

PHENOMENON OF BECOMING A MIDWIFE

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Abstract

My research explored student experiences of becoming midwives. It focused specifically on understanding their lived world experiences. The research is located in a hermeneutic framework as described by van Manen (1990). I chose to undertake a longitudinal study as the length of the students' course of study was three years. My study recruited two cohorts of student midwives from two universities in the North West of England (n=90). Each university had a different recruitment target for their midwifery programme of study; University A (n=60), University B (n=30). I prepared a PowerPoint presentation and an information leaflet which supported the recruitment strategy (Appendix B). My approach proved successful as the study originally consisted of a purposive sample of student midwives (n=22); University A (n=10) which equated to 20% of the cohort and University B (n=12) equated to 33% of the cohort. Four students from University B dropped out of the research following the first focus group, thereby reducing the total sample to 18. This reduced the sample size of university B (n=8) which equated to 27% of the cohort.

My use of narrative inquiry within focus groups enabled a hermeneutic cyclical process of gathering and interpreting the student holistic experiences in a constructivist paradigm (Clandinin and Connelly, 2000). I also used reflective diaries which enabled the students to reflect on their personal experiences. This added richness to the empirical data (Berg, 2009). The interviews were recorded and transcribed verbatim. Thematic analysis was undertaken using the principles of van Manen (1990). I gained ethical approval from LJMU and the two universities where the students were studying. The aims of my research directed the focus of the study. Discovering their interpretations of their experiences of becoming midwives brought

an understanding of the influences the working environment had on the process. The findings of my study brought new knowledge in respect of the education of student midwives. It also highlighted some of the restrictions imposed on their training within a medical model of care in an NHS Trust. The research also highlighted some of the challenges experienced by the students as they progressed through their training. The findings suggested there were many tension experienced by the students. The broad themes were related to: the students' understandings of their learning and development, the ideology of the role of the midwife and the role of the midwife within the philosophy of the medical model of care in NHS Trusts. This brings new knowledge in respect of the education of student midwives.

Key words: Midwifery education, hermeneutic phenomenology, focus groups, qualitative methodology, students' experiences

Preface

This thesis is the description of the work carried out in the faculty of Media, Arts and Social Science, Liverpool John Moores University under the supervision of Dr. Helen Churchill (Liverpool John Moores University), Professor Jane Springett (University of Alberta, Canada) and Dr. Nicola Smith (Liverpool John Moores University). Except where acknowledged the material presented is the original work of the author, and no part has been submitted at this or any other university.

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Chapter 1

1.1 Introduction

The lived world experiences of being a student midwife as the focus of my thesis evolved from my experiences of working with and teaching student midwives. The recruitment and training of student midwives has changed since the transfer of schools of midwifery to Higher Education Institutions (HEI) in the 1990s. Previously, all student midwives were required to have completed a State Registered Nursing (SRN/RN) qualification over a three year period. The original midwifery training was in two parts and took 12 months to complete. This was further extended to an 18 months continuous course of study. The education of midwifery students is currently undertaken within HEIs. They are required to undertake a three/four year degree course of study within a work based learning paradigm. Exploring the students' experiences first requires an understanding of the role of the midwife in a contemporary society in the United Kingdom (UK).

1.2 Midwifery in a contemporary society

The professional role of the midwife has evolved over time to keep pace with the changing needs of society. The philosophy of the midwife's role sits within the paradigm of normal midwifery care during the antenatal, intranatal and postnatal periods. This is clearly defined in the International Confederation of Midwives definition of the role of the midwife (See Appendix A) (ICM, 2005). The concept of 'normal' within midwifery practice is understood to encompass pregnancies that require no medical intervention by an obstetrician and are solely based within the midwifery model of care (NMC, 2004; NMC, 2013). Midwifery is regulated by the

Nursing and Midwifery Council (NMC) and all midwives practicing in the UK are required to sign their intention to practice and be registered with the NMC. The NMC sets the standards for practice, education and statutory supervision of midwives. It also sets the midwives rules and standards for practice (Masterson, 2010).

The majority of women now give birth in a hospital, whereas during the 1960s the focus was on the familial setting of the home. The provision of maternity services is quite complex, as its main area of provision is situated within the National Health Service (NHS). The propensity to categorise women into high risk and low risk has polarised the provision of maternity services, and this has affected the working environment of many care providers (DoH, 2010). The future focus of care provision suggests there is a need to return maternity services to a more community-based form of care, enabling women to choose the type of care and birth they would prefer (DoH, 2007). In recent years there has been a rise in the birth rate; statistics indicate there were 723,913 live births in England and Wales in 2011, a rise of 0.1% from 2010 (ONS, 2012).

There are many challenges within midwifery care, whether complications introduced by lifestyle choices (such as smoking, obesity and the misuse of drugs), or the complexities of multiple pregnancies. These can impact on the outcome of some pregnancies (ONS, 2012; SANDS, 2012). In the UK there were 3,811 stillbirths in 2011, a rise of 2.6% from 2010 when there were 3,714. This rise is credited to the increase in total births in 2011; this relates to 5.2 per thousand total births, an increase from 5.1 in 2010 (ONS, 2012).

The role of the midwife is to provide care, education and support to ensure women are at their optimum health during pregnancy and birth. Many stillbirths cannot be predicted or prevented, yet by highlighting the possible implication of some lifestyle choices to women and their families, these numbers could be reduced (SANDS, 2012).

1.3 The diverse role of the midwife

It is recognised that midwives care for pregnant women with complex needs, these include physical, psychological and social. The extended policy commitment that forms the structure and organisation of the delivery of health services impacts on the role of the midwife. Examples of these include the Diabetes National Framework (DoH, 2001) and the UK policy on Domestic Violence (Salmon et al., 2004; Barnett, 2005). The roles of specialist midwives were developed to ensure appropriate care was provided to women with medical and social needs. The diversity of the care needs of women in society has changed over time and this has impacted on the maternity services which needed to respond to a changing culture (DoH, 2001). In the UK the rate of teenage pregnancies appears to have fallen. Statistics from 2010 indicate there has been a decline of 9.5% in the age group of 18 and under (ONS, 2010).

There are many inequalities in health that exist globally (McLeish, 2002). In the UK there has been an influx of transient migration of women and their families that have impacted on the maternity services. In the UK there is a rising number of pregnant women living in poverty, and for some, English is not their first language. Some of these women are asylum seekers having escaped from their own countries with very

few possessions and without their families to support them (McLeish, 2002). The diversity of the care needs of women in society has changed over time and this has impacted on the maternity services which needed to respond to a changing culture (DoH, 2001).

The response to these changes has resulted in many midwives developing new skills to accommodate the needs of women and the service. These include specialist midwives, advanced practitioners and consultant midwives. The impact of these cultural changes in society appears to have caused an imbalance in the number of pregnant women needing the service and the number of midwives available to provide care (Bonner, 2012). In 2010 there were 27,154 direct entry midwives on the NMC register and 38,778 midwives who had a dual midwifery and nursing qualification. Currently there are 2,052 student midwives undertaking a three/four year degree course in midwifery education. There are 432 undertaking a midwifery conversion course of 18 months. To accommodate the needs of women in contemporary society there appears to be an acknowledgement that there is a shortage of midwives in the UK (Bonner, 2012; Hansard, 2012).

1.4 Maternal mortality

The recording of maternal mortality has a long history. Deaths in childbirth were first recorded by the Registrar General in 1847. During this time and the subsequent years up to 1934 the maternal mortality rate remained at 4.6 per 1,000 births (Loudon, 1984). Historical analysis of the causes of maternal deaths revealed many phenomena such as poor health and hygiene of the general population, the lack of antibiotics, and the possible lack of education regarding the physiology of pregnancy

and labour. Since the Midwives Act of 1902, it was recognised that midwives needed to be trained and educated in the art of midwifery practice and care (Loudon, 1984). In more recent times the confidential enquiry into maternal deaths has been an accepted, documented review of why women die in childbirth. The title of the report has changed over time but the rationale for its existence remains a constant reminder of how poor care impacts on the lives of women and their families. The current maternal mortality rate is 4.67 per 100,000 births. The major cause of death is identified in the current triennial report as sepsis (CMACE, 2011). Over the years these reports have helped to target both deficiencies in professional care practices and also how improvements could be made to many policies and guidelines within each hospital Trust. The recommendations in the reports have also helped to inform the development of midwifery curricula in the teaching of complex care in pregnancy. The current report has recommended that all professionals and students need to be educated in recognising the signs and symptoms of infection, and has recommended education of the public on their need for vigilance (NMC, 2009; CMACE 2011).

With other improvements in care provision highlighted in the latest report (2006-2008), the statistics on the whole revealed a decline in maternal deaths from the previous report 2003-2005. There remained a total of 261 women, who died, either from direct or indirect causes, between the years 2006-2008 (CMACH, 2007; CMACE, 2011). The reports indicated that education and standards of care were two of the key targets to improve care at all professional levels. This would decrease the mortality and morbidity rates of women within the maternity services (CEMACE, 2011). By acknowledging the increasing demands for improvements within the maternity services and the advances made in increasing conception rates in women

with medical disorders, there remains a need for student midwives to be educated to provide high levels of quality care to all women in contemporary society (Dyson et al., 2005).

1.5 Structure of my thesis

1.5.1 Methodological considerations

My thesis consists of 9 chapters. The research was designed to explore students' experiences of becoming midwives, focusing specifically on understanding lived world experiences. This could only be achieved by exploring the students' understanding and interpretations of their experiences of becoming midwives. Therefore my research was located in a hermeneutic framework as described by van Manen (1990). The philosophy and methodology of hermeneutic phenomenology was chosen as I wanted to focus specifically on understanding the students' lived experiences of becoming midwives. I discuss this further in Chapter 3 of my thesis. I chose to undertake a longitudinal study as the length of the students' education was three years. I utilised narrative inquiry within focus groups at specific times in their training.

- Reflection on research journey

In the planning stages of my research I focused on the possible influences I could have on the students' responses to my questions. My initial thoughts led me to consider concealing my professional qualifications and presenting myself as a researcher. My use of a reflective diary allowed me to explore my 'being' using the hermeneutic cycle. Placing me in the centre of the circle allowed exploration of the parts that made up my whole being. I discovered I could not deny the midwife within

me as this was a major part of my being and my life as a midwife encompassed many qualities that I valued in others. These included honesty, caring, compassion and professionalism, which included my ethical approach to life. I reflected on these qualities and decided they would support my approach to research and protect the students from any harm. Guba and Lincoln (1985) stated that it is accepted that both researcher and the research are affected by each other's presence. This must be acknowledged as my past experiences may influence my study. Reflexivity as discussed by Clancy (2013) can minimize the risks of contaminating the data analysis. The process of reflection became my constant source of support as I journeyed through my interpretation of the data. My use of *epoch* is discussed further in Chapter 4.

My study originally consisted of a purposive sample of student midwives (n=22). During the early stages, four students withdrew from the study. All students were from two universities in the North West of England. The sample consisted entirely of women, including both mature students and school leavers. The empirical data revealed many themes from their journeys to become midwives. The interviews were recorded and transcribed verbatim by me. Following transcription I undertook thematic analysis using the principles of van Manen (1990). My chosen methodology and my journey through the research are discussed further in Chapter 4. I gained ethical approval from LJMU and the two universities where the students were studying.

The aims of my research were:

- To discover the nature of the student's experiences of becoming a midwife
- To understand the influences of the working environment on the process.

1.5.2 Overview of the literature

The literature review in Chapter 2 explores the educational framework of work based learning within the paradigm of the National Health Service (NHS) in the UK. The literature review demonstrates how there is very little empirical knowledge regarding pre-registration students' lived experiences of becoming midwives. It does, however, reveal a plethora of empirical knowledge regarding student nurses. The review of the nursing literature offers some of the likely issues as both nurses and midwives undertake their training within NHS Trusts, albeit in different departments. The empirical literature revealed many themes that influenced the student nurses' lived world experiences during their training. Examples from their experiences in practice included adapting to a new working environment, working alongside different mentors, and the demands of the working environment on their personal lives (Cavanagh and Snape, 1997; Chapman and Orb, 2000; Begley, 2001; Arbon, 2004; Sharif and Masoumi, 2005; Lange and Powell-Kennedy, 2006; Moseley and Davies, 2007; Van der Putin, 2008). The juxtaposition of the demands of the university and the shift patterns of the working environment appeared to affect their theoretical learning (Cavanagh and Snape, 1997; Thompson et al., 2001; Spouse, 2003; Hascher, 2004; Baird, 2007; Finnerty et al., 2006; Armstrong, 2010).

The literature review does, however, explore the concept of midwifery and the public's intentionality of the role of the midwife in society (Dreyfus, 1987; Spinelli,

1989; DoH 1993; Valle, 1997; DoH, 2007). It also explores how the process of learning can bring about changes within one's being in order to become a midwife (Jung, 1973; Britton and Baxter, 1999; Kennedy, 2007; Askhan, 2008). This chapter also discusses the development of midwifery education during its transition from the level of post registration certification to its current degree status.

The following four sections provide a brief overview of the empirical data collected during my research study. Chapters 5, 6, 7, 8 of the thesis present a deeper exploratory analysis of the students' lived world experiences as student midwives. I undertook hermeneutic phenomenological analysis of the students' narratives to explore the students' interpretations of their experiences.

Chapter 5 revealed the lived experiences of the students in their endeavour to become student midwives. These interviews were conducted in the early months of their student career. Hermeneutic phenomenological analysis of the students' narratives revealed many phenomenologically sensitive themes. These have been grouped into three main themes (with ten sub-themes): reflection on future career, decision making process and identifying with the role of the midwife. The students approached their decision to become a midwife in two distinct ways. These were dependent on their life experiences. Those with children appeared to have been influenced by the care they received during pregnancy. This may be related to when they were possibly at a vulnerable time in their lives, or based on altruism. The students without children were either influenced by family members or experiences they had encountered with close relatives and friends. These students had researched professional career opportunities. For some, midwifery was an

alternative to studying medicine. The majority of students suggested midwifery was a vocation. This appeared to enhance their decision, as they stated they wanted to enter a caring profession.

Chapter 6 revealed the lived experiences of the student midwives at the end of their first year of training. The students had experienced clinical placements within a maternity environment and academic learning within a university. Hermeneutic phenomenological analysis of the interviews revealed ten themes as essential to their experiences. These have been grouped into three main themes: adjusting to new ways of learning, development (both personal and professional) and socialisation into the midwifery profession. For the majority of the students, their interpretations of being a student midwife were different to what they had expected. The juxtaposition of a work based learning course of study left them no time for socialising with family or friends. The students with children reflected on how their home life had changed. There was a tension that impacted on them being able to commit to such a demanding course of study. The demands of the working environment impacted on all the students' abilities to develop their learning styles. They questioned their abilities to retain so much information, which gave rise to feelings of stress. Demonstrating their new psychomotor skills to their mentor appeared to be their focus. The phenomena of pleasing their mentors were their priority as they desired to appear competent. For some of the younger students, this was a time of adventure as they had left home for the first time. Being independent brought a need for maturity as well as a time for adjustment.

Chapter 7 revealed the lived experiences of the students at the end of their second year of training. The data revealed many phenomena from the students' interpretations of their experiences of working outside of the maternity departments. Hermeneutic phenomenological analysis of the interviews revealed nine themes as essential to their experiences. These have been grouped into three main themes. These were: work based learning, mentorship in clinical placements, and phenomenon of midwifery within a hospital Trust. During their second year of training the students undertook placements in a general hospital on medical and surgical placements. For some of the students, their interpretations of the experiences were not favourable. They suggested they did not understand the relevance of caring for the sick and/or the dying. Some students appeared to resent the time away from their chosen course of study. For others, their reflections revealed a possible need to develop their nursing knowledge and skills further.

Chapter 8 revealed the lived experiences of the students at the end of their third year and the conclusion of their training. Reflecting on the student interpretations of their experiences throughout their training, a few recurring themes appeared. The students were constantly adapting and changing within their life-world. Their initial excitement of achieving their goal of becoming student midwives appeared to be lost. Their roller coaster ride throughout the three years was finally coming to an end. The mature students' narratives revealed their interpretations of what they considered to be the reality of the role of the midwife. Their reflections suggested sadness and possible disappointment as it was not what they had envisaged. Working within a medical model of care in a hospital Trust presented the students with a dilemma. Their original rhetoric of being autonomous practitioners had been

lost along the way, as they viewed the role of the midwife as in decline due to the pressures of work. The younger students were more optimistic; their reflections revealed their hopes for the future, pertaining to how they wished to practice and support women during pregnancy and birth. Their narratives revealed excitement and a sense of freedom at being able to work where they wished once they were qualified. Their desire for support was ever constant as they were fearful of taking their first step into midwifery.

1.5.3 Discussion

Chapter 9 offers a discussion on the findings of the study and the impact their training had on their lives. The impact of my findings on the provision of student midwifery education is explored in the context of being a student midwife within a work based learning programme of study.

Chapter 1 provided an introduction to the thesis, presenting an overview of each chapter. Chapter 2 follows which offers a critical analysis of the empirical evidence available regarding students' education.

Chapter 2

Literature Review

2.1 Introduction

The aim of Chapter 2 is to provide an in-depth analysis of the existing social and professional sources of understanding about midwifery education within a work-based learning programme of study.

My research focuses on the experiences of a group of students undertaking their midwifery degree programme of study. The aims of my study are:

- To discover the nature of the students experiences of becoming a midwife
- To understand the influences of the working environment in the process

The phenomenon of 'being' in the world of a student midwife will have different meanings for each student. Their lived experiences will present many challenges to their existential Being. This literature review provides an interpretation of the collated evidence of experiences from both previous empirical quantitative and qualitative research. Husserl's concept of intentionality brings focus to the phenomenon under study. He believed there must be human consciousness of the lived experience. As such, student consciousness of their learning experiences during their education was pivotal to this study (Lopez and Willis, 2004; Valle, 1997). In order to provide meaning to the experience, I offer my interpretation of being a midwife, which includes my understanding of the structure of the current programme of study.

2.2 The phenomenon of being a midwife

The intentionality of being a midwife focuses on the care of women throughout pregnancy. This is rooted in socially constructed meanings within their existential world. The interpretation of the role of the midwife lies within the identification of the work they do, and this provides the public with an intellectual knowing. Women accept that midwives are the professional providers of care for pregnant women throughout pregnancy and birth. The women's ontological knowing connects the *zu-den-sachen* (to the things themselves) with the *Lebenswelt* (life-world). This is further explored in Chapter 3 in which the philosophy that underpins the study is discussed (Dreyfus, 1987; Spinelli 1989; Valle, 1997). Each woman will experience pregnancy differently as their holistic needs are the primary focus of the care they receive. The midwife interprets the phenomena each woman experiences. Her ontological knowing supports the woman's interpretation of her needs. Having an awareness of the woman's existential being enables a holistic approach to care. Each midwife is required to provide individualised care to the women in her care. There is an expectation that all care will be good and based on current research (NMC, 2012). Nicholls and Webb (2006) questioned what makes a *good* midwife and if they exist, are there certain attributes that support the concept of being *good*.

The systematic review conducted by Nicholls and Webb (2006) regarding the attributes of a *good midwife* consisted of a small number of studies. The rationale for the small number was based on their inclusion and exclusion criteria. These were stated as a lack of access to some papers and a specified time-line for published paper. The lack of empirical evidence supports the findings of my study. Even though the topics are different there is very little up-to-date research published within

the midwifery press. The small number of papers within the review did have a limited effect on the findings by Nicholls and Webb. The papers reviewed were described as '*methodologically diverse*' (p 421) which can support the validity of the outcome of the review. Considering the overall methodology and method of the studies the balance between qualitative and quantitative studies revealed equality between the papers; one being a mixed method approach. The findings highlighted eight key concepts which were based on personality types, the role of the midwife, relationships with others; women and their partners, education and research. The important concept in regards to my study was education. The researchers identified 10 of the 33 studies that could be related to education. All these studies were based on the development of the curriculum, reducing the possibility of the theory-practice gap and preparing midwives to assess students. There were no studies that had gained the students experiences of becoming midwives. Whereas, my study will seek the students experiences of becoming a midwife and how the environment affects them. This will provide an alternative view based on their experiences. The researchers suggested that being a good midwife is not just about being *technically skilled* it is more about being there for women. I suggest it is also about being there for students and supporting them during their education.

The philosophy of midwifery encompasses a supportive and caring role which the midwife is trained to provide. Their interpretation of women's needs provides support for the choices they make throughout their pregnancies. This philosophy has been supported by various Government reports which include directives on how the midwife should work. These include choice of care, carer and venue for birth including where and how women wish to birth their babies (DoH 1993; DoH, 2007).

‘We believe that women and their families should be at the centre of maternity services which should be planned and provided with their interests and those of their babies in mind’ (DoH, 1993 p3).

‘Women and their partners are given the opportunity to make informed choices throughout pregnancy, birth and the postnatal period’ (DoH, 2007 p12)¹.

Considering the themes to emerge from these two statements it would appear that, in the 14 years between these two reports, midwives were still being encouraged to promote individualised care. It has to be questioned whether midwifery education is supporting students to be prepared for contemporary practice, or are their barriers within the NHS structures that prevent midwives from offering such care. *Midwifery 2020* (DoH, 2010) also suggests midwives should be prepared for their future role as leaders of care in normal birth. This contemporary question needs further exploration, given the fact that it has been over 20 years since midwifery education moved into HEIs.

Currently it is believed that most women choose to give birth within a hospital labour ward. This could be interpreted as a cultural phenomenon, as in today’s society there are very few home births within the UK. In fact, in 2011 the national average was 2.4%, a decline of 0.1% from 2010 (ONS, 2013). The scope of the midwife’s practice is based on the philosophy of normal pregnancy which encompasses the physiology of pregnancy and birth without any complications (NMC, 2010).

¹ Permission to reproduce all DoH excerpts has been granted by the Department of Health

2.3 Background and structure of midwifery education

A review of the literature reveals occasional confusion regarding the structures within the Nursing Midwifery Council (NMC). The NMC is a regulating body over midwifery and nursing, but each has their own professional body within its structure. Midwifery has always been a separate profession to nursing and each professional body directs the pre-registration educational requirements. The focus within midwifery is on preparing students for autonomous practice.

‘Education programmes must be designed to prepare students to practise safely and effectively so that, on registration, they can assume full responsibility and accountability for their practice as midwives’ (NMC, 2009 p3)².

Bosanquet (2002) highlighted that maternity service requirements are currently used as a reference point for the pre-registration educational structure for student midwives, as the culture of childbirth is placed within the NHS. As a student midwife, Bosanquet’s interpretations were based on personal observations and experiences of her training within one NHS Trust. Therefore, these reflections cannot form the basis for a change in midwifery education. They do however, provide her with a voice in which to express her feelings from her experiences. Her observations did reveal that her learning within an NHS Trust only exposed her to one approach to care, which was based on a medical model. The midwifery model of care identifies pregnancy and birth as a continuous process, but the medical model of care has divided this natural physiological process into three distinct areas of care: antenatal, intranatal and postnatal (Tew, 1995). This is particularly relevant to the aims of my

² Permission to reproduce all NMC excerpts has been granted by the NMC

phenomenological study as I will explore the students' interpretations of their experiences of becoming midwives.

Currently it is accepted that the clinical focus remains within the service provision of an NHS Trust (Bosanquet, 2002). Within the current educational structure of students' education, both midwifery and nursing utilise the philosophy of work based learning (WBL) (Boud et al., 2001). Students enrol onto a university programme of study and are placed within a hospital Trust to gain practical experience of caring for people; they are not employees of the Trust. This juxtaposition enables a ratio of 50:50 between theory and practice. The positive feature of working in an NHS Trust is that the students have access to pregnant women. This could be argued as the primary focus of being in the Trust.

The education of student midwives places them within a maternity environment. The ontological focus of the curriculum encompasses three distinct levels of study (NMC, 2009). The following is my interpretation of the curriculum, based on Bruner's (1966) spiral curriculum. The focus of the first year is on the normal physiology of pregnancy, labour and puerperium (NMC, 2009). It is also inclusive of the normal development of the embryo, fetus and neonate. Students are taught practical midwifery and nursing skills such as the taking and recording of observations such as blood pressure, pulse and temperature. They also undertake physical examinations of women during the antenatal, intranatal and postnatal periods. My understanding of the curriculum is based on the students' learning about the role of the midwife in the care and support of childbearing women.

Considering the development of the curriculum over the years, there has been progressive development focusing on the complexities of pregnancy, women's lives, and the subsequent role of the midwife as a leader of care (NMC, 2009). The Midwifery curriculum addresses all the traditional requirements of preparing students to become midwives, as each year there is a definite set of criteria to be achieved. It could be questioned whether the current programme of study prepares students for the professional role of the midwife, in a competitive world. In a small ethnographic study, containing 7 participants, Hobbs (2012) studied their transition from student to midwife over a 12 month period. This provided a snap-shot view of their experiences. Traditional ethnographic studies are much larger and study entire communities or cultures (Cresswell, 2007). Therefore, the findings of the study provided a limited analysis of experiences within a small community of midwives, these could not be generalised. The findings of the study were based around the theme *what is a midwife?* The methodology was based on Boudieu's notion of habitus, using Fuchs (2003) model for the analysis of the findings. The validity of the results of the study can be questioned as Boudieu has been criticised as being a reductionist. His work was based on materialistic views rather than cultural conception of socialisation (Alexander, 1995). One of the findings from the study by Hobbs stated these newly qualified midwives initially accepted the dominant culture and socially conformed, due to the internal forces of the Trust culture. It can be questioned if this was a reductionist view or a subjective analysis of their experiences. As this study was based within one NHS Trust, further research is needed to discover if this is a socially accepted view throughout midwifery. This is relevant to my study as my aims are to explore the students' experiences of becoming midwives, over a period of three years, within the culture of the NHS Trusts. One of the chosen methods of data

collection by Hobbs included an observational process, but there was little discussion on her presence as an observer or any influence she may have had on the data collection. Hobbs defends her presence in the research by stating she was able to participate in the study *'this approach allowed me to dip into a more participatory role as the need arose'* (p 393). There was very little information given regarding the 'need' to participate as this could affect the findings of the study. Hobbs revealed she was a midwife and acknowledged her presence by revealing her 'emic versus etic struggle' (p 393). There was little information stated as to how she overcame her 'struggle', or how she anticipated the effects it would have on her findings. This can be viewed as a flaw to the study as the true nature of the environment may not have been revealed or was influenced by her participation. One of her findings did however; reveal that a collective voice can start the process for change as Hobbs revealed;

'As the participants progressed through their first year of qualified practice, it was evident that they were more prepared to challenge practices that they did not agree with' (Hobbs, 2012 p 396)³.

Many of the findings of this study suggested upon qualification midwives are led by the more experienced midwives. It is only until they had gained further experience that their confidence grew in order to challenge care practices. Modern midwifery education needs to be preparing students to take control of their futures and not be reliant on hierarchical and social structures in the work place (Smith, 1990; Witz, 1992; Begley, 2002; Williams, 2006; Hobbs, 2012).

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The students are educated to the graduate level required for their future role as midwives. This incorporates certain guiding principles based on requirements for practice:

- The provision of woman-centred care
- Ethical and legal obligations
- Respect for individuals and communities
- Quality and excellence
- The changing nature and the context of midwifery practice
- Evidence based practice and learning; and lifelong learning

(NMC, 2009 p6-7)

The pedagogical structure is based on modular teaching and learning and assessments based on university requirements. The epistemological focus of the programme of study is prescribed by the NMC (2009). The pre-registration midwifery educational standards can be quite confusing as they incorporate midwifery standards, competencies and educational domains. The guiding principles state the student must be proficient in all educational standards of the programme and demonstrate competence in the standards in order to qualify as a midwife. These competencies are divided further into four domains which are:

‘Effective midwifery practice; professional and ethical practice; developing the individual midwife and others; achieving quality care through evaluation and research’ (NMC, 2009 p 11)

These competencies and standards form the ontological basis for the clinical assessment documents. There is little guidance given from the NMC as to how each

student is to be assessed by their mentors for each clinical placement, as there is no nationally set document that can be used by each HEI or Trust. Therefore, each HEI develops their own practice document through their interpretation of the pre-registration educational standards. The assessment of student midwives in practice is quite rigorous and must adhere to NMC Guidance (2009).

‘Assessment of practice, which is direct hands-on care, must be graded. The grades achieved must contribute to the outcome of the academic award. If the assessment of clinical practice involves a variety of components and the student fails to achieve competence in one of the components, then the student must fail’ (NMC, 2009 p18).

In addition the students’ record of achievement must also be signed by a mentor to prove their competence in midwifery-essential skills for each level of training (NMC, 2009). They must also demonstrate their adaptability by engaging in the shift patterns of the Trust.

Developing knowledge and skills is important. The student must be supported to apply knowledge to develop their clinical skills. A small qualitative study conducted by Sheehan and Wilkinson (2007) found that without recognising how students learn mentors cannot support their learning. The study was undertaken in New Zealand with a group of interns. The number of participants was not specified but was described as small. Therefore the findings cannot be generalised. The purpose of the study was to develop an assessment tool that supported their learning. It was also envisaged this would support the mentor to assess the progress of the students’ learning. The main findings were that the students had to be involved in the learning

process and each needed a supportive mentor. Each student had developed their own ways of learning. Therefore, a generic assessment tool did not facilitate internalisation of their learning. The assessment tool was found to be an aid to the mentor to monitor progress; it did not support the student learning. They revealed the mentor directed their learning which resulted in surface learning (Ramsden, 2003). The students in my study also have assessment documents to complete; I will explore their experiences of using them. Considering the findings from Sheehan and Wilkinson (2007) exploration of the different learning theories will be discussed.

2.4 Theories of learning

- Behaviourism, cognitivism, humanism

There has been much research in regards to learning. It has been referred to as a change in behaviour or understanding or just merely a process to be undertaken (Reece and Walker, 2007). Within adult education there are important components, which are not equally present in school age children. The identification of these principles is rooted in changing attitudes and areas of study over the years (Curzon, 2004). Educational psychologists have identified three main theories of learning: behaviourism, cognitivism, and humanism. Each has described various approaches to the understanding of how people learn. Many of these learning theories originated from the study of animals and their adaptive process in order to gain a reward (Fontana, 1995). The transference of this reward system has to some extent offered an understanding of possible educational processes in human learning. The reward may not necessarily be a morsel of food, but more akin to the reward of knowledge and personal development (Fontana, 1995; Curzon, 2004).

2.4.1 Behaviourism

Many educational theorists believe each person will engage with all three theories of learning at different stages of their educational development. It is believed behaviourism originated in the early 20th century. Behavioural psychologists Watson (1925), Pavlov (1927), and later Skinner (1972) suggested that the learning processes in humans were analogous to animal behaviour, involving the processes of stimulus and response. Further work included the effects of conditioning the response to the stimulus, which involved working with animals to predict responses to conditioning interplay. All these educational psychologists considered learning to be mechanistic devoid of emotions and instincts; Pavlov's salivating dogs are a prime example of conditional behaviour (Fontana, 1995; Reece and Walker, 2007). Skinner (1972) further described learning as a process of *operant conditioning* (Fontana, 1995). This involved three identifiable stages: the learning encounter, the response and reinforcement. These stages of learning can elicit either a positive or a negative effect on the student depending on the outcome of their engagement with the learning process. In midwifery, student midwives will initially experience this pedagogic process of learning in both university and in their clinical placement whilst learning the fundamental skills of the midwife (Skinner, 1972; Fontana, 1995).

It has been suggested that operant conditioning has many flaws as people may observe or undertake a socially acceptable behaviour for no apparent reward other than it can be performed or through imitation (Bandura, 1977). It can be argued that self gratification of the ability to imitate the desired activity would be reward in itself (Mazur, 1994). Some educational theorists consider operant conditioning to be a passive form of learning. Students do not necessarily engage in the true nature of

the learning experience which can be related to task orientated learning (Bandura, 1977; Mazur, 1994).

2.4.2 Cognitivism

The cognitivist approach to learning described by Bruner (1966) occurs when the students actively engage in the process of learning. A process Bruner (1966) described as *instrumental conceptualism*. This transformative process involves the acquisition of information, learning by transformation or manipulation of the information in order to deal with the task and a process of testing and checking the adequacy of the transformation. Bruner (1966) was also instrumental in the development of his cognitive developmental approach to curriculum development. He devised the spiral curriculum using three specific stages of development; enactive, iconic and symbolic; through the process of perception, thought and action. His theory combines well with experiential work based learning as it provides the students with the opportunity to learn develop and apply their knowledge to the situation. The students are able to analyse the information and transform their experience into newly found knowledge, which adds to their existing body of knowledge. Whilst a behaviourist approach such as operant conditioning is essential to confirm task orientated learning has occurred, cognitivist learning provides a deeper holistic view of the nature of the learning process within the student (Fontana, 1995).

2.4.3 Humanism

A humanist approach to learning as discussed by Maslow (1970) and Knowles (1980) suggested learning was a personal journey. Students learn by taking control

of their learning, developing the concepts of critical thinking and the ability to reflect on their learning experience. The philosophy of androgogic learning suggests that adults voluntarily engage in their learning. This may be influenced by the desire to improve their education and subsequent lives and gain meaningful employment. They may also have identified a need within themselves that has prompted them to improve their education, which coincides with a reward system suggested by the behaviourist psychologists. It could also be linked to a humanistic approach to learning as the student brings their previous experiences to their learning (Bruner, 1966; Curzon, 2004; Reece and Walker, 2007).

Bruner (1966) stated their past experiences of education as a child influence how people adapt to being adult learners. Bandura's, (1977) notion of *reciprocal determinism* represented an interactive process between the environment, the individual and behaviour, each influencing each other. He believed the environment determined the person and their behaviour but also the person's behaviour influenced the environment. It can be suggested this coalesces with the notion of combining behaviourist and cognitivist philosophies. It has been hypothesised that the combination of previous experiences and the acceptance of behavioural reward systems can influence how adults approach their learning (Bandura, 1977). The study by Sheehan and Wilkinson (2007) revealed the students adapted their learning styles when being assessed in practice.

2.5 Adaptation to learning

Accommodating new ways of learning can be difficult for some adults as learned behaviours are hard to change. Learning is not specific to one particular scheduled

subject there are processes that include accommodation, adaptation and socialisation that informs the learning process (Dewey, 1939). According to Ramsden (2003) adult learning is a quantifiable increase in knowledge that can be stored and reproduced when needed. Learning involves relating parts of the information to each other and to the real world. This involves a process of interpretation and understanding but learning also involves comprehending the world by reinterpreting knowledge. This corresponds to the previous work of Bloom (1956), his work on taxonomies of educational objectives suggest an adaptive mode to teaching and learning. His main principles are described as domains: cognitive (knowledge), affective (attitude), and psychomotor (skills), most often translated as - think, feel and, do (Bloom, 1956). These educational objectives are used as a guide to develop many midwifery curricula as each domain contains a progressive developmental concept. For example, in the cognitive domain each student progresses through a process of gaining knowledge, comprehension, application, analysis, synthesis and evaluation, these recognised stages in the learning process provide the student with the ability to engage with a deeper level of cognition rather than a surface approach to learning (Ramsden, 2003). The affective domain exposes the student to the conceptualisation of the value of receiving informing, responding, valuing, organising and valuing the change within themselves. The psychomotor domain takes the student on a process of learning a practical skill, from imitation, manipulation, precision, articulation and naturalisation. From an early age most people develop their skills through this psychomotor domain but it is the combination of these taxonomies of learning that supports the learning processes and the development of the individual (Bloom, 1956; Ramsden, 2003; Reece and Walker, 2007).

2.6 Work based learning

The phrase 'work based learning' (WBL) has been used to describe many health care courses but it is difficult to understand how it supports students learning.

'Work based learning is the term being used to describe a class of university programmes that bring together universities and work organisations to create new learning opportunities in workplaces. Such programmes meet the needs of learners, contribute to the long-term development of the organisation and are formally accredited as university courses' (Boud et al., 2001 p4)⁴.

This implies that the students are part of the organisation and their contributions aid further development of the organisation or work place. In fact, student midwives and nurses are classed as university students and not employees of NHS Trusts. Their status is supernumerary; as such they are learners in the organisation. I am keen to discover how this traditional WBL philosophy supports their learning. This philosophy does not fit with the current model of midwifery education.

Based on the traditional philosophy of WBL it is difficult to see how the professional programmes of midwifery and nursing are classified as WBL programmes of study. They are professional programmes of study based within Higher Educational Institutions (HEI) (Fraser, 2000; NMC, 2009). A small phenomenological study by Baird (2007) explored whether student midwifery education prepared students for the autonomous role of the midwife. Quota sampling was used to try and find a sample of students that were similar in key characteristics. This could have been the contributing factor to the small number of participants, as students have diverse

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backgrounds. The researcher stated her anticipation of identifying certain barriers that would influence the outcome of her study, these she failed to reveal. This presents a flaw to the research as there was an identified bias prior to her gathering and analysing the data. Her approach to the collection of the data was in keeping with phenomenology, she did not state which phenomenological approach she used in her research; descriptive or interpretive. Therefore, the trustworthiness and authenticity of the findings can be questioned. Semi-structured interviews were used to gather the data. Thematic analysis revealed 11 themes but Baird only chose to discuss four, which again could be seen as a limitation to the study. The themes discussed were based on the students' perceptions of being prepared for autonomous practice. There was no explanation as to why these themes were chosen, therefore, the validity of the findings can be questioned. The discussion focused on how midwifery education did not prepare students for their role as autonomous midwives, but did not state why. In contrast to the study by Baird, my use of hermeneutic phenomenology will explore the wider issues of becoming a midwife and what influences, if any, the working environment has on their leaning.

Baird did acknowledge that midwifery has evolved from an apprenticeship model of learning to undergraduate programmes of study. It is now based on professional regulations and the standardisations of education within HEIs (Jackson-Baker, 1998; Baird, 2007). The integration of academic theory with clinical practice is believed to provide a limited legitimacy for knowledge and learning (Boud and Salmon, 2001). Based on Bloom's taxonomies of learning, pedagogic learning and assessment is believed to support students' cognitive, affective and psychomotor development and this must be evident within their learning environment. The common theme to

emerge from the data from these studies indicates that the working environment has a major influence on the role of the midwife. This will place a limitation on students learning.

My position as a midwife within the research is discussed in Chapter 4, but reflecting on the history of midwifery education led me to acknowledge my midwifery education. This helped my hermeneutic reflections to place it in time and context as my education took place over 30 years ago. Historically, the epistemological approach to midwifery education required prior pedagogical education as a nurse (Currie, 1999). The consideration of ontological nursing knowledge was believed to provide the student midwife with cognitive knowledge and psychomotor skills related to the nursing care of patients with a variety of medical illnesses (Currie, 1999). These nursing skills were considered necessary in the care of women with complex pregnancies (Baird, 2007). Past pedagogic structures of midwifery education focused purely on midwifery education and the acquisition of knowledge and skills necessary for midwifery practice. There was an acceptance that all qualified nurses had acquired these skills as no-one appeared to test their competence (Begley, 2001; Baird, 2007).

As far back as 1999 Currie conducted a small grounded-theory study on the theme of autonomy in midwifery practice. The findings revealed that students needed to be prepared for their autonomous role through experience and guidance by other midwives, now known as mentors. The themes to emerge from the data were; recognition, incorporation and facilitation. The findings were all based on *knowing your student and supporting their development*. This can be seen as a positive

approach to learning in modern society. In fact the study revealed how midwives placed barriers to students learning by imposing a hierarchical system in practice. Many of the students in the study were post-registration students, having trained as nurses previously. Their knowledge and skills were not acknowledged as they were seen as students. The method of data collection was interviews, these were conducted in paired groups, student and midwife, this can be a major flaw as some students or midwives may not have been completely open regarding their experiences. The discussion also revealed that during the 1990s task orientated care was the main source of learning. Students were expected to comply with the midwives traditional ways of working, which would not support the development of becoming an autonomous practitioner.

In contrast to Currie (1999) a study by Begley (1999) explored the feelings and views of student midwives in Northern Ireland. The study was described as a phenomenological study; in fact Begley used a mixed method approach to gather her data. This she termed as triangulation using questionnaires, diary-keeping, interviews and focus groups. The article used verbatim quotes to demonstrate the qualitative results but there was little evidence of the quantitative data to support the findings, some discussion and a table of results would have been useful. This reduced the validity of the results presented. The study was relatively small for a mixed method approach. Begley did not reveal how many themes emerged from the data but proceeded to discuss five, *them and us*, *they all have their moments (older midwives)*, *knowing your place*, *counting the days*, *there's a definite hierarchy*. These themes described many hierarchical structures and a two tier system that did not support communication. This placed barriers in the way of students' learning. The

findings of this study are interesting as I intend to explore the students' experiences of their learning in modern day practice. The findings of the study can be viewed as flawed as only one set of data were revealed. There was an emerging pattern of a familiar theme evident across the two studies discussed which are based on the hierarchical structures of the NHS.

Since these studies were undertaken (Currie, 1999 and Begley, 1999) midwifery education is now recognised as an undergraduate university course. In most universities it is a three or four year programme of study. Each student is placed in different clinical areas for a set number of weeks at a time. It has been suggested by Spouse (2003) that there can be problems with this system as the sequence of placements does not necessarily support their theoretical learning. In fact, Bosanquet (2002) previously found many students were unprepared for the institutional requirements of an NHS Trust as they were placed where there was available space. On occasion students also experienced short placements which were not conducive to deep learning or the transference of theory to practice as this stymied the students' opportunity to explore and assimilate their knowledge (Morgan, 2005).

In a small grounded theory study by Rawnsion (2011) it was found that case-loading in a community midwifery setting enabled the students to develop their skills of being woman-centred. The themes to emerge from the data were; *making it good, developing and managing case-loads, learning partnerships, feeling like a midwife and afterwards*. There was little guidance as to how the grounded-theory approach was conducted apart from Rawnsion stating semi-structured interviews were

conducted. My interpretation of the methodology would suggest it was more of a modified approach than a full grounded-theory study and not in keeping with Strauss and Corbin's (1967) original design. This could be seen as a flaw as there was no mention of how the themes to emerge from the data were grounded to reveal new knowledge. Therefore, the validity of the results can be questioned. The discussion, presented as the conclusion, suggested there were mixed emotions regarding the process of case-loading. Some students revealed how it impacted on their home lives, while others embraced the opportunity to work with women throughout their pregnancies and birthing experiences (Rawson, 2011). The aim of this study was designed to explore students' experiences, which is similar to my own study, but that is where the similarities end. This study presented an alternative approach to providing midwifery care in an interesting way. Further research needs to be undertaken to discover if this type of placements supports students learning, which my study will explore. The study by Rawson (2011) involved final year student midwives who had completed their case-loading episode of care. It provided a snapshot view of their experiences of providing holistic care to women throughout pregnancy and birth. The finding suggested the commitment to provide such care was quite demanding but rewarding and differed for each student.

