack of suitable
631 lighting or supportive surface, others were open about their strengths being in different areas of
632 practice.
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639 *“If we only have 35 deliveries a year and then you are suturing 5 of them, is that good*
640 *enough to maintain a competency? I don’t know that it is.” (P14)*
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644 Time was felt to be a significant factor affecting the space of birth in community or hospital,
645 especially in relation to perineal assessment and repair. Time was considered an important
646 component of the learning journey, being given freely as a pre-registration midwife or preceptee.
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651 *“First of all its about having the time, to supervise someone, to talk through with*
652 *somebody, to go through step by step when you’ve got a busy unit you know raging*
653 *around you.” (P2)*
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658 However, time became a precious commodity once the midwife was deemed competent in
659 assessment and repair. The focus moved from skill acquisition and support to keeping the
660 process of the busy labour ward moving. The complexity of perineal repair was felt to be
661 devalued and taskified by the time pressure of the unit with an expectation that the midwife
662 would ‘just do it’.
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675 *“they think ‘oh come on you are signed off on your competencies, you should be able to*
676 *do this by now’. ... its almost like a taboo that you should be able to do” (P12)*
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680 *“I’ve seen my colleagues... come in and say things like ‘Well that’s only a small little*
681 *tear, come on you can do that, get on with it’” (P7)*
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685 Unless the midwife actively asked for help, she was absorbed into the workflow of the unit,
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687 impacting confidence and continued competence.
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690 *“...it’s not something we necessarily have to do every single day erm you lack of*
691 *confidence because of that maybe, the lack of practice.” (P13)*
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695 *“If a woman has just been admitted who is 8cm dilated, I’m going to move that midwife*
696 *and get someone else later to sort the suturing. I have to meet the constantly moving*
697 *priorities of the workflow on labour ward” (P16)*
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702 The pressure of keeping the system moving, alongside midwives’ sense of responsibility to the
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704 women they support, invaded the space of birth. This impacted participants’ confidence and
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706 maintenance of competence in perineal assessment and repair through restrictions on time,
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708 continuity and the availability of support.
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711 712 DISCUSSION 713

714 This study aimed to explore midwives’ experiences of perineal assessment and repair through
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716 their training and practice, highlighting facilitators and constraints to competent practice.
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719 Andrews et al (2006) labelled the clinical examination of the perineum at birth as the cornerstone of
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721 trauma diagnosis, despite recording wide variation in clinician competence. Despite considerable work in
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731 raising awareness of perineal trauma and the design of training modules in assessment and repair,
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733 midwives are still reporting a lack of confidence in this skill (Bick et al 2012, Webb et al 2019).
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736 Using a mixed methods sequential explanatory design, we discovered the persistence of variation in
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738 teaching models, support and practice in perineal assessment and repair after childbirth across the
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740 country. Interviewees linked competence in the skill of assessment and repair to a solid knowledge
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742 foundation and achievement of technical competence. However, this format reinforced the notion of
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744 ‘taskifying’ the perineum; reducing it to a disembodied fragment of a woman’s anatomy. The growth of
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746 confidence to incorporate the skill into the midwives’ toolkit came through working in close contact with
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748 an experienced colleague or mentor to develop expertise and validate or confirm decision-making. This
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750 approach is central to midwifery practice where intuitive, embodied knowledge is developed through
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752 practical, hands-on experience (Davis-Floyd & Davis 1996, Wilson 2012, Barnfather 2013). The feedback
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754 loop from colleagues also reflects an accepted style of practice based clinical learning, allowing
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756 discussion, explanation and rationalisation based on the individual context presented by the perineal
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758 damage (Singintree 2006, Bartlett & Muir 2018, Cheraghi et al 2019). Unfortunately, the context of the
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760 birth process does not always support this learning style due to time pressures and skill mix. Since
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762 accountability inevitably lies with the individual midwife if Trust level training is not felt to be adequate,
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764 this can lead to avoidance of suturing (NMC 2018).
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766 The issue of keeping the process moving underlay participants need to justify the time spent on perineal
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768 care, suggesting its low priority status in the workload of the birthing unit (Plotkin 2017). Despite a more
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770 fluid approach to time in a community birthing context, the time pressures exacerbated by transferring a
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772 woman in for suturing resulted in the need to justify a lack of supportive equipment for appropriate repair
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774 or appreciation of the inability to maintain a seldom used skill. This is a common concern across the
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776 highly specialized landscape of nursing and midwifery practice (Campbell et al 2015). Midwives also felt
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778 the need to justify their practice and care decisions in the increasingly culpable practice context felt to
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780 accompany the OASI care bundle, even if colleagues are supportive. The shame and guilt expressed by
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midwives if the woman sustains a third degree tear emphasizes her sense of accountability and solidarity with the woman in recognition of the life she will live with her perineum. Justification of practice and solidarity felt with women facing perineal trauma emphasizes the midwives' focus on long term perineal health of the woman, illustrating an embodied and holistic approach to care (Way 2012, Priddis 2015).

Limitations

Due to the convenience sampling method, characteristics of survey non-responders were not captured. While the participants of our study were self-selecting and generally confident in perineal assessment and repair, they reflect a national picture of practice variation and raised similar issues across practice contexts independent of years of qualification. We feel this saturation increases the applicability of our findings to a wider midwifery cohort.

CONCLUSION

The findings of this study recommend an expansion of the practice based competency models of the preceptorship year to all maternity units to consolidate and build upon the foundation of learning achieved as an undergraduate. An experiential and supportive learning system underpins the journey to competence and confidence in perineal assessment and repair and would do well to be formally recognized and incorporated into any training model. This would move away from the dissatisfying task approach to perineal care after birth to a more embodied, holistic approach supportive to women's well-being as well as their physical function.

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Number of years qualified	Number of participants	% of participants
No Answer	10	11%
1-2	10	11%
3-5	22	24%
6-10	11	12%
11-15	19	21%
16-20	8	9%
>20	12	13%

Table 1: Characteristics of survey respondents

Participant Number	Number of Years Qualified	Confidence in Perineal Assessment/Repair (0-10)	Current Work Setting
1	4	7	Community
2	16	8	Education
3	15	6	Labour Ward
4	20	8	Education
5	12	8	Labour Ward
6	6	9	Labour Ward
7	14	8	Community
8	23	5	Community
9	32	9	Labour Ward
10	1	6	Labour Ward
11	29	9	Labour Ward
12	12	9	Labour Ward
13	1	5	Labour Ward
14	3	7	Education
15	19	9	Labour Ward
16	4	10	Community
17	20	9	Labour Ward
18	5	9	Education

Table 2: Characteristics of interview cohort

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Declaration of Interest statement

The authors have no conflict of interest to declare.

Ethical Approval

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Credit Author statement

Jennifer MacLellan: Conceptualization; Data curation; Methodology; Project administration; Investigation; Formal analysis; Writing – original draft; Writing – review & editing. **Jo Gould:** Formal analysis; Writing – original draft; Writing – review & editing. **Sarah Lewis-Tulett:** Formal analysis; Writing – original draft; Writing – review & editing.