'The students expressed a deep sense of commitment and responsibility to the women, with a strong desire not to raise unrealistic expectations, and a need to build a mutually trusting student/woman case-loading partnership based on honesty' (Rawson, 2011 p789)⁵.

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As previously stated there have been a number of Government reports which suggested there needed to be changes made to the delivery of care within the maternity services. In particular: *Changing Childbirth Report* (DoH, 1993), *Maternity Matters*, (DoH, 2007) and *Midwifery 2020* (DoH, 2010). *Midwifery 2020* focussed specifically on the future role of the midwife within the provision of the maternity services, and in particular, public health:

'Midwives' unique contribution to public health is that they work with women and their partners and families throughout pregnancy, birth and the postnatal period to provide safe, holistic care. For optimum effect, midwifery should be firmly rooted in the community where women and their partners live' (DoH, 2010 p6).

The main theme of these reports concentrates on how midwives should work in partnership with women to provide woman-centred care. They also acknowledge how society has changed and the needs of women have evolved. It has to be questioned why the care of women is primarily based within NHS Trusts and whether students are being prepared for future changes in care practices. There remains a lack of empirical evidence to suggest that the current framework of midwifery education is fit for purpose in a contemporary society. Thus, I argue there is a need to research the current structure of midwifery education through the students' experiences.

My review of the current educational requirements for student midwifery education places students within an NHS Trust working alongside qualified midwives. The phenomena of their lived experiences are guided by the requirements of the NMC

(2009) and the structure of the provision of care in the UK. The ontological requirement of the curricula is designed to provide many learning opportunities within each placement. This is based on a collaborative approach that meets the needs of students (NMC, 2009) but not necessarily based on the needs of the women (Bosanquet, 2002). The *Changing Childbirth Report* (1993) stated women were no longer passive recipients of care. They were encouraged to take control of their pregnancies discussing their needs and choices with midwives (DoH, 1993; Kirkham, 1999). This philosophy of care exposes students to the changing needs of women in society and within their communities (DoH, 2010). It was anticipated that this would support the students to learn how to become autonomous practitioners; learning to apply theory to practice and provide individualised care to women.

2.7 The NHS as a place of learning

The organization of the NHS has evolved over time but its purpose has always been to serve the health care needs of the general public. In today's society the NHS presents itself with a corporate image, providing health care services to the general public in both private and public sectors of society (Hunter, 2008). The professional credibility within any programme of education is a priority for all professionals including midwifery and nursing, but the positioning of a work based learning model within the NHS structure is complex. The educational needs of the students' may not be one of the main priorities of the working environment, as the cultural values and politics of the workplace vary greatly (Brennan and Little, 1996). Gaining the students' experiences of these issues, while training within NHS Trusts, will support the aims of my study. Whilst control of the NHS is devolved by the government to quasi-independent bodies, the government retains overall power and funding. This

juxtaposition places student midwives into the same medical model of care structure as the student nurses (Davies and Atkinson, 1991; Begley, 2001; Bradshaw and Bradshaw, 2004).

This medical model of care dates back to the 19th Century when control over healthcare was given to the medical profession. This status has been described as a reward for the policing of standards of professional conduct; this is now enshrined in law (Harrison et al., 1992). This supremacy is strengthened by medical solidarity as it is supported by the British Medical Association and its medical Royal Colleges. The medical profession has direct links with the Secretary of State and this provides them with the authoritative voice on issues concerning health care (Harrison et al, 1992). Recent changes in NHS structures have seen the development of Clinical Commissioning Groups (CCG) (NHS England, 2013). The CCGs have been commissioned to develop services in the communities where people live. General Practitioners are now major providers of care as they hold budgets for many services. Unless there is an acknowledgement of midwifery within this new structure, the role of the midwife will remain under the administration of the medical model of care. To improve the maternity services for women and recognise the professional role of the midwife there needs to be development of midwifery CCGs, which will support a more community based service for women. This will improve students' learning in the communities. Considering the requirements of *Midwifery 2020* (DoH, 2010) this is a good opportunity to provide community midwifery services and enhance students' education.

My understanding of the midwifery model of care acknowledges that pregnancy and birth are a normal physiological process and not an illness. Nonetheless, medical power, supported by Government policy, appears to direct how midwives practice. This can be demonstrated by the suggestion that hospital birth is the safest option. Previous discussions have revealed that this medical guidance reduced midwives' autonomy to offer alternative birth options (Ministry of Health, 1970; Donnison, 1988; Tew, 1995). This philosophy appeared to change the culture of birth for women in the UK during the 1960s and 1970s, which it can be argued remains strong to this day. It has permeated the structure and values of midwifery education by focusing on the NHS provision of care (Tew, 1995). Hospital policies and guidelines direct how care is provided. These are designed to ensure the safety of women and patients and maintain a high standard of care (Ministry of Health, 1970). They do not necessarily focus on women's choice. In part they also manage how students are taught within the boundaries of local provision. The major managerial culture is to provide healthcare services to people who are ill and / or dying. The provision of maternity services appears to be a small part within the main business plan of many large NHS Trusts.

Obstetricians only consider pregnancy and birth are normal in retrospect, giving them power to direct care (Tew, 1995; Richens, 2002; Bradshaw and Bradshaw, 2004). The study by Richens (2002) explored the positioning of maternity services within NHS Trusts. It was stated as an ethnographic study. Her rationale for using this type of study was vague and was based on previous 'eminent' midwives usage (p 11). This can be argued as not being an authentic methodological reason. There was no information regarding the number of midwives including in the study, but

focused on the broad culture. There was no indication of the type of ethnographic study, but the writing does suggest a critical approach (Cresswell, 2007). The study was also undertaken where the author worked, which is acknowledged as a limitation, but there was no discussion on researcher bias. There was also no analysis for the choice of methodology, nor was there evidence of a model used to support interpretation, just methods of data collection described. Thematic analysis produced 6 main themes to emerge from the data, *doctors and monitors, policies and procedures, theory-practice gap, lack of support and all singing and dancing midwife*. Richens' revealed that the findings from this study represented barriers to the midwives practice. Midwives were longer able to use research in their practice as they did not have the time to access the information. Midwives were expected to comply with hospital policies and guidelines. The results of this study were from just one NHS Trust and therefore could not be generalised. The findings are of particular interest to my study, which will explore the students' experiences of their learning within a Trust. It was further stated by Richens that using research in practice may not be easy to achieve, as there are many impositions in place which contribute to a hierarchical structure. Further research is needed to explore students' experiences of these structures and how they support or hinder their learning. The aims of my study will explore the students' experiences.

In a relatively small exploratory study by Lavender and Chapple (2004) they sought midwives views of the system of maternity care in England. The study consisted of midwives who had been nominated by their Head of Midwifery (HoM) and a few students. This process of nomination revealed a bias to their purposive sample as only midwives deemed suitable by the HoM were used; this also questions the

validity of the findings. Considering the number of midwives on the NMC register the number of midwives was small, they were nominated from a variety of maternity care settings; *home, free standing midwifery-led (MLU) units and MLU in hospitals, birthing centres and obstetric-led units*. The method used was focus group discussions, which were piloted prior to commencing the study. This can be seen as a positive and a negative approach as a pilot study tests the validity of the research tool, but the findings can also influence the main study. There was no discussion regarding this issue. They did state however, that '*accessing the views of clinical midwives and managers prior to and following the focus groups increased the reliability of the information presented.*' (p326)⁶. This presents dilemmas with confidentiality issues and the authenticity and trustworthiness of the findings. This could be viewed as a checking system ensuring what has been revealed by the participants is in fact true. Thematic analysis was undertaken to reveal themes under three stages '*Discovery Stage, Dream Stage and Design Stage*' which is more in keeping with an inspirational model used by many business and universities (Chun, 2014). The findings revealed 8 themes which were subsequently discussed; verbatim quotes were used to support the discussions. There was no discussion on the pre and post focus groups verification meetings which reveals a covert approach to the collection and analysis of the data. The discussion focused on the views of the midwives, many feeling frustrated due to the impact of hierarchical restrictions placed on their practice; this has become a recurring theme in the majority of the studies discussed. The students also revealed that their training was compromised as they too were exposed to restrictive practices by many midwives. They were not allowed to use the '*gold standard*' of practice taught to them by their lecturers. This is

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in keeping with the theory-practice gap described by Lange and Powell-Kennedy (2006). Further research is needed to explore students' experiences of their education, which the aims of my study will explore.

The positioning of maternity services is considered to be of paramount importance within the philosophy of WBL as students have access to patients whom they can learn to care for. It can be argued that this is of particular relevance to student nurses but not necessarily student midwives, considering the physiology of pregnancy and birth. Also, within this paradigm there could be added consequences as many Trusts work to achieve Government targets which could impact on the students' learning experiences through cuts in services and personnel (Bradshaw and Bradshaw, 2004). From these many issues it would appear there are major implications that can affect student midwives' education, such as the positioning of the maternity services within NHS Trusts and the support students may receive.

A small study conducted by Curtis et al., (2006) explored why midwives leave the profession. The methodology was a mixed methods study; interviews and questionnaires were conducted. There was no discussion regarding the analysis of the data. It was listed in a table that a grounded theory approach had been used to collect the qualitative data. Further discussion was needed to demonstrate how the data was grounded to reveal new knowledge (Strauss and Corbin, 1997). The participants in the study were midwifery managers and midwives currently in practice. This caused me some confusion, as to why they had not asked the midwives who had left the profession; this was not commented upon. Therefore, the validity of the findings can be questioned, as the managers' perception of the issue

cannot authenticate the reasons. The findings however, suggested that midwives had stated to their managers that they did not feel safe in their practice, due to low staffing levels. This impacted on their care of the women. There was no discussion on the effects of low staffing levels on the education of students, but the title stated *challenges in contemporary care*. This is relevant to my study, as one of the aims is to explore the influences of the environment on the students' experiences.

2.8. A partnership approach to learning

The literature revealed the philosophy of midwifery has a major influence on the structure of the WBL curricula. Current maternity clinical placements were originally designed to enhance the students' learning, which encompassed the principles of woman centred care. Students on clinical placements now work alongside mentors who support them in their clinical learning. This is believed to encourage a partnership approach to teaching and learning (Bluff and Holloway, 2008; NMC, 2009; Rawnsdon, 2011). Considering the findings of the previous studies, it is worth exploring the role of the mentor in the support of students learning.

The qualitative grounded-theory study by Bluff and Holloway (2008) explored the phenomena of role modelling in midwifery practice. The sample size was appropriate for this type of study; there was opportunity for the mentors and students to discuss their roles within the partnership using semi-structured interviews. The approach to the study was transparent, which utilised a true grounded-theory approach as developed by Strauss and Corbin (1967). Participants were interviewed on more than two occasions, which suggested the data was grounded to allow new knowledge to emerge. The authenticity and trustworthiness of the findings can be

believed as the authors described the process well. The findings discussed were from the students perspective and revealed there were two types of midwives/role-models; prescriptive and flexible. It was found that both types are effective role models but adopted different approaches. This can be a subjective analysis as each student has their own personality and ways of learning. An interesting discussion focused on *influence* and/or *power* within these relationships. Midwives, who used power over others, subjected them to horizontal violence and restricted their practice; there was a need to control. The findings were similar to the studies by Currie (1999) and Begley (1999) who also found some midwives were bullies. These hierarchical structures were perpetuated by midwives who had been in practice over many years, which supported a medical model of care. The study also revealed that flexible midwives were the ones prepared to change and move forward despite meeting barriers in their workplace. The discussion revealed a pragmatic approach to student mentoring, which suggested students also need power to support their learning. Preparing student midwives for their future role as midwives is complex, which my study will explore. The study by Bluff and Holloway offered a view of mentorship over a variety of settings; this offered a snap-shot view of the culture that influences students learning.

Not all women choose to give birth within a hospital environment. Some prefer to give birth at home or in a birthing centre. Placing students in an NHS Trust environment does not expose them to the diversity of the physical environment of learning in alternative birth settings (Hunter, 2004; DoH, 2007). Previous research revealed that not all women are given a choice. Rather, birth setting is dictated by

factors that are not research-based such as hospital being the safest place to birth their babies (Tew, 1995; Kirkham, 1999; Richens, 2002).

An historic ethnographic study by Kirkham (1999) explored the culture of midwifery in the NHS in England. The researcher did not state which form of ethnography was used to approach the study. The style of the writing does suggest a realist ethnographic approach, which is used by cultural ethnographers (Cresswell, 2007). The study was relatively small considering it was undertaken across five sites in various geographical areas in the UK. The methodology of the study appeared confusing as the methods of data collection and analysis were stated as grounded theory; the data were grounded through subsequent interviews to reveal new knowledge. There was no discussion regarding the researcher's role in gaining insight into the culture of midwifery across the chosen sites. Therefore, the validity of the finding must be questioned. The confusion between methodology and method questions the trustworthiness and authenticity of the research process. There were 10 themes identified, which were discussed supported by verbatim quotes. The study did highlight the position of midwifery within the NHS during the 1990s. Kirkham suggested midwives were placed in a sub-servient position suggesting that they offered themselves for *service and sacrifice*; they did not have a voice in the culture of the NHS. This further impacted on the care they provided to women as they did not have the power to empower women.

The phenomenon of service and sacrifice described by Kirkham (1999) presented midwifery in an historic nursing paradigm. It is well established that midwifery is a separate profession to nursing. In my study I am interested in why the students

chose to become midwives. In my review of the literature I discovered that Williams (2006) had conducted a small qualitative survey to discover why students in one of her cohorts had decided to become midwives. The validity of the findings can be questioned as the students may have provided an answer that placed them in a positive light. The survey revealed that some of the students wanted to work in a caring profession. This was discussed as a cultural or social embodiment of their being. As their knowledge of midwifery developed the focus of their direction became clearer. For others there was more of an altruistic approach as they wanted to make a difference. Others related their decisions to an awakening and a divine experience, suggesting their desire to become midwives was innate. They had a vision of the type of midwife they would become, which could have been related to their past experiences. The study revealed some interesting findings, but these can only be related to this small group of students. Some were described as having an alternative life-style which will have influenced their choices. Life-world experiences affect many choices people make therefore, social background and geographical locations influence peoples' choices (Bandura, 1977; Mezirow, 1991). These results cannot be generalised. My longitudinal study will explore the students' choice of becoming midwives. It will also discover if during the course of their studies their experiences matched their expectations.

Within the aims of my research and via my chosen methodology of hermeneutic phenomenology I will explore the students' understandings of their lived world experiences of midwifery education and how it affects their being. My review of the literature suggests reflection in and on learning is a powerful tool as it supports reflection in and on practice. My understanding of reflection suggests it supports

them to assess, plan, implement and evaluate the care needs of women under the guidance of their mentor which supports their education in practice (Schon, 1983; Kirkham, 1999; Boud and Solomon, 2001).

Reflection on experiences provides a powerful exploratory tool (Schon, 1983). Providing individual care enables students to assess, plan, implement and evaluate the care needs of individual women. Students are then facilitated to process their learning by evaluating the outcome of the care provided. The student and mentor are able to assess if learning has taken place (Schon, 1983; Boud and Solomon, 2001).

Husserl suggested there must be consciousness of the lived world in order to perceive experiences.

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These modalities of self world relationships create meaning to all experiences; a humanistic approach to learning (Maslow, 1970; Knowles, 1980; Rogers, 1996; Valle, 1997). As part of their natural attitude students will engage with their everyday lives in a newly found accustomed world. Clinical placement experiences help the student to apply cognitive pedagogic theory to practice by developing the skills of

reflection-on / in-action. The students bring the *zu den sachen* (to the things themselves) to the *Lebenswelt* (life-world) by being able to make sense of what has happened. They are able to consider the theory surrounding the incident and learn how to apply it to similar situations in the future (Eraut, 1994; Schon, 1983; Finnerty and Pope, 2005). This is discussed further in Chapter 3 regarding the philosophy of the study and the debate on Husserl's use of *epoch*.

2.9 Mentorship within work based learning

The theory behind mentorship coalesce many models or frameworks; apprentice model, competence based model; team mentoring, contract mentoring and, pseudo mentoring. The midwifery and nursing curricula have adopted a competence based model this is thought to support the student in their achievement of learning objectives and outcomes within clinical practice. The phenomenon of mentoring midwifery students involves a behavioural pedagogic constructive process that supports the clinical education of the student.

There are two main approaches to mentoring: classical and reflective (Darling, 1984; Reece and Walker, 2007). Combining classical and reflective mentoring adopts a constructivist approach to teaching and learning. The student is able to interact with the pedagogic and social phenomena of learning within the philosophy of women centred care (Pedlar, 1974; Darling, 1984; Kolb, 1984; Beck, 1994; Raelin and Schermerhorn, 1994; Portwood and Garnett, 1995; NMC, 2006; Gopee, 2008; NMC, 2009). Classical mentoring is explained as informal or primary. Educational theory suggests this has evolved from a naturalistic self chosen relationship. Reflective mentoring is based on an androgogic model of learning. The latter is believed to

maintain the ontological being of the student. Being in the world of a mentor requires a pragmatic approach to the students' learning needs. The existential life world of the student requires a critical friend that provides guidance to their learning (Boud and Solomon, 2001).

Academic theory suggests there is a correlation between Bloom's taxonomies of learning and the definition of a mentor (Darling, 1984). Being in the world of a mentor supports the students' analogy to cognitive knowing, affective being and psychomotor skills development (Bloom 1956). Intentionality or the act of consciousness directs the mentor's focus onto the student's learning. The mentor becomes aware of the existential lived world of the student and how they learn (Von Eckartsberg, 1998; LeVasseur, 2003). Gaining a conscious knowing of their lived world brings the mentor 'to the things themselves' the mentor gains the qualities of inspirer; investor; and supporter (Darling, 1984). These qualities combine both behaviourist and cognitivist philosophies in the support of two pedagogical approaches to mentoring students. One suggests that it is either structured or facilitated the other suggests that learning occurs when the chemistry between the mentor and student is correct (Murray and Owen, 1991; Gopee, 2008). Empirical evidence has suggested that many students are not supported in practice. The studies by Currie (199) and Begley (1999) revealed that many students were left to work on their own. This caused them much stress.

It is believed the ontology of the midwifery curriculum (NMC, 2009) supports the combination of these approaches to mentoring; acquiring cognitive knowledge and skills can assist the students in the care of women. The students learning should be

directed towards supporting the women's choices regarding place of birth and their holistic needs. The work of Cavanagh and Snape (1997) and Moseley and Davies (2007) revealed that the lack of support for students impacted on the care of patients. Gopee (2008) suggested reflection provides a powerful tool in the processes of learning. It provides a constructive ontology to the creation of a pragmatic learning environment as students are able to learn and optimise the care of their patients (NMC, 2009). Mentorship supports the ontology of learning having an awareness of the students' experiences of their lived world connects the *zu den sachen* (to the things themselves) to the *Liebenswelt* (life world); this offers support to their needs (Dreyfus, 1987; Spinelli 1989; Valle, 1997).

Educational theorists suggest students' lived world experiences will have many challenges. Within the complexities of mentorship learning is individual (Reece and Walker, 2007). Their pedagogic experiences may be compounded by the different learning strategies adopted by the students themselves. Their epistemological style of learning may depend on their interpretations of the tasks to be learned (Honey and Mumford, 1982). Qualitative research lends itself well to research on lived experiences of learning as it provides information on many levels of being. My hermeneutic phenomenological study will capture the students' experiences of their learning within a WBL environment. This I can equate to van Manen's beliefs that the ability of qualitative research is to capture the depth of human phenomena such as the students' beliefs and attitudes that support their learning processes (van Manen, 1990; Curzon, 2004; Reece and Walker, 2006). Qualitative research is undertaken in a natural setting rather than an experimentally controlled paradigm. This enables the researcher to explore the lived phenomena as it is experienced as opposed to a

priori of ideas (Honey and Mumford, 1982). This inductive approach will enable me to explore the students' experiences of becoming midwives.

2.10 Review of the literature

On reviewing the literature regarding pre-registration midwifery students' experiences of becoming a midwife I discovered there is very little empirical knowledge. The nursing literature can provide some indication of the likely issues, therefore a review of the literature regarding student nurses' training was undertaken. Student nurse training is undertaken within a similar WBL learning environment to that of student midwives. They both undertake their clinical learning within a hospital Trust albeit in different departments, and student nurses' experiences of their training may be similar to those of student midwives. However, student nurses care for people who are sick and / or dying in a hospital environment while student midwives care for women who are essentially well. This diversity within each profession may have affected their different choice of career pathways.

A review of empirical studies that used qualitative research methods to explore the elements of WBL within a nursing programme follows, some quantitative research studies were also considered. The review demonstrates the usefulness of qualitative research in the exploration of the key concepts (van Manen, 1999; Riessman, 2008). It demonstrates its ability to highlight the students' experiences in terms of their training within a WBL environment. A range of qualitative methods were used in these studies, for example: phenomenological methods, descriptive and interpretative: descriptive phenomenological study by Chapman and Orb (2000), Begley (2001), Spouse (2003), Hascher (2004); hermeneutic phenomenological

study by Arbon (2004), Sharif and Masoumi (2006), Finnerty et al (2006), Baird (2007), Van der Putin (2008): grounded theory methods: Currie (1999); Licqurish and Seibold (2008); mixed methods: Begley (1999), Thompson et al (2001). There were also quantitative studies included in the review, these were: Cavanagh and Snape (1997), Lange and Powell-Kennedy (2006), Moseley and Davies (2007) and Armstrong (2010). The methodology for this thesis is hermeneutic phenomenology.

2.10.1 Themes to emerge from the data

The lived experiences of the student nurses can be divided into three main themes, guidance, support and learning. These themes are comparable to the work of Boud et al., (2001) in regards to the needs of people undertaking a work based learning programme of study. They suggested these were contributory factors to the success of any programme of study, which also includes midwifery. The studies reviewed support these themes and can be related to the following categories: i) the application of theory to practice (Currie, 1999; Begley 1999; Licqurish, 2007), ii) adjusting to a new learning environment, (Begley, 1982; Cavanagh and Snape, 1997; Chapman and Orb, 2000; Arbon, 2004; Sharif and Masoumi, 2005; Cavanagh and Snape, 1997; Lange and Powell-Kennedy, 2006; Moseley and Davies, 2007; Armstrong, 2010), iii) development of new knowledge and skills (Cavanagh and Snape, 1997; Thompson et al, 2001; Spouse, 2003; Hascher, 2004; Baird, 2007; Finnerty et al, 2006; Armstrong, 2010). Even though the themes have been subdivided they are all interrelated. I will demonstrate this in the following discussion.

i) The application of theory to practice - students' experiences of learning to apply theory to practice

The phenomenon of learning is dependent on human motivation and actions that are influenced by what people perceive to be real, as consciousness gives meaning to experiences (Valle, 1997; Lopez and Willis, 2004). Humanist educational theorists and phenomenologists suggest that lived world experiences provide opportunities to process modalities of self-world relationships, enabling meaning to occur (Van Manen, 1990; Valle, 1997; Reece and Walker, 2007). Within the ontology of reflection, a retrospective process occurs. The students' lived world experiences give value and support to their cognitive approach to learning. Not all students are the same, and entering the world of higher education may cause the students to reflect on their past learning styles. Their previous experiences may not support the requirements of the study skills necessary for degree level. This can cause much doubt regarding their abilities to succeed (Kolb, 1984; Reece and Walker, 2007). The epistemological framework of the nursing and midwifery curricula is quite prescriptive in terms of learning theory (NMC, 2009; NMC, 2010). It is often viewed as a combination of cognitivist, behaviourist and humanist approaches to learning.

For the students, learning in these three domains does not occur in isolation, it is a combination of all three. For example, a behaviourist approach looks at the step by step instruction which may be needed for the acquisition and development of psychomotor skills when learning to care for someone. When combined with a humanist strategy, the students' needs, strengths and challenges are identified. This supports their skill development and provides an understanding of how to apply theory to practice allied to instrumental conceptualism (Bruner, 1966; Reece and

Walker, 2007). The addition of Maslow's (1970) motivational theory and hierarchy of needs would add a humanist approach enabling the students' to identify areas for personal development. This would support the student in their learning (Dewey, 1939).

Learning is progressive in nature. Dewey (1939) maintained that all experiences accumulate in some form of learning, many of a positive nature. Intentionality of their lived experiences may present many challenges to students, as learning to care for someone else can be difficult. Their self awareness may impede their learning (Licqurish and Seibold, 2008).

A small grounded theory study undertaken by Licqurish and Seibold (2008) explored students' experiences of achieving competence in clinical practice. The study was undertaken in Australia where the mentorship system is different to that of the UK; a preceptorship approach was revealed. The students were all based in their final clinical placement, this could account for the small number of students in the study. There were no discussions on the original number of students in the cohort. Their approach to grounded theory was confusing, as they described the use of in-depth interviews at pre and post experiences of the placement. This is more in keeping with a comparative study as opposed to a qualitative grounded theory approach, as developed by Strauss and Corbin (1967). They also revealed they approached the data collection and analysis as a constructivist approach using their own interpretations of the data. There was no evidence of the involvement of the students in subsequent interviews to ground the data to produce new knowledge. This presents as a flaw to the study, it also questions the validity of the results. The

findings did however reveal 6 themes, of which they chose to discuss the theme *working with midwives*. The findings in this category stated there were *helpful and unhelpful midwives*. Helpful midwives provided students with the opportunity to explore their learning and use their theoretical knowledge to develop their clinical knowledge and skill. Unhelpful midwives were described as poor role models who did not allow the students to take control of their clinical learning. This impacted on their care they provided to the women. The findings of this study are supported by Bluff and Holloway (2008) who found different styles of mentorship in the UK affected students learning. The issues raised in the research impact on students' learning, the aims of my research are linked to the students' experiences of working alongside midwives.

The students' experiences highlighted their behavioural pedagogic need to be cared for by their mentor (Licqurish and Seibold, 2008). This can be argued, is a natural desire in a new environment, a possible desire for the process of operant conditioning and instrumental conceptualism (Fontana, 1995). The findings of the study by Licqurish and Seibold (2008) would have presented a more balanced view had they included the mentors' perspectives on the support they gave to the students. A recurring theme in this and other qualitative studies was a need for encouragement. This can be related to a desire for support from their mentor in order to instil confidence in their learning and development (Fontana, 1995; Begley, 1999; Currie, 1999). It could also support their behavioural cognitive and affective development. The data also revealed that the lack of support and negative criticism is one of the contributing factors for the attrition rates in midwifery and nursing (Begley, 1999; Currie, 1999; Licqurish and Seibold 2008).

- **Students experiences of learning in the work place**

Within phenomenology experiences are explored as a whole emotion, perceptions, cognition and language. These are acknowledged as intrinsic to the lived experience (Van Manen, 1990).

‘All phenomenological human science research efforts are really explorations into the structure of the human life-world, the lived world as experienced in everyday situations and relations. Our lived experiences and the structures of meanings (themes) in terms of which these lived experiences can be described and interpreted constitute the immense complexity of the life-world’ (Van Manen, 1990 p101)⁸

Therefore, exploration of the students’ experiences may reveal conflict between academic and practical knowledge which can challenge their learning depending on their previous lived world experiences (Begley, 1999; Begley, 2001; Boud and Solomon, 2001; Licqurish and Seibold, 2007). It has been acknowledged that many students have previously struggled with their new life-world due to these new experiences, which were initially extrinsic to their Being.

Intentionality of the students’ learning as suggested by Kolb (1984) promotes an ontological focus that supports the students to reflect on their lived experiences of teaching. It offers a process of analysis to their learning that can be related to their learning and development in the application of theory to practice. Experiential knowledge gained within each clinical placement can promote a process of reflection

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as part of their framework of students' framework of learning, thereby increasing their knowledge and confidence (Kolb, 1984; Licqurish and Seibold, 2008).

- **Possible dissonance in applying theory to practice**

A small quantitative study using a survey approach was undertaken by Lange and Powell-Kennedy (2006) to explore students' perception of midwifery practice; ideal and actual. The study used a mixed methods approach to gain descriptive data about the programme of study and the location of their practice. They did not identify which qualitative methodology they used for that part of the study, this presented a flaw to the study. The survey targeted newly certified post-registration nurse-midwives in America. The survey consisted of a questionnaire containing three broad questions, which identified 39 variables. There was some confusion regarding the approach to the survey as the researchers used an unpublished *framework of midwifery care based on a Delphi study* (P 73) used in another study. This, questions the value of the survey, as there were no indications this framework had been validated for its use in this study. The findings may in fact mirror the findings from the original study. Therefore, the validity of the results can be questioned. The findings of the quantitative arm of the study were presented in tables and discussions. There was little in-depth evidence of qualitative analysis or use of verbatim quotes to support the findings from the qualitative data. This questions the validity, authentication and trustworthiness of the study and its findings. However, they did find that in relation to their study there exists a theory-practice gap.

'The theoretical knowledge may seem to the student or new practitioner to have little relevance to the actual applied part of the curriculum, which deals with everyday complex and unpredictable events. This common educational

approach can lead to disparity between learned theory and clinical practice, referred to as theory-practice gap' (Lange-Powell-Kennedy, 2006 p71-72)⁹.

The findings revealed that occasionally the ward activity impacted on the mentor's ability to spend time with the student (Lange and Powell-Kennedy, 2006). This supports the work of Begley (1999) and Currie (1999) who also found that the ward activity affected students' learning. There was a lack of synthesis of theory to practice as students were left on their own (Lange and Powell-Kennedy, 2006). This is particularly relevant to my study, as the students are placed in practice to learn the skills of the midwife.

Previous quantitative research by Rolfe (1996) suggested that students take abstract knowledge into the clinical area. It was acknowledged that cognitive learning offered support to the development of psychomotor skills. Both Rolfe (1996) and Lange and Powell-Kennedy (2006) discovered there was disparity between what was actually practiced by the mentor and what the students had been taught. Therefore, it can be argued that the phenomenon of the theory-practice gap is not new. It has been suggested that being in the world of NHS Trusts may expose students to possible inconsistencies in care practices. Learning alongside different mentors may impact negatively on their learning (Rolfe, 1996; Lange and Powell-Kennedy, 2006).

ii) Adjusting to a new learning environment

Historical chronology of the development of the education of nurses and midwives suggested it has developed over time from a pre-technocratic model to a

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technocratic model of education within a university, thus separating the physical locations of theory and practice (Chapman and Orb, 2000; Freshwater and Stickley, 2004). However, current education remains within a WBL environment. This juxtaposition may cause much turmoil as the demands of the university structure mean it is no longer sufficient to be just fit for practice at the end of the degree programme of study. Students must also be fit for award in order to graduate from the university (Chapman and Orb, 2000). This has prompted much debate in regards to the need for nurses to be more self-aware and reflexive on the quality of care provided.

Previous discussions regarding nurse training focused on the acquisition of skills that ensured the nurse was fit to practice. Cognitive learning and psychomotor development were taught separately by the teaching of propositional knowledge in the classroom and practical knowledge in the ward environment (Freshwater and Stickley, 2004; Sharif and Masoumi, 2005). The students' lived experiences of becoming a nurse focused on meeting competencies and standards. This has previously been referred to as an essentialist form of education, whereby the student was trained to be fit for practice at a service level (Freshwater and Stickley, 2004). These competencies and standards were defined by the nursing and midwifery governing bodies of the day (Chapman and Orb, 2000; Freshwater and Stickley, 2004)

Within the humanism educational theory it can be argued that the use of emotional intelligences within the curricula supports the transformative model of education, suggesting nurses and midwives are more self-aware of their emotions (Bines and

Watson, 1992). Some qualitative studies highlighted the need for support for students leaning to care within the work place (Cavanagh and Snape, 1997; Chapman and Orb, 2000; Begley, 2001; Arbon, 2004; Sharif and Masoumi, 2005; Lange and Powell-Kennedy, 2006; Moseley and Davies, 2007; Van der Putin 2008). Previous qualitative studies suggested not all students had developed the instinct to provide care. Lacking in the perception of empathy led to an inability to acknowledge the care needs of patients (Bines and Watson, 1992; Freshwater and Stickley, 2004). There appeared to be an expectation that they would instinctively know how to provide holistic care. The students' interpretations of their abilities revealed a lack of cognitive development as their instinct to care did not coalesce with their knowledge, as they lacked psychomotor skills (Begley, 2001; Sharif and Mousami, 2005).

A large qualitative study by Sharif and Masoumi (2005) was undertaken to investigate nursing students' views about clinical practice in Iran. Normally qualitative studies have small numbers of participants and this could be seen as a flaw as the amount of data to analyse would be huge. There was no discussion on the type of methodology used; this questions the validity of the study and the findings. The data were collected using focus groups interviews. These were quite prescriptive as there were 9 subjects identified to guide the interviews. Such a strict schedule of questions suggested there was a hidden agenda for the rationale for this study. This was revealed in the conclusion, which implied a review of clinical placements was in progress; hence the vagueness of the methodology. Therefore, it is questionable whether this was a true piece of research or a planned exercise to support the necessary changes that were already in place. The results of the study will have had

little significance to the planned changes, but the researchers stated they used content analysis as discussed by Graneheim and Lundman (2004). This resulted in 4 themes which were identified as; *initial clinical anxiety, theory-practice gap, clinical supervision and professional role*. The trustworthiness and authenticity of the findings can be questioned, but the themes are similar to those of previous studies discussed; students need support in their learning in practice.

The students' narratives did reveal an overwhelming embarrassment during their initial engagement with someone who was sick or dying. The students were astute in recognising their lack of knowledge and skills. Their reflections revealed an inability to recognise the patient's needs (Sharif and Masoumi, 2005; Chapman and Orb, 2005). The students experienced a transformative process. Communication with other team members was initially difficult but their new identity appeared to enable a new socialised being that did not relate to their previous life-world (Moseley and Davies, 2007). This phenomenon impacted on their adjustment to their new hospital working environment as their interpretations revealed a naivety regarding professional relationships. There was an acceptance that being a student nurse was a time for adjustment and personal change (Eraut, 1994). The phenomenon of caring for the sick / dying was a new experience for some students. Meeting new people and learning to work in a new environment appeared to be overwhelming. It was suggested that this period of adjustment brought the students many challenges, which they had not anticipated. The students' desire for support in their learning in practice from their mentors was overwhelming (Bandura, 1977; Begley, 1999; Currie, 1999; Sharif and Masoumi, 2005; Licqurish and Seibold, 2008).

A Husserlian phenomenological study conducted by Chapman and Orb (2000) explored the students lived experiences of clinical practice In Australia. The number of participants was appropriate as these facilitated interviews with *repeated contacts*. There was little discussion about the types of interviews undertaken or what was meant by repeated contacts. Further clarification of the approach would have supported the trustworthiness of the results. The data were analysed using Colaizzi phenomenological method as described by Streubert and Carpenter (1995). The researchers commented that there were several themes to emerge from the data but they only discussed three. There were described as; *clinical practice: the real world, enhancement in learning and hindrance: what makes clinical harder*. The findings revealed clinical practice did enhance the students' learning as it enabled them to link theory to practice. This is in contrast to other studies which have revealed this can be a problem within the UK. There was no discussion on the types of clinical placements the students encountered, which presents a flaw to the study. There was no opportunity to compare their exposure to practice with the students in the UK.

- **Students lived experiences of being mentored**

The philosophy of mentorship has evolved over time along with the education of students (Lange and Powell-Kennedy, 2006). It has been suggested that the phenomenon of mentorship encapsulates a humanism hermeneutic cyclical approach. Licqurish and Seibold (2008) revealed that teaching and learning is only one part of the WBL structure in nursing and midwifery. There is also a need to provide holistic support for the students. They suggested it involves a process of understanding the student within an ever changing environment. Exploration of previous learning and achievements enables the student and the mentor to reflect on

future learning needs (Rolfe, 1996). Previous studies revealed working in an NHS Trust presents many problems for students as the work place dynamics can impact on students' learning. These can include the type of environment and the everyday activities of an NHS Trust ward and the type of mentor (Begley, 1999; Currie, 1999; Richens, 2002; Bosanquet, 2002; Curtis et al., 2006). Patients are admitted and discharged on a regular basis and each will have different needs. There is a constant need for reflection on the students' position within their learning (Boud and Solomon, 2001). These issues I will explore with the students in my study, to gain their experiences of being a student midwife

Many policies and guidelines direct care and this epistemological knowledge must be shared. The ontology of knowledge suggests an interaction between tacit and explicit knowledge, which enables the student to develop (Ortiz Levered, Baragano, Sarriegui Dominguez, 2003). A cyclical approach to teaching and learning enables the students to reflect on their needs. This can support their future development of becoming qualified nurses and midwives (Kolb, 1984; Boud and Solomon, 2001; Boud and Solomon, 2001; NMC, 2009; NMC, 2010).

- Difficulties experienced while being mentored within a Trust

There has been previous qualitative research which highlighted gaps in the students' knowledge that often impeded their ability to develop and adjust to the new learning environment of the clinical areas. Not all the research concentrated on the inadequacies of the students. Mentors also struggled to cope with the juxtaposition of mentoring students and meeting their contractual obligations of working within an NHS Trusts. Many experienced difficulties managing their time and this gave them

much stress (Cavanagh and Snape 1997; Chapman and Orb 2000; Begley 2001; Arbon 2004; Sharif and Masoumi 2005; Lange and Powell-Kennedy 2006; Finnerty et al., 2006; Moseley and Davies 2007; Van der Putin 2008).

A small multi-methods case study was undertaken by Finnerty et al., (2006) to explore mentors experiences of supporting student midwives in practice. The study was undertaken across five sites in England, they recruited 19 mentor / student pairs. The data collection process presented some confusion as they interviewed Lead Midwives for Education, Heads of Midwifery and Link Tutors. This group of midwives did not mentor students. There was no rationale why they were included in the study; this presented a flaw to the study design. The data collection encompassed, initial interviews, the use of diaries, observations and exit interviews; these were undertaken with the mentor/student pairs. There was no discussion on the involvement of the others in the data collection. This can impact on the validity of the findings. The researchers presented five topics for discussion, these included: *preparedness, managing the learning, assessing practice, support, micro-support and a positive model for mentorship*. The discussion was based on verbatim quotes as the foundation. The findings revealed mentors enjoyed teaching students. At times the work-load impacted on the ability to support students. Some viewed the role as an addition to their already busy shifts which impacted on their working lives. The influence of being a role model was seen as a powerful position, this was described as a student shadowing or echoing their mentors. This was also found in the study by Bluff and Holloway (2008). They revealed mentors had much influence over students learning, which was either supportive or not. The historic study by Darling (1984) suggested there were three main components that made up a good

student-mentor relationship. These were described as *attraction*, *action* and *affect*; all these must combine to support students' learning. Considering the basis of these components there must be development of a partnership that is productive and sustained. This type of support enhances learning on the students different levels of support and depending on their learning style. The study by Bluff and Holloway (2008) suggested some midwives used the students to update their knowledge, which may be a haphazard approach to study. The study presents a positive approach to mentoring students but it was acknowledged that having a student on a busy shift did impact on getting through the work.

Qualitative research by Van der Putin (2008) highlighted the naivety of some midwives during the transition stage from student to newly qualified midwives. The data suggested they felt unprepared for the expectations of working as a midwife within a hospital Trust. This can be related to the work of Hobbs (2012). Van der Putin discovered the phenomena of being a midwife held much disappointment as the role of the midwife did not meet their expectations. Her study revealed newly qualified midwives missed the support mechanisms, which were in place during their training. Being a qualified midwife brought much pressure as the demands of the work-place became diverse. The juxtaposition of providing appropriate care to the women and meeting the needs of the students was overwhelming. These phenomena were supported by the work of Begley (2001) and Moseley and Davies (2007) who suggested at times there were too many students allocated to one placement area. The students were often left to work alone. The research highlighted the diversity within the students' levels of knowledge also impinged on the mentors' abilities to adjust to the students' learning needs on a busy ward.

A survey conducted by Moseley and Davies (2007) explored mentors attitudes to their role and also what they found easy or difficult. There were two methods of data collection a Thurstone scale and two 7 point Likert scales. The rationale for their use was defended well by the researchers. The Thurstone scale contained 14 statements; a tick box format was used to indicate agreement. The results were presented in tables and in the discussion. The Likert scales were designed to try to discover the rationale for their choices from the results of the Thurstone scale; a positive or negative experience. The method of data collection at first appeared quite intense, but on further reading and analysis, it did become clear. I found this supported the trustworthiness of the findings. The article appeared as a report with no literature review on the topic of mentorship. This does not provide the reader with any background information. It reduced the rationale for the study, as they stated two *common impressions* (p 1628) were the impetus for the study. These were based on the mentors' satisfaction with the role. The survey was relatively small, but from the targeted group the uptake was high. Therefore, the results could not be generalised as the sample was not randomised. This can also question the validity of the results. The findings were mixed as some mentors were not happy with their role as mentor. They found that mentors struggled with the cognitive part of their role. This was related to providing feedback on students' performance, keeping up to date and assessing students' knowledge and performance. As a hermeneutic phenomenologist I needed to deconstruct their method section and study how the survey was constructed. Other quantitative researchers may find it easy to understand. The survey presented useful information regarding the views of mentors in this study. The aims of my study will explore the students' experiences of learning in an NHS Trust, where they will meet different mentors.

The study by Moseley and Davies (2007) highlighted how the lack of focus on the students' learning needs impacted on the students' abilities to communicate tacit knowledge. They used vague and inappropriate language when the needs of the patients were acute. Their lack of cognitive knowledge and poor communication skills brought serious delays in the administration of emergency care for patients. This resulted in added pressure and stress to the mentors. It also had an adverse effect on the mentors as many reported feelings of tiredness and frustration (Moseley and Davies, 2007).

- **Supporting students to adjusting to a new learning environment**

The research already discussed, revealed students completed their clinical education under the guidance of different mentors (Finnerty et al., 2006; Moseley and Davies, 2007; Bluff and Holloway, 2008). It has also been revealed that the students lived experiences of guidance and support can vary as they progress through their training. This may not necessarily support them as revealed by Currie (1999); Begley (1999) and Licqurish and Seibold (2008). Being in the world of a student needs to provide an intentional structure to their horizon of meaning. Providing focus to their learning can impact on how the students learn (Mulhall, 2005).

A Husserlian phenomenological study conducted by Chapman and Orb (2000) explored the students lived experiences of clinical practice In Australia. The number of participants was appropriate as these facilitated interviews with *repeated contacts*. There was little discussion about the types of interviews undertaken or what was meant by repeated contacts. Further clarification of the approach would have

supported the trustworthiness of the results. The data were analysed using Colaizzi phenomenological method of analysis as described by Streubert and Carpenter (1995). The researchers commented that there were several themes to emerge from the data, but only discussed three. There were described as; *clinical practice: the real world, enhancement in learning and hindrance: what makes clinical harder*. The findings revealed clinical practice did enhance their learning enabling the students to link theory to practice. This is in contrast to other studies which have revealed this to be a problem within the UK. There was no discussion on the types of clinical placements the students in the study were placed in, which presents a flaw to the study. There was no opportunity to compare their exposure to practice with the students in the UK.

Students enter the world of midwifery to discover their horizon is focused on their interpretation of the phenomena and structure of the midwifery curriculum. This directs their life-world for the duration of their programme of study (NMC, 2009). The students' intentionality of their experiences can be an ever changing concept as they progress. Students' interpretations of their experiences from research in nursing revealed many phenomena (Cavanagh and Snape, 1997; Chapman and Orb, 2000; Lange and Powell-Kennedy, 2006; Moseley and Davies, 2007). The students suggested it was a difficult world to traverse as disparity existed between the students' and mentors' philosophy of teaching and learning. There was an expectation that they would adapt their mode of learning to suit each mentor. This will be interesting to explore in my study, as the existing literature revealed this caused much stress to the students as their learning needs were not met (Rolfe, 1996; Lange and Powell-Kennedy, 2006).

Evans and Allen (2002 p42) in their reflective writing suggested students should be taught how to develop emotional intelligences in order to support their learning needs. They advocated it was the mentor's role to facilitate the students 'from pre-contemplation to maintenance', which has been referred to as a behaviourism approach to change. It can be argued that the role of the mentor is to support the students and help them to develop their potential as individuals (Bruner, 1966; Curzon, 2004; Reece and Walker, 2007). The previous studies discussed have revealed this can be difficult (Cavanagh and Snape, 1997; Begley, 1999; Currie, 1999; Chapman and Orb, 2000). Educational philosophy has suggested a transformation only occurs in the student when the adaptation of teaching styles offers diversity for success (Gopee, 2008). There must also be parity between teaching and learning (Dewey, 1939; Hascher et al., 2004). Focusing on the life-world needs of each student also requires a deconstruction of the many pedagogical approaches to teaching and learning (Gopee, 2008).

In midwifery pregnancy and birth are considered to be a continuous physiological process but the medical model of care separates it into various stages: antenatal, intranatal and postnatal care (Tew, 1995). The students learning can then be subsequently divided into these categories, which provide a limitation to their developing knowledge. This approach to care can also impede some students' style of learning and their relationship with their mentor (Tew, 2007; Baird, 2007; Gopee, 2008). The research revealed not all mentors supported women's choice. The majority of midwives work for NHS Trusts, policies and guidelines direct how they provide care (Bosanquet, 2002; Nicholls and Webb, 2006). This may not provide the students with an alternative approach to care as suggested by Tew (1995).

Mentors should also be aware of their learning style; this supports their reflection on learning and teaching (Gopee, 2008). The philosophy of education requires a process of adaptation to each student's ways of learning. Learning can only occur when the mentor takes a pragmatic approach to discovering the needs of the student (Hascher et al., 2004). Hascher et al., further revealed that learning can only occur when the tri-partite relationship between the mentor, student and curriculum is good. The students in my study are part of this type of partnership; I will explore their experiences throughout their programme of study. It was found by Moseley and Davies (2007) that some mentors had difficulties understanding the cognitive processes of learning and assessment. The students in my study could be exposed to this type of mentor which may expose them to an apprenticeship approach to learning. It will be interesting to explore their experiences. Engaging with the pedagogical requirements of the curriculum suggests a principled mentor (Gopee, 2008). The ontological focus of being in the world of a student midwife or student nurse requires utilisation of formative and summative assessments. Its focus is on a constructive approach to achieving success within the confines of the curricula (Finnerty et al., 2006; NMC, 2009).

- Adjusting to a diverse cultural learning environment

The philosophy of work based learning does not only focus on the application of abstract knowledge to practice. Learning to be a member of a social group requires knowledge of language used and also existing customs and practices (Spouse, 2003). The study by Bluff and Holloway (2008) explored the phenomenon of role modelling. Their results revealed two types of role models that can influence the future practice of students upon qualification. The phenomenon of socialisation

suggests it is more concerned with group identity and an evolving self image as a member of the community. The study by Bluff and Holloway revealed that working in a Trust exposed students and some midwives to horizontal bullying, which restricted their practice. Therefore it can be suggested that role modelling can have a negative impact on students and midwives. The study by Hobbs (2012) also found that newly qualified midwives were possibly coerced into conforming to some midwives ways of working.

It can be proposed that the Trusts imposition of the wearing of a nurse uniform is a form of oppression. All nurses and midwives wear the same uniform as do student nurses and student midwives. The study by Kirkham (1999) revealed phrases such as *service and sacrifice* and referred to midwives as an *oppressed group*. These phrases can be viewed as either authoritarian symbols or as the uniform of the oppressed under the direction of the medical profession. Spouse (2003) suggested that students are expected to learn and adopt behaviours, language, dress and modes of thought that are characteristic of the group. This can support their student membership within the Trust workforce, but not necessarily within their profession, as many student midwives and student nurses wear the same uniform. It can be argued that these aspects are intended to maintain homogeneity and create a shared identity. New members of the group are faced with the choice of conformity or risk being cast as an outsider resulting in rejection. For some students their uniform did indicate their level of learning. Spouse also revealed informal interactions with their own peers from different year groups resulted in craft knowledge being passed from student to student, which was not necessarily researched-based practice.

The process of imitation within the theory of operant conditioning can reveal self-gratification but not necessarily a true form of learning. Mazur (1994) suggested this was often related to task orientated learning, which had limited value to the students. The mentors and students place great value on gaining experience of the cultural knowledge of the ward whilst on clinical placement, a form of reciprocal determinism. This was particularly relevant during the first few days or weeks of their placements (Bandura, 1977; Finnerty and Pope, 2005).

The qualitative research study by Finnerty and Pope (2005) explored non-formal learning from a sub-group of students from a national study (Pope et al., 2003). The original study contained 19 student-mentor pairs; they presented the findings of three students taken from the main study. The methodology was a multi-methods case study design. These included a review of the original interviews, non-participant observations and diaries. There was some confusion as the diaries were later described as audio diaries which the students used to record their learning experiences at the end of each span of duty. These entries were guided by set criteria which focused on learning and support. The researchers used discourse analysis to explore the language the students used, which they describe as the action nature of language (Wood and Kroger, 2000). The researchers used a sub-group from the original recordings to analyse the findings. This was focused just on the audio diary entries by the students. This could be seen as a duplication of the original study, which may not offer new knowledge in respect of students learning. The two authors were part of the original research team so had access to the material. Duplication of research studies can cause ethical dilemmas, as the issues of authentication and ownership of the results can highlight copyright issues

(UKCCS, 2014). There was no discussion regarding group authorship permission to use the data. The research presents four themes of analysis; fear, crowded contexts, implicit monitoring and metaphors. These were interpreted as fear - past experiences can block learning, crowded contexts – a feeling of intruding and being self-absorbed, implicit monitoring – relating theory to practice, metaphors – to alleviate moments of stress. The results of this study cannot be generalised, but it does highlight how students view their presence in clinical practice and the effects it has on them. These findings can be related to the aims of my study as I will explore the students' experiences of clinical practice. The researchers also found that the transfer of craft knowledge from mentor to student was a subtle form of learning, which supported the findings of Spouse (2003). The discussion suggested students were exposed to ambiguity in practice.

The study by Finnerty and Pope revealed students experienced mixed feelings regarding their role within the clinical placement. They suggested the aim of the initial practical experience was to reduce the phenomena of fear and self-consciousness, to being self-confident and knowledgeable as they became familiar with their role and expectations (Eraut, 1994). It can be argued that familiarity with their role of being a student enabled their perception of the process of socialisation to begin. It can also be suggested that they gained social capital and status as they progressed through their programme of study (Bandura, 1977; Finnerty and Pope, 2005). This can be related to my study as I will explore the students' experiences as they progress through their programmes of study.

- **Possible tensions experienced by students**

Phenomenological research regarding nursing and midwifery education stated there was much tension experienced by the students as they were in the juxtaposition of undertaking a university course of study and working within a hospital Trust. This made heavy demands on their time as the Trusts operated a 24 hour shift system, which the students had to engaged with to fulfil the NMC practice based requirements (Cavanagh and Snape 1997; Thompson et al., 2001; Spouse, 2003; Hascher et al., 2004; Baird 2007; Finnerty et al., 2006; Armstrong 2010). Spouse, (2003) and Finnerty et al., (2006), suggested many students' experienced feelings of self doubt, anxiety, vulnerability and stress as they had difficulties identifying with the role of a university student. The demands of the clinical environment took priority over their studies. They suggested the focus of their learning was on the attainment of psychomotor skills within clinical practice which demonstrated their dexterity and competence in performing clinical tasks. This they equated to the possibility of ultimate success and the achievement of pleasing their mentor (Spouse, 2003).

This can be related to Skinner's teachings on the operant conditioning process of seeking reward (Skinner, 1972; Fontana, 1995). The data suggested that many students demonstrated much doubt regarding their ability to remain on the course of study due to the impact this had on their private lives. They also reflected on their ability to apportion time to the development of their cognitive learning as the shift system afforded them very little time to study (Cavanagh and Snape, 1997; Finnerty and Pope, 2005).

The small mixed method study was undertaken by Cavanagh and Snape (1997) explored stress factors in midwifery education. The sample consisted of pre-registration midwives, from both long and shortened midwifery courses. The method of data collection was a questionnaire and interviews. The questionnaire was quite long and contained 45 questions. This was developed from the literature reviewed. A small sample of students was interviewed regarding stressful situation, both in college and practice. The researcher did not state the rationale or the aims of the research which questions the authenticity of the study. A psychometric test, in the form of a Likert scale, was used to gain opinion. It can be argued that this form of research is more in keeping with a survey, which generates a collective opinion (Cluett and Bluff, 2000). The length of the questionnaire can be criticised as it would be quite time consuming to complete, thus adding to the students stress. The qualitative arm of the research and the results were not discussed or presented. The quantitative results were presented in six tables with discussion around the findings. This questions the validity of the result as not all the findings were discussed. The results could not be generalised, but it does offer some insight into the lives of students. This is appropriate to my study, as the aims are to investigate the students' experiences of becoming midwives. The study did reveal that stress plays a major part in students' lives both in the organisation of their learning and the impact it has on their private lives. This study has highlighted how the adjustment to being a student midwife is a difficult one to navigate.

iii) Development of new knowledge and skills

Educational theorists have suggested the experienced phenomenon of learning is different for each student (Bloom, 1956). Students' lived experiences of being

mentored presents some challenges. Being in the world of WBL places them in a juxtaposition of teaching styles. There may be some inconsistencies in their approach to learning. The students' ontological knowing supports their contemporary practice, but a lack of cognitive being can promote a traditional apprenticeship style of working, which manifests itself as surface learning (Bigge and Shermis, 1999). Previous qualitative research suggested inconsistencies to teaching and learning existed (Cavanagh and Snape 1997; Thompson et al., 2001; Spouse 2003; Hascher et al., 2004; Finnerty et al., 2006; Baird 2007; Armstrong 2010). A recurring theme within these studies suggested students' experienced poor support from their mentors. Due to fear of reprisals and possible failure of the placement, the students preferred not to challenge their mentors (Thompson et al., 2001; Armstrong, 2010).

A small survey by Armstrong (2010) explored whether final year students were influenced by their mentors traditional ways of working. The researcher offered three hypotheses but no null hypotheses; this could indicate a bias to the study. The method of data collection was a questionnaire which contained 15 questions; open and closed. These were subdivided into four factors; these could be viewed as directive, as they divided learning into two separate categories; practice and HEI. There did not appear to be synthesis between the two. This calls into question the validity of the results and the trustworthiness of the data collection tool. The students were required to complete a Likert scale, similar to that of Cavanagh and Snape (1997). The participants were from two cohorts of study; 3 year degree and 18 months shortened course. Therefore, there was an equality in midwifery experiences, as some students will have a background in nursing. They will have brought this experience to their studies. Therefore, the validity of the findings can be questioned.

The findings were clearly presented in two tables. The abstract indicated a quantitative approach to the research; in fact, it was a mixed methods survey. Transparency of the methodological approach was not evident. There was no discussion which methodology was used to interpret the data for the qualitative arm of the study. This demonstrates a flaw to the research approach. The findings revealed that mentors influenced students learning in practice, as they controlled how the students practiced. Students felt powerless to try and use research in their practice for fear of reprisals. As this was a small study the findings could not be generalised. It does offer insight into students' experiences of learning in practice. Further research is needed to explore students' experiences throughout their programme of study, which my study will explore.

The philosophy of mentorship is to support the teaching and guidance of all students. Many students view their mentors as role models whom they wish to imitate (Mazur, 1994; Hascher et al., 2004; Bluff and Holloway, 2008). Supporting the students' development can enable the mentors to reflect on their own ontological being. Hascher et al., (2004) found that learning was multifaceted. It was dependent on the curriculum, the student and the mentor enhancing a form of reciprocal determinism.

The study by Hascher et al., (2004) focused on student teachers' experiences of support from their mentors during their course of study. The study was undertaken in Switzerland. It was a small mixed method study and consisted of questionnaires and reflective diaries. The keeping of a diary enabled them to write about their learning experiences. This is similar to my study, as I will encourage the students to maintain a reflective diary to document their experiences throughout their course of study. The

differences between the two methods of keeping a diary is Hascher's et al., participants were directed on what to write such as *please describe today's learning situation in your own words*. There were other directions given regarding the school children's' behaviour whom the participants taught. This appeared to be controlling and gave the impression of a set of objectives to be completed. This is not the primary focus of a reflective diary as discussed by Berg (2009). This can affect the authenticity of the findings, as the students will be obliged to complete the questions. The students in my study will be encouraged to reflect on their experiences of their learning and document what is appropriate for them. This will support the trustworthiness and authenticity of my study. The quantitative part of the study by Hascher et al. was described as a comparative study, but this was not stated. The students completed a pre and post experience questionnaire which tested their perceptions of their knowledge and experience before and after the teaching session. Even though the focus of this study was on teacher training, the findings were interesting. The student teachers were given a mentor to support them in practice, just the same as students in NHS Trusts. The students valued the time spent in practice and suggested this would prepare them better for future work. This supported the work of Spouse (2003). They also experienced the phenomena of the theory-practice gap as described by Lange and Powell-Kennedy (2006). The findings also revealed that their learning was affected by the type of mentor they worked with, which is similar to previous studies discussed. The focus of this study was on student teachers' learning in practice. This is only one part of students learning experiences. My study will explore their experiences in a tri-partite relationship, throughout their course of study.

Considering the findings of these studies many worrying themes have emerged from the data. Many students do not receive the support they need to sustain their learning. The focus should be on supporting their learning to achieve success (Jacob and Lavender, 2008). Research data reveals a need for a supportive humanism style of student-mentor partnership. Mentors need to be aware of the many different approaches to teaching and learning which accommodates each student's learning style. Traditional ways of working does not teach students to use research in their practice. Being in the world of a mentor needs to enable the ontological development of many attributes. Therefore, communication between the student and the mentor is a major factor in the process of teaching (Hascher et al., 2004).

It has been suggested that being in the world of a student facilitates a cognitive learning partnership to emerge. A contract of learning, which supports both the students and mentors, needs to be developed. Progress in the students' development is revealed in the form of instrumental conceptualism (Bruner, 1996). This is demonstrated when parity between cognitive and psychomotor development is revealed as the students learns to apply theory to practice. The students' learning should always be the focus of the experience. Progress also supports their professional affective development as the student is able to appreciate their professional role (Bloom, 1956; Kolb, 1984; Bruner, 1996; Ramsden, 2003; Hascher et al., 2004).

- The life-world of the mentor

The life-world of a mentor has been described as a teacher, observer, and guide (Jowett et al., 1994). Mentorship brings an acknowledgement of the existence of the

partnership between the mentor and the student's being, *zu den sachen* (to the things themselves) to the *Lebenswelt* (life world), to the experience of becoming a midwife. Being conscious of the students' new life-world within midwifery brings structure to the horizon of meaning. This in turn is grounded in structure and importance in their lived experiences (Mulhall, 2005). The connection between teaching and learning supports the correlation with the taxonomies of learning: cognitive, affective and psychomotor development within the student (Bloom, 1956; Lyotard, 1984; Kierkegaard, 1989; Jarvis and Gibson, 1997; Batchelor, 2006; Barnett, 2009). The life-world of the mentor operates as a guide for the students' offering pedagogic supervision. Previous studies have demonstrated this can be difficult (Cavanagh and Snape, 1997; Currie, 1999; Begley, 1999; Moseley and Davies, 2007; Licqurish and Seibold, 2008; Armstrong, 2010).

Within the life-world of a student midwife there are many horizons of meaning. The student becomes part of a hermeneutic cyclical process that constantly revolves around their learning. New information adds to their understanding of the existential world of childbirth. The student integrates new knowledge to the developing whole. Professional programmes of study, such as midwifery, necessitate the requirement of knowledge that informs clinical practice, each mentor should contribute to the phenomena of learning (Bruner, 1996; Hascher et al., 2004; Finnerty et al., 2006; NMC, 2010). Ontological reflection promotes the construction of knowledge and being in the world of a student promotes their development. A supportive mentor contributes to their progress (Daloz, 1986; Morton-Cooper and Palmer, 1993; Jarvis and Gibson, 1997).

2.11 Types of knowledge

Much educational research and theory has been developed in regards to the different types of knowledge. The pedagogic requirements of midwifery education place students within a university alongside their contemporaries. Knowledge within higher education has two distinct concepts, pure and applied. These theories divide knowledge into

‘The pursuit of knowledge for its own sake and the utilisation of knowledge and, between the creation and advancement of theory and its application’ (Henkle, 1988, p32)¹⁰.

These distinctions can be applied to any discipline which is able to identify its own structures and criteria. In midwifery it is recognised that abstract knowledge is taken into clinical practice and applied to maternity care (Hirst, 1972; Henkle, 1988). The epistemology of knowledge suggests knowledge can be created by the individual through their lived world experiences. This can be applied to midwifery as each student will observe their mentor providing care. It can be argued that each student will develop their own interpretations of what is tacit knowledge which will be based on their mentor’s actions. The study by Hunter (2004) revealed that the diversity of placements can have a major impact on the midwives work ethic. The study focussed on the diversity of community and hospital based practices. The students can also be exposed to different types of knowledge. Hunter related her study to *emotion work*, which was based on where the midwives in the study worked; hospital or community. The study found students learning was affected by the ideology of the

¹⁰ Permission to reproduce this excerpt has been granted by the Department Education and Employment

midwifery practiced by the midwife. This is relevant to my study as I will explore their experiences of their learning throughout their studies. Therefore the work of Hunter does question the process of gaining knowledge as this can be dependent on the placement and the midwife. Eraut (1994) suggested there are distinctions between propositional knowledge and process knowledge, which can be related to professional knowledge and competence.

Previously propositional knowledge has been differentiated into three forms. These were categorised as disciplinary based theories and concepts derived from bodies of knowledge; generalisations and practical principles of the professional field; and specific propositions about decisions and actions to be taken. It can be suggested in relation to midwifery that some propositional knowledge will already be publicly known regarding the role of the midwife in the care of pregnant women. Many students will enter the midwifery profession with some ideas of what the role of the midwife entails (Williams, 2006). Therefore, propositional knowledge will be enhanced as they progress through their course of study (Eraut, 1994; Baird, 2007). Therefore supporting the students to apply theory to practice enables knowledge to be processed, thus enabling the ontology of tacit to explicit knowledge (Ryle, 1949; Eraut, 1994; Brennan and Little, 1996).

The epistemology of knowledge in general terms has been demonstrated as truth propositions: rational logic, empirical, and pragmatic. Student midwives gain knowledge primarily through empirical knowledge that is research based. This supports the students learning and offers a pedagogical framework for the ontology

of abstract knowledge to be applied to clinical practice (Kelly, 1963; Scheffler, 1965; Heller, 1984; Lyotard, 1984; Jarvis, 1994).

2.12 Development of new knowledge and skills

Student midwives enter university from diverse backgrounds each will have developed their own style of learning. There are many causal issues that affect the development of individual learning styles. These have previously been thought to have developed over time with the formation of personal identity, maturity, previous learning experiences and with the nature of the subject to be learned. Dewey (1939) described a progressive process to inform learning which included accommodation, adaptation and socialisation. All these dynamics can impact on the future development within the students. Their learning styles initially direct how tasks are learned, utilising an interpretive and understanding process (Honey and Mumford 1982; Kolb 1984; Mezirow, 1990; Berger and Luckman, 1996; Hillman, 1996; Roesler, 2008). It has been suggested that the phenomenon of learning is a transformative experience which is related to feeling or thinking. Whereas grasping experience is related to doing or watching.

Previous educational theory states there are four main learning styles (Honey and Mumford, 1982). They have been classified as: activists who prefer to be involved in doing tasks, reflectors who prefer to observe and consider the situation, theorists who possess a need to understand theoretical reasons, concepts and relationships and pragmatists who prefer to experiment and discover new ways of doing things (Honey and Mumford 1982). The pedagogic structure of the midwifery programme of study can accommodate any of these learning styles due to the nature of WBL.

Students can experience a process of transformation which encompasses many aspects of a journey and each stage of the journey involves a process of adaptation, transformation and ultimately the acquisition of knowledge (Kolb, 1984; Bruner, 1996). Not all students learn at the same pace some will need extra support as they learn to adapt their learning styles (Honey and Mumford, 1982). Student midwives develop their knowledge and skills by gaining a quantifiable increase in knowledge during their experiences on clinical placements. This can be dependent on the support they receive from their mentors (Ramsden, 2003). Previous studies discussed suggest support is not always available (Cavanagh and Snape, 1997; Currie, 1999; Begley, 1999; Moseley and Davies, 2007; Licqurish and Seibold, 2008; Armstrong, 2010).

Kolb's (1984) theory on experiential learning provides a framework for reflective learning. He described four adaptive modes which he termed as concrete experience, reflective observation, abstract conceptualisation and active experimentation. He believed it was the connection between these four adaptive modes that enabled the process of learning to occur. Kolb believed the phenomenon of experiential learning had two distinct dimensions that needed to occur. These he termed as concrete experience/abstract conceptualisation, illustrated as grasping via apprehension and, grasping via comprehension. This theory supports active experimentation/reflective observation, transformation via extension and, transformation via intention. Midwifery students are placed In NHS Trusts to engage with the care of women. They need to identify their needs and provide the relevant care. With a supportive mentor this could provide active engagement with their learning. The process of reflection on / in practice enables the students to participate

in their learning. This constructivist approach to learning supports the students' cognitive being (Kolb, 1984).

2.13 Types of knowledge the students can experience

Four types of knowledge have been described: accommodative, divergent, convergent and assimilative. These structural dimensions underlie the process of experiential learning. Using a process of reflection a transformative step by step approach to learning is utilised to understand and learn from experience. The phenomenon of success is an accommodative process where each student is supported to identify their approach to learning and apply it when caring for pregnant women in the future (Honey and Mumford, 1982; Kolb, 1984; Begley 1999; Currie, 1999; Licqurish and Seibold, 2007). Previous research suggested that many students were exposed to an apprenticeship form of learning which would not support their development (Begley 1999; Currie, 1999; Licqurish and Seibold, 2007; Armstrong, 2010).

2.14 Bloom's taxonomies of learning applied to midwifery

Some midwifery curricula adopt Bloom's taxonomies of learning within their pedagogic framework. The students are expected to progress through each domain of learning, cognitive, affective and psychomotor, this provides the student with the knowledge, skills and values of the profession (Bloom, 1956). Following the concepts of Bloom's (1956) taxonomies of learning to become a qualified midwife the student must reach the level of internalisation of the values of the profession enabling a cultural change within the students (Dewey, 1939; Bloom, 1956; Spouse, 2003; Curzon, 2004). Considering previous research discussed, exploration of what is

meant by a cultural change in training to become a midwife is needed. Many studies have suggested that many students adopted their mentors' ways of working which were based on the demands of the NHS Trusts (Kirkham, 1999; Bosanquet, 2002; Hunter, 2004; Armstrong, 2010). I will explore this phenomenon as one of the aims of my longitudinal study is to explore the influences of the working environment on the students' experiences of becoming midwives.

(¹¹The image originally presented here cannot be made freely available via LJMU Digital Collections because of copyright. The text was sourced at <http://classweb.gnu.edu/ndabbagh/Resources/Resources2/bloomstax.htm>)

Table 1: The application of Bloom's Taxonomies of Learning within the complexity of work based learning (Bloom, 1956)¹¹

2.15 A process of self-development

Clinical experience is part of the development of the person as a whole, 'It impacts on our understanding of the Self in non-clinical situations as it does in clinical ones'

¹¹

(Arbon, 2004, pg 152). Life experiences the students bring to midwifery can influence how they approach their clinical learning. Students should not be seen as isolated individuals they are part of a wider social construct. Their understanding and meanings of situations is based on personal and social influences (Berger and Luckman, 1996; Hillman, 1996; Roesler, 2000; Arbon, 2004).

The process of 'meaning making' is complex. It involves the student re-formulating existing knowledge in order to make sense of new experiences. It is made up of two dimensions these are known as meaning schemes and higher order schemes (Mezirow, 1990). These must link for the process of learning to occur. Meaning schemes are made up of related expectations whereas higher order schemes such as theories, goals orientations and evaluations are meaning perspectives. Meaning perspectives are the product of structured assumptions that link past experiences with new experiences through the process of interpretation. These can include how objects or events are expected to be connected to each other (Mezirow, 1990).

Meaning perspectives are gained through cultural or stereotypical assimilation. These can be focussed upon self reflection bringing knowledge and understanding to the possibility for change or self development. These perspectives are accrued throughout life but usually during childhood within the process of socialisation. People learn through experiences which are usually reinforced through emotional contexts of learning such as praise or reprimand (Kelly, 1963; Rogers, 1977; Fontana, 1995). This is linked to my study as student midwives will experience a new culture that is based in an NHS Trust. For many this will be a new experience and my study will explore their experiences. The research previously discussed

suggested many students were exposed to stereotypical assimilation in the form of an apprenticeship form of training; surface learning (Hunter, 2004; Licqurish and Seibold, 2008; Armstrong, 2010). The philosophy of WBL suggests that students engage with the culture of midwifery and accrue further perspectives that support their learning. There was little evidence from the empirical studies reviewed to support this theory, which related to the students' relationship with their mentor and their approach to care. The research suggested not all students experienced support in their learning (Sutton and Arbon, 1994; Carberry, 1998; Hunter, 2004; Arbon, 2004 pg154; Armstrong, 2010). It has been revealed by Mezirow (1990) that experiences strengthen the structures of meaning through reinforcement whereas perspectives provide principles for interpreting meaning.

2.16 Acknowledging one's identity in order to learn

The process of 'becoming' should include primarily 'becoming oneself'. In order to become what you want to be self-realisation should commence with a process of self-reflection and acceptance of personal attributes and personality. This could be related to Bloom's affective domain as students learning should progress to encompassing the values of the midwifery profession. A descriptive qualitative study by Butler et al., (2008) revealed that on qualification midwives must have developed certain competencies. They described them as *being a safe practitioner, having the right attitude and being an effective communicator*. It can be argued that many students have two of these attributes on commencement of their studies. These will be dependent on their previous life-world experiences. The findings of the study suggested being a safe practitioner involved having the knowledge to provide effective care for the woman and her baby. The concept of safety can be seen in a

variety of ways. The study by Butler et al., suggested that a student was safe if she was deemed competent to pass her assessments. Considering the affective domain of learning there needs to be a change within the person. Their focus on the self must move to the focus on others. There must be an acknowledgement of who they are and a willingness to make the change. This transformation can only emerge when complimented by the cognitive and psychomotor domains. This is crucial in the process of becoming (Mezirow, 1990). The aims of my study focus on the students experiences of becoming midwives. I will explore with the students their experiences of their development. Kierkegaard (1989) and Batchelor (2006) suggested within this self analytical process the focus for change can start to emerge and direct future developments.

The pedagogic focus of midwifery training is on the care of pregnant women. The phenomenon of birth for some students can be emotionally challenging as the midwife's responsibility for the woman and the fetus/baby is huge. Within the framework of learning there must exist a process of re-evaluation of their own self-concept / constructs and definition of who they are as people and as students and also within a collaborative relationship with others (Mezirow, 1990). Past experiences within their own development may help to support their learning. Taking responsibility for someone other than themselves may be a new experience for some (Arbon, 2004).

2.17 Assimilation into the midwifery profession

Many people develop symbolic categories which can enhance or restrict learning. These symbolic systems represent so called ideal types which are projected onto

events through social interaction. These can be related to as observing the work of a knowledgeable caring midwife. This can provide the students with the desire to emulate the midwife's 'being' (Bandura, 1977; Mezirow, 1990). The study by Williams (2006) revealed many students entered midwifery for many reasons, some being altruism, a sense of inevitability, making a difference. It can be argued that these students categorised themselves with similar attributes they had seen in others. This categorisation of people is rarely performed in a dispassionate or objective manner. Their Previous life experiences may impact on their outlook on life. The process is often performed with reference to the self (Tajfel and Turner 1979; Abrams and Hogg, 1988). This was highlighted by Williams as some had experienced an alternative life-style that impacted on them. This can be classed as a subjective frame of reference process; people categorising themselves with others (Turner, 1985; Turner et al., 1987). This is pertinent to my study as I am interested in why the students wanted to become midwives. I will explore their experiences to discover if their subjective frame of reference lived up to their expectations. It can be argued that people who wish to become midwives assume all midwives are kind and caring which could be based on their own experiences.

Classifying others is often done on the basis of similarities and differences to the self. For many student midwives, group identity is important. On the other hand, this may cause turmoil as many desire the reputation of being an outstanding student, which can ultimately raise their profile above their peer group in order to secure employment as a midwife. This process of personal categorisation can also lead to a higher self-esteem which places the individual on a par with the in-group rewarding

the student with a sense of well-being and improved self worth (Tajfel and Turner, 1979; Turner, 1985; Turner et al., 1987; Abrams and Hogg, 1988).

2.18 Conclusion

This chapter provided an in-depth analysis of the existing social and professional sources of understanding about students' education within a work-based learning programme of study. I also presented a review of the literature regarding students' experiences of training in NHS Trusts. Due to the minimal amount of literature regarding student midwives' experiences, the review contained analysis of qualitative and quantitative empirical studies regarding student nurses' experiences of working in a similar WBL environment. The main themes to emerge from the literature revealed there were many structures within the Trusts that imposed barriers to students learning. These barriers included the phenomenon of the theory-practice gap (Lange and Powell-Kennedy, 2006). Traditional ways of working also imposed restrictions on students learning (Currie, 1999; Begley, 1999). Placing students learning within an NHS Trust exposed them to a medical model of care (Richens, 2002). It was also revealed that mentors can affect students learning through a lack of support and communication (Cavanagh and Snape, 1997; Hascher et al., 2004; Moseley and Davies, 2007; Armstrong, 2010). These small studies provided a snapshot view of students' experiences. My longitudinal study will involve student midwives over the course of their studies using a hermeneutic phenomenological approach, which has rarely been done before.

The majority of the studies focused on student nurse experiences of working in a hospital Trust caring for the sick and the dying, within a medical model of care. The

main contribution to my study lies in the fact that midwives care for pregnant women who are relatively fit and well, yet contemporary society expects birth to occur within a hospital Trust, exposing them to a medical model of care. My study will provide a much broader view of the students' competing experiences of the juxtaposition of training to become midwives within a NHS Trust and being university students. The study's findings are presented in Chapters 5-8.

In this chapter I discussed the structure of the midwifery programme of study and the tri-partite relationship between the university, the student and the Trust. There was also exploration of the possible influences of the working environment on the process of becoming a midwife.

Hermeneutic phenomenology is the philosophy and method used in my thesis to explore the lived experiences of the phenomenon of becoming a midwife. Chapter 3 provides an in-depth discussion on hermeneutic phenomenology.

Chapter 3

Philosophy - Hermeneutic Phenomenology

3.1 Introduction

The aim of Chapter 3 is to provide more in-depth information on hermeneutic phenomenology. I also include its origins within the philosophies of phenomenology and hermeneutics and its influences on my study as a whole.

A study's philosophical approach has a major influence on the choice of methods used to collect and interpret data (Clough and Nutbrown, 2002; Crotty, 2003; Denzin and Lincoln, 2003; Creswell, 2007). This longitudinal study explores the students' lived-world experiences of becoming a midwife over the course of their midwifery degree. This exploration is intended to uncover what brought the students to midwifery and then to discover the nature of the students' experiences of becoming a midwife within a work based learning environment. The philosophical paradigm of this study is phenomenology, which is congruent with constructivism. The principles of phenomenology are widely used in qualitative research when exploring lived world experiences. My choice of hermeneutic phenomenology was directed by the methodology and the nature of the study (Spinelli, 1989; van Manen, 1990; Laverty, 2003; Carter and Little, 2007).

3.2 Phenomenology

There have been many interpretations of phenomenology. It has been referred to as a philosophy, a paradigm, a methodology, and a movement. It is associated with qualitative research (Ehrich, 1999). The word phenomenology originated from the

Greek words *phainoemn* meaning appearance and *logos* meaning reason (Gearing, 2004). Hammond et al. (1991) suggested that it is mainly based on the description of phenomena as experienced by humans. Therefore, phenomenological research can be equated to the study of human experiences of their lived world.

Husserl's philosophy was that experience, as perceived by human consciousness, has value and should be studied. He believed that human motivation and human actions are influenced by what people perceive to be real (Lopez and Willis, 2004). Consciousness is the only access humans have to the world. This access is through acts of consciousness such as "perceiving, willing, thinking, remembering and anticipating are our modalities of self-world relationship" (Valle, 1997 p8). Consciousness is believed to be intentional as it is directed towards something that appears to occur naturally in the world as it is experienced. It also creates meaning from the experience (Valle, 1997). Husserl describes this as the natural attitude. People engage with their everyday lives in their accustomed world. This subsequently constitutes world values, obligations and practical affairs (Stewart and Mickunas, 1990; LeVasseur, 2003). Therefore, without consciousness, life cannot be experienced (Hammond et al., 1991).

Within the pedagogical framework of reflection, phenomenology provides a constructive ontology of the content and processes of lived world experiences as they are encountered. It is retrospective in nature, as the process of reflection can only occur following the lived experience (Van Manen, 1990; Valle, 1997). Phenomenology explores experiences as a whole. It acknowledges that experience involves all senses and emotions, perceptions, cognition and language. Every day activities can be

continuously shaped and informed by our understanding of others and ourselves within the meanings of situations (Hammond et al., 1991; Valle, 1997). According to Lopez and Willis (2004) phenomenology offers an approach to enquiry that fits in well with nursing philosophy. Gaining descriptive accounts of lived experiences assists in understanding interactions and meanings with others and the environment. It is said to follow a holistic approach to the study of experiences (Hammond et al, 1991; Valle, 1997; Moran, 2000). Using a phenomenological approach to the research allows me to explore the students' lived-world experiences of becoming student midwives, and ultimately midwives.

3.3 Husserl's phenomenological method

Phenomenology as a movement was first established by Edmund Husserl. Having trained originally as a mathematician, he put forward many of the phenomenological foundations of logic. This generated a theory of knowledge and also re-established the science of philosophy (Moustakis, 1994; Moran, 2000; Gearing 2004). His philosophy required scientists to investigate the phenomenon directly. Husserl stated *zu den sachen*, (to the things themselves). This requires not only an acknowledgement of the existential existence of objects but also the recognition that they are objects of consciousness (Dreyfus, 1987; Spinelli 1989; Valle, 1997). Husserl's studies led him to believe that experiences of the world are unique to the individual, each experience offering a directional and referential focus. He suggested that it was necessary to strip away the excesses of interpretational layers in order to uncover the true nature of the experience. This unearthing would allow knowledge of the things themselves to become visible. This exposure would only reveal a description of the phenomenon itself (Moran, 2000).

There are two main phenomenological approaches: descriptive and interpretive. Husserl's philosophical ideas gave rise to a descriptive phenomenological approach to inquiry which was formerly studied by Brentano, Kant and Hegel (Moran, 2000). Husserl believed that philosophy is a precise science. His logic was influenced by his previous background in mathematics (Spinelli 1989; Valle, 1997; Gearing 2004). His view came from the belief that philosophy consists of descriptions, not causal explanations of life experiences (Moran, 2000). Husserl believed that people go about their daily lives without critical reflections on their experiences. He therefore developed a scientific approach to gain insight into the essential components of lived experiences. Husserl achieved this by developing a philosophy that contained key concepts. Subsequent phenomenological philosophies have used Husserl's approach as a basis for development. Husserl's key concepts are interrelated and not necessarily in linear order (Van Manen, 1990; Gearing, 2004).

3.3.1 Epoch

Epoch, also called phenomenological reduction, refers to Husserl's belief that the researcher should put aside their initial biases and prejudices in order to suspend or bracket their expectations and assumptions of the research topic (Stewart and Mickunas, 1990; Ehrich, 1999). Husserl used the mathematical process of 'bracketing' to lay aside pre-assumptions about the topic in order to avoid research bias. His epistemological view was to aid the process of transcendental focus on the subject of observation (Ehrich, 1999; Maggs-Rapport, 2001; Lavery, 2003; Lopez and Willis, 2004). This process of bracketing is designed to bring a transformation in attitude needed for philosophical inquiry. This brings the researcher to the things themselves. Husserl's' intention was to return to a philosophical reflection of the

fundamental essence of the description of the phenomenon in its intentionality and horizontality (Stewart and Mickunas, 1990). Husserl thought that the result of bracketing would purge all assumption of the world and the thing itself, bringing about the state of transcendental ego. This primary state would bring the phenomenon to a state of purity (LeVasseur, 2003). His method of observation of *zu den sachen* (to the things themselves) requires reflection on the primary focus of the experience, thereby grasping the essential lived experiences of the phenomena (Dreyfus, 1987; Spinelli 1989; Valle, 1997). Husserl did not pursue phenomena to its interpretive ontological level. He was interested in the descriptions of experienced, lived-world phenomena (Hammond et al, 1991; Moran, 2000; LeVasseur, 2003).

Ontological reflection is intended to facilitate an awareness of thoughts, feelings and pre-assumptions concerning the phenomenon at an interpretive level, which Heidegger developed further (Annells, 1996; Laverty, 2003). Bracketing preconceived thoughts and ideas is used to allow the researcher to be open and objective in their approach to the research. This will help to prevent the researcher from influencing the descriptions of the phenomena under study (Spinelli, 1989; Ehrich, 1999; Moran, 2000; Lopez and Willis, 2004). It has been suggested by Ehrich (2004) and Spinelli (1989) that by being aware of the processes of bracketing it is possible to control any influencing factors.

There is, however, criticism of Husserl's philosophy regarding epoch (Mulhall, 2005). Heidegger refutes the ideology of epoch, suggesting that all ontological understanding is rooted in time and experience. Lived world experiences provide a presence and a history for being. To suspend all concepts of experiences would

change the meaning of being except in terms of temporality. Without this ontological perception of being, there would be a lack of historicity. Lived world experiences help to provide a pragmatic view of the world as it is lived. It has been argued that it is impossible to be free from all judgments when researching experiences of a phenomenon. Husserl himself struggled with this concept throughout his life (Mulhall, 2005). It has been suggested that pure reduction is impossible to achieve, as people are in the world (Merleau-Ponty, 1962; Heidegger, 1962). There was criticism of Husserl as having betrayed his own doctrine of intentionality. Husserl believed that consciousness was/is necessary to engage in the world, as consciousness is always directed towards something (Hammond et al., 1991; LeVasseur, 2003; Gearing, 2004).

Valle (1998) describes how Husserl's development of the idea of the person's life-world (*Lebenswelt*) in essence presents an issue within intentionality and horizontality. This would include interpretations of phenomena such as activities and rational meanings. Husserl stated that humans are rooted in socially constructed meanings of their existential world (Dreyfus, 1987; Spinelli 1989; Valle, 1997). Consciousness is always directed towards objects and the understanding of the things they are. Identification of certain objects is possible, which ensures an intellectual knowing. These intentional structures are part of the horizon of meaning (to the things themselves). These horizons ground objects with structure and potential that can be expected in the course of the lived experience of them (Mulhall, 2005). Objects may thematise horizons but horizon can also thematise objects. This connects the *zu den sachen* (to the things themselves) to the *Lebenswelt* (life-world) through the essence of meaning to the lived world; the ontological understanding of

being (Husserl, 1929/1973; LeVasseur, 2003; Mulhall, 2005). Accordingly Husserl's philosophy of bracketing allows the researcher to suspend judgment on the emerging phenomena to enable the essences of the phenomena to emerge in their natural state (Moran, 2000). This incorporates Husserl's method of movement from the natural attitude to the transcendental attitude (Spinelli, 1989). The debate regarding epoch focuses on the ability to transcend all pre-conceived knowledge of the phenomena. To enable a neutral view of the entity as it exists (Moran, 2000), value judgments are removed and the phenomena are described as they appear (Hammond et al., 1991).

3.3.2 Description

One of the characteristics of Husserl's phenomenology is description (Ehrich, 1999). The aim of Husserl's philosophy is description of the phenomena that presents itself. Phenomenology requires an examination towards the existence of phenomena (Von Eckartsberg, 1998; Spinelli, 1989; Cohen and Omery, 1994). Describing the phenomena as it truly exists to the individual is considered to be the golden rule (Spinelli, 1989). Researchers must suspend all value judgments of the phenomena so as not to contaminate the data which supports Husserl's ideology of bracketing (Le Vasseur, 2003). This state of transcendental attitude will allow the researcher to study the phenomena as it exists, without conceptual interpretation within the life-world of others. Thus the notion of *zu den sachen* (to the things themselves) is linked with the notion of *Lebenswelt* (life-world) (Ehrich, 1999; Von Eckartsberg, 1998).

3.3.3 Horizontalisation and Free Imaginative Variation

These two processes occur at different stages during the process of description. They can arguably be construed as opposing or complementary factors within the phenomenological concept of Description (Spinelli, 1995). Horizontalisation is the avoidance of any hierarchical structure within the emerging themes. This process allows the researcher to see all items of description as having equal value by seeing all parts of the data as equal parts of the whole (Spinelli, 1995). . On completion of the analysis, Free Imaginative Variation is applied to the themes as they emerge from the data (Ehrich, 1999; Rapport, 2004; Spinelli, 1995; van Manen, 1990). This process will reveal which themes are essential to the phenomena and which are incidental (Maggs-Rapport, 2001; Spinelli, 1989; van Manen, 1990). Essential themes are those that identify the phenomenon for what it is. Without these themes the phenomenon does not exist. Incidental themes are those that exist, but which have no bearing on the phenomenon under study (van Manen, 1990). Discarding incidental themes would not affect the fundamental meaning of the phenomenon. They could also be grouped together to suggest another essential theme (van Manen, 1990). The juxtaposition of these two contrasting processes brings the researcher closer to the essence of the phenomenon under study.

3.3.4 Intentionality

Intentionality is a phenomenological term which pertains to consciousness. Husserl advocated that consciousness is always directional. It is directed at something or of something (Husserl, 1973; LeVasseur, 2003; Von Eckartsberg, 1998).

'Intentionality indicates the inseparable connectedness of the human being to the world. This inter-relationship, within hermeneutic phenomenology, allows the discovery of the person's lived world' (van Manen, 1990 p181)¹².

Husserl's epistemic approach to phenomenology focuses on the acquisition of knowledge. His approach to exploring the life-world focussed on gaining knowledge of and describing the phenomenon under study. It did not allow for interpretation of the essence of the phenomenon (Husserl, 1973; Cohen and Omery; 1994; van Manen, 1990; Annells, 1996). Husserl's phenomenology appears to isolate the description of the phenomenon in terms of research ontology (Husserl, 1973). Acknowledging the essential pedagogical processes of horizontalisation and free imaginative variation with the notion of intentionality propels research to a higher level of interpretation (van Manen, 1990).

3.4 Heidegger's hermeneutic phenomenology

Heidegger's main interest was originally in theology. His work brought him to the interpretation of theological texts. This is thought to have been the impetus for his interest in hermeneutic phenomenology. Heidegger was a student of Husserl, which brought him into close contact with his teachings on phenomenology (Rapport, 2004). He eventually succeeded Husserl as Chair of Philosophy at Freiburg University (Mulhall, 2004; Rapport, 2004). Heidegger came to question Husserl's Cartesian and transcendental idealism. Heidegger did not view experiences as a mind and body split. He believed that prior experience of the lived world as a whole was necessary to understand the nature of being. Heidegger believed that personal

¹² Permission to reproduce this excerpt has been granted by SUNY Press

history and culture played an important role in the understanding of being in the life-world of all individuals (Moran, 2000). Heidegger believed that everything human beings think, say and do is implicit within the state of being. They cannot be separated from their experiences of the lived world (Heidegger, 1962). Heidegger's key concepts are interrelated and not necessarily in linear order (Heidegger, 1962; Rapport, 2004).

3.4.1 Being and the importance of interpretation

Heidegger focused on the issue of the meaning of being. His philosophy was ontological. He questioned the experience of 'what is being?' Whereas Husserl's epistemological position questioned the experiences of 'what do we know as persons' (Cohen and Omery, 1994 p142). Husserl's descriptive questioning did not fulfill Heidegger's desire to discover the person's experiences of their lived-world (Annells, 1996). Heidegger believed that in order to understand the explanation of the phenomenon there needed to be some form of interpretation by the observer (Heidegger, 1962). Having previous experience of the life-world enables a form of interpretation. Allowing the essence of the phenomenon to emerge provides interpretation and an understanding of what it is (Cohen and Omery, 1994). Heidegger agreed with Husserl's teachings on *Zu den Sachen* (to the things themselves), viewing the phenomenon for what it really is. Description alone did not fulfill his thinking. Heidegger believed that it was not the mind that projected meaning of the phenomenon but the thing itself (Palmer, 1969). It is through language that phenomena are revealed. Human language provides the medium for the lived experience of all phenomenological experiences (Laverty, 2003; Annells, 1996). The experience of the phenomena is unique to each individual. It is through the person's

unique interpretation of the phenomena which brings them into existence (Palmer, 1969). Therefore, it was essential that I should meet with the students to gain their unique interpretations of their experiences of becoming midwives. This provided me with access to their lived experiences during their programme of study.

There are many theories regarding the origins of the term hermeneutics. The word hermeneutic is said to be derived from mythology and the name of Hermes, a Greek god. He was responsible for interpreting messages between gods (Thompson, 1990). Hermeneutics is traditionally associated with theology and the interpretation of biblical texts (Gadamer, 1976; Lopez and Willis, 2004). In modern society the focus of hermeneutics is on human experiences of being rather than on what people know (Solomon, 1987). Discussing experiences places the phenomena within a given time frame: being in the world (Lopez and Willis, 2004; Rapport, 2004).

3.4.2 Being in the world - *Dasein*

Heidegger did not accept that the researcher should remove their existing understandings or pre-assumptions of the lived world (Heidegger, 1962; Mulhall, 2005; Mackey, 2004; Smith, 2009). He believed that all experiences form human existence in the world. Human beings have unique understandings of themselves and how they experience the world around them (Moran, 2000). This can only be experienced by being in the world and not from detachment of it (Rapport, 2004). The main theory of Heidegger's hermeneutic phenomenology is that of 'Being' or 'Being-in-the-world'; this he expressed as *Dasein* (Heidegger, 1962; Smith; 2009; Draucker, 1999; Moran, 2000, Rapport, 2004; Mulhall, 2005). *Dasein* is a German word which has no English equivalent. It is loosely interpreted as a human

experience of being or what it is to be human in the world. Heidegger considered access to *Dasein* as the process of living out a life (Heidegger, 1962; Moran, 2000). In order to understand the meaning of *Dasein*, it must be interpreted in the context of time and space (Annells, 1996; Mackey, 2004; Le Vasseur, 2003; Mulhall, 2005; Moran 2000).

3.4.3 Co-constitution

Existentialist thought rejects Husserl's theories regarding transcendental idealism (Hammond et al., 1991). It rejects the transcendental ego; stepping outside the natural world of the observed phenomenon. It also rejects Husserl's account of the objective world. Existential phenomenologists state that phenomenological description reveals a totally different view of the subject and the world; both being co-constituted. They are reliant on each other for the experience to exist (Hammond et al., 1991).

Husserl's teaching focused on the suspension of pre-assumptions regarding any existing knowledge of experiences, thereby separating knowledge of prior existence (Le Vasseur, 2003). The existentialists would argue that human experiences are reflective of being in the world as all existence is reflective (Annells, 1996; Laverty, 2003; Boyd, 1989). Therefore it would be impossible to bracket all pre-existing knowledge of previous experiences. This I carefully considered throughout my research as I was aware of my previous experiences. My awareness of my presence within the research enabled a form of epoch to be established. I discuss my use of epoch in Chapter 4 of this thesis. Each person has their interpretation of an experience and cannot be separated from it (Le Vasseur, 2003). Heidegger

suggested that there is no separation between the observer and the observed (Heidegger, 1962). Within a hermeneutic phenomenological study the researcher and participants are co-constituted within the interpretation of the life-world experiences (Rapport, 2004). *Dasein* supports the notion of this interconnection with the life-world that exists (Draucker, 1999; Moran, 2000; Rapport, 2004; Mulhall, 2005).

3.4.4 Hermeneutic circle

Hermeneutic phenomenology is regarded as an inquiry into experiences. More specifically, it has been associated with enquiry into experiences of the life-world of individuals (van Manen, 1990). Hermeneutic phenomenology encourages the researcher to undertake a journey through the text in a cyclical, open-ended manner. This cyclical approach is known as the hermeneutic circle. It requires reading and re-reading of the text in order to get a sense of the whole and not just certain parts. Through the hermeneutic circle the researcher becomes immersed in the text (van Manen, 1990). Reflection takes place during this time spent in the hermeneutic circle. This reflection allows for the examination of the researcher's own pre-existing assumptions prior to reading the text (Moran, 2000; van Manen, 1990; Le Vasseur, 2003; Churchill et al., 1998). This was particularly relevant to my research as it was essential that I should not contaminate the data. Reflecting on my experiences made me aware of my pre-assumptions and possible misunderstandings of what the students were saying. Therefore as Smith et al., (2009) suggested, it was essential that I was aware of my own prior experiences, assumptions and pre-conceptions as these would have impacted on my interpretation of the text.

Husserl's notion of bracketing enables the researcher to move from the natural attitude to the transcendental attitude in a to and fro motion. This movement of thinking supports the reflective process of the interpretation of the text. The journey through the interpretation of the text can never end as a conclusion would only indicate a juncture of pre-understanding (Le Vasseur, 2003; Churchill et al., 1998). The destination of the journey allows the researcher to follow their own interpretations of the text and this will be different for others. Thus the adventure for each researcher will be new, allowing alternative interpretations to be made (Lopez and Willis, 2004; Moran, 2000; Smith et al., 2009).

The hermeneutic circle constitutes a returning to the nature of the lived experience in a spiraling, open-ended course of action. This assists in a *sense-making* process. Each person has their fore-knowledge of experiences of life, but in a unique way. By studying the phenomena of the lived experience of others, a deeper understanding is gained (von Eckartsberg, 1997). As my research was a longitudinal study I was able to re-visit many of the students' interpretations of their experiences. Taking into account the parts of their experiences that made up the whole, I was able to gain a deeper understanding of their experiences. Reading and re-reading their narratives and listening to their taped conversations allowed many themes to emerge from the data. I sorted these into essential and incidental themes that would support my interpretation of their experiences of becoming midwives.

The validity of the findings of hermeneutic research is interpreted as 'the logic of probability' using the available knowledge rather than logic of empirical verification (Titelman, 1979 p190). The value of the results within hermeneutics is not based on

absolute truths, but on whether they support people to understand everyday being in the world. Conclusions are open-ended presentations of people's realities (van Manen, 1990; Smith, 2009). Therefore the criteria used to evaluate the trustworthiness of hermeneutic phenomenology are different from those used in quantitative research and other types of qualitative research.

3.5 Conclusion

The use of hermeneutic phenomenology in my research study enabled me to connect the '*zu den sachen*' (to the things themselves) to the students' '*Lebenswelt*' (lived world) (Ehrich, 1999; Eckartsberg, 1998). Heidegger's contribution to the further development of phenomenology to the interpretive level provided me with the ability to allow the essence of the phenomena to emerge, revealing its true being as interpreted by the students (Moran, 2000; Mulhall, 2005). Being in the world of a researcher enables a conscious access to the students' lived world. Acknowledging my need to employ *epoch* was a subjective requirement (Ehrich, 2004; Spinelli, 1989).

Chapter 3 explored hermeneutic phenomenology, its origins within the philosophies of phenomenology and hermeneutics, and its influences on the study as a whole. Chapter 4 provides a discussion on the choice of methodology used in the thesis.

Chapter 4

Methodology

4.1 Aims of the research

My research study developed from two distinct aims. This development initially followed a review of the literature which was based on students' experiences of their education. The design of the research was hermeneutic phenomenology. The aims of the research explored the students' interpretations of their experiences (Smith et al., 2009). The research aims were clear and directive:

- 1) To discover the nature of the students' experiences of becoming a midwife
- 2) To understand the influences of the working environment on the process.

4.2 Introduction

The aim of this chapter is to explore the development and use of hermeneutic phenomenology as a research methodology and the researcher's position within the study.

My research focused specifically on understanding lived world experiences. Using phenomenology moves away from the quantitative scientific approach. This positions the researcher to become immersed in the research process and analysis of the data. My research was designed to explore the nature of the students' experiences of becoming midwives. This was achieved by exploring their interpretations of their experiences of becoming midwives. The research was located in a hermeneutic framework as described by van Manen, (1990). My longitudinal study utilized narrative inquiry within focus groups over the students' three year degree

programme of study. A purposive sample of student midwives was recruited to the study (n=22).

In this chapter I explore the aims of the research around which the research was structured. I reflect on my professional biography and its possible influence on the study and consider the use of *epoch* within hermeneutic phenomenology. This chapter critically defends the use of focus groups within hermeneutic phenomenology. Ethical considerations regarding the research are explored throughout the chapter.

4.2.1 Research Outline

I recruited 22 student midwives from two universities in the North West of England by contacting each of their Head of Midwifery; University A and University B. Following ethical approval I met the students in their universities and presented a power-point presentation as a visual aid, supplemented with a letter of information (Appendix B). During this recruitment stage we exchange email addresses and telephone numbers, these remained our means of contact throughout the study. Towards the end of each academic year I emailed the students to request a meeting and these took place every year. They always responded positively with suggested dates and times that were suitable for all. I initially conducted five focus groups (FG) and these took place in their home universities. University A, FG1 had 5 students, FG2 had 5 students. University B, FG1 had 4 students, FG2 had 4 students and FG3 had 4 students. I chose to use narrative inquiry which allowed each student to tell of their experiences while the others listened. They each discussed each other's experiences. This was the format for all the FG discussions. I was the facilitator of the FGs, initially I

encouraged the students to speak using prompt questions but as time went by I only needed to maintain focus on the aims of my study. I asked the students to maintain a reflective diary as we were only meeting once a year. The decision to meet once a year was based on their commitments to their studies, the shift patterns in the Trusts and their family lives. They were encouraged to write any significant incidents in their diaries that they felt were important to their learning as an aide memoire. I asked them to bring them along to support their discussions of their experiences. I did not get access to their diaries but their reference to what they had written supported my interpretation of their experiences. This supported the trustworthiness and transparency of my study. I kept my own reflective diary to explore my position within the study. My use of reflection enabled me to attempt to bracket my pre-conceived ideas from my own experiences. This remained a constant struggle but using reflexivity during my data analysis supported my study. I maintained confidentiality by setting ground rules and discussing the need for privacy and not discussing anything outside of each FG. This was particularly essential as the FGs were made up of friends. My main concern was ensuring the students were safe. Safeguarding is important and as a Supervisor of Midwives (SOM) I needed to protect the public from harm. I provided the students with a letter of support directing how they could find support in their universities and in their Trusts. At one point a concern was raised regarding the practice of a midwife. I encouraged the students to speak to a SOM in the Trust but also to speak with their practice education facilitator and their Link Tutor. The students assured me that they had taken my advice. My reflective diary supported my turmoil of stepping outside the role of researcher but I could not ignore the information I had been given.

4.3 Pilot study one

The study received ethical approval from Liverpool John Moores University. The decision regarding the choice of method for the research was based on two pilot studies. These were considered valuable in the planning of all research studies. These small scale studies are used to test the authenticity and trustworthiness of the data collection tool (Graneheim and Lundman, 2004). They also ensure there are no unanticipated problems in gaining a suitable sample for the study (Rees, 1997; Cluett and Bluff, 2000; Graneheim and Lundman, 2004). Initially I approached a group of first year student midwives to participate in individual interviews. Some phenomenological researchers consider this to be the ultimate choice for the collection of hermeneutic data, as it is believed individual interviews reduce contamination of the data (Webb and Kevern, 2001; Webb, 2003).

There were eighteen student midwives in the first year of their degree. I contacted the students through their university email addresses to recruit volunteers; four students responded positively. My main study is longitudinal; therefore the choice of first year student midwives appeared appropriate. I planned to follow groups of students throughout their three year degree course. The interviews took place at their university. The students were a purposive sample (n=4). The Initial focus of the research was on why these students wanted to be student midwives. I asked each student to tell me their story. I used a semi-structured interview approach as I felt this would support the students to maintain their focus. This type of interview is considered to be supportive and gives respondents time to formulate their responses. I considered this approach would also enable me to clarify any misunderstandings with the students (Marchant and Kenny, 2000).

On this occasion, individual interviews were not successful. Hermeneutic phenomenology explores the lived world of peoples' experiences as they understand them. These include the socially constructed phenomena that make up their being (Miles et al, 2013). As the researcher I wished to explore their lived world that brought them to the decision to become a midwife. I discovered the students were reserved regarding their life stories. They related stories regarding their children or parents. The majority described their experiences in the university and their clinical placements. It did not provide a hermeneutic phenomenological exploration of their lived experiences. The data revealed a more Husserlian description of their lives at university. This first pilot study proved to be invaluable as this method of data collection did not support the students in the telling of their understandings of becoming student midwives. Following discussions with my supervisory team, I agreed that a different approach should be taken. The discussion culminated in the decision to use narrative inquiry within focus groups.

4.3.1 Pilot study two

I approached a group of approximately twenty-one third year student midwives and invited them to participate in a dialogical focus group. Five of the cohort responded positively. The students were from a local university in the North West of England who were about to qualify as midwives. The focus group took place at the Higher Education Institution (HEI) where the students studied. The student midwives were a purposive sample (n=5) as I was interested in why they wanted to become midwives.

I asked the students to tell me their life stories in relation to what brought them to midwifery. The group listened to and discussed each other's stories. I regarded the

students as co-researchers and as narrators of their stories. The focus group was taped with permission and transcribed verbatim. The focus group lasted approximately 1.5 hrs. This pilot study confirmed the approach to the study. The number of participants in the focus group was appropriate (n=5). Each member of the focus group could tell their story and this led to the production of much rich data. Each participant had sufficient time to speak and this led to a discussion about each other's stories in a non-competitive environment.

The location of the study was essential as privacy encouraged the students to speak, reducing their fears of being overheard. The use of a digital recorder initially appeared overwhelming for the students. Familiarity with its presence soon enabled the students to accept and acknowledge the device. This was demonstrated by students speaking softly when not wishing to be heard while relating an amusing story from practice. The use of a digital recorder proved invaluable as the need for immersion in the data was essential (van Manen, 1990). Transcription of the data and listening to the recordings gave depth to my analysis. The interaction between the group members was supportive, which afforded relaxation within the group. The students were amicable and sociable while relating their experiences. There was a strong element of camaraderie within the focus group.

For my main study, identification of the students in each focus group led to me to consider giving each student a number. This allowed me to identify each student with their demographic data within their different universities. Confidentiality of each student was my priority, therefore names were not used. I consider the second pilot study supported my decision to use focus groups using narrative inquiry; I discuss

this later in this chapter. The feasibility of the study to employ this approach was overwhelmingly supportive. Aspects of transparency, trustworthiness, and authenticity were supported within my data collection and analysis. On analysis of the data I was able to authenticate the emerging themes using the students' narratives of their lived experiences. Transcribing the data verbatim brought transparency and trustworthiness to the analysis of the data. I used the same approach to the analysis of the data in the main study. This is discussed further in Chapters 5, 6, 7 and 8 (Rees, 1997; Cluett and Bluff, 2000; Graneheim and Lundman, 2004).

4.4 Researcher

Investigating the lived experiences of student midwives evolved from reflecting upon my experiences. Previously I worked as a practicing midwife in a local National Health Service (NHS) Trust. The Trust was approved to train student midwives. On qualification the midwife is eligible for admission onto the midwifery part of the Nursing and Midwifery Council (NMC) register. My own midwifery training was based in a school of midwifery. This was part of a District General Hospital (DGH) with a maternity unit. At that time, student midwives were required to have a nursing qualification prior to undertaking midwifery training.

I undertook my three year nurse training within the same DGH and upon qualification I became a Registered General Nurse (RGN) known as a Staff Nurse. My midwifery training was eighteen months long and, because of my previous nursing background, it focused purely on midwifery. It was accepted that student midwives possessed the cognitive, affective and psychomotor nursing skills necessary to care for women with

complex medical disorders (Bloom, 1956). I entered midwifery to become a practicing midwife. I subsequently spent the rest of my career as a midwife. I remained working at that NHS Trust for thirty one years; twenty of them in the maternity unit. I then moved into higher education. With this change of career came many questions and concerns regarding students' experiences of midwifery education. My concerns revolved around the treatment that pre-registration student midwives received. I observed many midwives subject students too much criticism regarding their lack of knowledge. Listening to the students' discussions revealed similarities to the findings of a phenomenological descriptive study by Begley in Ireland (2001). The study described many post-registration students' experiences of being subjected to ridicule and criticism. This was related to their lack of midwifery knowledge and poor performance during their initial training (Begley, 2001). My study takes the process a step further by using a hermeneutic phenomenological approach to explore the students' interpretations of their experiences during their education. This will provide new knowledge regarding how student midwives are educated in the current system of midwifery education.

The philosophy and methodology of the research is hermeneutic phenomenology. This was chosen as it focused specifically on understanding the students' lived experiences of becoming student midwives. It is accepted that both researcher and the research are affected by each other's presence, discussed above (Guba and Lincoln, 1985).

- Reflection on research journey

The writing of my biography brought back graphic memories of my days as a student nurse and student midwife. I remember my student days with much affection. My phenomenological reflection placed my experiences within a timeframe. Reflecting on my experiences during the 1970s and 1980s brought memories of much fun and carefree days. There were also periods of hard work and study as each year heralded new challenges bringing a deeper level of learning. There were no mentors during these days. It was the duty of the ward sisters and the staff midwives to teach the students on the wards. The structure of the curriculum was different to today's programmes of study. We attended blocks of study in schools of midwifery. Clinical learning was directed by midwifery tutors who came onto the wards to observe students learning. The equipment of the time was very basic in comparison to today's technology. Therefore my memories of student midwifery education have a historic basis. Midwifery education was completely different to the current programme.

In order to bracket these assumptions and experiences I needed to place my experiences within a temporal framework. My reflections were placed within a hermeneutic reflective circle which revolved around the different aspects of my training that made up the whole. These included the dates and times of my student days, the length of my midwifery training at certificate level and the governing bodies that had developed over the time. I also considered the content of my midwifery education over the 18 months. Comparing my training with the current degree programme of study enabled me to acknowledge and set aside my previous experiences and assumptions. I reflected on these differences often as I read and

listened to the students' narratives. I accepted that I would never achieve the total transcendental ego state that Husserl (1973) discussed, as my past has influenced my present being. Therefore, I used the process of epoch as a reflective tool to ensure I remained within the students' experiences, maintaining the trustworthiness and authenticity of the data.

Presenting my biography offers some understanding of my assumptions and the research itself. It sets the scene of my research focus and the key concepts that influenced its development (Guba and Lincoln, 1985). The research evolved through many stages and involved much discussion and new ways of thinking on my part. The key concepts that influenced my research are:

- The students lived experiences of becoming midwives – in a work based learning environment
- Taxonomies of learning – pedagogy to androgogy
- Positivism and constructivism – as different research paradigms
- Hermeneutic phenomenology – as a philosophical framework as well as method.

4.4.1 Positivism

Positivism is mainly associated with the scientific paradigm of quantitative research. There are many definitions of positivism (Lincoln and Guba, 1985; Guba, 1990; Crotty, 2003).

- Its ontological basis suggests that reality exists 'out there'. The Realists believe reality is driven by natural laws and mechanisms. Knowledge is summarized in the form of generalizations, suggesting a cause-and-effect approach to analysis. The scientific stance suggests that the world can be taken apart and the parts of

the whole can be studied separately (Lincoln and Guba, 1985; Guba, 1990; Crotty, 2003).

- Its epistemological basis focuses on the scientific analysis of the world. Dualists consider that the researcher remains objective, standing apart from the research. The researcher has no influence on the research, offering an objective value free analysis.
- Positivism's methodological stance is propositional questions, with hypotheses stated in advance. They are subjected to empirical testing and are carefully controlled. Large representative samples of the population are needed to support generalization of results (Guba, 1990; Brown and Lloyd, 2001).

I consider that these positivist assumptions can be assimilated into the pedagogical structure of educational systems (Freire, 1993; Curzon, 2004; Reece and Walker, 2006). My interpretation of the dualism of the system suggests that the teacher delivers the information to the students. The pedagogic provision of education can be judged as propositional. The students' abilities to engage with the learning are dependent upon many factors. These factors require the development of a partnership which is more in keeping with an androgical approach to learning. Within educational systems in the UK, the Department for Education collates quantitative data regarding performances and examination results which are presented as league tables (DfE, 2011). It is suggested that parents make important judgments based on league tables as to which school they will send their children to. Further analysis of the data may reveal academic achievement may not necessarily be the most important factor regarding children's education (DfE, 2011). The same could be applied to choosing which university to attend to study midwifery. The NMC

prescribe the content of the pre-registration midwifery degree educational programme but each university will apply the principles differently, focusing on either the art of midwifery or the science of midwifery. This can be demonstrated as the choice of a BA(Hons) or BSc(Hons) approach in the different universities.

4.4.2 Constructivism

Constructivism is associated with qualitative research paradigms. There is much dissimilarity to positivism (Lincoln and Guba, 1985; Guba, 1990; Grix, 2004).

- The ontological position of constructivism is based on the belief that social phenomenon is dependent on social interaction. Social reality is subjective and is constantly being constructed. This leads to multiple levels of different interpretations (Guba, 1990; Bryman, 2001; Grix, 2004).
- The epistemological position suggests that the researcher and participant are co-researchers and dependent upon each other, with their interactions affecting each other. There is a continuous process of revision and reflexivity as each determines their place and influences within the research process (Guba, 1990; Bryman, 2001; Grix, 2004).
- Within constructivism the significance of data collection is important. Qualitative data provides an insight into the lived experiences of the participant. Their interpretation of their multilayered experiences provides the researcher with rich data. These enable deeper analysis to occur as sample sizes tend to be smaller. Results cannot be generalized as they can within a positivist paradigm, yet the results bring to the fore a better understanding of human experiences (Hennink et al, 2011).

The focus of my research design came from the ontological belief that all human beings experience life differently from each other. I believe being in the world has many attributes that impact on our Being. These attributes play a major role in how people experience their lived world (van Manen, 1990). Social constructivists believe that most people do not live in isolation. People experience their lived world through interactions. These interactions with the world are based on four thematic structures: lived body, lived space, lived time, and lived relations. These four existential life-worlds provide intentionality for people in their lived world (van Manen, 1990). Therefore, humans do not discover knowledge, it is constructed through their experiences (Clandinin and Connelly, 2000; Mulhall, 1996; van Manen, 1990; Polkinghorne, 1988; Schwandt, 2001). This ontological perception suggests that daily interactions impact upon the development of the self be it good or not. Only the person experiencing their lived world can interpret their experiences (Polkinghorne, 1988). These interpretations help to construct knowledge of their lived world.

Considering my research aims, my chosen methodology for the research supports the constructivist approach. I was interested in the students' understandings of their lived experiences of becoming midwives. The students in my study brought their lived experiences to their studies. These impacted on how they approached their studies and how they constructed their knowledge of midwifery. Their interaction with their learning environment is designed to support their learning (Polkinghorne, 1988). It can be suggested their social interaction with the process supported the development of the Self within the role of the midwife as they progressed through their studies (Clandinin and Connelly, 2000; Mulhall, 1996; van Manen, 1990; Polkinghorne, 1988; Schwandt, 2001).

4.5 Selecting and recruiting a sample

I recruited a purposive sample of student midwives to my study. This type of sampling is associated with people sharing similar experiences. The sample permits access to a particular perspective of the phenomena under study (Smith et al., 2009). The aims of my research defined the characteristics of the sample (Smith, 2008). Access to a suitable sample proved initially complex. Much discussion ensued regarding the recruitment of the students. As a midwifery lecturer, students from my own university were briefly considered. This choice was quickly removed as protection of the students was a priority. Ethical considerations of coercion, anonymity, and confidentiality were discussed (Bryman, 2008). I contacted Heads of Midwifery from two different universities to ask for permission to approach their ethics committees. I received positive responses. Following ethical approval from both universities I commenced recruitment to the study.

I believe planning is important to avoid errors later. I considered that obtaining an appropriate number of students was an important aspect at the recruitment stage (Cluett and Bluff, 2000; Rees, 1997; Smith, 2008; Smith et al., 2009). Having sufficient numbers of students in each focus group is important. The size and structure of each group needed to facilitate an atmosphere that encouraged discussion and relaxation. Each student needed sufficient time to relate their story (Berg, 2009). My initial plan of four to six students per focus group was considered. The number of groups remained elusive at the planning stage. I reviewed previous nursing studies using focus groups of similar numbers, as these appeared successful. Their students were able to discuss many aspects of their nursing experiences. Sufficient time was given to each student. The studies reported aspects

of support which enabled the procurement of rich data (O'Brien et al., 2007; Finnerty et al., 2006; Mc Gowan, 2006). Ensuring confidentiality and support was essential as the students were encouraged to share their lived experiences. Lack of support may easily jeopardize the cohesive nature of the group (Berg, 2009; Smith, 2008).

The recruitment strategy focused on direct contact with two groups of first year student midwives from both universities; University A and University B. The venue for the study was to be their home university campus. The students' familiarity with the research setting would support their recruitment to the study (Smith, 2008). The recruitment process to my study involved speaking to two cohorts of student midwives from two universities in the North West of England (n=90). Each university had a different recruitment target for their midwifery programme of study: University A (n=60), University B (n=30). I originally recruited a purposive sample of student midwives (n=22); University A (n=10) which equated to 20% of the cohort and University B (n=12) which equated to 33% of the cohort. I divided the sample into five focus groups; University A two groups of five, University B three groups of four. Subsequently, four students from University B withdrew from the research following the first set of focus group meetings. This equated to having a significant 82% retention rate for the remainder of my study. The four students that withdrew were all from one focus group, which left me with four focus groups; two from each university. This reduced the total purposive sample to 18. This also reduced the sample size of university B (n=8) which equated to 27% of the cohort. Reflecting on the loss of one complete group of students was upsetting as their experiences were lost to my study. It has to be acknowledged that this might have affected the results of my study. Their choice to withdraw from the study had to be respected.

My presentation was carefully planned. I prepared a short power point presentation supplemented with an information leaflet (Appendix B). My contact details were included to support the recruitment. This proved successful, as having a visual aid and a leaflet to read supported the students' internalization of the information (Reece and Walker, 2007). The ethical consideration of the students understanding the research was a priority. The students were preparing to undertake their training within a healthcare setting caring for women during their childbearing years. Due to the demographics of the sample it was anticipated that some of the stories from practice may affect the students (Proctor and Renfrew, 2000; Berg, 2009). I considered it essential that all research participants should be protected from harm (Smith et al., 2009). Therefore I designed a leaflet to give to the students. This outlined where they could find support in their universities and their Trusts (Appendix C). I was delighted with the positive responses I received. I then decided to organize the students into focus groups. The number of students directed the number of focus groups. I decided to keep the two main groups of students in their university groups. This was a tactical decision as it would aid data collection and reduce costs of travel for the students between each university. The two groups were sub-divided into a total of five focus groups (FG); University A: (n=10), FG1 had 5 students, FG2 had 5 students, and University B: (n=12), FG1 had 4 students, FG2 had 4 students and FG3 had 4 students. Placing the students into the focus groups was performed based on my analysis of how the students had volunteered. I decided to place the students within their friendship groups, which were interpreted from emails received.

Prior to the commencement of data collection I asked the students to sign a consent form (Appendix C). Careful consideration was given to ensure the students

understood the research. I assured them they could withdraw from the study at any time. They were informed that withdrawal would not impact on their future studies. There are two major considerations regarding Informed consent: informed and consent. A definition of consent suggests that one gives permission or there is an agreement to something (Oxford, 2005). Without knowledge of an agreement to something, consent cannot be ethically sought or expected. The ethical principles of informed consent centre on the rights of the individual: the right to know and the right to information (Oliver, 2010). Research activities with human participants preserve the right to informed consent. Gaining informed consent was essential to my research study. It focused on providing the students with the relevant information about the study. My decision to gain written consent focused on a partnership with the participants.

My sample consisted of women whose age range was eighteen to thirty eight years. The demographic data demonstrated that there were many differences between the students from each university. The students from university A were from a younger age group than the students from university B. The students from University A were also single whereas the students from university B were either single or had a partner. The students from university B also had dependent children. The majority of the students from university B entered university through the Access to Health route, whereas the students from university A entered higher education through the traditional route of A levels. Their siblings' educational status varied also. The siblings of the students at university A followed a traditional educational route, whereas the siblings of the students at university B varied. The students' parents from university A appeared to be either semi-skilled or have a profession. The

students' parents from university B varied from unskilled to having a profession. This coincided with their parents' educational status in both groups, this being from CSE to Doctorate status. Drawing on the students' demographic data, the students from university A appeared to have followed the traditional educational route into university, studying GCSEs through to A levels. The students from university B appeared to be part of the government strategy that supports widening participation into higher education. They entered university through an Access to Health Care course.

4.6 Collection of narrative data

Narrative has been accepted as a method of inquiry, the subsequent story being the phenomenon of the inquiry. People relate their lives in story form (Clandinin and Connolly, 2000; Riessman, 2008). The role of the researcher in narrative inquiry is to collect these stories and relate them to others as narratives of lived experiences (van Manen, 1990; Clandinin and Connolly, 2000; Berger and Quinney, 2005). Narrative inquiry situates the narrator within the context of experience. Experiences provide temporality, which allows the person to be situated within a time and place.

Experiences necessitate a learning process. For learning to occur there must be an acceptance of accumulated knowledge and a willingness to build on such knowledge. Placing learning within a context supports Bloom's taxonomies of learning (Clandinin and Connolly, 2000; Bloom, 1956). Narration of experiences involves an acceptance of foreground knowledge and background being (Goodson, 2003). There is an acceptance that in narrative inquiry the data collection process is an imitation of experiences. This mimesis involves both action and experience.

Researchers do not have access to the actual experience but narratives are centered on events and depict human action (Riessman, 2008).

Sharing of experiences provides a self-centered authentication of the experienced, lived world. Narratives also create experiences for the listener (Mattingly, 1998). Through an accumulative process the researcher builds upon narrated experiences. Interpretation of their mimetic experiences provides the researcher with an inference of their life-world. Verification of communal knowledge can provide cohesion within cultural values. This is particularly pertinent among a group of people with similar experiences, such as student midwives. This in turn can impact on the determination of laws of social becoming (Goodson, 2003; Goodson and Sykes, 2001). Narrative inquiry offers the researcher a snap-shot view of lived experiences. Personal narratives are concerned with human potential and development in which people construct their lives. This is accomplished through connecting the past with the present and the future (Eatough and Smith, 2008).

I commenced my data collection in January 2009. The students were in their first year of the pre-registration midwifery degree programme. During the planning of my research I considered the ethical consideration of protection of the students and myself in particular the issues of confidentiality. The NMC website provides some guidance which is broadly based on the disclosure of information to another person where the issue of confidentiality is an expectation. This is governed by common law and statute law. The Data Protection Act (1998) governs the processing of information and this includes holding, obtaining, using and disclosing information. This applies to many forms of media; paper and electronic. Therefore confidentiality

in research must respect the rights of the individual. Considering the implications of confidentiality and its application to my study I wrote ground-rules. These I took to the first focus group meetings for discussion. During the discussions each group added to their list, which supported the group's needs. Safe-guarding the students from harm were a major concern as I anticipated they would discuss both personal and practice issues within their professional and social groups. I emphasized the need for confidentiality and protecting each other from harm. No information was to be shared outside of each focus group; the students agreed. My major priority was to provide the students with support should they disclose any issues of concern from practice. We discussed the possibility of disclosing something that may be of harm to themselves and/or to the women in their care. It was made clear to the students that such incidents were not to be discussed in an open forum outside of the focus group as confidentiality must be maintained in Supervision of Midwifery (SOM). The philosophy of SOM is to protect the public from harm. I directed them to their university lecturers, personal tutors, link lecturers, Lead Midwife for Education and the Supervisors of Midwives in the Trusts. To support this information I provided the students with information leaflet (Appendix C). As a SOM I also informed them that I would support them in the reporting of such incidents. If necessary I would take the issue forward in order to protect their anonymity. This I discussed with them outside of the focus group discussions.

The need for confidentiality was important and this was emphasized during each focus group meetings. The sharing of information was to remain within each focus group. Helping the students to feel at ease was important. I informed the students I

would not use their names so I allocated them a number which I used in my verbatim quotes.

The initial data collection focused on why the students wanted to be student midwives. I collected their demographic data at this point. Following this initial meeting with each focus group I decided to meet with each group at the end of every academic year: first year, second year, and third year. My decision to follow this design was based on the structure of their programme of study. The students informed me that they were based at different NHS Trusts working a shift system. It was acknowledged that it would be difficult to co-ordinate each focus group meeting to include every student. It was decided that we should meet during one of the theory weeks of their curriculum. This ensured no-one would be on-duty. I decided to use reflective diaries to supplement their reflection on their learning experiences in between our focus group meetings. I believe this to be an innovative approach to support the students' reflections on their experiences. I discuss this later in this chapter.

During the second stage of data collection the members of one focus group decided not to continue with the research. Four students from University B, group two, did not meet to discuss their experiences. Attempts were made to contact the group but they did not respond. My attempts to interpret their decision not to continue led to feelings of disappointment and prompted a process of reflection. Consideration of their initial data suggested many motives for their decisions. It quickly became apparent that without their interpretation of their reasons for not continuing with the research the answer would remain elusive. This is supported by Leonard et al.

(2014) and Kim. (2014), who stated it is inevitable that some people will drop out of research studies no matter how much support is offered to the candidates.

4.7 Focus groups within narrative inquiry

Phenomenology involves the description of a phenomenon in its natural state. Hermeneutic phenomenology takes the process further, involving interpretation of the phenomenon as experienced (van Manen, 1990). I chose to use a hermeneutic phenomenological method of inquiry as it was appropriate to my study. This allowed for description, interpretation, and investigation of essences and phenomenological reduction (Kvale and Brinkman, 2009).

I wanted each student to reveal their lived world experiences of becoming midwives. I encouraged each student to tell the group their experiences. I then encouraged the group to discuss each others' stories. This provided each student with the time and opportunity to explore their own and each others' learning experiences. The students used their reflective diaries as an *aide memoire* to narrate their experiences. This inventive approach provided support and depth to the students' narratives. In my analysis I undertook a thematic approach to study their stories and discussions taking into account their existential lived world experiences as suggested by van Manen (1990).

This brought me to reflect on communication skills that I had developed from my health care background. I was aware that at times from my days in practice I needed to direct care. During the early days of my research I became aware of my position within the research. I decide that I needed to improve my knowledge and skills in

qualitative research. I enrolled on a two week residential course in the South of England, which enabled me to view situations differently. I no longer needed to be in control of other peoples experiences as these were unknown to me. They were not my experiences. I developed the ability to accept people's experiences for what they were and to consider the themes that emerge from their experiences. Developing the skills of a researcher encouraged a self-awareness of my position in the research. This allowed the students to tell me their stories and not for me to jump to conclusion. These skills enabled me to adopt a hermeneutic phenomenological approach and an awareness of self-world relationships. The students were able to relate their understandings of their experiences to each other without my interference. This encouraged verbal interaction between the students in their focus groups. As the research developed I found myself offering very little guidance to the focus group discussion as I was interested in their experiences. I had learned to accept the students for who they were while listening to their stories, this was important to my study. The research focused on the students' lived experiences of becoming midwives within a work based learning environment. Following the successful use of a digital recorder in the pilot study I gained consent from the students to use this technique. I transcribed the data verbatim, which enabled me to become immersed in the data as described by van Manen (1990).

4.8 Focus Groups

Much debate regarding the use of focus groups for phenomenological research has been generated (Robinson, 1999; McLafferty, 2004). Many researchers contest the idea of focus groups, suggesting it is an oxymoron. Phenomenological inquiry is associated with an in-depth exploration of sensitive issues on a one-to-one basis.

Focus group discussions are considered by some researchers to be unacceptable. They question the trustworthiness and authenticity of this method of data collection (Webb and Kevern, 2001; Denzin and Lincoln, 2003; Graneheim and Lundman, 2004; Bradbury-Jones et al., 2009; Kvale and Brinkman, 2009).

My use of focus groups within phenomenology is defensible. The use of focus groups supports the exploration of human experiences with a group of people undergoing similar experiences. Attitudes and perceptions are developed by interactions with other people (Krueger, 1994). Heidegger's hermeneutic phenomenological position within *Dasein* (being in the world) brought me to the position of co-constitution within my research. This enabled knowledge of the students' lived experiences. Using focus groups within phenomenology provides a constructive ontology of the content and processes of lived world experiences in similar situations. Each student in my study had enrolled onto a midwifery programme of study but their experiences of the programme would be different. This co-constitution enriches interactions with others. Focus groups provide an interactive medium to hear each other's stories. This interplay allowed the development of rich data (Krueger, 1994; Webb and Kevern, 2001).

I planned to use small numbers in the focus groups to encourage an element of intimacy, which would encourage interaction amongst the students, thus aiding depth of discussion and therefore producing rich data. This had proved successful during my second pilot study, which I previously discussed on page 93. Choosing to use friendship groups promoted a relaxed atmosphere. This supported my use of narrative inquiry in the research as the students appeared relaxed in each others

company. This was demonstrated by their laughter and banter with each other as they talked quite freely. I was interested in the students lived experiences of becoming midwives. I wanted them to tell me what they had experienced during each year of their education. Each student was given time to relate their experiences and the group discussed them. Their stories provided me with knowledge of what it was like to be a student midwife in the 21st century. Their discussions provided trustworthiness, authenticity and transparency to their experiences as many of the students' experienced similar experiences to each other. My use of friendship groups is supported by Kitzinger (1994) who stated that utilising friendship groups assists the researcher to observe familial interactions regarding shared experiences. Interaction in focus groups is considered to be an important element within the analysis of the data (Krueger, 1994). Group dynamics play a vital role in how the group works. Group formation can affect how the groups function. Each member can influence each other through their responses (Krueger, 1994).

Initially there was an element of authority to each group. The more vocal students spoke first. In time the dynamics of the groups changed. The less vocal students engaged in conversation and would lead into their stories quite unobtrusively. This subtle change of direction altered the atmosphere of the discussion. These students presented a positive focus to the discussion. They were quite pragmatic about their experiences. Whereas the more vocal students had at times something negative to convey. With this negativity came a disruptive element as each student would defend their experiences. There were disagreements within the discussions. There was also an acceptance that each should be able to voice their opinions. Some researchers suggest that this observed behaviour should not be ignored when analysing the data

(Kitzinger, 1994). Without discussing social interaction only part of the data is being used and the trustworthiness and transparency of the research may be called into question (Kitzinger, 1994; Wilkinson, 1998; Morgan, 2010).

Focus groups have a specific purpose. They bring together people with similar experiences (Krueger, 1994; Kitzinger, 1994). The purpose is to obtain qualitative data from a sample of people. Working with pre-existing groups provides discussion within social contexts. Focus groups provide an environment which encourages and nurtures disclosure. The researcher provides a focus for those disclosures through open-ended questions (Krueger, 1984; Bloor et al., 2001). Following discussions with the students they decided on the venues for the focus groups, which were within the familiar settings of their home universities. This provided an intimate atmosphere where the students felt comfortable and they talked and laughed freely.

I decided to use open-ended questioning. This generated discussion as similar experiences stimulated recognisable situations. The aims of my research were the focus of my interview guides (Appendices F, G, and H). I commenced each focus group by asking each student to relate their experiences from their relevant year of study. I explored their understandings of their experiences. I kept the questions to a minimum, focusing on specific topics relating to their year of study. This approach complemented the students' narratives and maintained a focus to their specific year. At times I did not need to prompt the students as they were keen to talk about their experiences. I recorded in my reflective diary how the students had related to the focus group discussions as counselling sessions. They stated that no-one had asked them about their experiences in such an informal setting before.

Following each student's narrative the group was encouraged to discuss and explore the relationships within their experiences. Each student took turns to relate their experiences with subsequent exploration and discussion from the other students. This supported the hermeneutic phenomenological approach to my research. The group of students patiently listened to each others' narratives. This supported the trustworthiness and transparency of the research as suggested by Graneheim and Lundman (2004). The students discussed their experiences of being a student midwife. My use of open-ended questioning allowed the student to explore their views and opinions of becoming a midwife. My non-directional questioning allowed the students to speak freely. Using this technique provided me with further opportunity to explore the phenomena of becoming a midwife. This ontological view of focus group research supports the phenomenological hermeneutic analysis of the data, which is supported by the use of van Manen's (1990) principles of data collection and analysis.

Narrative enquiry is concerned with capturing meaning and its construction. It encapsulates the horizons of people's experiences. Using their own words, people express meaning about their experiences (Holstein and Gubrium, 1995). Capturing these experiences is essential to the analysis of the phenomena of their being (Berger and Quinney, 2005). In the revealing process of hermeneutic phenomenology the researcher becomes immersed in the unfolding experience. The myriad experiences produce rich data that must be preserved in time. Recording these experiences allows reflection and analysis (Kruger, 1994; Berger and Quinney, 2005; Holstein and Gubrium, 1995). The use of either video or an audio digital recorder enhances the analysis of the data ensuring transparency in the process of

data collection. Field notes alone fail to capture the nuance of the narrations (Holstein and Gubrium, 1995; Graneheim and Lundman, 2004).

I used a digital recorder to record the narratives of the students with their consent. They were assured of confidentiality and all data was stored securely (Bryman, 2008; Kvale, 2009; Clandinin and Connelly, 2000). Capturing the students' narrated stories enabled immersion into the data, as listening to their stories and their intonations regarding the various subjects was revealing. Listening to the recordings and re-reading the transcriptions allowed hermeneutic phenomenological-sensitive themes to emerge from the data (Kidd and Parshall, 1994; van Manen, 1990). Confidentiality of the identification of the students was important. As previously stated, each student was given a number. This supported the analysis of their experiences. My system of identification of the students was transcribed into the data.

4.9 Reflective diary

The use of a diary within social research has many interpretations (Bryman, 2008). The three main uses for a diary are: method of data collection, the diary as a document, and the researcher's log of their activities. The epistemological use of a diary as a form of data collection is found mainly in quantitative research. The researcher is quite prescriptive in the format of the data collection tool (Proctor and Renfrew, 2000; Bryman, 2008; Reissman, 2008). The use of a diary as a document of a person's life can provide an in-depth view of lived experiences. Importance is given to such documents as the writer details their being. They are the participants and informants of events. They also document their interactions with others (Berg, 2009). The use of reflective diaries may contain significant description and analysis

of emotions and atmospheres. These may be pertinent to their future experiences (Valimaki et al., 2007).

It has been suggested that there is a sense of vulnerability regarding the use of a diary. The diarist may often create a safe environment for disclosure of sensitive information. Exposing its contents may lead to feelings of exposure (Smith and Lev-Ari, 2005; Hobbs, 2007; Bennett-Levy et al., 2001; Glenn and McSherry, 1990). Within the security of a diary, there is a sense of self preservation in the writing of an autobiographical account of events (Bogdan and Taylor, 1998; Denzin, 1978; Allport, 1942). Allport (1942) distinguishes between three types of autobiographies: comprehensive, topical, and edited (Berg, 2009). There is an intimacy that is rarely explored with the usage of diaries within research. There is a freedom of expression afforded by diaries that provides an in-depth exploration of feelings and thoughts (Alaszewski, 2006). Diaries also provide memories of particular experiences (Berg, 2009).

Ethical consideration regarding the right to privacy must be observed (Homan, 1991; Vardy and Grosch, 1999; Beauchamp and Childress, 2009). A research diary demands the same respect as a personal diary. Ownership of a diary within research is tentative as the content belongs to the diarist. Permission to read the entries must be established on commencement of the research study. Without consent the data remains elusive. Agreement to complete a diary does not necessarily give the researcher the right to access the contents. It is well established that research participants have the right to withdraw from the research at any point. Therefore

denial of access can be established (Homan, 1991; Vardy and Grosch, 1999; Beauchamp and Childress, 2009; Riessman, 2008).

As previously stated, I asked the students to keep a reflective diary. Due to the longitudinal nature of the research I asked the students to write down in their diaries any significant issues regarding their learning they wished to discuss. I asked them to bring the diaries along to the focus groups to aid their discussions. The students indicated that they used the diaries but were not prepared to bring them to the focus groups. I respected the students' right to privacy and confidentiality. I accepted that I would not have the privilege of reading their diaries.

My own reflections in my reflective diary revealed my disappointment. I had previously written about the excitement I felt when I bought the books that were to be used as diaries. I had selected different colours for each focus group to aid identification. I remember vividly writing their university and their allocated number on the books stating - *these are just perfect*. I remember when I gave the diaries to the students how they were visibly pleased and assured me of their use. I do not doubt they used the diaries as their reflections on their experiences were broad. This was demonstrated by their referral to the entries they had made in their diaries in the focus group discussions. They discussed their learning alongside different mentors on different wards and departments over the course of the three years. There was much comparative analysis about their experiences across their years of education. Towards the end of the training they suggested how they appreciated the diaries as they were able to follow their development over the three years, thus proving them with many memories. This supported my belief of their use of the diaries. I wrote in

my diary how I had to - *accept my disappointment at not reading the diaries and move on.*

- My reflective diary

I initially started my reflective diary as a means to plotting my progress through the research. It became far more than a description of events as the diary became my companion throughout the study. I became aware of my position in the research and the possible influences my experiences could have on my interpretation of the data. I considered the use of a reflective model to analyse my position and progress of self awareness. The work of Wall et al., (2004) provided me with some initial inspiration and I considered using Kolb's (1984) learning cycle to support my journey. I quickly became aware that a prescriptive approach to self-awareness would not enable me to analyse and acknowledge my presence in the study. Clancy (2013) suggested that the process of reflexivity provides the tool for placing individual experiences in context to their lived-world as interpreted by individuals. Considering the tool of reflexivity and my position within the research I became aware of possible influences I could have on my study. My role as midwife and lecturer placed me in an authoritarian position as I had gained the knowledge the students were hoping to achieve through their education. I needed to acknowledge my position in order to deconstruct how I would approach the students and the interpretation of the data. I considered not informing the students of my qualifications but I felt this would impact on our relationship if they found out. Therefore I decided *honesty was the best approach*, I did emphasise my position as a researcher. Due to the nature of the research regarding the students being in clinical practice I could not disregard my

position as a Supervisor of Midwives. I accepted my interpretation of the role and placed it in context should the need arise.

- Reflection on my research journey

My motivation and rationale for the study drove my reflexivity on my position in the research, which linked with my previous experiences. Training to be a midwife in another time and place encouraged me to deconstruct my pre-conceptions, assumptions and experiences. My study of Husserl's (1929) notion of *epoch* offered a solution which, in part, allowed me to place my experiences to one side. I never did achieve his state of *transcendental ego* as my attempt to bracket my experiences remained a struggle. This I have to acknowledge as the students' narratives awakened memories of my training, and these hovered on the periphery of my mind. This prompted me to write my biography and place it in perspective. My constant use of reflection eventually separated my past from the students' present. My diary entry stated *these are the experiences of university pre-registration degree students and not post-registration nurses as I was*. My next issue was my experiences as midwifery lecturer versus being a researcher. This was a long struggle as I wanted to assess the students' interpretations of their experiences, which suggested I was being judgmental. During these times I wrote in my diary *stop assessing their experiences, accept them for what they are!* My diary provided support during these difficult times.

I decided I needed to develop my skills within qualitative research methods of analysis and interpretation. My reflections on my time away in the South of England, looking at various source of knowledge and also talking to other research students

offered me direction. I read the narrative as they had been told; stories of their experiences. My diary entry stated *listen to their stories as an audio book. Listen to what they are saying*. This supported my struggle to distance myself from my experiences. Gradually the themes from what they were saying emerged from the data; *eureka moment*. My reflection on my experiences supported my progression over the stumbling blocks I encountered. This became part of a constant hermeneutic cyclical approach that supported my need not to contaminate or influence the data.

4.10 Ethical considerations

The collection of data was through the re-telling of the students' experiences. The focus on their lived experiences inevitably brought the students to examine their understandings of their midwifery education. Being in the lived world of a student midwife is a subjective experience. The corroboration of their lived experiences was an eidetic experience. Their personal experiences demonstrated their own particular position within their lived world. Only they could experience their world. This brought a delicacy to their phenomenological experience (Oliver, 2010; Mortari, 2008). Subjective experience has been defined as intentional effects (Oliver, 2010). The qualities of experiences affect how people understand their world. Everyone is affected by the experiences of their lived world. This ontological aspect cannot be shared (Oliver, 2010). The vulnerability of the student midwives was recognized. These new experiences brought exposure to an unknown milieu for the majority of the students. It was considered unethical to probe their vulnerability when the students indicated an uneasiness or unwillingness to share some of their experiences. Confidentiality within health care practices is a statutory requirement

and consent to share information should always be sought (NMC, 2004; NMC, 2012). There was an acceptance that each student recognized their professional obligation. They were, however, candid in their discussions and their dialogue and clarification of their experiences brought authenticity to the research data.

Ground rules were established at the commencement of the focus groups, these were previously discussed on page 107. The students were encouraged to voice their concerns about sharing their experiences. These concerns formed the basis of the ground rules. The main themes that concerned the students were confidentiality, embarrassment, and feelings of exposure. The theme of confidentiality focused on the fear of them sharing information that may become public knowledge to other students, lecturers, and midwives in practice. They did not wish to be identified for fear of reprisal in practice from their mentors. This linked with the theme of feelings of exposure. The students did not wish their thoughts and discussions to be taken into practice. There was a need for anonymity in what they discussed from practice and in university.

They suggested their embarrassment was based on discussing their personal feelings in front of peers who were also their friends. As the ground rules developed I questioned whether I had placed the students in a difficult position with my construction of the focus groups. I reflected on this in my diary and with the students, asking if they would prefer to change their groupings. The students assured me that being with friends was better than being with acquaintances. They had built an element of trust with their friends in their early student days. This familiarity became evident as they progressed through the focus groups when they related discussions

they had had after a span of duty. I discussed my rationale for the use of focus groups on page 118. The ground rules stated that all information revealed and discussed was to remain confidential within each focus group. I gained permission to use the broad themes from the data for use in my research. I assured them of confidentiality as I used numbers to use as pseudonyms.

At times the students became emotional in their discussions. These were based on their understandings of the treatment they had received from their mentors in practice. At times the students struggled to apply their cognitive knowledge to their practice. This supported the work of Lange and Powell-Kennedy (2006) regarding their work on the theory-practice gap. Many of the students expressed feelings of frustration. They suggested their mentors rebuked them for not complying with their ways of working even though the mentor's practice was not considered to be research-based. On occasion the students' emotions were centered on their interpretations of the treatment the women received based on the midwives ways of working.

My reflections on the incidents the students discussed placed me in a difficult position. My original thoughts of my use of epoch caused me much turmoil. As a midwife and a supervisor of midwives (SOM) I am bound by my sphere of practice to protect the women from harm (NMC, 2012). For this reason I advised the students to speak to a SOM in their home Trusts regarding what they had observed and experienced. I had originally provided the students with a letter of support offering guidance to where they can seek support and help for themselves during the research (Appendix C). My duty of care to the women as a midwife and a SOM

became a priority, as I could not ignore their concerns (NMC, 2006; NMC, 2012). I offered to act as an advocate for the students but they assured me they would speak to their student link SOM. I accepted their plan as they were passionate about improving the care for the women. In my reflective diary I wrote of my *struggle* as a researcher to step outside the boundary of impartiality. But as a midwife and SOM I wrote how *annoyed and frustrated I was for the women and students for being subjected to poor/bad practice in modern midwifery*. If I had remained impartial I would have been culpable of condoning bad practice. This I could not accept or ignore. Accepting the confidential nature of Supervision of Midwifery, I later asked the students if they had spoken to a SOM regarding any issues of concern they had experienced following each focus group meeting. This contributed to their analogy of the focus groups as being part of a counselling process. This was an interesting new discovery to emerge from the data.

4.11 Heidegger's Hermeneutic Phenomenology as a research method

'Phenomenology is a philosophical approach to the study of experiences' (Smith et al., 2009 p11). This philosophy has been developed over many years. In particular there are three main schools of thought: Dutch, French, and Duquesne (Gearing, 2004; Ehrich, 1999). For the current research the Dutch school was the most appropriate method as it combines both interpretive and descriptive phenomenology; hermeneutic phenomenology. The French school was not appropriate as Husserl's focus was on the explanation of experience. The Duquesne school was also not appropriate due to its strong focus on psychology. Heidegger's philosophical concerns were ontological; his aim was the understanding of 'being' itself (Mackey, 2004). Heidegger's work was written at a theoretical level. He did not provide

guidance on one choice of method when conducting hermeneutic phenomenological inquiry. He considered this to be restrictive (Ehrich, 1999; van Manen, 1990; Lavery, 2003). Research requires structure to be evident. Adapting previous techniques of interpretation and description to one's own study is generally accepted practice. There have been many phenomenological theories and research methods used in nursing research. These include Giorgi, Colaizzi, and Van Kaam. Their methods were devised from the ideals of Husserl. They had a psychological orientation, focusing on 'nurses and patients experiences of existing in a health attainment environment' (Annells, 1996 p707). These methods and theories were rejected as they were not in keeping with the philosophical approach to the current study.

Within the phenomenological and hermeneutic tradition Heidegger considered phenomenology as interpretation of the life-world as it is experienced. Van Manen's work was influenced by the Dutch school and the German tradition of 'human science pedagogy' (van Manen, 1990; Maggs-Rapport, 2001). Through his studies of Langeveld, van Manen came to realize the importance of understanding the meaning of human phenomena:

'His pursuit was to understand the phenomena of the life-world in order to see the pedagogical significance of situations' (Ehrich, 1999 p30)¹³.

Van Manen suggests that phenomenological human science research is based on the explorations into the structure of the human life-world as experienced in everyday life. These experiences are individual to each person throughout their life which can be grounded in fundamental thematic structures. He describes four existential structures: lived space, lived body, lived time, and lived human relations.

¹³ Permission to reproduce this excerpt has been granted by RMIT Publishing

These existential themes assist in researching the human experiences of the world (van Manen, 1990). Due to his approach to a variety of subjects, his method has been commonly adopted by a number of health care professionals, such as sociologists and social scientists (Maggs-Rapport, 2001). His method demonstrates the interrelationship of phenomenology, hermeneutics, and semiotics. He demonstrates a research process of textual reflection that adds to understanding practical action. His style of writing is both amenable and has an emphasis on ways of dealing with complex research issues (Maggs-Rapport, 2001; Munhall, 1994; Ehrich, 1999; Morse, 1994). For these reasons van Manen's guidelines were chosen to inform the current research.

The method used by van Manen synthesizes hermeneutic phenomenological principles into six research activities. These six activities offer guidance on selecting appropriate research methods, techniques, and procedures for a particular question. They should not be used unquestionably but should be used as a principled form of inquiry (van Manen, 1990). They are:

1. Turning to a phenomenon which seriously interests us and commits us to the world;
2. Investigating experience as we live it, rather than as we conceptualise it;
3. Reflecting on the essential themes that characterise the phenomenon;
4. Describing the phenomenon through the art of writing and re-writing;
5. Maintaining a strong and oriented pedagogical relation to the phenomenon;
6. Balancing the research context by considering parts and the whole.

(van Manen, 1990 p30)¹⁴

¹⁴ Permission to reproduce this excerpt has been granted by SUNY Press

Comparing the work of other researchers with van Manen, such as Colazzi and Giorgi, the activities described by van Manen (1990) are similar. All three researchers follow the principles of the hermeneutic circle. They incorporate reading and re-reading the text and extracting significant sentences and then describing them. The main difference is that Colazzi and Giorgi stop at the point of description, which is a Husserlian focus. They re-integrate the themes back into the whole, having achieved their understanding of what the essence of the experience was and how it happened. Van Manen, on the other hand, takes the research a step further to allow interpretation of the lived experience of the phenomena to occur, which is the philosophy of hermeneutic inquiry. This clearly demonstrates the differences between phenomenology and hermeneutic phenomenological research.

There have been other Heideggerian methodological guidelines of inquiry. In particular, in nursing research, Dieckmann et al (1989) developed a seven stage process that involved data collection and analysis by a team of researchers. The hermeneutic process involved multiple stages of description and interpretation. A criticism of this work was that there was no evidence of the use of the hermeneutic circle (Annells, 1996). This is in contrast to van Manen's method, which can be applied by a single researcher and which is grounded in movement within the hermeneutic circle. This increases the suitability for the use of van Manen's guidelines for the current research.

4.12 Applying hermeneutic principles to the method used in the research

As previously suggested within hermeneutic phenomenology there is constant movement. The hermeneutic circle encourages an evolving reflection and

interpretation of the life-world of others. Language provides the medium for a window into the life-world experiences of others. As a corollary this movement pre-disposes to an ever evolving interpretation of the method used to understand the interpretation of the data. There must be a consensus that the principles of hermeneutic phenomenology are maintained so as not to change to a different phenomenology.

In the current research Van Manen's guidelines were adapted as follows:

1. It focussed on the phenomenon of becoming a midwife within a work place environment
2. It investigated the phenomenon within the work place environment where the student received clinical experience of caring for women during pregnancy and childbirth
3. It drew on hermeneutical phenomenological principles while reflecting on themes
4. It drew on hermeneutical phenomenological themes while describing and interpreting the students' experiences
5. It followed the hermeneutic circle's cyclical principles while describing and interpreting the students' experiences
6. It considered all extracts of the material and themes on their own, as well as in the context of the bigger picture of the study

The analysis of the transcripts was supported by following van Manen's (1990) research activities. Though the activities are discussed individually below, the process was cyclical and as such became a continuous flow of interpretive analysis.

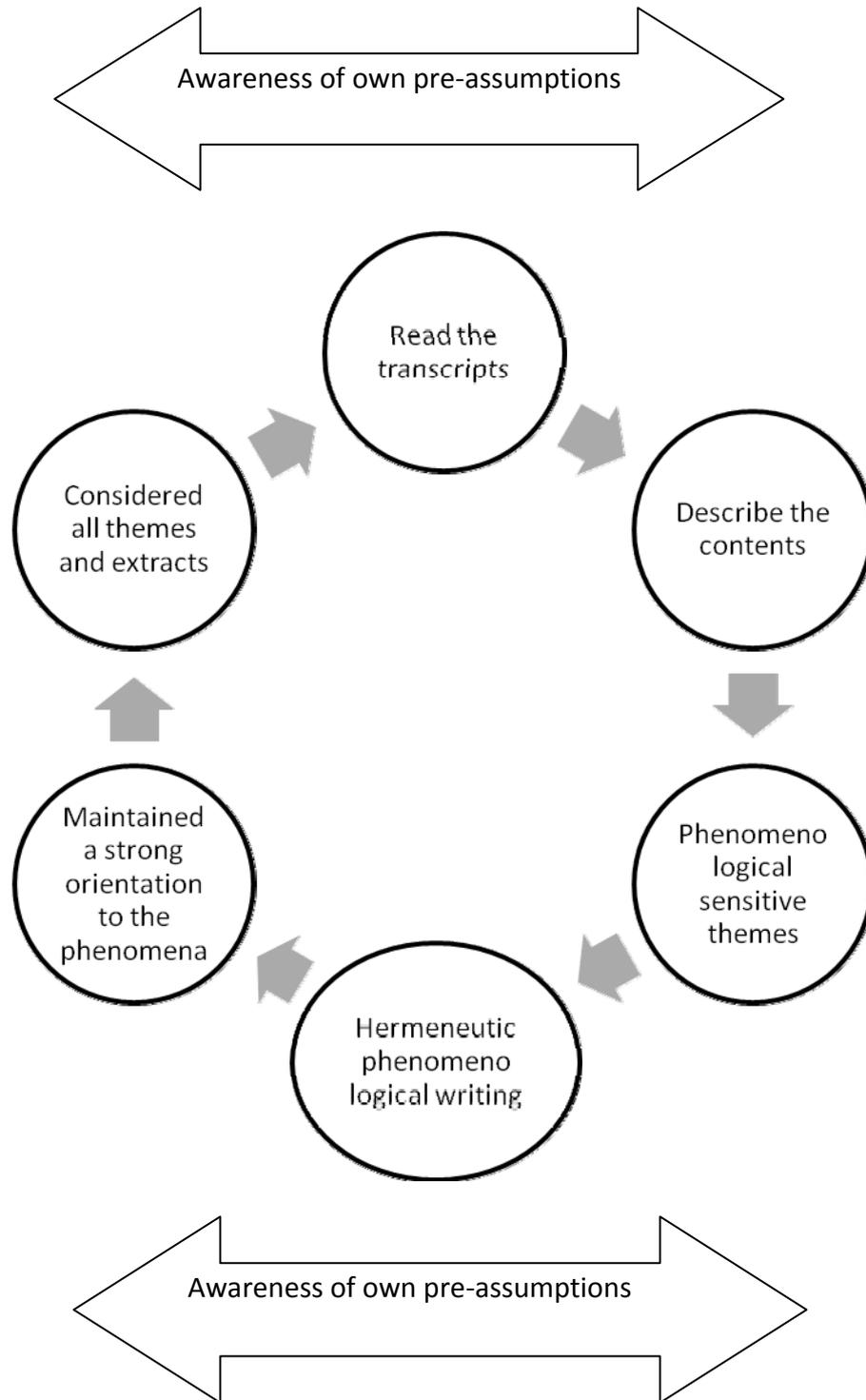


Table 2: My use of van Manen's guidelines in the current research

The table demonstrates the cyclical process that informed the interpretation of the data. Van Manen (1990) suggests that analysis should not be a linear process but

should demonstrate constant movement throughout. Having an awareness of one's own pre-assumptions allows flexibility of thought to pervade the analysis.

Stage one: Following my transcription of the interviews I read and re-read the data. I listened to the audio recordings highlighting any nuances such as laughter, sighs and elements of concern and frustration which were expressed as raised voices or whispers. This enabled me to become totally immersed into the data. It also enhanced my memory of each student's narratives. I was able to identify each student's physical presence/position in the focus group in relation to their voice. This provided me with an overall phenomenological framework for the exploration of their lived experiences within clinical practice. Following this examination of the whole I was then able to see what parts of their experiences made up the whole as described by van Manen (1990).

Stage two: I continued to read the text throughout the process of analysis. Following each focus group I attempted to describe the students' experiences. This provided a basis for analysis. I questioned what were the students telling me about their experiences. This was a continuous/recurring process of analysis. Being able to generalise the content gave the data direction and a flavour of the whole of their experiences. Stages one and two were a recurring process throughout the analysis; keeping to the true nature of the phenomena was essential (van Manen, 1990).

Stage three: I used a highlighter pen to identify and select relevant themes that emerged from the data. This was achieved by reading and re-reading the data in its original and subsequently described form. I placed these into a separate document,

ensuring I maintained the original data in its original format. This was to ensure I remained true to the students' interpretations of their experiences. I considered all the selected themes to be of equal value to the students' experiences.

This was followed by an activity known as Composing Linguistic Transformations (van Manen, 1990). This is regarded as a creative hermeneutic process that aims to transform selected statements into phrases that are phenomenologically sensitive. As Husserl suggested, the process of Free Imaginative Variation was undertaken (Ehrich, 1999; Rapport, 2004; Spinelli, 1995; van Manen, 1990). I then undertook further analysis by sorting the data into themes that were considered to be essential to the students' experiences of becoming midwives. Those that were incidental to it were separated. The incidental themes were discarded and the essential themes were kept for further analysis. The task of separating the incidental themes was robust as I questioned whether these discarded incidental themes would change the phenomena under study. Van Manen (1990 p107) states that there is a need to 'discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is'. On occasion it is acceptable to incorporate incidental themes into essential themes or amalgamate some incidental themes together to produce another theme that is essential to the phenomenon (van Manen, 1990). To establish if the themes were supportive of the phenomena I asked questions such as: 'If I delete this theme from the phenomenon would it change the meaning of the students' experiences of becoming midwives?' 'Is the theme essential to the students' experiences of becoming midwives?'

Stage four: During this stage of the analysis the hermeneutic phenomenological interpretations of the student midwives' experiences were transformed into phenomenological textual descriptions. I studied the selected essential themes and related them to the students' narratives. Identifying the phenomenological and self-world experiences supported my analysis and writing. I explored the emerging themes from each focus group in each university. I then compared and contrasted these themes across both universities. This provided further descriptions which aided my hermeneutic phenomenological analysis. I selected relevant narrated passages from the data to support my interpretation.

Van Manen suggests that writing involves a difficult process of bringing to life the phenomenon that can only be expressed in words, stating, 'the problem with writing is that one must bring into presence this phenomenon that can be represented only in words – and yet escapes all representation' (van Manen, 2006 p718). Silverman (2003) previously suggested that it is the role of the researcher to interpret the cultural life stories of the participants. This creates a tension between what is presented and its representation; seeing and understanding (van Manen, 2006). The act of phenomenological writing takes this into account. It does not claim to hold the definitive interpretation of the phenomenon, which in the current research is the experience of the student midwives. Van Manen (1990; 1997) suggests that the organisation of one's writing is important in relation to the fundamental structure of the phenomenon. It was very important to consider the structure of the research in terms of parts and wholes. He demonstrated a possible approach consisting of five categories:

- Thematic: searching for generative themes as guides for writing

- Analytical: analysing interview transcripts to search for anecdotes that support the life-story
- Exemplificative: proceed from a description of the phenomenon and systematically extend the description taking into account other interpretations of the phenomenon
- Exegetically: organising one's writing around other authors to show something that is typical to the phenomena
- Existentially: '...weave one's phenomenological description against the existential of temporal, spatiality, corporality and sociality' (van Manen, 1990 p172)¹⁵.

For this research I used a combination of thematic and existential approaches. This approach supports the research, as the student midwives were from two different universities. The students' entries to the universities were also at varying times in their lives. Therefore, considering existential phenomena with the thematic analysis of their lived experiences produced rich hermeneutic descriptions and interpretations of the data.

Stage five: Maintaining a strong orientation to the phenomena requires a process of self-reflection and an immersion into the data. This is contrary to Heidegger's beliefs regarding the phenomenological practice of bracketing and the hermeneutic position that pre-assumptions cannot be set aside (Maggs-Rapport, 2001; Lopez and Willis, 2004).

¹⁵ Permission to reproduce this excerpt has been granted by SUNY Press

I felt the process of bracketing my pre-assumptions was important to the research. Having previously trained as a midwife, albeit a number of years ago, I was aware of the possible risks of my contamination of the hermeneutic descriptions and interpretations of the students' lived experiences. Immersion in the data awakened many memories of my previous experiences. The process of bracketing allowed me to transcend these thoughts and feelings, permitting the development of *zu den sachen* (to the things themselves) to occur. The process of bracketing was accomplished by:

- Writing an account of my biography. This highlighted how midwifery education had changed over the years since my days of training. Prior to entering midwifery there was a requirement of a nursing qualification; this took three years to complete. Therefore upon entering midwifery training, of 18 months, I had advanced knowledge and skills of caring for vulnerable people in many care settings. Students currently entering a three year degree midwifery programme of study do not have this advanced standing; therefore it became easy to bracket my pre-assumptions, in order to explore the students' experiences of becoming midwives.
- Prior to starting my data collection with the student midwives I undertook a two week residential course on qualitative data analysis. This allowed me to explore my knowledge and skills regarding the various qualitative research philosophies, methodologies and methods. The course confirmed that my chosen philosophy of hermeneutic phenomenology was correct. I developed the skills of thematic analysis and hermeneutic description and interpretation.

This learning process has enabled me to progress utilising the hermeneutic circle (van Manen, 2000). I view the data in terms of the parts that make up the whole of the lived experiences of the students. Through the analysis of the data I am able to consider themes and their related extracts. This supports the description and interpretation of the students' experiences and is in keeping with Stage 6 of van Manen's guidelines (1990).

- Authenticity, transparency and trustworthiness

Judging the value of a study is important as this supports the credibility of the finding. The terms authenticity, trustworthiness and transparency of qualitative research have evolved away from the scientific model of quantitative research (Lincoln and Guba, 1985). Considering the concept of authenticity, Reason and Rowan (1981) stated that the focus is on the researcher and their commitment to their study. The philosophy of qualitative research requires the total involvement of the researcher. The researcher and also the participants are involved in several layers (Rowan, 1981). Therefore there is a need for personal commitment to the study, which demonstrates an ability to be reflexive throughout the study. This can bring about an altered state of mind (Reason and Rowan, 1981). Reflexivity supports the researcher to be aware of their pre-assumptions and commitment to the study (Rosen, 1981). Considering the concepts of authenticity in relation to my study, my commitment has been proved as the study has been completed. I never questioned whether I should continue with my study as this would have been a selfish decision. My longitudinal study took me on a journey of discovery. The process of reflexivity enabled my development and a change in attitude. My decision to undertake a two week residential course on qualitative research supported my understanding of interpreting

the data objectively. This supported a change in my outlook on life in general. It also enabled me to accept the students for who they were and their experiences as their own.

The concept of transparency is based on the structured approach to the study. Yardley (2008) stated that transparency is based on the power and clearness of argument. There should be consistency between methodology and method used and transparency between the method and the collection of the data. Evidence of reflexivity is essential and this was supported my understanding of their experiences. I chose to use hermeneutic phenomenology, which seeks to explore human experiences. I wanted the students to see themselves as partners in the study. The structure of my study enabled me to return to the students for further insights, views and opinions and this supported my analysis of the data (Smith, 2008). The methods used in my study were consistent with hermeneutic phenomenology. To be of value and benefit this study had to reflect the central principles of good inquiry. The use of focus group discussions and diaries supported my transparency in collecting the students' experiences. My use of reflexivity has been honest and at times personal as I detailed my struggles with my dual role as researcher/midwife in my reflective diary. I believe this added to the transparency of my study.

The concept of trustworthiness is based on the truthfulness of the findings (Cresswell, 1998; Koch, 1996). This is something that must be considered at every stage of the inquiry. It is concerned with the ethical aspects of the study through to the analysis of experiences and the interpretations of the understandings that are created for the wider community. Lincoln and Guba (1985) stated there should be

evidence of their applicability to other contexts and other respondents. That the study can be replicated with the same respondents and also that the responses have not been influenced by the researcher. There must be confidence in the findings. I gained ethical approval for my study from Liverpool John Moores University and the two universities the students attended. This guided the interpersonal and ethical aspects of the study. The ethical principles were applied at each stage of the study from my first contact with the students, through the managing and protection of the digitally recorded experiences. All the students were volunteers and I provided written information about the study. I only asked the students to sign a consent form once I was sure they understood what the study was about (Moustakis, 1994).

My role was to encourage the students to tell their experiences. I had to generate an environment that was supportive for this to take place. This would help me to uncover the understandings that I sought (Baker, 1997). I reflected at each stage of the inquiry, particularly during the interviews and at the analysis and interpretive stages. I needed to maintain my focus on the students and their experiences. This supported my exploration of the themes that emerged from the data. Considering this concept in relation to my study my use of reflexivity and my reflective diary were my constant companion. My phenomenological reflection supported me in all aspects of the study, which kept my focus on what I was trying to achieve. It also allowed me to critically reflect on my presence in the study, in particular my dual role of researcher/midwife.

There is much discussion regarding qualitative content analysis. Graneheim and Lundman (2004) suggest that the basic issue when performing qualitative content

analysis is focused on manifest or latent content. Manifest analysis deals with what the text says and the obvious connections to the subject. Latent content analysis, in contrast, deals with relationships which involves an interpretation of the underlying themes and meaning of the text. The analysis of data from the focus groups involved a latent content analysis ensuring trustworthiness and authenticity of the data. This approach supported my choice of data analysis using the guiding principles of van Manen (1990).

4.13 Conclusion

The empirical research that informed my thesis focused on narrative inquiry in focus groups. The purposive sample of student midwives (n=22) was taken from two different universities. The age range of the students was 18 to 38 on commencement of the research. This was a longitudinal study over a period of three years. Using hermeneutic phenomenology as the research methodology allowed for description and interpretation of the students' lived experiences of becoming midwives. The ethical issues concerning the sharing of their lived experiences were numerous. This may have contributed to one focus group (n=4) declining to continue with the research, but this would be pure conjecture on my part. Within hermeneutic phenomenology there is an element of reflexivity. This brought me to reflect on my own biography and how this supported my methodology. During this period of reflection the use of *epoch* was found to be appropriate.

Using the methods illustrated in this chapter I consider the research provides a new contribution to the phenomenon of becoming a midwife. Using focus groups within hermeneutic phenomenology provides an innovative approach to the collection of

data. The following chapters discuss the phenomenologically sensitive themes found within the data. These chapters represent the students' lived experience from each year of the midwifery degree course.

Chapter 4 presented a focused rationale for the choice of using hermeneutic phenomenology as the research methodology. In Chapter 5 the findings of the first stage of the study 'The Lived Experiences of Becoming a Student Midwife' are presented.

Chapter 5

Lived experience of becoming a student midwife

5.1 Introduction

This chapter presents the empirical findings from the first stage of the study: 'Lived Experiences of Becoming a Student Midwife'. The students had commenced their studies five months previously. They had experienced both theoretical and clinical learning. They were asked to reflect back on why they wanted to be midwives.

5.2 Phenomenologically sensitive themes essential to the lived experience of becoming a student midwife

Hermeneutic phenomenological analysis of the narratives of the student midwives revealed many phenomenologically sensitive themes. These have been merged into three main themes that provide a better understanding of the essence of the students' experiences

- Reflection on future career
- Decision making process
- Identifying with the role of the midwife

Table 3 below provides an overview of the main themes and their related sub-themes.

Main theme	Sub-themes
Reflection on future career	<ul style="list-style-type: none"> • Education – planning for university / career • Life choices • Exploration of career choices / influences
Decision making process	<ul style="list-style-type: none"> • Birth experiences of family and friends – role of the midwife • The wonder of nature – development and birth processes • Woman-centred care – relationship between woman and midwife
Identifying with the role of the midwife	<ul style="list-style-type: none"> • Identity - caring personality types • Educational development • Professionalism • Cultural ideology of the birthing process

Table 3: Sub-themes organised next to Main themes.

The three themes and their sub-themes are explored further below. Each is supported by representative samples of quotes taken from the transcribed narratives of the students. The quotes are typed in *italics* to facilitate differentiation between the quotes and their description. The words and numbers represent each student and their university. Each student was given a number to ensure confidentiality. The

students were in the first year of their midwifery degree. They were interviewed when they had completed five months of their midwifery training.

5.2.1 Reflection on future career

Reflection on a possible future career as a student midwife will have a separate meaning for each student (Radford and Kirby, 1975). Interpretation of the phenomena that each of the students experienced was based on the narratives of their experiences. These were constructed by each student. Individual experiences are formed through feelings of identity and they convey a uniqueness of one's own life (Roesler, 2008). Identities consist of the stories of lives and experiences that are continuously related, both implicitly and explicitly. This narration presented an interpretation of the experiences made. Roesler (2008) suggests that humans are constantly constructing their lives with each experience. Each new experience needs to be interpreted against an already known construction to be of added value to the person. These constructions provide the person with identifying factors that give a sense of belonging (Kerby, 1991). Possessing personhood is viewed as having an embodied, conscious being with the capacity for language and morals (Mayr, 1982; Morris, 1991; Benedict, 1934; Leach, 1982). These concepts place the person within a cultural category. Being part of a cultural community provides the person with lived experiences through cultural representations of everyday life within the community (Mayr, 1982; Benedict, 1934; Leach, 1982).

It has been suggested by Erikson (1974) that identity was formed mainly in adolescence, and upon reaching adulthood was formed completely. This has since been disputed (Gergen and Gergen, 1978). Identity is a form of inner authority which

provides the person with continuity and uniformity over time and in different situations. It provides cohesion between different experiences in all aspects of life (Roesler, 2008). In modern society Roesler (2008) advocated that the uniformity of past social identities appeared to have been eroded. People are now exposed to multi-media experiences that challenge traditional ways of being. They are able to identify with many ways of life, differing philosophies and many different cultures. The media may have gained an important role in the formation of modern day identity, as suggested by Jung in his earlier work on individuation (1973). It could be argued that people now have fragmented personalities that are dependent on place and associations with others they encounter at particular times in their lives (Jung, 1973). Conflict may arise within their identity as inherent values may be challenged (Roesler, 2008; Gergen and Gergen, 1978). These developments will result in the person consisting of part-identities or part-personalities within the ever evolving self, which has become dependent on the relationship to others, and not as an entity in it (Gergen and Gergen, 1978).

Past experiences and personal backgrounds during childhood help to form the character of the person (Allport, 1955). Allport suggested that the course of personal growth is in part guided by certain factors. Among these are genetically linked characteristics that can be described as inherited traits such as temperament, physique, intelligence and personality. Yet there is no biological evidence that this genetic make-up exists (Morris, 1994). There is, however, a suggestion that chance factors such as environment, culture and health issues may influence personal characteristics (Allport, 1955). Morris (1994) supports this suggestion by stating, 'The self being constituted within a social context; mediated by social praxis' (p13).

Having the ability to grow and adjust to external forces that affect normal everyday life influences the development of the self. These adjustments are part of the evolution and construction of the person throughout their life. These adaptations become entrenched within the psyche, allowing the person to become who they are (Allport, 1955). Jung, in his work on individuation, suggested that the personality is formed through the interpretation and understanding of past and present experiences, thus suggesting there is a constant mode of adaptation to new experiences (Jung, 1973).

Exploration of the students' experiences of their decision to become student midwives provides numerous narratives. These are characterised by personal experiences encountered during their lives. The decision to become a student midwife appeared to have been influenced by many internal and external factors during their development. These led to the theme title of 'becoming a student midwife' as a key element in the exploration of the decision making process. The following sub-themes contributed to this theme.

- **Education – planning for university / career**

The training of student midwives is now at graduate level. Most universities require entrants to have appropriate academic qualifications. This is considered a potential guide to the student's educational ability to study at degree level (Baird, 2007). The students viewed their education on a wider scale than gaining the required degree points to enter university. There was an element of a wider social and lifelong educational development to becoming a student midwife that impacted on their lives. This they explored through their narratives with each other.

'The main reason I chose to be a midwife is because I think it's a really amazing opportunity to really empower women at a really important time in their lives. I'm really attracted to the fact that each day is new, each woman is a different experience... and it's also a great learning sort of career for you as well. What swayed my decision to be a midwife was that both my sisters, one's four and one is one, were born at home and I was there for the birth of my youngest one; I was quite involved in her experience. I was there for all the antenatal checks... I was quite involved in the birth.... I just found it such an amazing experience and seeing the emotions that my mother went through, and the midwife, I decided that's definitely the career I wanted to progress with, and I'm very happy' (University A, Group 1, No. 5).

'I always knew I wanted to be in a health care profession but I knew I didn't want to be a nurse or a doctor. I wasn't clever enough to do that... I was reading my sister's pregnancy book and I realised how interesting I found it and how fascinated with pregnancy I was... I've never really put two and two together; it was like a light bulb moment again. I was just like, 'why have I never thought about this before?' Then I couldn't imagine doing anything else, but I think it was being around a lot of pregnant people like my brother's wives and sisters that made me realise, I think?' (University A, Group 2, No. 4).

'I first found out about babies and things when my mum fell pregnant with my brother but I was only little, I was nine and I just have like a memory of being sat on the bathroom floor with the baby book and just looking at all the pictures and being amazed at how he was growing and... I remember sitting there and being like, wow he's the size of a key and a grape and now he's this big, and just being absolutely fascinated by it all and then as I grew up I just thought... I wanted to do something within the health profession ... I didn't want to be a nurse, I just did not, I didn't. There was no drive in me to do that and my mum was – 'Well look into other areas,' and then I looked into midwifery and I thought that could be quite good, and then I realised how fascinated I was with it all... the whole pregnancy and the psychological aspects of everything and I just thought – that would be quite good' (University A, Group 2, No. 2).

- Life choices

The issues surrounding the students' choices of becoming a student midwife are closely linked to the previous sub-theme. Their choice of career appeared to focus on providing care to well women with a possible social aspect to the job.

'I think pregnancy is healthy most of the time and it's just giving that care' (University B, Group 2, No. 2).

'I've wanted to be a midwife for a long time... when I left school... I was told there was a waiting list to get on - so do nursing first and then midwifery. So I did travel and tourism first and then went onto work on cruise ships for 8 years. So went off in a different direction, then when I came back to England I decided it was time to do what I wanted to do all along and applied for the course and got in, thankfully' (University B, Group 1, No. 1).

'I looked at nursing, midwifery and occupational therapy and in the end I did some work experience on a paediatric unit and the neonatal care unit at my local hospital where I live. I really enjoyed it I did quite like what the nurses did but I wanted more responsibility and I wanted to be able to make my own decisions so that lead me to midwifery' (University A, Group 1, No. 4).

- Exploration of career choices – influences

The decision to become a student midwife developed from internal and external influences, as suggested by Kerby, (1991) and Roesler, (2008). Some of the students related that they were encouraged to become a midwife mainly by their mothers. Others were dissuaded by their fathers/step-fathers. *'My dad was really like, no – go into the army'* (University A, Group 2, No. 3). The ultimate decision though was made by the student. The students with children appeared to have been influenced by the midwife who provided care to them during their pregnancies and birth experiences. *'My decision to become a midwife was about 14 years ago when I had my first child, and it was my community midwife that inspired me'* (University B, Group 1, No. 4). These holistic experiences of care provided by the midwife during a particularly vulnerable time in their lives provided a cultural experience that generated a need to share that experience with others. Narration of the events of their birth stories highlighted the history of these events, thereby keeping the experience in the present (Polkinghorne, 1988). This gives the experience the view of parts and whole, which may need to be shared or resolved (Gadamer, 1987; Polkinghorne, 1988). The need to recreate and share their experiences may be a reason for their career choice.

'I just wanted to be a midwife then my dad just tried to persuade me – 'oh why not be a paediatrician because it's more money, better hours and stuff?' I was there like, 'I don't want to do it.' I never changed my mind, if I didn't do it I don't know what else I'd do it's just always been my dream to do it' (University A, Group 2, No. 1).

'...my mum was really – 'yeah you'll love it,' being really supportive. I think (my dad) thinks it's really like you stay at one level all the time and I'm like, no there are - you can get up to like pretty good wages if you work your way up. I said, 'It's not like you just stay and you are a midwife on a normal wage, you can work your way up and become a supervisor,' and he still doesn't... I think he's secretly proud of me now, but he's still quite like, 'hmm'. My mum had lived the army life for about ten years, so my mum was like, 'Yeah it's a really good life, everything's done for you...' If I would of gone into the forces with a nursing degree I would have been an officer so I would have had everything done for me, everything paid for me, my course would have been paid for me, wages throughout my course and my dad was like 'What's wrong with that?' I was like, 'I don't want to do that' (University A, Group 2, No. 3).

5.2.2. Decision making process

- Birth experiences of family and friends – role of the midwife

Part of the decision making process for the students was their interpretation of the role of the midwife. This appears to have been generated from their experiences of being a birth partner to others or through a chance meeting.

'I wanted to be able to make my own decisions so that led me to midwifery. I went to some antenatal appointments with a family friend and I really enjoyed it and got to palpate her abdomen and things like that and the midwife was really nice and I got given loads of information so then I was absolutely sure that's what I wanted to do...' (University A, Group 1, No. 4).

'...my sister got pregnant and had quite a lot of problems with the pregnancy so she was in hospital for a month before. She was induced six weeks early so really she was in hospital ten weeks before the baby was due. She saw loads of doctors because she's got lupus so they didn't quite know how it would affect the baby. She saw like loads of doctors and they were really sort of, didn't have a very good manner with her. They didn't explain things very well to her and she was always terrified. Then the midwives came in and you could literally see her just relax when they came. She knew they wouldn't be talking about lupus. They'd literally come in and tell her about her baby and that was what it was for her and that sort of was what started it off for me' (University A, Group 1, No. 2).

'I didn't know what I wanted to do at all until my gap year. I'd done my A levels and everything and went travelling. I met a girl from Holland who was a midwife, twenty four, and she'd just graduated and absolutely loved it. I just thought - I was just chatting to her and I thought – 'why haven't I thought about that before'; it was just like a light bulb cliché, it was just like a light bulb. I just thought, 'that's what I want to do'' (University A, Group 2, No. 3).

- The wonder of nature – development and birth processes

The biological processes of the development of the fetus to the birth of the off-spring appeared to hold some fascination for the students.

'I first wanted to do midwifery about 10 years ago, purely based on the principle that I think the miracle of life is absolutely fascinating. I find that anatomy and physiology is quite hard, but I really find it interesting. I just want to be a part of the birthing experience; see life being formed from the early stages to the birth, you know, final moments and beyond' (University B, Group 1, No. 4).

'I've wanted to be a midwife since I was really young and why... I think the fascination of how a baby can grow and develop inside a woman is a sort of starting point for it' (University B, Group 2, No. 1).

'My decision sounds a bit silly but it's not really. I watched a programme that was animals in the womb when I was about fourteen. Then there was another one, it was like a little series of twins in the womb and it was showing how they all could connect through their amniotic sacks and things. I just loved watching it and I just thought it was amazing that they're living inside of you. Then I just became fascinated with pregnant women and I'd stare at them in the street!' (University A, Group 1, No. 1).

- Woman-centred care – relationship between woman and midwife

The students offered their interpretations of the midwives relationship with women and their role.

'And I was about to pick my GCSEs and I just couldn't come up with anything. I was sat there reading this... magazine (laughter). And there was like a full page advert for the NHS. And it had this woman pushing this baby in the park and it said... this woman had so many people deliver her baby but she'll always remember the care the midwife had given her. It sort of suggested that hadn't she remembered the rest of the care given, she would remember the care the midwife had given her' (University B, Group 1, No. 3).

'I had my son in hospital had a so-so experience with him as (Name) said there were quite a few midwives who were really generously good and out going towards me and things like that. And then I started processing everything in my head and decided I wanted to look into it putting more into it and decided why can't I be a midwife? Why can't I be the person who changes peoples' lives in a nice way? Be thought of in a nice way that if you are doing something for a woman and her family and comes to a good at the end that you know that midwife did all she can. So I want to be that sort of a person' (University B, Group 2, No. 1).

'I think it's a lot more personal as well, isn't it? It's like, being the midwife you have to sit and talk to them, whereas if you're a nurse you just make them better, it's like, 'see you later'. Whereas the midwife has to have a relationship with the patient, well, the woman, you're with so... You don't get that continuity like if you were with a woman and she's come in labour. You're with her unless she's in labour for like however long where you have to shift change... Whereas I got the impression with nurses it was - go and do that to that person, do that to that person - and if you helped one person you'd never see them again even if you're on the same sort of shift you'd be with lots of different people. Whereas on placement I've been with women for my whole shift, seen them come in, in established labour, delivered and then on post natal like the whole thing it's like a beginning and an end to it. You get to see the whole thing' (University A, Group 2, No. 2).

5.2.3 Identifying with the role of the midwife

- Identity - caring personality types

In their shared narrations of their decisions to become student midwives they appeared to interpret the role as vocational and a need to provide care.

'You find, yeah, you find a lot of the people on the course. We're all really similar as well and it makes you think, is it only certain types of people who can be midwives? It is really weird because I remember coming in on the first week and just realising everyone was really similar and like we're all interested in the same things, like when we talk about things' (University A, Group 1, No. 2).

'Because it's not just a job, it takes a special kind of person to be a midwife and to be a good midwife, and that's without blowing anyone's - my own trumpet or anyone else's' (University B, Group 2, No. 3).

'Because I think they (midwives) do love their job, they love working with women they just don't want to abandon them. This is the message that I get and somehow I think a lot of them think it's going to change eventually' (University B, Group 1, No. 2).

- Educational development

The students reflected on their experiences regarding their studies.

'I've given myself seven months and until Christmas because I'm not seeing it as a three year course. I'm seeing it as three months, three months, three months and I'm thinking, OK two and a half years left, it's a bit scary now. I think they made the right choice picking me! I don't think exam marks should have anything to do with it, its people skills I have got' (University B, Group 2, No. 2).

'I was very overwhelmed with theory to begin with, very frightened, addressed my concerns to everybody, tutor and friends' alike and fellow students and now I am finding I am doing quite well in revision which I didn't think I would be able to do. I didn't think my memory was any good any more with my age to keep the information in and.... before Christmas we were really led into a false sense of security because we weren't given any work to do, hardly any homework, no essays nothing and we were told to leave OSCE's until after Christmas so our first piece of work has got to be handed in on the 15th February. And before Christmas I felt like I hadn't done anything and now I suddenly realised we've got an exam in 11 weeks and a mock before that and now we have to revise' (University B, Group 1, No.4).

- Professionalism

The students appeared to view the role of the midwife as something to aspire to.

They discussed attributes that they considered to be requirements for their chosen career. Their narrative suggested a sense of respect for the midwife and the woman.

'The communication that I learned on the ship dealing with different situations and different people from different classes, and confrontation... and just being able to meet new people and being able to speak to them about different things, that has really helped me... you see everyone from different nationalities and you have to be sensitive to their different cultures so it has definitely helped me from that side' (University B, Group 1, No. 1).

'When I'm in the uniform I'm thinking, 'yes I am a student midwife. I can do this.' I don't know, it gives me a confidence boost, thinking I can get through it, I'm a student midwife and wearing the uniform I have to be up to that professional standard as a student whereas I think if I was in my own clothes I just feel a bit like oh! Back to work back on placement oh! I don't know, I always feel like you have to step up to the bar when you're in uniform because you're expected to step up to the bar' (University A, Group 1, No. 4).

'I come home amazed and thinking how multitalented are these (midwives) and I've got to be one of them because there's so much more to just being a midwife than just OK... a palpation... take blood... deliver a baby! There's an unbelievable amount, there's so much more than that. You don't see... you can't read from anywhere' (University B, Group 2, No. 3).

- **Cultural ideology of the birthing process**

The students discussed the place of birth in relation to culture and custom. The theme emerging from their discussions suggested that birth in the UK was based in NHS Trusts while pregnancy and birth in other countries is different.

'My mum's from Thailand and she grew up in Thailand and had all my brothers and sisters in Thailand... I was the only one of my mum's children to be born in England and she just thought it was horrible, like really she hated it when I was born and I think that's probably why I was the last child. Yeah and she just said it was so different, like one of my sisters was born on a lorry that she flagged down when she was at a market and she gave birth in a lorry on her own and in Thailand, it's just like that. You just have your neighbour and give birth on your floor, and that's just the way it is, and she said she came here and she was on a bed and there were a million people around her and she just hated it, she said it was horrible. So I think I do definitely think it's like the way you're brought up to think is normal really gives you a different perception of what birth is like' (University A, Group 1, No. 5).

'The delivery suite was very like... loads of complicated births. Everyone was put on a machine... Everyone was lying down to give birth, so I've only seen that side of it. I think I could get coerced into doing things if I was on the delivery suite because, seeing how some of the midwives are... you can't move and I'm thinking well you could if you really wanted to. They (the midwives) can't tell you what to do, it's your own decision and if you really wanted to move and get up you physically could get up. They don't actually strap you down... I think some women when they're there they're just like ok, ok I'll do that' (University A, Group 1, No. 3).

5.3 Hermeneutic phenomenological writing on becoming a student midwife

A hermeneutic phenomenological exploration of becoming a student midwife provides a snap-shot view of the essence of this phenomenon. The first stage of the study addressed several distinct elements of becoming a student midwife including

self-actualisation, aspiration and motivation. This is in contrast to previous research which focussed on student nurses becoming nurses (Sharif and Masoumi, 2005; Boud and Middleton, 2003; Chapman, 2000; Eraut, 1994). The hermeneutic phenomenological interpretation of the data has been written with reference to phenomenological literature. This is guided by the main themes and sub-themes that emerged from stage one of the study.

- **Reflection on future career**

Being-in-the-world of wanting to become a student midwife is driven by a self reflective process. Past experiences play an important part in the construction of the life-world of each individual (Roesler, 2008; Kerby, 1991). Phenomenological inquiry focuses on what is experienced consciously by an individual. The reality that we are is proof of existence. Heidegger (1962) stated that *Dasein* (being-in-the-world) is interpreted as 'existence is its own disclosure'. Being-in-the-world requires a view that the person and the world are co-constituted (Koch, 1994). Making the decision to become a student midwife appears to have come from their existence within their life-world. Husserl used the term intentionality to describe 'the relationship between the process occurring in consciousness and the object of attention for that process' (Smith et al., 2009 p13). The four existential themes: lived body, lived space, lived time and lived human relations, as described by van Manen (1990) assist in the analysis of human experiences. These four existentials are intricately woven within human experiences of everyday life. Van Manen suggests that while researching human experience of the lived world, it is possible to study each existential separately, always being aware that each is dependent on the others. For the students in study one being in reflective mode took them on a journey through their

life-world. Considering their desire to become a student midwife began initially by the de-construction of their past and present lives.

'There is a sense you always find that you come home every evening, you can't do a good job if you are not doing the best for the people you are working with. I want to do a job where I can come home and feel I have done a good job and helped people out - type of thing' (University B, Group 3, No. 3).

This brought an exploration of their conscious acknowledgement of the role of the midwife and the force that drove the decision to become a student midwife. This exploration appeared to provide the students with a form of direction. The students who were mothers were conscious of the role of the midwife through their own experiences of giving birth. There was an element of admiration for the role and support they had experienced from their midwives. Some saw the role as providing stability and a future for themselves and their families. The midwife would have provided a stabilising force during their most vulnerable time in pregnancy. This may have been projected by the midwife during their regular contact during pregnancy. This stability was a desirable trait which the students admired and referred to within their narrative of their birth stories. *'My midwife was so kind and knowledgeable – she was always there for me to talk to.'* (University B, Group 2, No. 1). There was also high regard for the confidence the midwife exuded regarding knowledge and skills of care practices. This brought the status of the midwife to a position of being a role model, which they desired. They appeared to desire these attributes in order to be a role model to other women when they become student midwives/midwives. They also hoped to encourage their children to do well at school and go to university thereby perpetuating their need to change their lifestyle.

To become a student midwife the student needed to enter university. For some of the students, they would be the first member of the family to achieve this status. They considered this to be a privileged position within the family. A determined effort was made to achieve this goal. Careful consideration of their academic needs brought the students to consider their educational background. Most of these students had left school with minimal qualifications having pursued a different course in life other than academia. There was no discussion regarding their experiences of being encouraged to do well at school. Their reflections revealed that they had accepted their fate to leave school and find employment. They spoke positively about the various jobs they had done to support themselves and their families. *'I have had a lot of jobs since leaving school. I needed to work to pay the bills and put food on the table'* (University B, Group 1, No. 1). The main focus of their employment at the time was to earn enough money to support their needs. They spoke positively of the skills they had gathered along the way, suggesting that life skills are important. They had returned to study via a further education college, studying an Access to Health Care course following the birth of their children. None of them spoke of regret or having had the desire to have undertaken further education earlier. Some spoke of this being the 'right time' to look for a change of direction. They spoke very lovingly of their children, some of whom were very young. *'I've got a little boy he is only eighteen months old'* (University B, Group 1, No. 1). There appeared to be an acceptance that this was the pattern of their lives. Having completed their families, it was now their turn to choose their life's course. They suggested that they had previously put their educational life on-hold while they had their families. The role of the midwife seems to have re-awakened their need for an identity through education.

The decision to become a student midwife appeared to have turned their lives in a different direction.

Some of the students were now one parent families. The midwifery programme of study had caused chaos to their previous childcare arrangements. Having been the sole carer for their child/children had forced them to rely on others for this demanding support. This was reflected in their discussions regarding their previous partners and the children themselves. They discussed negotiation of support and care for the children, but on their terms. There was an expectation of support from these individuals. They also placed many pressures upon themselves in order to fulfil their goal of becoming a student midwife. All parenting and household chores revolved around their assignment brief. The promise of good times ahead was always on the horizon as a driving force. The students in stage one of the study appeared to have lost the sense of their previous lives as a whole. *'When you start the course you have to become selfish. I have spent my whole working life around my son. I've just got to put him to one side'* (University B, Group 2, No. 1). The addition of their overwhelming desire to be student midwives had fragmented their lives into separate parts, these being: student, mother, partner and daughter. Each had a demand of its own. Their sense of integration of themselves as a whole within the family was also lost (Morris, 1994). They considered their needs to be a priority. Life did appear to be difficult at times for these students. Having to re-organise their previous lives to accommodate the demands of the course was evident. There did not appear to have been any anticipation of this disruption to their lives and those of their children.

The students who did not have children accepted the pattern of their academic career. This was to complete their A levels and continue into higher education. The choice of subjects to study focused on their likes and dislikes of subjects and their academic ability. They appeared to have had more choice and freedom. The decision to go to university was a social event within the family. For most of the students it was an expectation that this would be the course of their lives. Family disagreements became evident when the student's choice of career did not meet one or both parents expectations. Family traditions ranked high within a couple of students' families. Following tradition was seen as the normal order of life and breaking with tradition caused a transitory rift within the family. This rift caused the family unit to split into various parts, father/step-father, mother and daughter. The student discussed how they influenced their mothers to affect a normalisation process. This manoeuvring nurtured conformity by encouraging the father/step-father to abandon his preferred career option for his daughter (Turner, 1991). Once reconciliation had taken place, the family became whole again (Morris, 1994). The daughter's decision to become a student midwife was acknowledged. This highlighted the possibility to move away from home to go to university. The student had experienced a form of independence and an achievement of a goal.

Choosing to become a student midwife was not the first choice for some of the students. Exploration of various professions, such as medicine, brought the students to reflect on their own academic abilities. Accepting that they could not achieve high grades in a subject limited their final choice of career. *'I picked the necessary A levels to be a doctor. I did my first year of A levels and realised I couldn't do chemistry! So I looked at other options'* (University A, Group 1, No. 4). These

students were quite accepting of their limitations and sought other professions to explore. They did not consider this to be a failing but an adaptation to be undertaken. They approached this adaptation with maturity, exploring options allied to the medical profession. They acknowledged that their careers should have an element of care involved. This they acknowledged as a trait of their personalities. They discussed the role of the nurse as a doctor's 'handmaiden', doing as they were told. They envisaged the role of the midwife to be autonomous and of equal standing with the medical profession. This type of role was more analogous to their self-assessment. They did not acknowledge the role of the midwife as caring for anyone who was sick or dying, which they considered to be the occupation of a nurse. They considered the role of the midwife to be one of caring for well women, whilst acknowledging that most women give birth in a hospital.

- **Decision making processes**

Making a decision regarding future career pathways involves a process of self-reflection (Allport, 1955). This ability to look inwardly provides an understanding of personal uniqueness and current course of growth. Allport suggested that being-in-the-mode of decision making brings people to reflect on inborn dispositions. These are centred on:

'the impress of culture and environment', 'emerging self consciousness', 'personal conscience', 'evolving style of expression', 'choice and freedom', 'handling of conflicts and anxieties' and 'the formation of maturing values, interests and aims in life' (Allport, 1955 p23).

Inborn dispositions are considered to be the raw material for the development of the personality. The process of becoming is based on the realisation of the possibilities available to each individual. Being able to incorporate early stages of development into the later stages involves the process of becoming self-aware, self-critical, and self-enhancing (Allport, 1955). The decision to become a student midwife appears to have been developed from this cyclical analysis. Utilising a hermeneutic cyclical approach, they appear to have de-constructed their lives into various parts in order to view what makes them who they are. This is in keeping with the teachings of Husserl (1982) and Gadamer (1976) about individual parts making a whole (Annells, 1996). Viewing themselves within their life-world caused the students to develop a framework of possible career pathways. Reflecting on experienced phenomena regarding birth processes highlighted incidences which led to their decision. They discussed many influential factors which occurred during their lives. Pressure to make a decision regarding a career pathway was apparent. The education system in the UK controls how students are taught. Commencing GCSE and A levels at specific ages encourages students to consider a future career pathway. At this time in their lives, some of the students were influenced by the media. They demonstrated this through reflection on their impressions from television programmes about pregnancy and birth. Their fascination of embryology and birth was cultivated by watching various nature programmes. *'I watched a programme that was animals in the womb when I was about fourteen... I just loved watching it'* (University A, Group 1, No. 4). The media appears to have been a powerful influence on these students at the age of fourteen.

Many of the students spoke of their life-worlds as being the eldest sibling; participating in the care of their younger brothers and sisters. Reflecting on their observational experiences of their mothers' pregnancies and births impacted upon them, in a positive way. They saw their mothers as being influential in their birth choices, these being facilitated by an equally strong midwife. *'(My mother) she's really pro breast feeding and pro natural birth... And that's definitely rubbed off on me I've learnt a lot from her'* (University A, Group 2, No. 2). This admiration appears to have impacted upon the decision to become a student midwife. There were many anecdotal stories regarding their family and friends birthing stories. They saw themselves as the future advocates for women's choice. The realisation of their abilities to develop these attributes appears to have been the driving force that brought them to the decision of becoming student midwives. Being influenced by others focused the students' decision making processes.

- **Identifying with the role of the midwife**

Many of the students discussed their need to be involved in a *'caring profession'* and needing a *'hands on'* approach in their future careers. In fact, some of the students appeared surprised by how much they enjoyed working in this capacity during voluntary work: *'I realised that I wanted to do something more hands on care'* (University B, Group 2, No. 1). The desire for a caring role became selective as they researched the role of the midwife and nurse. This ontological foundation of being-in-the-world of the carer appears to have developed into the desire to become a midwife. The debate of the role of the nurse and the midwife became pervasive. All the students were adamant that they did not wish to be a nurse. This role was seen as caring for the *'sick and the dying'*. They appear to have determined the role of the

midwife as having a form of power. They spoke of being an '*advocate for the women*' and '*empowering women to make informed choices*'. Role and self image play an important part in life. Identifying with a role is a key concept in how a person relates to society (Radford and Kirby, 1975). These students are made up of many parts: students, daughters, mothers and sisters which require different sets of behaviours. Many of these parts are given to them but others such student midwife is desirable. Self image propels people to achieve a desirable interest or career (Radford and Kirby, 1975). Their ideology of the role of the midwife appears to have the desirable characteristics they wish to attain. The roles of the nurse and midwife have differing social influences. As previously stated, midwives are socially accepted as providing care to pregnant women. In their narratives, the students demonstrated that the two roles are quite distinct. Their desire for this self-image was clearly stated. Being-in-the-world of the midwife was their clear goal in life.

The students suggested that the role of the midwife was '*vocational*'; they did not see it as just a job.

'I don't think you see it as just a job either I think I see it as a way of life. When I wrote my personal statement I saw it as more of a vocation, a calling to do it. I think it's a way of life' (University A, Group 1, No.1).

Giving themselves to the care of women was accepted as the role of the midwife. In their discussions there appeared to be some discrepancy regarding their understanding of the autonomous professional role of the midwife. They suggested that their understanding of the role of the midwife supported women's choices. This should include their choice of home birth, yet the students expected to undergo their training within a hospital Trust and discussed how they would enjoy working on a

labour ward in the hospital. They appeared to have accepted that the birthing process had taken on a medical model of care. The fact that most women gave birth in the hospital setting was accepted as normal. The students were candid discussing how birth had become a hospital based activity. *'I don't think I'd feel comfortable, not with my first child, being on my own at home with a midwife'* (University A, Group 1, No.3). Nonetheless, they insisted that the midwife was a practitioner for normal midwifery. The cultural aspect of childbirth had led the students to consider childbirth as a hospital based activity. In the discussions they spoke of home birth as unique and the normality of childbirth as the exception rather than the rule. Being-in-the-world within this cultural background provided the students with a set of circumstances that suggested that childbirth is possibly only safe in retrospect (Allport, 1955; Richens, 2002). The students accepted the medical model of care as being the safest option, in case anything went wrong. Their desire to be a midwife appears to be conditional within their cultural background. They freely used the word 'autonomy' to describe how the midwife's practice should not be associated with this cultural ideology.

5.4 Summary

This discussion of the students' narratives provides an understanding of the lived experiences of becoming a student midwife. The analysis has presented the themes and sub-themes essential to the phenomenon. A hermeneutic phenomenological framework was used to discuss how each theme is inter-related with the others. The students' decision to become a midwife could be strongly influenced by theme one, i.e. reflection on future career. The search for a rewarding, fulfilling career that had future prospects may have influenced their choice. The nature of the work

undertaken by the midwife may have supported their search for a career with caring capabilities. This could be related to theme two, i.e. decision making process. The decision making process may have contributed to the motivation to achieve their goal. Distinguishing between the nursing role and midwifery practice may have strengthened their desire to achieve their goal. This relates to theme three, i.e. identifying with the role of the midwife. The phenomenon of being-in-the-world of the student midwife as revealed in Study One reveals experiences characterised by a positive process of personal development.

Chapter 5 presented the empirical findings from the first stage of the study: lived experiences of becoming a student midwife. Chapter 6 follows in which the findings of the second stage of the study are presented: the lived experiences of being a first year student midwife.

Chapter 6

Lived experience of being a first year student midwife

6.1 Introduction

This chapter presents the empirical findings from the second stage of the study: lived experiences of being a first year student midwife. The students had completed their first year of their midwifery education. They were asked to reflect back on their experiences of being first year student midwives in both university and clinical practice.

6.2 Phenomenological sensitive themes essential to the lived experience of being a first year student midwife

This chapter focuses on the student midwives experiences during their first year of training to become midwives. The students had undertaken work based learning in a Maternity Unit in a General Hospital Trust. They had received academic teaching at their home universities. The ratio of theory to practice was 50:50; this is a requirement of the Nursing and Midwifery Council (NMC) (NMC, 2009).

As with the previous chapter, this chapter will be divided into two sections:

- Providing the results of composing linguistic transformations. Identifying statements that were essential to the student midwives' experiences. These were then transformed into phenomenologically sensitive themes.
- Themes were developed into hermeneutical phenomenological writing on being in the first year of midwifery training.

Hermeneutic phenomenological analysis of the interviews with the student midwives and discussion on their reflective diaries revealed 10 themes that were essential to the students' experiences. These could be grouped into three main themes; this allowed for a better understanding of their experiences.

- Adjusting to new ways of learning
- Development – personal and professional
- Socialisation into the midwifery profession

Table 4 below provides an overview of the main themes and their related sub-themes

Main theme	Sub-themes
Adjusting to new ways of learning	<ul style="list-style-type: none"> • Reflection on learning • Skills acquisition • Coping with assessments
Development – personal and professional	<ul style="list-style-type: none"> • Maturity • Confidence in new abilities • Coping with a new life style • Approaches to midwifery education
Socialisation into the midwifery profession	<ul style="list-style-type: none"> • Being a first year student midwife • Midwives professional status • Being a student in an NHS Trust

Table 4: Sub-themes organised next to main themes

The three themes and their sub-themes are further explored below.

6.2.1 Adjusting to new ways of learning

Current pedagogical frameworks of education in schools are structured around students engaging with the learning process (DfE, 2011). Students are no longer expected to acquire teacher-led epistemological knowledge. Instead, the focus is on the ontology of learning in support of the student (Freire, 1993; Reece and Walker, 2007; Kolb, 1984). The combination of cognitivist, behaviourist and humanistic approaches to learning prepares students for lifelong learning (Kolb, 1984; Curzon, 2004; Reece and Walker, 2007). Combining these approaches to education and learning enables a transitional process in which the school leaver is enabled to become a reflective learner. This process enhances future learning potential (Kolb, 1984). Bloom's (1956) taxonomies of learning support the developmental changes within the student. Work based learning combines the taxonomies of learning. The application of theory to practice supports the learning continuum (Bloom, 1956). The combination of cognitive, affective and psychomotor development provides a learning framework. This supports the student's learning capability and the ontological increase in knowledge, thus providing a deeper, holistic approach to learning (Reece and Walker, 2007; Ramsden, 2003). Reflection on learning encourages the students to dissect their knowledge. Being in reflective mode allows the whole to be broken down into its various parts. This sophisticated process allows for the identification of gaps in knowledge. It also encourages learning as the pieces are made whole again. The ability to develop deeper learning is an individual trait. Not everyone will have the capacity to undertake this process (Ramsden, 2003).

The exploration of the students' experiences during their first year of the degree programme provided numerous narratives. These were characterised by the new experiences of a work based learning environment. This led to the theme title of adjusting to new ways of learning as a key element in the exploration of their new life-world experiences. The following sub-themes contributed to this theme.

- **Reflection on learning**

Being a student midwife exposed the students to a new world of learning. Exploration of their experiences at the end of their first year highlighted many phenomena. The students expressed emotional turmoil as a result of having to adapt to a different life-world. They viewed their learning experiences as a developmental process. They also revealed much anxiety as a result of having to retain large amounts of information and new knowledge. They suggested the amount of information to be retained was overwhelming. Their focus became fixated on their ability to pass the assessments, which impacted on their personal lives, causing varying levels of insomnia and nervousness. As a result of their stress, the students became critical of the structure of the curricula, suggesting there were elements of care they had been exposed to in practice which they had not yet been taught in theory. Their urgency for extensive knowledge became apparent. Their struggle to cope appeared to impact on their logic, as they presented a contradiction in terms of their capabilities. The students spoke of many adaptations to their lives as a result of working in a busy NHS Trust and being a full time university student. Their lives had changed, which they appeared happy to accept. Having a social life outside of midwifery had become secondary to becoming midwives. Some younger students spoke about lost liberties regarding the juxtaposition of the work based learning

environment. The loss of previous carefree days was now a distant memory. There was an acceptance that working and studying was now the normal way of life if they wished to be successful.

'I can't remember the stuff when it comes to assessments. I didn't do essays at A level, I haven't written an essay since GCSE. Writing reflections, I've really struggled with. All the referencing and things like that. It is like trying to teach yourself to get into the degree mind-set.... organising your time around it. When you're in placement and you are doing the shifts and, if you are doing long days, it is difficult to find the time to sit down and get into the mood to write an essay. It's the last thing you want to do at the end of a shift. You just want to sleep!' (University A, Group 1, No. 4).¹⁶

'You don't feel like your knowledge base is enough... There are so many things we don't actually know and it is a bit worrying because we are half way though knowing the basics and knowing you've got to know the complex things and that's quite scary.... it's OK to learn it for the exams but will you remember it afterwards.... that is quite daunting to think that only a couple of years and we'll be there.....' (University B, Group 1, No. 2).

The students were quite pensive in discussions recapping their previous educational experiences. Each student accepted that there was a need to develop their approach to learning. In each group the students were amicable and supportive of each other as they appeared to recognise a shared desire. They understood the need for each person to decant their previous experiences in order to dispel some form of negativity, which allowed them to move on. During the discussions the students did not interrupt each other's stories, they sat patiently and listened, possibly recognising characteristic traits within themselves. On numerous occasions the students referred to the focus group interviews as counselling sessions. There was a sense of honesty in this statement even though it caused much mirth.

¹⁶ Within the NHS patterns of shift work vary from a) early morning shift; b) late afternoon shift; these are a spans of duty for 7.5 hours or c) a long day; a span of duty for 12 hours with required refreshment breaks.

- Skills acquisition

Many themes emerged from the students' narratives. These focussed on working with different mentors and acquiring psychomotor skills. They desired acceptance from their mentors. They saw this as a challenge, as they wished to prove their competence in practice. Their learning style reverted back to a pedagogic framework which resulted in the need to please their mentors through their display of acquired skills. They appeared to require constant feedback. They appeared to assume that having dexterity suggested the possibility of knowledgeable abilities. Having these abilities affirmed appeared to support their development. Learning was self-focussed, as not appearing inept or ignorant was important to them. The needs of the woman appeared to be secondary to the students' skilled abilities. It was only when their learning developed from surface to deep that they recognised the significance of their actions on the care of the woman.

'It is mad how things click... you can be doing (a skill) and (you) don't know what you're doing. You say you do because you don't want to look stupid. You go outside and say to the midwife – I don't know what I'm doing here and she says don't worry it will click... and then stuff does click! I did my first vaginal examination the other day and I actually knew.... I don't know what I've been feeling for weeks but it wasn't what I felt the other day..... Suddenly I see now! I did the same with palpations and using the pinard stethoscope for weeks. I struggled' (University B, Group 3, No. 3).¹⁷

'I was so scared at the beginning when they told me to go and take someone's blood pressure. I was like 'Oh My God!' what if I get it wrong, then I would come out and say it's this. When the midwife says, 'I'll check it'... I use to think..... I feel like an idiot! ...They are just making sure that I've got it right... Before I was thinking about myself and how I was doing rather than... Hold on this woman could actually have high blood pressure... I have moved my way of thinking' (University A, Group 2, No. 4).

¹⁷ Student midwives must achieve competency in vaginal examination; abdominal palpation; and auscultation of the fetal heart using a pinard stethoscope (NMC, 2009)

The students focused on self image during their discussions on acquiring skills. They were quite amicable and jovial when relating their tales from practice. Their laughter possibly masked their embarrassment at their initial ineptitude. Their stories regarding their life in clinical practice suggested their need for guidance and possible control. They needed someone to tell them what to do. Their mentors appeared to become their idols, from which they sought praise and affirmation. They appeared to crave approval. This encouraged the students to become self-motivated; their needs were a priority until, in their eyes, they became skilled. The consequences of their actions only emerged later as their cognitive knowledge developed. There was an essence of guilt regarding their selfishness. In their haste for dexterity they appeared to have lost their purpose in life, which they reflected on as being the care of the woman.

- Coping with assessments

The issues surrounding the students' abilities to cope with assessments are closely linked to the two previous sub-themes. Many students found assessments to be difficult at times. Some students had not studied formally for many years. Reflecting on past experiences brought much anxiety to some students. Success at assessments appeared to support their analogy of achievement. Achieving success at the end of their first year supported their need for acceptance as a university student. This appeared to authenticate the hard work they had put into their studies and self-reflected glory seemed to bolster their egos.

'I felt a relief... I felt I had completed something! I had passed and it was all great and I don't pre-empt having the same work load again at the beginning of year two, but I will. I just feel like I had done it' (University B, Group 1, No. 3).

I do find exams stressful but as long as I am organised and plan my time around revising early then I am fine' (University B, Group 3, No. 2).

At the end of their first year there was a sense of relief. The students were appreciative that they had been successful as they were able to progress to the second year of their studies. Their comradeship suggested there was time to pause and celebrate their achievements. This increased their morale with the possible affirmation of their capabilities to become midwives. The atmosphere within the groups was relaxed, as previous tensions were put on hold during their acclamations of success. Their praise centred on themselves, with no references made to support mechanisms within their home life or the university structures. The students' attitude to their previous academic life appeared to have changed as they had achieved success which they enjoyed.

6.2.2 Development – personal and professional

- Maturity

Part of the developmental process for the students was their interpretation of personal and professional maturity. For some students this was their first experience of living away from home. Their ability to cope without parental support gave them a sense of freedom and a need for maturation. This new found autonomy was conditional, as they appeared to exchange their dependency from family to their peers. This new reliance led the students to consider their being. Self-reflection enabled them to accept their need to evolve. They appeared to adapt their ways of being in order to be accepted. Being a member of a community was different to being a member of a family. Their developing maturity brought a sense of

responsibility, both personal and professional. Learning to be accepted brought subtle changes to their identities.

'I don't think I would have grown as a person. I think if I was at home I would be even more stressed.... at least being away from home I'm organising my time when I want to do stuff... being at home my mum would make me do things. I can put stuff off when I'm on my own.....It's one of the best things I did, moving away from home' (University A, Group 1, No.1).

'...It (midwifery) has consciously made me more aware of myself and my behaviour both in placement and out. You know before you would go on a night out and get really drunk and take some silly pictures and put them on face-book. Now I am conscious about the situations I put myself in, in my personal life as well as... if that makes sense. You are conscious of what public is' (University B, Group 3, No. 2).

'You learn to take everything on board... If someone is speaking to you in practice or everyday life you just say 'OK'. Even if a friend is talking to you about something you just like take it on board and don't react to it... That is what you have learned to do in practice... 'I can deal with that, I can cope with that'... 'Yes that is fine'... I think that carries on in your personal life as well... (University A, Group 2, No. 4).

Some of the students had moved into Halls of Residence, this being their first attempt at living away from home. They saw this as a graduated step to independence. Many of the group were in fact flat mates, which they suggested initially helped to support their comradeship and studies. Within their discussions there was a sense of honesty which suggested that living and working together may have had its tensions. They revealed that many of their conversations were practice focused. The students did, however, imply life had changed, and their need to conform was becoming implicit. Being a responsible adult was far reaching, as the public persona had taken on a new meaning for them. They accepted that their lives had changed alongside their outlook on life in general. The students intimated there could be possible tensions within their private lives as they continued to develop.

- **Confidence in new abilities**

The issues surrounding the students' confidence in their new abilities are closely linked to the previous sub-theme. Being in the world of a student midwife exposed them to many experiences which the students did not appear to be prepared for. They expressed incredulity in their abilities to cope with their evolving world as their horizons had been broadened. Their social and professional links were more complex. They expressed astonishment in their abilities to communicate with many other professional people, and providing care had become innate.

'I am quite shocked that we get to do things in our first year. I would consider myself to be quite competent now at taking blood. I never imagined it would be sort of as easy as I've found it really' (University B, Group 3, No. 2).

'I think the confidence thing as well, I think for a lot of people who have come from smaller places, they've gained a lot of confidence from where we are... and knowing so many people... Even just the people on the course; you know 60 people more than you knew before you came and then you've got to meet different people every day. Just the whole experience has changed everyone, I think' (University A, Group 1, No 2).

The students expressed their astonishment regarding their abilities at the end of their first year. Many of the students had come from various parts of England, some from small villages where they had lived for the majority of their lives. Moving to a city had proved to be a life-changing experience, as they now recognised changes within themselves through interactions with others. *'Your confidence has grown even more without realising. Everyone's confidence has grown, even mine. I was pretty confident when I came here, but even mine has in different ways'* (University A, Group 1, No. 4). For other students who were from the locality of the university, they also appeared to have been affected by entering a midwifery programme of study. *'I think everyone's horizons have been broadened just because they had to. We've*

seen things we would have never seen before' (University A, Group 1, No.2). The students had developed mechanisms of support for each other. This seemed to help with most aspects of the integration into university life. The students discussed how a supportive network of friends had improved their confidence and subsequent development in the care of women from diverse backgrounds.

- Coping with a new life style

The students appeared to find satisfaction in their achievements over the past year. They suggested the demands of their studies had aided the passage of time. They also expressed amazement at their development whilst reflecting on their previous lives. They suggested they had developed new coping skills, which they never had before. They considered their lives had changed and that midwifery had possibly taken over their lives.

'I think my first year has gone really quickly. It has been really, really hard. One of the hardest things I've ever done in my life. But easy at the same time! Certain aspects like communication I've found really easy... Individually what we have to do isn't difficult, it's putting it all together and meeting your deadlines... constantly having enthusiasm to get up and do it when you really think, 'I need time to catch up.' This time last year I'd just applied. It's been a good year; it's been really hard' (University A, Group 2, No. 3).

'I think it has gone really quick... scarily quick. This time last year I was leaving school. It's so weird now I'm delivering babies and things, which is madness...' (University A, Group 2, No. 2).

I've really enjoyed the first year. I found it quite challenging adapting to this whole new midwifery life, because it is your life, you don't have a life outside of the course. We don't get holidays and time off and things... it is so stressful. It's so hard going when you are on placement. I think we need more life time, but other than that the actual academic part of it I've enjoyed. The actual work hasn't been difficult... the assessment part, the academic work has been a lot harder than I thought it would be' (University A, Group 1, No. 3).

The students were asked to reflect on their experiences during their first year. Their narratives suggested incredulity regarding their development. They were very animated in their discussions, suggesting an excitement they had not anticipated with the retelling of their stories. Their development appeared to far outweigh their previous expectations of being a student midwife, as midwifery had taken over their lives. The course structure provoked the students into considering the ideology of normal midwifery and the place of birth. This gave them a cynical view of the women's experiences of pregnancy and birth, as their own analysis of woman-centred care was skewed toward being on placement in a hospital Trust.

'People are looking for problems, and I would benefit from seeing some 'normal'. Within hospitals we are not getting the normal training, out of my 21 deliveries two of them were normal' (University A, Group 1, No. 2).

'It's like you were saying, 'NHS, or what?' ... Maybe that's the only way we can train because we need to be funded by someone' (University A, Group 1, No. 5).

- Approaches to midwifery education

The issues surrounding the midwifery curriculum are closely linked to the previous three sub-themes. The students suggested conflict within the juxtaposition of the work based learning philosophy. Some students considered they were apprentices. Their narratives indicated they were training to be midwives and not necessarily studying the profession. Their epistemological interpretation of a theory-practice gap indicated a stymied attempt at learning. An element of confusion emerged, which led to dissonance in being a university-based student.

'What I find most difficult is practice it is so different to theory. You get taught to do it one way but practice is nothing like the way we are taught! It's just like vaginal examinations; it's not what you see in theory at all... it's really bizarre! It's hard to write an example on that and then do it a different way. Pawlick's

grip¹⁸ we are told not to do that. We were told to do an abdominal pelvic examination. So when they do it I always think, should I do it this way just as they are...?’ (University A, Group 3, No. 2).

‘I have not once felt like a university student. Like from the offset even in fresher’s week – it’s not fresher’s week because you are a student midwife and you are not a proper student; so get over it and move on. I think I’m learning, I’m training I don’t feel like I’m studying. When someone says, what degree are you doing? I say I’m training to be a midwife. I say I’m training because I feel like, in a way, we are doing an apprenticeship’ (University A, Group 2, No. 4).

During discussions regarding their thoughts on being a university student, the atmosphere of the group changed from being amicable to one of disappointment and resentment. Their narratives focussed on the structure of the course suggesting there was no time to enjoy being a student midwife as they were constantly studying and working. There was already a sense of exhaustion in their enthusiasm. Being the first person to attend university from the family had lost its self respect. Their resentment appeared to have trivialised the university status of the midwifery profession, suggesting it to be an apprenticeship. The students supported their analogy as they suggested the existence of a theory-practice gap. Not all midwives used research-based information to support the students’ clinical needs. For many of the students, this perpetuated an apprenticeship style of teaching and learning.

6.2.3 Socialisation into the midwifery profession

- Being a first year student midwife

The students’ narratives indicated an element of innocence associated with being a first year student midwife. They appeared unprepared for the diversity of many cultural experiences. Using a process of self-reflection they analysed their position

¹⁸ Pawlick’s grip: this is an abdominal pelvic examination to ascertain the relationship of the fetal head to the woman’s pelvic brim.

within their new society. They expressed their need to adapt and change in order to be accepted. Their narratives highlighted the adaptive processes they undertook in order to resolve inner conflicts.

'I feel more confident now. I am more confident going into work, I don't feel frightened anymore. I'm now getting used to going into different areas of the hospital, whereas before I was petrified to move from one mentor to another. I felt so safe with one person and then having to go with different people; you are always pre-empting how they are going to treat you and what their attitude is like having a student. That's quite worrying for me, as I'm a bit of a worrier' (University B, Group 1, No. 1).

'I think I thought it would be easier than it was. I always knew that was one of the main things about midwifery, to be able to form that relationship with women instantly... because I am quite an outgoing person, I would find it quite easy to make friends in general. It wasn't really that straight forward. It took a while to sort of get that confidence. The women have different personalities too... you are never really in their situation, such different people' (University A, Group1, No.5).

Within the students' discussions there were mixed emotions and expectations. Entering a caring profession, they too appeared to expect they would be cared for. They vocalised their vulnerability in their desire for a supportive mentor as fear of the unknown perpetuated their initial experiences. Past experiences of mistrust and possible mistreatment may have caused the students to be wary of working with people they were unsure of. There appeared to be some misunderstanding regarding their relationships with the women in their care. They found this difficult to cope with, as the midwife demonstrated a working relationship with women which appeared to cause some concern. This level of misunderstanding permeated through their experiences with other members of the multiprofessional team. They expressed resentment of their treatment by some doctors suggesting they had not anticipated a hierarchical structure within a team.

- **Midwives' professional status**

The students' interpretations regarding the professional status of the midwife led them to discover the phenomenon of the multiprofessional team. Their evaluation of the team's construction caused them to question their pre-conceived ideas regarding the role of the midwife and their own status within a hierarchical structure. Their expectations of being equal partners appeared to produce disillusionment on their part. Their interpretations of what they observed prompted them to question the autonomy of the midwife.

'I think you've got to be quite confident as a midwife... midwives have their own profession... We are the experts in normal birth, we get told this and then we go into placement and the doctors treat us like... the cleaner – pass me this pass me that. You've got to be there and say... I know some of the midwives don't, I know a couple of midwives will say 'No, I'm doing this and you are going to have to get it yourself'. I think great to them because that is what you need to do because that is your job. I think we are going to have to develop ourselves to be like that, because that's how you've got to be' (University A, Group 1, No. 2).

'(Doctors) they never get their own stuff they expect us to be there... for example suturing, they just suture and then leave everything, they don't even tidy up. I'm thinking you have just left sharps there.... They leave everything out... You're a doctor; you're paid more than me. I'm doing this for free and I have to sort your stuff out... You shouldn't be paid that much for leaving your sharps out...' (University A, Group 1, No. 4).

The students became quite vocal and defensive of the role of the midwife suggesting their treatment as students by some doctors was unacceptable. They expressed disappointment at the subservient role some midwives adopted when working with the medical profession. They no longer desired to be identified with this status of the midwife. Their original vision of the role of the midwife did not appear to be representative to what they had envisaged. They questioned the midwife's status and their desire to become one. Their resolve to improve their situation gathered impetus as they criticised the doctors' expectations of them as students. Their

resentment perpetuated throughout their discussions. Their desire to protect the status of the midwife may have resulted in a misinterpretation of the working relationship within the multiprofessional team; their concept of team work appeared to have eluded them.

- **Being a student within an NHS Trust**

In their shared narratives of working within an NHS Trust, the students described their experiences regarding the demands of a 24 hour health service working alongside their mentors. Their stories presented a possible naivety about being a student midwife. There appeared to be an expectation that their learning needs were important to everyone. The operational demands of a busy hospital ward appeared to come as a shock to them. The reality for some impacted on their personal lives.

'I had a mentor on the ward that would not do any paperwork on her breaks... While you are on the ward with 31 women between three midwives, if you don't get a break when do you do it? It is only 15 minutes at the end of the day... You can do your OSCE's in that time' (University B, Group 3, No. 2).

'I think I've got better at dealing with criticism, someone saying to me – 'that's wrong'; 'don't do that' or 'I wouldn't say that like that'. I use to be... I still am worried I may do it wrong... It's not criticism really; they are there to help you develop, not to help you feel worse. I think now I can do something wrong and I can learn from it, whereas before I was – I can't do anything wrong! I wanted to make a really good impression. I think now I can make mistakes, obviously not big ones, there is always someone to back you up... It is important if you do something wrong to say...' (University A, Group 2, No.4).

In their narratives the students became critical of working for a hospital Trust. There was a realisation that the system worked over a 24 hour period and that they were expected to comply with the demands of the service. Their discussions became quite philosophical as there was an element of defeat in their acceptance of certain situations. Their lives had changed during the first year of their studies. They

appeared to have conformed to the demands of the service and their need to accept criticism from their mentors. There was a sense of inevitability from their demeanour that should they choose to continue their studies; they needed to acknowledge that their lives had changed forever.

6.3 Hermeneutic phenomenological writing on being a first year student midwife

The hermeneutic phenomenological exploration of the second stage of the study allowed several distinct themes to emerge from the data. Interpretation of the students' experiences revealed elements of being a first year student midwife. These included: adjusting to new ways of learning, personal and professional development, and socialisation into the midwifery profession. There is some linkage with the themes that emerged from the first stage of the study with stage two. These can be related to the development of their learning in both clinical and theoretical learning, their personal development and life choices and their emerging analysis of the professional role of the midwife in practice.

The hermeneutic phenomenological interpretation of the data continues to be written with reference to phenomenological literature. This is guided by the main themes and sub-themes that emerged from stage two of the study.

- Adjusting to new ways of learning

Being-in-the-world of a student midwife requires the completion of a three year degree programme of study. The programme of study is directed by the educational standards set by the Governing Body of the Nursing and Midwifery Council (NMC,

2009). The Council is quite specific regarding the content of the midwifery curriculum. The education and training of midwives is guided by 'the international definition of a midwife (Appendix A) and the requirements of the European Union Directive Recognition of Professional Qualifications 2005/36/EC Article 40 (NMC, 2009 p3). The role of the NMC is to safeguard the health and wellbeing of the public. Each qualified midwife is required to maintain their registration on the midwifery part of the NMC register. This is achieved by signing their Intention to Practice and by maintaining and developing their own competence.

The midwifery curriculum is designed to educate students in the provision of the holistic needs of the woman and her family (NMC, 2009). The current programme of study is designed to prepare students for their future role as midwives. They are taught how to provide research-based care within a work based learning environment that is governed by NHS Trust policies and guidelines. The role of the midwife is to follow the midwives rules and standards and The Code set by the NMC (NMC, 2008; NMC, 2012). These ensure the care of the women is the priority of the midwife. It has been suggested that there may be conflict between the employment status of the midwife and the role of the midwife as Trust policies and guidelines direct care (Tew, 2007). Within this confusion the students are expected to learn how to provide midwifery care based within a medical model of care structure. The midwifery model of care places midwives as the lead professional in normal pregnancies and birth. Therefore, placing the midwife within a medical model of care structure has perhaps reduced their autonomous status, as many obstetricians review birth as being normal retrospectively (Richens, 2002 Tew, 2007). Therefore it

can be argued that the unique role of the midwife may be undermined within an NHS Trust.

Being-in-the-world of a first year student midwife brought an ontological consciousness to the phenomena of becoming a midwife. For the students in the second stage of the study this ontological knowing brought them to reflect on their new life-world. Considering their desire to become midwives began initially by the deconstruction of their past and present lives. This can be related to the findings of stage one of this study. It also brought a conscious awareness of their lives as student midwives and the impact on their life-world. This exploration appeared to provide the students with a form of direction. The students discussed the phenomena of training to be midwives in two diverse learning environments. Their explorations exposed a journey of complexity in which they gained support from each other's life-world experiences. The students with children discussed the phenomena of balancing home life with the demands of the course. Discussions focused on the juxtaposition of being a student midwife on a work based learning programme.

'You don't have time to really have a social life. The amount of essays and placements and everything is quite full on. It is so stressful; it is so hard going when you are on placement' (University A, Group 1, No. 3).

They had not anticipated the demands of a full-time university course combined with the shift patterns of the hospital Trusts. Being-in-the-world of a student midwife had taken over their lives, causing much fragmentation. Utilising a hermeneutic cyclical approach, they appeared to have deconstructed their lives into various parts in order to view their new being. Their new life-worlds brought a process of constant

adaptation, incorporating being a student midwife, university student, mother, partner, and daughter, each with competing demands. Life for the students appeared difficult at times. The students who were mothers discussed their anguish at not being there for their children during significant times. They suggested it was difficult to study with young children competing for attention; family life had become difficult.

The students stated that midwifery had taken over their lives. Their reflections revealed many struggles during their first year. This they expressed as needing to manage their time between work, family life and assessment deadlines. The students had not anticipated the demands of a busy NHS maternity unit. As student midwives they discussed their need to acknowledge the role of the midwife/mentor as their superior. The more mature students suggested their identity was encapsulated within the inferior, pedagogic role of being a first year student. Their acceptance of these diverse positions demonstrated a complex adaptive process. The constant change from being a mother, with the responsibilities of meeting the needs of their children, to being reliant on another was quite profound for some. The students had acquired the abilities to switch between the multiple roles in their lives. In their narratives some of the students suggested many of the women and their partners found this phenomenon difficult. *'Because I am older, the women always ask me. My mentor doesn't like it but I do explain that I am a student'* (University B, Group 1, No. 4). The focus of the women's questions was directed to the mature student rather than to the younger, qualified midwife; maturity appeared to coalesce with knowledge. All the students expressed many differences between their previous life-worlds and their current student roles.

The students considered that the educational demands of the curriculum were different to their previous studies. Their narratives suggested they were unprepared for the demands of the programme of study. Their previous life-worlds in education were more analogous to pedagogical structures. Being university students brought a more androgogic focus, prompting them to reflect upon the phenomena of learning. Some students had entered university straight from school, while others had left school with no formal qualifications. Their experience of learning was diverse, as some had not engaged in formal education for a large proportion of their adult lives. Reflecting on their choice of becoming a midwife became tenuous; they expressed a sense of vulnerability. Their desire to become midwives directed the students to reflect on their level of education. There was an acceptance that they had been eligible to enter university but their ability to cope with the quantity and level of learning caused much stress. Their reflections brought them to discuss the phenomena of success. Their desire to succeed as university students produced a considerable amount of pressure.

'I think it has gone well! I've passed everything so far, so I am not doing too badly. I don't know though it all leads on to next year don't it?' (University A, Group 2, No. 1).

Being successful in the eyes of their family and peers was important to some. Their goal of becoming midwives was fragmented into manageable portions, providing a pedagogic framework for success. They approached each assessment on an individual basis; there was no correlation between previous and current learning successes. This provided a temporary sense of relief at being able to progress. They de-constructed their previous approaches to examinations, enabling an exploration of their conscious acknowledgement of their weakness, strengths and barriers to

overcome. Their narratives exposed a consciousness of different taxonomies of learning with no actual correlation. This disparity was expressed as a theory-practice gap. There appeared to be an acceptance that this gap existed. The students suggested that the university focused on the '*gold standard of care*' while the hospital Trust provided a service level of care. Their discussions regarding research-based care were cursory, suggesting that research was not always used when providing care and that this was dependent on the midwife/mentor.

While discussing their learning experiences within the clinical area, the students' narratives focused on activist learning; psychomotor learning became their priority within each clinical area. The students acknowledged the processes of experiential learning: grasping via apprehension and grasping via comprehension, their learning was self-focussed. Their need to gain the required skills became pervasive; until they had achieved success this became one less concern to worry about. The students' discussed their cognitive development following skill acquisition, which was expressed with phrases such as '*it just clicks*'. The students demonstrated peer support for those who had not undertaken a specific clinical placement. There was an assumption that their peers would experience learning as they had done. The phenomenon of providing care to women was considered as a future goal. This was a finding from stage one of my study. Their desire to learn new skills was constant and their determination to succeed focused their learning.

Their reflections suggested that previous pedagogic study skills were inadequate for their level of study and they acknowledged the need for self-discipline in the pursuit of knowledge. They considered that being-in-the-world of a university student

required a higher approach to learning. Some students considered the course demands were comparable to other allied professionals such as *doctors and dentists*. Their narratives suggested their studies were superior to those of nurses. These observations were suggestive of sibling rivalry and / or observations of *flat-mates* who were studying to be nurses. There was recognition of stress relating to their studies as coping mechanisms focused on their need for peer support. There was acknowledgment of a possible limited understanding from families and friends outside of midwifery. The need to vent their anxieties was a priority. Previous home life became a burden, as mundane chores prevented them from being in the world of a student midwife. *'If I was at home my mum would give me chores to do – she wouldn't understand'* (University A, Group 1, No. 2). Their new life-world took precedence.

- Development – personal and professional

Utilising a hermeneutical cyclical approach the students appear to have deconstructed their lives in order to view their progress and development. Reflecting on the phenomena of change the students viewed themselves within their life-world, they considered the various parts of the whole of their experiences. They discussed many influential factors which appear to have occurred during their first year as student midwives. For some students their need to move away from home was apparent, they viewed this as a rite of passage to being a university student. This was demonstrated through their reflections on meeting new people and making new friends. Achieving their independence was viewed as a sign of personal development. Gaining approval from family regarding their development supported their ego, *'I feel so much better about me, and my family have noticed'* (University B,

Group 3, No. 2). Their need to maintain regular contact with family was demonstrated through reflections on their home visits. Being a member of a family was important to their development. Many students spoke of their life-worlds as coping with new challenges, and their ability to self-manage became evident. There were many anecdotal stories regarding their cooking skills and how they met each other. The students with families viewed this time as a period of adjustment for themselves and their families.

The structure of a work based curriculum brought an element of disappointment. This they confirmed through their reflections on the lack of long summer holidays and a student night life. The students with children also considered the lack of a summer break was frustrating as pressure on child care requirements became apparent. They discussed many phenomena which emerged during their first year as student midwives. Being in the world of a hospital Trust was a new experience for many students. Their discussions focused on the demands of the shift systems of work.

'It's the shifts, if you are doing a long day, days or nights. You wipe out a day before and a day after the night shift. I quite enjoyed last weekend because I was on (name of ward) and I had 15 hours during that week. I asked the mentor if I come in over two nights and do the hours (7.5 X 2 nights). She agreed. It was lovely as I had plenty of time to sleep' (University, B, Group 1, No. 4).

The students with children had not anticipated how disruptive this would be on family life. Most of the students' reflections indicated there was an element of tiredness they had not anticipated. Their dissonance of balancing study with practice became apparent in their discussions. They revealed a lack of understanding of the

juxtaposition of the education of student midwives within an NHS Trust and a Higher Education Institute (HEI). Their reflections revealed an analogy of an apprenticeship style of training as they did not consider their status to be that of university students. The younger students spoke of the demands of the programme restricting their engagement with university life. Pressure to achieve the required standards was evident.

- **Socialisation into the midwifery profession**

Being-in-the-world of a student midwife caused the students to reflect upon becoming a member of a new society. They deconstructed their understanding of the world of being a student midwife. Their hermeneutic cyclical analysis revolved around their expectations and confidence in their new status. Their discussions revealed the need for pedagogical support and guidance. Their mentors were seen as knowledgeable midwives who would support their learning. The students suggested that being a student midwife brought certain responsibilities. This emerged while discussing their position within a multiprofessional team. Their interpretations of their treatment by allied professionals, such as doctors, caused them to feel inferior to them.

'Doctors just expect you to do things. They said, 'go get this'. I just stood there and said, 'I don't know what that is' and I feel so stupid like I should know. They don't ask you, 'do you know where that is,' they say, 'go and get'' (University A, Group 1, No. 2).

Not having the knowledge of certain equipment or procedures caused them much anxiety. Initially there was a lack of confidence in stating their level of knowledge and experience to other members of the multiprofessional team. Their interpretations of being student midwives suggested that others should know their level of knowledge.

'I think in placement as well we are mixed with other students. When I'm with my mentor, someone you have never been with before, you are mistaken for a third year student' (University A, Group 1, No. 2).

Their exposure to the wider multiprofessional team appeared to increase their vulnerability. The wearing of a uniform brought recognition of their role but not of their status, and this was reflected through discussions regarding their knowledge of clinical practices. Their need for identity caused them to reflect upon modifications to their uniforms such as the use of epaulettes stating their level. This was suggested as a means of increasing their confidence. Their discussions revealed a need to prove their abilities to their mentors but there was also a revelation of contentment at being accepted as a member of the team.

Being-in-the-world of a student midwife brought the students to reflect on their projected image to the public. The students discussed their fascination of the trust women placed in them. They suggested a plethora of emotions they experienced while caring for women. Their discussions revealed excitement and joy that appeared to drive them on to achieve. Being a student midwife brought a new way of life, which caused them to reflect on their being. Their discussions revealed a contrast between their new social being and their previous lives. The students suggested there was a rift between the two as their experiences exposed a new identity within their holistic being. Their exposure to new ways of working and new language caused the students to reflect upon their relationships, which they suggested had *broadened their horizons*. There was an indication that they had changed. This was revealed while discussing the journeys that brought them to

midwifery. Many students had come from smaller towns and villages. Their exposure to a major city appeared to be in stark contrast to their previous experiences.

6.4 Summary

This discussion of the students' narratives provides an understanding of the lived experiences of being a first year student midwife. The analysis has presented the themes and sub-themes essential to the phenomenon. A hermeneutic phenomenological framework was used to discuss how each are inter-related with each other. Their experiences of being a student midwife could be strongly influenced by theme one: adjusting to new ways of learning. Reflecting on their ways of learning appeared to have exposed the challenges of applying theory to practice. This could be related to theme two: personal and professional development. This development appeared to have prepared the students for a different way of life. This could be related to theme three: socialisation into the midwifery profession. The phenomenon of being a first year student midwife as discussed in study two revealed experiences characterised by vulnerability, development, challenges and acceptance.

Chapter 6 presented the empirical findings from the second stage of the study: lived experiences of being student midwives at the end of their first years of study. Chapter 7 follows in which the findings of the third stage of the study are presented: the lived experiences of being a second year student midwife.

Chapter 7

Lived experience of being a second year student midwife

7.1 Introduction

This chapter presents the empirical findings from the third stage of the study: lived experiences of being a second year student midwife. The students had completed their second year of their midwifery education. They were asked to reflect back on their experiences of being second year student midwives in both university and clinical practice. During this year, the students experienced alternative placements to midwifery that exposed them to medical, surgical and gynaecological experiences.

7.2 Phenomenologically sensitive themes essential to the lived experience of being a second year student midwife

This chapter focuses on the student midwives' lived experiences during their second year of training. During this year the curricula were designed to expose the students to a variety of non-midwifery placements. Their experiences consisted of working in medical, neonatal and out-patients clinical areas. To undertake these experiences the students were placed within a general hospital Trust. Hermeneutic phenomenological analysis of the students' narratives revealed many phenomenological themes. These could be merged into three main themes:

- Work based learning
- Mentorship in clinical placements
- Phenomenon of midwifery within a hospital Trust

Table 5 below provides an overview of the main themes and their related sub-themes.

Main themes	Sub-themes
Work based learning	<ul style="list-style-type: none"> • Non-midwifery placements • Self-doubt • Relevance of placements
Mentorship in clinical placements	<ul style="list-style-type: none"> • Supporting the student • Building self-confidence • Tri-partite support
Phenomenon of midwifery within an NHS Trust	<ul style="list-style-type: none"> • High risk care • Medical model of care • Challenges facing normal midwifery

Table 5: Sub-themes organised next to three main themes

The three themes and their sub-themes are further explored below.

7.2.1 Work based learning

The phenomenon of work based learning will have separate meanings for each student midwife (Boud and Solomon, 2001). Interpretation of the phenomena is based upon the students' narrated experiences of being in the world of work based learning. The hermeneutic phenomenological experience consists of a university programme that combines two diverse learning environments. A cohesive tri-partite collaborative partnership is needed for work based learning to be successful (Boud, Solomon and Symes, 2001). Work based learning as a field of study has developed many epistemologies that inform curricula (Costley, 2000). The focus of curricula

education is more ontologically focussed; universities no longer have the monopoly of knowledge production. External partnerships now share this responsibility. A collaborative focus on the students' clinical placements within the curricula supports learning. Cognitive development provides support to affective and psychomotor learning. The application of knowledge to practice is important as this enables artistry (Raelin, 2008). Epistemological learning coalesces with ontological knowing. Learning is a process of transformation (Kolb, 1984). It is not just the accumulation of knowledge, it is the ontological process of transforming implicit knowledge to explicit knowledge. This hermeneutic phenomenological circular process involves the students, clinical placements, and the higher education institute (Nonaka, 1991). Reflection on and in learning is crucial. Identification of learning needs offers the impetus to develop. Reflection involves a form of judgement making processes. The phenomenon of reflection enables the person to explore their being. Knowledge becomes implicit through construction and interpretation. Mezirow (1991) suggests reflection provides a journey through three processes: content, process, and premise. Influences play an important part in how people perceive, feel and act. Approaches to solving problems are quite complex. Each person has their own strategies, assumptions and procedures to use. The ultimate process involves the beginning of an additional journey. Fundamental beliefs about our ways and being are challenged. Work based learning environments support the process of transformative learning (Onyx, 2001; Mezirow, 1991; Kolb, 1984). The transfer of learning poses many problems (Argyris, 1990). Learning in specific situations may block transfer to others. There are two kinds of learning: near and far. Learning a specific skill in context does not necessarily promote its application in a new situation; this is near learning. Far learning is classified as having the ability to use

the skill in any situation. This interpretation is analogous to surface and deep learning (Ramsden, 2003). In work based learning, having the ability to develop from a near to a far learner is essential. Without this development the transference of skills to different situations may stymie learning. The phenomenon of learning to learn in any situation supports an ontological approach. The belief in self-directed study is essential for the success of work based learning (Goleman, 1995).

The exploration of the students' experiences during their second year of the degree programme provides numerous narratives. These are characterised by their experiences of different work based learning environments. This led to the theme title of 'work based learning' as a key element in the exploration of their learning experiences. The following sub-themes contributed to this theme.

- **Non-midwifery placements**

Being in the world of a second year student midwife requires them to undertake non-midwifery placements. It is anticipated that they will be exposed to the pathology of illness. Work based learning undertaken by nursing students is different. Learning to care for the sick and / or dying enables students to provide nursing and palliative care. Student midwives use many nursing skills within their practice. Exploration of their experiences highlighted many phenomena. Their narratives suggested they experienced fears and frustrations throughout these clinical placements. The students expressed their fears at having to work on medical and surgical wards and departments with people they did not know. They spoke of a lack of appreciation at having to take time out of midwifery to attend outpatient clinics. Their frustrations became highly vocal at times. They appeared to channel their embarrassment

through the emotion of anger as they compared the medical needs of pregnant women and the needs of male patients attending urology clinics. Their narratives expressed a possible lack of understanding of the needs of the patients. They suggested being used as a chaperone annoyed them. They did, however, appreciate the embarrassment their presence may have caused the men. The students appeared surprised at the lack of clinical procedures nurses were allowed to undertake. They expressed pride at being able to take blood. During their discussions the students appeared to develop an air of self-assurance, which suggested their analysis of midwifery was superior to nursing. They appeared not to comprehend the significance of providing care to the sick, and its relation to their role as student midwives.

'I think the first six months of second year was quite horrific in my opinion. It was just so... some of it was really boring and irrelevant. I know I was really stressed then, the last few months have been better. I think that is because we have had different placements. We've had our medical and gynae placements...' (University A, Group 1, No. 4).

'The pace is so much slower, even in A&E; some of the nurses are busy, but a lot of the general nurses, they don't have the work load that we have. Last night I realised, the nurse I was working with - I could do more than she could. She can't take blood; she can't do loads of things. She hasn't even got a log-in for the computer. She can't literally do anything. She sees someone, takes their blood pressure and passes her straight onto the doctor. There is no fulfilment with that, they all hate it. I am just so glad I didn't do nursing...' (University B, Group 1, No.3).

The students were quite vocal during their discussions, expressing their annoyance at having to work on other clinical placements. There was no concept of the pathology of illness, as they had never cared for the sick or the dying during their midwifery training. There appeared to be the belief that pregnant women with medical problems were transient through the maternity services. Their analysis of

care for these women appeared to focus on providing midwifery care only. They viewed these alternative placements as additional to their course of study and not as an integral part. Their lack of understanding prompted a comparative critical analysis of the role of the nurse, who in their eyes lacked their clinical skills. The students accepted that midwifery was a separate profession to nursing, but insisted on comparing themselves to the nurses. When challenged regarding the comparative roles of midwives and doctors they expressed an acceptable difference. The students appeared confused regarding their future professional status.

- **Self-doubt**

Many themes emerged from the students' narratives. The students expressed their embarrassment in their lack of confidence to care for people who were sick. The issues surrounding the students' confidence in coping with the diversity of placements are closely linked to the previous sub-theme. They expressed feelings of helplessness and embarrassment when dealing with illness. The students revealed trepidation when attending to the basic needs of the sick and dying. There was a dependency they had not experienced before. This they explored through their narratives with each other.

'...it sounds really awful, but it has been the hardest year with medical and Gynae. They have been such awful placements. It just makes you feel you have lost your midwifery somewhere, it's been really, really hard' (University A, Group 2, No 1).

'As a student midwife giving old dying men bed baths I thought this is not... why am I doing this?' (University A, Group 2, No 2).

'I ended up as a health care assistant, like a dog's body really, making beds and things like that. I am not the sort of person who thinks that's beneath me because I do that sort of work, but at the same time I wanted to get more out

of it. One of the group ended up on a clinic for prostate problems she queried whether it would ever be relevant. The doctor did ask if she wanted to see it, it was embarrassing for the man, she was stood there as a student midwife and she didn't need to see it' (University B, Group 3, No. 2).

During their narratives the students became quite reflective on their abilities. They expressed much compassion for the people in their care. Within the groups they questioned their abilities to provide appropriate care. Their self-doubt revealed an essence of kindness that possibly brought them to their choice of career. There was a plethora of emotions they found difficult to express. Their support for each other was overwhelming. They were empathetic to each other as they connected with each other's stories. They appeared mournful at the loss of midwifery during their second year, as they appeared to lose their way.

- Relevance of placements

The issues surrounding the relevance of the non-midwifery placements are closely linked to the previous sub-themes. For some students, providing nursing care to women with underlying medical problems caused them to reflect on their career choice. Discussing individual experiences brought to the fore an element of care they had not previously considered. Providing nursing care to women and babies enabled diversity to their learning experiences. Gaining knowledge provided a need to share their learning and skills with others.

'I wouldn't want to have done nursing but I can see the advantages to it... But I also think there are disadvantages to it. We do deal with a lot of women with underlying medical problems that we aren't taught about. It is not a maternity problem... there are loads of women with problems and they are still having babies. We are expected to do all their care... I think I could have done my nursing placement. I don't think it was as bad – I didn't find it as bad as... I quite enjoyed it. It was nice to do something different. It was nice to think I

was learning stuff that would be handy... I could have done my nursing training, I probably wouldn't have chosen that way around it but I could have...' (University A, Group 1, No. 2).

'I found the medical placements useful. I have been dressing someone's feet who had twins because they were so badly swollen. I now know what all the creams are for and I have been teaching the midwives all about the different creams. Yes I found the medical placements useful, but I wouldn't want to be a nurse' (University A, Group 1, No.5).

'Neonatal... that is relevant... Gynae I did not get much out of because I was placed there during the swine flu epidemic. All non-essential surgery was cancelled. The ward was full of people with elderly people with fractures; which was useful for the nursing students. I don't feel I gained a lot from that placement. Whereas on the neonatal unit one day I was looking after a baby in the intensive care unit, a nurse came over and said she had half an hour, 'what do you want to learn? I will go through everything with you'. I was doing resus practice. For me that placement was more positive, the nurses there want you to really learn, they want you to take away as much as you can from the placement' (University B, Group 3, No. 2).

In the focus groups some of the students defended the relevance of undertaking alternative placements. They expressed their contentment with the learning opportunities offered. Their persuasive discussions allowed the groups to take a pragmatic view of their experiences, suggesting a nursing qualification would have added to their knowledge. This created a lively discussion in one particular group. Reflecting on their experiences enabled a more in-depth analysis of particular placements. These they considered more relevant to midwifery such as gynaecology and neonatal care. There appeared to be an abhorrence of caring for men in some of the focus groups. This could be related to their age or their habituation of caring for women.

7.2.2 Mentorship in clinical placements

- Supporting the student

During their midwifery training students are supported by midwives who have undertaken a mentorship course of study. The students work alongside different mentors throughout their midwifery training. The level of supervision of the student varies as they progress through the course. This is considered safe practice, as protection of the public from bad practice is mandatory (NMC, 2004; NMC, 2013). The majority of students consider midwifery mentors to be supportive and helpful, using the term '*my mentor*'. In contrast, during their discussions concerning their non-midwifery placements, they did not take ownership of '*the nurse(s)*'; they appeared to be outside the students' social environment of midwifery. The students appeared to have experienced feelings of alienation, as their dissatisfaction prompted them to suggest the nurses '*did not know what to do with them*' (University b, Group 2, No. 1). The lack of a nursing mentor left the students feeling unsupported. Their discussions regarding mentorship did not include any nurses. Their various experiences of being mentored within midwifery were explored. They expressed confidence in the development of their midwifery knowledge, but also a need for re-assurance and encouragement from their mentors.

'You are given a couple of women to look after and you go to your mentor and tell them about the care you have given. I looked after a woman who was really pale so I decided to do a blood count - it came back really low so she was given treatment. We are just starting to do things that need doing and not ask the mentor if we should do it... You don't feel helpless anymore'
(University A Group 2, No. 4).

'It is nice that the midwives have confidence in you as well... You do something and the midwives say, 'well done!' Just picking things up like doing VE's (vaginal examinations) on your own; the midwives don't check them anymore. They trust you and that builds trust in yourself and it really helps...'
(University A, Group 2, No. 2).

'The amount of student midwives currently on placement, meaning sometimes it is difficult to get continuity of mentor which is really difficult. So when you do get a mentor - I'm usually in shock...' (University A, Group 1, No. 4).

The majority of students were quite animated and complimentary regarding their mentorship experiences. They considered the level of support met their learning needs. Demonstrating their knowledge to the mentor bolstered their egos. They appeared to need positive regard in all tasks they undertook. Demonstrating their aptitude to work semi-independently provided a much needed morale boost. For some students, gaining continuity of working with one mentor appeared to impact on their learning. There was a related essence of neglect and isolation within their narratives as they struggled to cope with a lack of direction in their learning. This produced much frustration and unhappiness. The students became quite revolutionary, as their determination for change was overwhelming. There was some urgency for success.

- Building self-confidence

During their discussions of being a second year student they discussed many phenomena. Confidence appears to be a recurring theme, as this complex attribute emerged during their first year discussion. The students recognised their need to build upon their self-confidence in order to develop further. There was an acknowledgement of their developing self, which they related to being accepted into the social network of midwifery. They recognised their abilities in maintaining their presence within this evolving arena. This provoked much self-praise. Working with different mentors, they perceived, promoted their popular presence; their happiness played a major role in building their confidence.

'It is going really well and it all sort of comes together. I've gained a lot of confidence and it all sorts of fits into place now. It is nice being a known familiar face around your hospital, you feel like you are part of the team. You are well worthy of that position. You know what you are talking about and you've got a bit of experience and you're confident with the care you are giving' (University A, Group 1, No. 5).

'I like working with different people, I like having a different mentor for each placement. In first year I had the same mentor for both delivery suite placements because they can see me right at the beginning and then at the end. It is just in different areas it's nice to have a different mentor because you pick up things and everyone is different, you get to see how you want to be and not want to be' (University A, Group 2, No. 2).

'I have worked with a midwife who helps me to reflect but will also reflect on her own practice with me as well. So after a delivery she will say – I did this what do you think about that? We have a conversation about that. It makes sense because as midwives we do have to reflect on our practice. It makes things clear in your head if you've seen something a bit different it also gives you the opportunity to ask questions' (University B, Group 3, No. 3).

Their discussion promoted a lively discussion regarding their presence in the hospital Trusts. They appeared to assume that because the mentors knew who they were, they were popular. There was a possible element of naivety regarding their position within the multiprofessional team. Being knowledgeable and competent did not necessarily account for inclusiveness. There appeared to be an element of exploitation of each mentor they had worked with, which culminated in picking and choosing how they wished to practice in the future as midwives. Their acceptance of many psychomotor skills demonstrated by their mentors was dependent on their approval of acceptable ways of working. Being-in-the-world of a second year student appeared to provoke independence in their learning, which they possibly assumed improved their self-confidence in clinical practice.

- **Tri-partite support**

The phenomena of learning within a work based learning environment highlights the relationship between the university and the hospital Trust for the students. In their discussions they explored the many highs and lows of becoming a midwife as a university student. There appeared to be a realisation of the links between cognitive, affective and psychomotor learning within clinical practice. There was diversity of opinions regarding the support offered during the assessment process.

'The one thing that influences is all the politics and nonsense that goes on with the hospitals, and with university more than anything. That is what stresses and creates so much fuss and palaver in midwifery more than anything. I have had some family run-ins recently that are easier than this course and the stuff that comes with university and the hospital. People make mountains out of mole hills and they come up with loads of different things and its like – what's the need? That makes midwifery hard at times...' (University B, Group 1, No. 3).

'You get more involved – I don't think university has been as bad as it was in the first year. I think the essays – there are not so many essays, most of them are reflections, there have only been a few that were actual essays. We have learned about the complications of midwifery, it is what you have actually seen in practice, now I have got a better understanding of what is going on. I feel more in the know when I'm in placement' (University A, Group 1, No. 3).

'I think I have more knowledge than I think I have. I surprise myself sometimes that I do actually know something. I do shock myself with the things I come out with...' (University A, Group 2, No.1).

The students expressed many frustrations while discussing the tri-partite relationship between the university and the hospital Trust, suggesting a lack of support from both. At times the discussions became vocal and heated as some appeared to apportion blame when life became difficult. Their inabilities to manage their outbursts became obvious, suggesting there was a possible element of immaturity in their coping strategies. For others, their pragmatic approach to learning difficulties

enabled a calmer approach to many unforeseeable situations. This appeared to allay many worries, which resulted in peer support.

7.2.3 Phenomenon of midwifery within an NHS Trust

- Provision of care

Pregnancy and childbirth are considered to be a physiological process of life. The regulation and supervision of midwifery culminated in the passing of the 1902 Midwifery Act. Education of midwives was established to reduce the rates of maternal and neonatal morbidity and mortality over time. The medical profession provided the original format of education to the upper classes of women. The majority of women gave birth at home during this period (Donnison, 1988). Over time there has been much disparity in places of birth, culminating in the publication of a report from the Ministry of Health (1970). The Report (1970) reduced the domiciliary provision of maternity services, thus increasing the availability of hospital beds for pregnant women. This appears to have coincided with the development of the use of technology to monitor fetal well being. Over time, women came to acknowledge that birth should be undertaken within a hospital environment. This cultural change may support the popular view that women lost their autonomy in their choice of place of birth. The students demonstrated an element of frustration when caring for women with a normal pregnancy within a medical model of care. The students' discussions focussed on the juxtaposition of being a midwife as an expert in normal midwifery, and working within a medical model of care in an NHS Trust. There was an element of frustration in their discussions regarding their training needs and the needs of the woman. They expressed doubt regarding the future role of the midwife and the possible loss of normal midwifery.

'When you ask women about home birth some will ask about the MLU (Midwifery Led Unit) they say it is nice, things are there in case you need it. Some think that if they are at home and something goes wrong, the baby is going to die or something. But they have all the resuscitation equipment at home and would still be monitored at home as if they were on the MLU. If anything changes they have got the time - it is not like everything goes wrong' (University B, Group 3, No. 1).

'This year I have only had six weeks on community for the whole of the year. I had two shifts a week. I think there should be more emphasis on the skills that would be required in the community...' (University B, Group 3, No. 3).

The students' discussions provoked a lively debate regarding the role of the midwife. They suggested midwives are practitioners for normal midwifery, but their educational experiences revealed to them that they needed to be prepared for *'complicated situations'*.

'I think we need to be trained in a high risk hospital, if we don't see high risk things how... (are we able) to recognise deviations from the normal, which is part of the NMC standards. However we wouldn't know how serious the thing would be if we haven't seen it' (University A, Group 1, No. 4).

'I think it can have the opposite effect. Midwives who are trained within the high risk area lose that normality. They lose their normal skills, which are even scarier than working out a complicated situation because that is... they are going to happen less often. Basic midwifery skills are important. If that is all you know – complicated...' (University A, Group 1, No. 5).

- Medical model of care

The issues surrounding the students' experiences are closely linked to the previous sub-theme. The students' discussions focussed on their experiences within the hospital environment. In the previous sub-theme they appear to reveal their confusion regarding the sphere of the midwives' practice. Here they relate to the role of the midwife within the hospital setting, in which they distinguish between the

sphere of practice and the midwife's role. Within these myriad terms the students explored their frustrations regarding the lack of autonomy of the midwife.

'It is just monitoring, all of the machines do all the work and they (the midwives) just write it all down. Midwives are just nurses really, giving medication on the ward and writing up their observations and things' (University B, Group 3, No. 1).

'I do try and get them (women) off the bed but it's the women who don't want to move. Some women just want to get on the bed. I try and encourage them because the bed can move. I put the bed into a chair so that they are sat up or in different positions. We are not allowed birthing balls anymore because of infection control. We are not allowed bean bags either – infection control – it is literally a bed in a room. So the women are either on a bed or stood up' (University B, Group 3, No. 3).

'It's like you were saying, 'NHS, or what?' Who says we have to work as a midwife in an NHS hospital? There are plenty more things we can do. Maybe that's the only way we can train because we need to be funded by someone...' (University A, Group 1, No. 5).

During a lively debate, the students appeared to accept the midwife had a role to play in the care of the woman. Their discussions focussed on the labouring woman, which may imply to the general public that midwives just deliver babies. Their focus was on the tasks midwives perform, and not necessarily on the provision of care in a controlled environment. This may suggest that policies and protocols direct care. Their understandings of midwifery appeared to focus on the sphere of the midwife's practice in the provision of normal midwifery care, as they suggest the autonomy of the midwife promotes woman-centred care. Their observations regarding the role of the midwife at their level of training suggests that midwives may not be practising autonomously, but appear to be working as maternity nurses within the medical model of care.

- **Challenges facing normal midwifery**

The students were asked to reflect on their level of knowledge in regards to normal midwifery during high risk situations. Being in the world of a second year student had exposed their theoretical learning to high risk pregnancies. The majority of their midwifery placements were based within the Trusts, where women with complicated pregnancies received care. For many students, this was a natural transition in their learning which they appeared to manage. For some this caused much anxiety.

'With regards to sufficient knowledge, I feel at the end of our second year we have covered most of the things we see day to day. I do feel... I have fairly sufficient knowledge whereas last year we didn't. The way the course works we were only taught normal and we just didn't know anything really especially in a high risk unit. We barely knew anything, we knew the mechanisms of labour and that was about all. We were out of our depths...' (University A, Group 1, No. 2).

'It is all about getting a balance from the university's point of view, we wouldn't know what a good blood pressure was so there is no point in knowing about the bad things if you don't know the good things. Trying to figure out why it is abnormal. It must be really hard for the university to decide to do it like that' (University A, Group 1, No. 3).

'...I am on labour ward at the moment and I go in and I am actually... I do really enjoy it. Time just passes really quickly, it is those times it's one of the best jobs in the world. When things go wrong and you are tired and you haven't had anything to eat and all those things come into it then that's the time when you question it. There is a balance... that does affect it' (University B, Group 1, No. 1).

The students' discussions revealed a possible flaw in the structure of the curriculum and the positioning of midwifery education within an NHS Trust. This provoked a lively debate as many students explained that placing first year students in a high risk unit only exposed them to high risk care. They were unaware of the concept of 'normal' midwifery in practice. Their embarrassment was blamed on the university, as they were unprepared for such a high level of exposure. Their argument was based on the theoretical structure of their first year which had focused on the normal

physiology of pregnancy. In their reflections on their experiences so far, it was suggested that perhaps a community based programme of study may solve some of the issues raised. The students could not envisage this as a solution, as they acknowledged that women give birth in a hospital and the home birth rate was very low. Their socialisation into the midwifery profession appeared complete.

7.3 Hermeneutic phenomenological writing on being a second year student midwife

A hermeneutic phenomenological exploration of being a second year student midwife provides a snap-shot view of the essence of this phenomenon. The third stage of the study addressed several distinct elements of being a second year student midwife. These included processes of reflection, self awareness and personal capabilities.

This hermeneutic phenomenological interpretation of the data continues to be written with reference to phenomenological literature. This is guided by the main themes and the sub-themes that emerged from stage three of the study.

- Work based learning

Being in the world of a second year student midwife took them on a journey through their life-world. Consideration of their experiences so far began with the deconstruction of their past and present lives. This led to an exploration of their conscious acknowledgement of their experiences of being student midwives so far. This enabled the students to reflect on their progress. The majority of the students suggested they were comfortable with their learning. This was supported through

their discussions regarding the influences of their peers. Having taken heed of the warnings from previous students, they suggested they were well prepared. They spoke of their timely submissions of their theoretical assessments. This brought much relief to the students.

There appeared to be great distress for some students when clinical assessment deadlines were approaching. They discussed many influential factors. Some students discussed their commitment to their families, while other students found difficulties with accommodation and monetary issues. For many, the re-organisation of the maternity services within their Trusts caused some disruption. The students discussed their difficulties with the completion of practical assessments. They suggested the lack of time their mentors received to complete their paperwork delayed their submissions. There was an expectation that their mentors should receive the time from their employers. Some of the students complained about the lack of understanding from the university regarding their difficulties. They suggested there should be more flexibility.

Some students did discuss the possibility of being on-call for home births, but this was quickly dismissed. The need for the completion of practice hours appeared more important. Not being called to a birth would mean a reduction in their hours. Being a community midwife was discussed as a decision for the future; their immediate needs appeared to focus on the successful completion of the course.

The students explored their experiences of non-midwifery placements. There was much debate regarding the timeliness of such placements. Their discussions

revealed their disquiet at being placed in areas other than midwifery. They suggested the placements were not as they had anticipated. They de-constructed their experiences of learning in general out-patient departments, medical care gynaecology and neonatal care. There appeared to be an appreciation of being placed in the latter two. These were related to women and child health. The students' discussion focused on the stress of the other experiences.

Being a second year student brought them to an epistemological consciousness of the phenomena of illness and the process of dying. This was a new challenge for the students. Their explorations revealed a de-construction of their interpretation of hospital based care. There was an acceptance that people who were ill would attend the hospital for care and treatment. They questioned the need for them to engage in the wider processes of care. They accepted that they would encounter different placements. They did question the relevance of many of the placements as they had not anticipated the impact these experiences would have on them. They appeared to have a subjective awareness of the working lives of nurses. Their discussions revealed an element of admiration for nurses, as being exposed to the lived experiences of nurses brought an exploration of their ontological knowing. Their reflections and interpretations were suggestive of fear and uncertainty. Being exposed to an unfamiliar environment brought insecurity to their lives. For some students, the phenomena of working with the sick and the dying did not equate to their future role as midwives.

For some students these experiences brought difficulties. They suggested they were '*used*' in the out patients clinics. Not having a choice of which clinics to attend

caused friction in their reflections. Their explorations revealed tension between the students and the nurses. The students suggested they were unable to equate some nursing skills to the care of pregnant women. The discussions also revealed they were not allowed to use their skills within nursing, as they stated they were prevented from *'taking blood'* from patients. They confirmed they had been taught this skill in their first year of training. They expressed their frustrations at this restriction of practice. Through their narratives, they confirmed they had chosen the correct career pathway. The students explored the voyeuristic nature of gaining experience in some care settings. Their narratives revealed elements of embarrassment and self-consciousness regarding the lived experiences of illness and dying. They expressed their need to respect the person by questioning their presence in some situations. Being in the world of the student midwife brought much tension to many circumstances. They questioned the need for their engagement with some placements. They explored the role of the nurse within the multiprofessional team. Their discussions revealed a possible misunderstanding of the role of the nurse. Their analogy was one of a 'handmaiden' to a doctor. There were no discussions regarding the students' understanding of the concept of nursing care.

- **Mentorship in clinical placement**

Being in the world of a second year student midwife brought many challenges to the students. This they revealed through their discussions regarding the support they needed. Their hermeneutic cyclical analysis revolved around their expectations and experiences of working with their mentors. Reflecting on the phenomena of guidance, the students viewed themselves within their life-world. The students revealed a prescriptive element that was required to fulfil their needs. They

suggested there was a strong bond between their being and the mentor. The deconstruction of this relationship revealed a strong reliance on the mentor to support their psychomotor development. Having a mentor who helped them to reflect on their practice gave the students much support and confidence. Gaining approval from their mentor enhanced their development. Having a mentor who motivated them to learn was important. The students discussed many scenarios that culminated in positive and negative experiences of being mentored. They related their positive experiences with a 'nice' mentor. There were also critical elements to their discussions, as working with different mentors on one placement caused confusion to their experiences. This hindered their learning and confidence.

The students spoke of conflicting advice. This caused them to reflect on the mentors' capabilities and knowledge. The students suggested some midwives would not let the students use their accumulated knowledge. The midwives expected them to *do it their way*. The students suggested this caused much confusion and aggravation. Being able to build their confidence in practice was important for the students. They were keen to share their knowledge with their mentors. Demonstrating their skills of analysis of care needs brought joy to the students. Being accepted as a knowledgeable student was important. It also appeared to be their goal. The students' reflections revealed coalescence between their psychomotor and cognitive development. This provided them with much enjoyment while reflecting on their previous first year challenges.

Being in the world of a student midwife within a work based learning programme of study revealed many issues. Some students expressed disappointment regarding

the partnership between the university and the Trust. Their reflections on past experiences revealed two distinct institutions. Their de-construction of the support mechanisms suggested the students were the conduit. The students' interpretations of support revealed a breach in communication which was revealed during their discussions regarding clinical placements. They suggested a lack of support from the university when they requested an alternative placement. This they found confusing and worrying.

Some students suggested there were difficulties surrounding assessment submission dates. Their discussions revealed dismay that theory was just as important as practice. Their narratives suggested there was an acceptance of the difficulties experienced within the Trust. These were revealed as sickness rates among the mentors and too many students on each placement. Their focus of discontent appeared to be with the university as their reflections revealed being an adult learner had its difficulties.

- Phenomenon of being a midwife within a hospital Trust

Being in the world of a second year student midwife caused the students to reflect on the role of the midwife. Their discussions revealed a deconstruction of what they originally anticipated the role to be. Their narratives revealed a possible sense of disappointment. Their original analogy of a midwife was one of an autonomous practitioner. This was revealed through personal experiences, as previously discussed. The students' narratives were suggestive of a different aspect to the role. Their discussions were more directed towards one aspect of care. Their main focus

was on the birth of the baby. For many students, this appeared to be the ultimate joy of midwifery.

The students did not discuss the care of the woman during the antenatal or postnatal periods. Their experiences highlighted the care midwives provide to women who have hospital births. There was an acceptance that women gave birth in the hospital. Home birth was considered to be something out of the ordinary. There were mixed opinions regarding where women should birth their babies. Not all the students agreed with home births. This was revealed during their narratives regarding risk factors. The students discussed their training needs in order to support women. Being trained to recognise and care for women with high risk pregnancies appeared to be their priority. The students' narratives suggested care was driven by hospital policies. Their narrative revealed the rigidity of some midwives' practice. All women appeared to be treated the same. Their adherence to policies provoked a *cascade of interventions* upon the women. Some students implied the midwives had *lost the art of midwifery; being watchful and waiting*. Some students envisaged their practice would be different. They spoke of allowing women to move freely in labour.

Their discussions revealed how time had become important in the care of women on the labour ward. Their discussions focused on the safety of the woman and fetus. They implied this was also the woman's prime concern. The students' main focus was on being prepared for any eventuality. Having the necessary skills was important to the students. They criticised the structure of the second year. Their reflections on their second year revealed criticism of the non-midwifery placements.

'...when you add it all up it is probably three months out of midwifery, we have a month on Gynae, a month on Neonatal and two weeks on A+E and Out-

patients. That's 25% of our year out of midwifery. When you take out our holidays and things like that, that's another seven weeks; that is another couple of months. That is nearly half the year gone' (University B, Group 3, No. 2).

It was suggested they had lost valuable time.

Practicing their skills in midwifery was more important. In their narratives, the students acknowledged that women with medical disorders do become pregnant. Their interpretations of care for these women appeared to focus upon the pregnancy. They viewed the medical condition of the mother as the domain of the obstetrician. They spoke of these women as being *high risk*. As such they accepted care would be directed by the obstetrician. Their reflections revealed a level of frustration regarding the care of women in labour. They suggested women listened to the doctor's orders more than the midwife's advice. Their analogy of the midwife within the hospital labour ward was one of a *maternity nurse*. As such, their reflections suggested that having a nursing qualification could possibly have some benefits. They acknowledged how some nurse/midwives provide holistic care to women. They agreed that as the education of midwives had changed these nurse/midwives would not be replaced. There was no discussion regarding a possible loss to the profession.

7.4 Summary

This discussion of the students' narratives provides an understanding of the lived experiences of being a second year student midwife. The analysis has presented the themes and sub-themes essential to the phenomenon. A hermeneutic phenomenological framework was used to discuss how each are inter-related. Their

experiences of being a student midwife could be strongly influenced by theme one: work based learning. Reflecting on their experiences in non-midwifery placements appears to have exposed the students to the pathology of illness. Their need for support became evident. This could be related to theme two: mentorship in clinical placement. Working with supportive mentors enabled the students to develop their practice and reflect on their future role as midwives. This could be related to theme three: phenomenon of midwifery in a hospital Trust. The phenomenon of being a second year student midwife, as revealed in phase three of the study, revealed experiences of working within a multiprofessional team, high risk midwifery care and the juxtaposition of the role of the midwife within the medical model of care.

Chapter 7 presented the empirical findings from the third stage of the study: lived experiences of being student midwives at the end of their second year of study. Chapter 8 follows in which the findings of the fourth and final stage of the study are presented: the lived experiences of being a third year student midwife at the completion stage of their studies.

Chapter 8

Lived experience of being a third year student midwife

8.1 Introduction

This chapter presents the empirical findings from the fourth stage of the study: lived experiences of being a third year student midwife. The students were at the completion stage of their studies, they were asked to reflect back on their training and experiences of being student midwives.

8.2 Phenomenological sensitive themes essential to the lived experience of being a third year student midwife

This chapter focuses on the student midwives' lived experiences during their third year of training. During this year the curricula were designed to introduce the students to the midwife's role as a leader of care in preparation for their role as qualified midwives. Hermeneutic phenomenological analysis of the students' narratives revealed some emotive phenomenological themes.

- Accountability - a sense of uncertainty in their abilities to become midwives
- Sphere of the midwife's practice
- Medicalisation of childbirth

Table 6 below provides an overview of the main themes and their related sub-themes in relation to the third year of their studies.

Main theme	Sub-themes
Accountability - a sense of uncertainty in their abilities to become midwives	<ul style="list-style-type: none"> • Realisation of the role of the midwife • Critical analysis of the course structure • Self motivation
Sphere of the midwife's practice	<ul style="list-style-type: none"> • Taking the first step • Ability to do the job
Medicalisation of childbirth	<ul style="list-style-type: none"> • Pressure to conform • The role of the midwife in society • Quiet confidence

Table 6: Sub-themes organised next to main themes

The three themes and their sub-themes are explored below. There is an inter-relationship between them that highlights the students' nervousness and the realisation that they are at the end of their journey of becoming midwives. In each focus group, their narratives revealed mixed emotions tempered with excitement and foreboding. The phenomena of becoming midwives were soon to become a reality. Some questioned their intentionality of the role of the midwife and the effects this had on their being.

The students' interpretations of their experiences revealed a sense of finality. In each of the focus groups there was an air of sadness as they acknowledged that these would be their last meetings together. They suggested they would miss meeting together as they considered these meetings had been supportive during their

training. The students stated there were no other opportunities to reflect on their journeys within their training schedule. They placed value on being able to share their experiences in a confidential setting with someone other than their tutors. Interpretation of the phenomena revealed the students' desire to reflect on their development with their peers as equals in a relaxed environment. Their encouragement of each other enabled experiences to be shared, which subsequently enabled them to reflect on the phenomena of becoming midwives. Their openness and laughter brought much delight to the research and to me. There were times of despair during their journey, which they regarded as part of their development in order to reach their goal of becoming midwives.

8.2.1 Accountability - a sense of uncertainty in their abilities to be become midwives

As the students approached the end of their studies, the enormity of the responsibility of the midwife formed part of their discussions. This caused anxiety and stress as they reflected on their future roles as midwives. Leaving the relative safety of their programme of studies led the students to reflect on what the rhetoric of being accountable would mean for them. The midwives' rules and standards and the Code (NMC, 2004; NMC 2008; NMC, 2013) outline the professional boundaries of the midwife and the responsibility they have for providing care. Accountability within their practice is suggestive of a legal responsibility to the women, their families, the employing Trust and to themselves as practitioners. For some students their interpretations of these requirements overwhelmed their being as they explored their capabilities of fulfilling the role.

'...knowing that you are 100% accountable for everything that you do'
(University A, Group 2, No.2).

- **Realisation of the role of the midwife**

For some students their narratives suggested a lack of understanding of the immediacy of their responsibilities as a midwife on qualification. Their interpretations of being a newly qualified midwife focussed on their need to be supported in practice until they were ready to take on the role. Their focus did not appear to encompass the legal requirements of the statutory role of the midwife; their accountability and responsibility to and for the woman. There appeared to be an element of self centredness and possible fear.

'I think I would benefit from extra support if I were to go to another hospital, which I am not opposed to be doing, I am in favour of my Trust where I trained simply because it is easier because I know it, but you do get more support somewhere else' (University A, Group 2, No 3).

'I feel I could be a qualified midwife in the Trust where I work at the moment; I've trained in for three years, I know where everything is and I know everyone, I feel I work quite autonomously. There would be a transition period and I could cope with that. If you put me in a different hospital with different protocols and people and equipment I feel that scares me a bit even though you will be qualified I will be back at stage one for your training because that is when you don't know where everything is. You don't know who anyone is and I feel that will be quite difficult' (University A, Group 2, No 4).

- **Critical analysis of the course structure**

Their narratives exposed their vulnerability, which caused the students to reflect on the cause of their embarrassment. Their focus led them to consider the structure of the curricula. There appeared to be a need to apportion blame for their fear and anxiety and lack of confidence in their abilities. Many of the students were worried at

the possibility of being placed on departments and wards where they lacked the most confidence. This they attributed to a lack of experience during their training.

'I keep thinking about things like when you are qualified, you could be put out on the community – in my own Trust it might not be the same area so it's not going to be the midwifery side of it that scares me, it's the geography of finding places with everything else that comes with being a community midwife' (University A, Group 2, No 4).

'My fear is in certain areas, the university hasn't helped, I've been given six months on community and four weeks on delivery suite and I feel – I've done six months on community in first year, there is only so much you can learn on there, as interesting as it is, whereas on delivery suite there is something different every day. I think they could have made us feel better about going on delivery suite by giving us a longer placement. In four weeks we did 12 shifts which is nothing! You get back into it and then, you've got your night shifts and I think that could be made better to get us ready to go out on our own' (University A, Group 2, No 1).

'I also agree that there are some placements were you think, yes I am absolutely fine and I know what I am doing. I can practice on my own and I'm OK, but there are still other parts were I feel I am scared of going there, like delivery, it petrifies me but I think that is always going to be the case' (University A, Group 1, No 2).

- **Self motivation**

The true nature of the role of the midwife appeared to have been lost for some students. Their original view of midwifery as a vocation appeared to have disappeared. Their narratives indicated they considered midwifery to be just a job as their lives revolved around completing their placement allocation within the time-frames of the shift patterns. There was much discussion regarding the relevance of many other aspects of the curricula. The wider aspects of their theoretical development brought quite animated reflection. The students' main focus revolved around the practice part of the curriculum. The theoretical part appeared to be a burden to be endured and this sparked much discussion and criticism.

'I also don't think we had enough lectures on drug management and drugs in pregnancy. We didn't have anything in first year, we had a general overview on pharmacy, but it wasn't specifically midwifery related. Today is the first day in three years we've actually had anything specifically related to midwifery medicines and drugs and contraindications. That is a massive fear... we haven't been directly responsible for giving a lot of the drugs out, but we will be very soon... We will be expected to know who can and can't have those drugs. I feel a lack of confidence in that department... I feel I would be unsafe to practice, also we haven't had much time to do anything' (University B, Group 1, No 2).

8.2.2 Scope of the midwife's practice

The midwives' rules and standards (NMC, 2004; NMC, 2013) dictate the scope of the midwives' practice. This is enshrined in law; the word *Midwife* is written in statute. The current rules and standards indicate there are 15 rules that the midwife must abide by in their practice. Rule 5 clearly sets out the responsibilities and scope of the midwives practice. The midwife is required to provide antenatal, intranatal and postnatal care to the woman and baby. If there is any deviation from the normal, the midwife refers the woman to the relevant professional with the necessary qualifications. The midwife continues to provide care in such a situation. The midwife's responsibility or accountability cannot be removed from her/him nor can it be given to someone else (NMC, 2004; NMC, 2013). This statutory requirement governs the sphere of the midwife's practice, as midwives are practitioners for normal midwifery.

- Taking the first step

As the students approached the completion of their programme of study, their reflections revealed an appreciation for the support they received from their mentors. Their narratives revealed a confidence that they suggested could only be gained from caring for pregnant women. There appeared to be a sense of pride and

achievement that could only be gained from this solitary act. There was a sense of quiet confidence to their Being. Their narratives expressed an acceptance of this element of internal knowledge, which gave them a soupcon of personal indulgence at having achieved this phenomenon.

'Midwives do make a bond with them (women), the women get excited to see you in your clinic, they come in with their latest gossip from their family and they want to tell you and they want to see you and I think that is lovely. I don't think any other people get that and I think that is part of the role of the midwife being able to make a relationship with someone' (University A, Group 1, No. 2).

'It is nice when they remember your name. When you are on delivery unit and they ask you not your mentor, that is what I've found recently, they have been asking me – what is happening, why are you doing this and what is it for? Explaining things to them makes them trust you, and I've found that really valuable this year. This is the first time it has happened and I think, I've grown obviously and I feel confident. I must be showing confidence, otherwise why are they asking me the questions? They trust me, so I found that really nice, they see you as a person as well not just a midwife or student midwife which is nice. When women say thank you it makes it all worthwhile even when you haven't had a break in eight hours. You think, well at least I made a difference to them!' (University A, Group 1, No.4).

- Ability to do the job

From their discussions there appeared to be a constant level of doubt regarding their knowledge. This would manifest itself when reflecting on the care of women who were considered to be high risk, such as women who took illegal drugs, victims of domestic violence or women with mental health illnesses. Their interpretations from practice revealed care for these women would be provided by the *specialist midwife*. For some students there appeared to be little comprehension that these issues could become evident at any point in pregnancy. In their discussions, it appeared that the students believed the women with these problems would be known to the maternity

services already and that they would have very little contact with them in their own practice.

'There are a lot of people who take drugs and I think it is an area that we need to know about - I am a bit naive to be honest' (University B, Group 3, No.3).

'I didn't realise there would be so many women who would need support, I suppose I am going back to the women with drug and drink issues... I think it is the same as I thought it would be but then I think it is different as well...' (University B, Group 3, No. 3).

'If I knew I would only ever have to look after a normal, low risk woman then yes, abnormal things – no. I've looked after more low risk and I feel really confident to do that but if something went wrong then no, not yet!' (University A, Group 2, No 2).

8.2.3 Medicalisation of childbirth

In the students' reflections regarding the role of the midwife there appeared to be an element of sadness. The role of the midwife in their eyes was not what they had envisaged three years ago. Their analogy of the midwife was of one who was controlled by many people and surrounding factors. The obstetrician and the medicalisation of childbirth loomed large in their discussion. Some students blamed the midwives for not being pro-active in their care of the women, suggesting they were fearful of litigation. For others it had become a social phenomenon.

'We are moving away from being with women. It does depend on the midwife some are very medicalised but others are so pro normal. It does depend on what midwife you get. There should be one standard of care but there isn't. Women can pick and chose so much now, everyone is so scared of litigation' (University A Group 2, No 2).

'In the beginning, you think you are going to go in and make everyone breast feed and everyone is going to have a normal birth but you've got to accept that that is not always possible or the best thing... I've got used to that in the three years. Midwifery as a whole is keeping up with society' (University B, Group 3, No. 2).

- **Pressure to conform**

Much of the discussion focussed on their interpretations of the role of the midwife. They expressed some disappointment that role had been eroded from what they had perceived to be an autonomous practitioner. This caused them to reflect on their developing self and their future practice.

'I think maybe it is the transition to real life, not just midwifery. You are not a student anymore, you are going to have to start paying council tax and find a house; you've got to be an adult' (University A, Group 1, No. 3).

'Morale at the moment is low, many midwives want to retire or move speciality where there is not so much responsibility. Litigation and defensive practice and the way they are being forced to practice is not how they envisaged autonomy to be. To see that as eager students, who want to change the world within midwifery services... you are brought down to earth when you see the reality' (University B, Group 1, No 4).

- **The role of the midwife in society**

The media remained an influencing factor for many of the students. Their discussions varied regarding the various television programmes they encountered during their training. Their vision of becoming a midwife still had a nostalgic essence as they visualised themselves cycling to their community cases and antenatal clinics. For some students, their interpretations of the role of the midwife appeared to have been changed.

'I would have loved to have been a midwife in the 1950s' (University A, Group 2, No 2).

'...you see programmes on TV and they are terrible, even my mum, who has nothing to do with midwifery, asks' why are they all on the bed?' (University A, Group 1, No 3).

'I see the role of the midwife diminishing really. When I first started, I wanted to go and do all the things the midwife did. At the minute I feel things are being taken off us, like people are talking about postnatal care going to assistant practitioners, they are doing the community care; heel pricks, they

do everything. Interventions are soaring again, I do think our job is slowly been taken away, obviously we are still needed. We are becoming recovery midwives we are expected to do things that are not really related to midwifery... Our main midwifery role is no longer there, we are told to do more screening such as carbon monoxide screening. There is an understanding as to why we are doing it but...' (University A, Group 2, No. 1).

- Quiet confidence

For some students there was an air of anticipated excitement as the completion of their training approached. Their narratives suggested they were prepared for the next phase in their lives. For some this was the first step to a prosperous career pathway.

'It may sound a little cheesy but I think the world is now our oyster now we have a skill like this you could spend your career within the one Trust and it could be really fulfilling, you could make a huge difference to thousands of women's lives or get into things like policy making or research that affects other parts of the world and make a difference and change things for women and their families. I think that is really exciting that we could get as far as we wanted to. I do feel I could go anywhere and do anything, if I wanted to and make differences to women. That is really exciting, that you have a skill that is transferable, there is no limit to what you could achieve' (University A, Group 1, No. 5).

'People do underestimate what midwives do, people think we are just glorified nurses but we're not! We don't just catch babies it is a lot more difficult and challenging than anybody can comprehend. They don't understand what the university course is like as well. People actually say to me - you're in your final year now have you delivered any babies yet? I say, yes a lot of babies...' (University A, Group 1, No.3).

'I think the role of the midwife is a fabulous one when you are being a midwife I don't think there is anything better. The buzz of it, even though it doesn't go according to plan, being there for that woman and not leaving her side for 12 hours, seeing them through that whole birthing experience is fantastic' (University A, Group 2, No 4).

8.3 Hermeneutic phenomenological writing on being a third year student midwife

The hermeneutic phenomenological exploration of the fourth stage of the study allowed several distinct themes to emerge from the data. Interpretation of the students' experiences revealed elements of being a third year student midwife. These included accountability, sphere of the midwife's practice and the medicalisation of childbirth.

The hermeneutic phenomenological interpretation of the data continues to be written with reference to phenomenological literature. This is guided by the main themes and sub-themes that emerged from stage four of the study

- Accountability

The term accountability in midwifery can be related to decision making and having expert knowledge and skills that appropriately support the care the midwife provides. In this regard, the midwife is required to give an account for the actions taken (Mander, 2004). The intentionality of the role of the midwife focuses on the acceptance of the issue of accountability and her/his responsibility for the decisions and timing of the midwife's actions (Greenfield, 1975; Griffiths, 2011). This duty is associated with anticipating the actions necessary to provide care to the woman and / or baby utilising expert knowledge and skills. To become an accountable midwifery practitioner, the students need to have received adequate preparation. Accountability cannot be imposed, it needs to be accepted as part of the students' intentionality of the role and statutory function of the midwife (Griffiths, 2011).

The students reflected on their experiences of being a third year student midwife. This led them to consider the enormity of their future as midwives. The students were near to the completion of their course and the stark reality of being a midwife with its responsibilities appeared to be a frightening prospect for some. They did not feel prepared for the role. In their narratives, they discussed the responsibilities and accountability the midwife has for the woman. They suggested within their Being they were not ready to take on this status. They understood that being-in-the-world of a midwife requires an understanding of the consequences of actions and omissions in the care provided to the woman. The midwife is co-constituted with the world of midwifery; her/his existential being is focused on the professional role of the midwife (NMC, 2004; NMC, 2008; NMC, 2012).

'I don't think I thought of the responsibility even when I was at the end of second year I think it kind of dawned on me I got that feeling... when you finally realise it!' (University B, Group 3, No. 3).

'If you don't notice something and it goes wrong it is your fault! It makes you want to learn more definitely... so that you can do it...' (University B, Group 3, No.1).

Being socialised into the world of midwifery enabled the phenomenon of being a professional to emerge. This they suggested they had experienced as students, as their worries centred on taking the first step as newly qualified midwives. Heidegger's (1962) interpretation of *Dasein* (being-in-the-world) brings the existential world of the midwife into the students' being, enabling them to pursue the professional status and responsibilities of the role (Koch, 1994; NMC, 2004; NMC, 2013). The realisation of becoming a midwife appeared to have developed within their existential world of

being a third year student. The phenomenon of becoming a midwife had become a reality for them.

The students' interpretations of their development and readiness to take on the role enabled them to reflect on the next stage in their careers (Fontana, 1995). For the students with children, this status led them to de-construct the existential world of the midwife and its legal responsibilities. Their explorations revealed elements of trepidation within their conscious knowledge of being in the world of a midwife. Many students believed they had not been adequately prepared for the role. They questioned their own ability to internalise their knowledge and understanding of the legal aspects of the midwife's accountability. Their fear and panic appeared to consume their being, revealing their doubt in their ability to take on such a responsibility. There appeared to be a juxtaposition between their new life and their previous life.

'This course has consumed our lives. I don't have much time for my family and with all the extra study you do... They keep saying soon you will be out here on your own, well it has really put me off! I am still questioning whether midwifery will be my fort  or whether I'm ready for that sort of career' (University B, Group 1, No.2).

For the students without children, their demeanour was one of anticipated excitement. They appeared to embrace the challenges that awaited them in their new life-world.

'I felt before going onto placement this year I wasn't ready, but actually being left on my own and being given confidence cases that made me realise I can actually do it. When you have a midwife with you constantly it provides reassurance but when you are on your own you realise that you do know what you are doing, that really helped. You are in charge of the situation rather than doing as you are told you are being in the situation of being a midwife, it is a stepping back moment and thinking, what do I do, and that helps' (University A, Group 2, No. 1).

Griffiths (2011) discussed the four key functions of accountability within midwifery, describing them as having: a protective function, a deterrent function, a regulatory function and an educative function. He stated these were the foundations that protect the public from harm. In the students' narratives, their intentionality of harm was directed towards themselves, suggesting they needed to be protected while they became more confident in their practice. Their discussions revealed indecisiveness as they discussed the prospects of employment. Their need for familiarity with the workplace appeared to transcend their professional need for development. For some of the younger students, there was an element of trepidation and a need for familiarity within their home Trusts. Others in the same group embraced the prospect of new horizons.

'I also feel if I work at the Trust where I trained I would never leave, it is one of those Trusts where people train at and they have been there for 25 years. Everyone is really friendly and it's really great hospital which is really nice but I don't want to work there forever. I don't know if I even want to work there... I feel as though I would need to move on but it would be really nice to stay' (University A, Group 2 No.1).

'If I had to go somewhere else I would be very nervous, you would have to learn everything all over again because part of me would be really worried, being that newly qualified midwife who comes across as she should not have qualified...' (University A, Group 2, No. 2).

They reflected on the careers of midwives who had remained in one Trust for many years. There was uncertainty as to whether this was in their plan for their future development. The students expressed admiration for these midwives, as they appeared to have the knowledge the students desired. They expressed concern about these midwives leaving the profession. Their interpretation of this natural movement of staff appeared to focus on the loss of experience and not as an opportunity for them to gain employment and experience. Within the concepts of

accountability this caused the students to reflect on their life-world experiences over the past three years. Considering the role of the midwife they were about to become they de-constructed their learning experiences in order to understand their lack of confidence in their abilities. Their intentionality focused on what they perceived to be a lack of education and support from their tutors during their course of study. Being in a large group of students appeared to affect the younger students' engagement with their lecturers.

'We (are a) large cohort and I think sometimes you don't get the support that you need. Personally I haven't felt particularly supported by uni. So I would prefer to be in a smaller cohort where all the lecturers know my name...' (University A Group 1, No. 4).

The more mature students focused on the content of the course and how they adapted to clinical situations. They used texting as a form of learning in clinical situations. This social form of information gathering demonstrated their lack of knowledge as they appeared to rely on peer support rather than asking their mentors for guidance.

'We have not been taught any of that (drug calculations) we are constantly texting each other when we are on the wards what are the contraindications for this drug or that drug...' (University B, Group 1, No. 4).

The phenomenon of becoming a midwife for the students revealed much anger and frustration regarding their unresolved disquiet. This was aimed at the structure of the second year of training and the relevance of the medical placements. They suggested this time out of midwifery practice interrupted their midwifery education. For some, the existential world of the sick and the dying appeared to be irrelevant to the role of the midwife. As they reflected on the impending completion of their training, the students appeared quite apprehensive regarding their ability to be

midwives. Their focus on culpability towards their tutors and the structure of the programme appeared to appease their sense of vulnerability as they sought someone to blame (Chamberlain, 1997; Finnerty and Pope 2005; Licqurish and Seibold, 2007).

Reflecting on the students' experiences, their interpretation of the status of the midwife appears to be an all-encompassing state of being. They appear to suggest the midwife is required to focus their intentionality on the true nature of a professional practitioner within their public and personal lives. This may imply a possible change to their state of being. For some students this evolving self seemed to reveal worries that needed to be resolved as they approached the completion of their training (Tajfel and Turner 1979; Hogg and Abrams 1988; Mezirow, 1990). The intentionality of the phenomenon of being accountable for some students revealed their need to re-evaluate their capabilities and knowledge. For the more mature students they projected their nervousness onto the finer structure of their experiences of their training. They suggested a longer course of four years would support their needs.

'...a four year course, maybe you could consolidate your skills...' (University B, Group 3, No. 3).

The students without children appeared to accept this ontological change within them. Their intentionality of the next phase of their careers brought the *zu den zachen* (to the things themselves) to their *Lebenswelt* (life-world). They viewed this as a challenge to be embraced and accepted that they would need a period of adjustment in order to hone their skills. Each student expressed their preferred area

of practice such as working in the community (Dreyfus, 1987; Spinelli, 1989; Valle, 1997).

'In areas I feel ready in the community. I feel ready but it is all the practical things like my car, being able to park in a car park space (laughter.....) I can drive I just can't park so I am finding where places are... the actual midwifery that's alright I can do that. Then, it is learning when you go to a new Trust, learning all their different policies, something you do in your old Trust I feel quite confident with and know where they have come from, but if it was something totally different in a different Trust, I would struggle with that.. I would worry I'd do something wrong that wasn't to their Trust protocol, so I think it is that, not being familiar with' (University A, Group 1, No. 4).

Within the students' narratives there was an acceptance that they would only gain the confidence they aspired to by working in the field. The students without children demonstrated their self-assurance by suggesting they were prepared to work anywhere, as they had no family commitments.

- Scope of the midwife's practice

Within their discussions the students revealed their knowledge of the scope of the midwife's practice. They accepted that the focus was on providing midwifery care to women during the antenatal, intranatal and postnatal periods of pregnancy. The ontological domain of the status of the midwife is within normal midwifery (NMC, 2004; NMC, 2013). Being in the world of a third year student midwife revealed a variety of experiences to reflect upon. They appeared to regret not having experienced many home births as the national average for home births was 2.4%, a decline of 0.1% from 2010 (ONS, 2013). They were keen to demonstrate their knowledge of the sphere of the midwife's practice. They suggested that as midwives they would be able to provide care in a variety of locations. These being: in the

woman's home, a birth centre or an NHS Trust, as some women are given the choice of place of birth (DoH, 1993; DoH, 2007).

For some of the students, the phenomenon of becoming a midwife evoked a reflective process in which they questioned their original ideology of the midwife as being an autonomous practitioner. Their awareness of what they considered to be outside influences made them question the status of the midwife within an NHS Trust. Their discussions revealed a disappointment in what they had observed over their final year. Their narratives suggested their understanding of the role of the midwife did not match the rhetoric of autonomy.

'It is worrying that experienced, fantastic midwives, who have been qualified 30 years, and know everything, are leaving the profession because they don't like how the profession is going... They don't like their units have been closed and have to work in huge super units... I think that is sad, they have fallen out of love with it. They can see how midwifery has changed to what it is now' (University A, Group 2, No. 2).

The students viewed what they considered to be the role of the midwife as in decline. They suggested that the impact of hospital policies and guidelines appeared to control the midwife, and not necessarily to support the role. In their eyes, midwives had become maternity nurses doing as they were told, particularly on the labour ward. They questioned the woman's choice of caesarean section and the influences of the media and social networking sites. Their interpretation of the women's experiences of pregnancy and birth appeared to be one of the women demanding a painless birth and being bed ridden and attached to a cardio-toco-graph (CTG) monitor. Their narratives revealed their frustrations regarding the choices women make. There appeared to be dissonance in their interpretation of women's choice as

their ideas focused on what options the midwife gave to the women, which perhaps reflected their nostalgic view of traditional midwifery.

Within their discussions, there appeared to be a lack of understanding of the current cultural ideology of childbirth, which has developed since the Ministry of Health report (1970) and more current Governmental guidance on women's choice (DoH, 1993; DoH, 2007; DoH, 2010). Their views may have been influenced by the structure and content of the midwifery curricula. Some students suggested the focus of their clinical experiences was similar to being an apprentice; learning from more experienced midwives in practice. Their discussions suggested that they received very little theoretical support regarding obstetric emergencies such as shoulder dystocia (difficulties birthing the baby's shoulders). Their interpretations of learning and support focused on practicing the manoeuvres correctly on a regular basis in the safety of a skills training room, while being directed by their tutors. Their criticism focused on the structure of the curriculum at their university, suggesting other students were better prepared for practice.

'We had shoulder dystocia skills-drills in second year and I have not seen one since then, and when you are a third year you are expected to do one then. I remember the manoeuvres but it would be good to be able to do it a few times' (University B, Group 3, No. 1).

'We don't have anything like that in third year. We have been told we could nag a lecturer to go through stuff like this but we think it should be automatic in the curriculum' (University B, Group 3, No.2).

Some students felt inhibited from using researched-based care, which they found frustrating. Their interpretations of working alongside the midwives revealed they were expected to adapt their style of learning and practice to suit each mentor. Their discussions revealed they became quite adept at obliging each mentor with their

practice by anticipating the mentor's needs and not the women's. Their frustrations revealed a need to relinquish the student persona and become midwives offering research-based information.

'You don't want your enthusiasm to be dampened but there is an element of, 'it should be like this... we are taught it should be like this...' I see independent midwives and think, wow, this is how I want to practice...' (University B, Group 1, No. 4).

'Some midwives do have a terrible attitude towards women – huffing and puffing when asked to lift baby out of the cot for them...' (University B, Group 1, No.2).

The students without children revealed their course of study was ignored in the major planning of the university timetabling, as basic services were closed during traditional university holidays. They suggested the university's planning department did not understand their needs as a work based learning programme of study within the conventional NHS structure. The students revealed feelings of neglect and a lack of identity within the university, as they suggested they did not feel as though they were traditional university students. This was also linked to the demands of work based placements, as they did not have the same holidays as many other courses.

'As a university culture we are left out. The other week everyone was on Easter holidays, all the cafes were shut, everywhere was closed, everyone forgot about us – it just makes you feel rubbish. In the holidays there are conferences and things going on and these business people looking at you funny thinking what are you doing here?' (University A, Group 1, No.3).

Most students revealed many issues regarding the lack of support during stressful times. They became quite defensive and resentful towards their midwifery tutors as a collective. For some students, their focus on this lack of support helped to develop their idea of being apprentices, as the support in practice was clearly evident. Their mentors offered them direction at times of stress in practical situations. The students'

interpretation of personal support in university was compromised by contrasting personalities, which they appeared to be unable to cope with.

'When I have had problems I haven't felt supported at all. Sometime I think I have wondered how I have kept going; I really have... that is what I personally felt. I don't think it is a problem with me. The way it is structured where you get support from, it's from your personal tutor and if you struggle with your personal tutor, you can try and go to others but they suggest you go to see your personal tutor. If you say you don't get on they say - she is so lovely. The lecturers seemed to group together and protect each other, they always back each other and protect each other so it is you against them... They don't treat you as adult learners, we are still children and that's been another thing that has been really irritating. I have felt patronised, been in tears in meetings with some tutors... Placement, I am quite happy with placement, but it is the lack of support... that may be my personal experience...' (University A, Group 1, No. 4).

The students' narratives revealed a mixture of levels of support and care the midwives gave to women. The students' assessment of them varied. They appeared to classify the midwives by the level and amount of information they gave to the women. Their criteria focused on women being able to make an informed decision about their care. Providing information was considered a good attribute as this enabled the women to make a decision regarding their care. The students' interpretations of the work undertaken by other midwives within the Trusts suggested there was a reason for their lack of engagement with the holistic needs of the women. They proposed this could be due to other influencing factors such as a shortage of staff or burn out. This could possibly be viewed as a demonstration of professional loyalty which they had accumulated over their three years of training; a process of a maturing self (Berger and Luckman, 1996; Hillman, 1996; Roesler, 2000).

'My mentor on community, quite a few people have said you are so lucky to have her. She is a brilliant midwife and everyone compliments her. Every midwife should be like that, and I think it's sad that some midwives may feel a bit down trodden and they don't have the passion for it anymore, probably

because there is stress and they don't... they are not able to be the midwife anymore, they just kind of conform to their mould of being just one of the midwives... nothing special' (University A, Group 1, No. 3).

- **Medicalisation of childbirth**

This theme is closely linked to the previous one. The students reflected on the role of the midwife in today's society from their point of view. Their narratives revealed a perception of a lost innocence of their pre-conceived nostalgic view of midwifery which they had brought to their studies. They acknowledged that life must have been tough for many women in post-war Britain, but the longing to be with women was overwhelming. Their apparent glamorising of the role of the midwife appeared to be a point of reference. Many discussed becoming independent midwives, practising how they wished to practice and not being dictated to by others within a hospital Trust.

Their discussions revealed a defensive stance regarding their interpretations of the media's influence over women and their families regarding childbirth. Their interpretations of women's behaviour during labour suggested that some women had been influenced into thinking they should give birth on a bed. The students became quite defensive while discussing the possible influences of TV programmes that sensationalised women with high risk pregnancies and the role of the midwife within these programmes.

'Virtually every woman in this series has been on a monitor and on the bed with an epidural in. The women watch these programmes and they are going to think well that's normal, that's what I'll do' (University A, Group 1, No. 3).

They were quite passionate in their defence of the work midwives were trained to do. They criticised many influential factors that gave childbirth a medical standpoint,

suggesting there is ignorance of what a midwife does. They maligned social media and programme makers for their lack of insight. Within their discussions there appeared to be a lack of insight into TV ratings and the need to increase viewing statistics. Being-in-the-world of the media appeared to focus on sensational reporting. Their defence of the role of the midwife appeared to be an admirable trait.

In their reflections some students believed the media did portray a truth that was endemic within some Trusts. Their experiences forced them to realise this medicalised focus was what some women were offered. They stated the care provided by some midwives had become routine, as women were not offered woman-centred care to meet their individual needs. This realisation brought the students to reflect on the midwives they had worked with over their training. Some, they considered to be good role models, as these midwives had focused on normal midwifery within the milieu of an NHS Trust. Some students' interpretations of their experiences suggested they had also started to provide routine care, as they reflected on their ability to take on the role of the midwife. Their perceptions of this process revealed they were expected to follow procedure, abiding by the Trust's guidelines. Their revelations suggested they could not be innovative without being questioned and advised appropriately.

The development of the Self as midwives was interpreted as being socialised into the midwifery profession. This included accepting the constraints of the medical model of care imposed on the midwifery profession (Barnett, 1999; Elliot, 1999; Kennedy, 2007; Batchelor, 2006). Their discussions revealed a level of dissent and disappointment at this revelation of their inability to be 'with woman'. They expressed

a desire to re-discover their passion for midwifery as they reflected on the role of the midwife. Within the intentionality of their being, they appeared to re-establish the role of the midwife as one to aspire to, suggesting there was nothing better.

'I think that it is the best job in the world. I think you get to do things that no-one else gets to do and be with women and get to know women in a way no other job you do' (University A, Group 1, No. 2).

This appeared to be the driving force that supported their achievement of becoming midwives. They wished to improve people's knowledge regarding the role of the midwife and the work they did/do. Within their narratives there was a maturing pragmatism regarding their view of midwifery. Their interpretations of their experiences suggested their enthusiasm could be viewed as transitory, as they discussed their role as midwives in society. Their discussions were tinged with melancholia as they reflected on the possibilities of not achieving their goals. Their reflections revealed a sense of foreboding as they suspected their predecessors were once just as keen as they were at the end of their training. The students appeared to have projected their interpretations of their experiences onto their predecessors. They appeared to believe that every student midwife will have experienced their excitement and anticipation of changing midwifery for the better.

'There are a lot of midwives still trying to keep things normal, and they work quite hard at keeping things normal, and there are some that have just got carried away with things and just accepted interventions maybe thinking it is not worth trying to keep things normal...' (University B, Group 3, No. 2).

The younger students' reflections expressed an awareness of the pitfalls of becoming disillusioned, having worked alongside their predecessors in practice. There was much amusement as they reflected on midwives' attitudes when women had compiled a birth plan. Their interpretations of the situation suggested the woman

was perceived to be awkward as she did not comply with the midwives method of care.

'It will be nice to be able to do what we want to do, but then on the other side of it I am sure every midwife went into it thinking they wanted to be the best midwife and thinking about all the horrendous things others did, but obviously would never do, but when you've got 10 women on the ward and babies dropping their temperatures, not feeding and... I don't think you get the chance to be the midwife you want to be' (University A, Group 1, No.2).

'I also find that midwives don't like it when they are informed about things. She is an awkward one, she's got a birth plan - she won't sit on the bed... I just think why should she... it is her birth! If it is out of the rules of what the midwife knows – her regimented thing, her own practice, the woman wants to do it different – all hell breaks loose!' (University A, Group 1, No.4).

The students perceived this to be the loss of seeing midwifery as a vocation it had become just a job to many senior midwives. In their reflections the students recognised the influence that society had on childbirth and midwifery practice. Their discussions revealed conflict between what the students viewed as natural childbirth and the women's view of the same process. Their interpretations suggested women demonstrated their choice of care by opposing the students' ideology of care and advice. The students' interpretations revealed women accepted the medicalised model of childbirth.

Some students' reflections revealed sadness regarding the pressure of work on the midwives time. They highlighted the need for more midwives, suggesting women were not receiving adequate care. The students discussed incidents they had observed that had impacted on their ideology of the role of the midwife, as Trust requirements appeared to be a priority for some midwives. The students' interpretations of what they had observed in practice suggested midwives were

expected to undertake more than one role within the team, which in the students' opinion culminated in an inadequate service for women.

'Too much documentation, no one-to-one care and midwives having to take on too many roles within their team... The service is really poor as clinics are cancelled and care is given via a telephone conversation... There are extremes of care analysis; women who have a six hourly discharge will say their care is good; women on the ward for three days or so will complain as midwives do not provide adequate care due to staffing numbers' (University B, Group 1, No.2).

The older students' interpretations of the role of the midwife appeared to be focused on working within an NHS Trust. Their narratives revealed a possible lack of understanding regarding the NMC's guidance on the use of technology in modern practice (NMC, 2004; NMC, 2013). They appeared to interpret the concept of being 'with woman' as a physical presence. It may be suggestive that their interpretation of being a midwife is actually a job and not necessarily a vocation. The younger students' discussions appeared to embrace the importance of the vocation of being a midwife. They became quite animated while discussing the possible opportunities they could embrace both locally and worldwide. Their focus demonstrated their understanding of future possibilities of improving the care of women.

'We work in one Trust within a small community, a certain type of woman and you follow certain types of policies and I think sometimes we forget the brilliant transferable skill, what it is, within all aspects of all communities, like worldwide. I think we do just become focused on your role, you do this or that you go to work. I think we forget how important it is for individuals in communities/societies. I think some people forget about the bigger picture and how important it actually is and how much is out there we are able to do really or what an important skill it is to have' (University A, Group 1, No.3).

In their narratives the students discussed the differences they had observed among many midwives. From their observations, they had classified midwives into two groups: those who they considered were dedicated and those who were not. Their

perception of the dedicated midwife was one who kept midwifery normal and worked primarily in the community. They considered the midwives who worked in the hospitals as constrained by hospital policy. They suggested from their observations those that worked hard were often overworked and suffered from burn out.

8.4 Summary

This discussion of the students' narratives provides an understanding of the lived experiences of being a third year student midwife. The analysis has presented the themes and sub-themes essential to the phenomenon. A hermeneutic phenomenological framework was used to discuss how each theme is inter-related. Their experiences of being a student midwife could be strongly influenced by theme one: accountability. Reflecting on their experiences of being prepared for the statutory requirements of accountability in midwifery appeared to have prompted the students to reflect on their knowledge of midwifery and how they had been prepared for the role. Their need for support and guidance remained evident. This could be related to theme two: scope of the midwife's practice. Training within a hospital Trust led the students to reflect on their original ideology of being a midwife. This is closely related to theme three: the medicalisation of midwifery. The students' perceptions of the phenomenon of being a midwife had changed. Working within a hospital Trust was directed by hospital policies and guidelines. The students appeared to suggest this restricted the role of the midwife.

Many students expressed their fear and anxiety of leaving the safety of the programme of study. Their need for continued support was tangible within their reflective discussions. This fear may be more relative to being accountable for their

practice than the actual process of stepping off the programme. Many students criticized the structure and content of the midwifery programme of study and what they perceived to be a lack of support from the universities. The more mature students appeared to accept that life would be difficult initially, but given time they anticipated a more settled outcome for their future careers.

Their need to secure employment close to home was evident. This would support their families' needs, as moving to find employment was not a high priority for them. The younger students were prepared to move to find employment, in fact a couple of students had secured employment in the South of England. This appeared to reduce some anxiety as they approached the end of their studies. During their discussions the students revealed many midwives did not practice research-based care due to the restrictive nature of the hospital Trust policies and guidelines. This they hoped to change as they expressed their desire to improve the care for women, offering research-based evidence as an option for some care practices. They expressed their hope that they may be part of the generation that does make a difference to women and midwifery.

Chapter 8 presented the empirical findings from the fourth stage of the study: lived experiences of being student midwives at the end of their third year of study. Chapter 9 offers a discussion on the findings of the study.

Chapter 9

Discussion

This chapter discusses the relationship between the professional, social, and historical discussions that have shaped the students' experiences of pre-registration midwifery education.

9.1 Introduction

Understandings of pre-registration midwifery education have evolved over time, but the main aim is to prepare students for the autonomous role of the midwife. This study set out to discover the students' interpretations of their experiences of becoming midwives, and the influences the environment had on their experiences. It identified the main themes that have emerged from the data using hermeneutic phenomenology. These themes are related to the students' understandings of their learning and development, the ideology of the role of the midwife and the role of the midwife within the philosophy of the medical model of care within the NHS Trusts. Table 7 demonstrates the inter-relationship between the themes that emerged from the study:

Overall themes to emerge from the study	Main themes from each year (Chapter No.)	Sub-themes from each year (Chapter No.)
1. The students' understandings of their learning and development	<ul style="list-style-type: none">• Reflection on future career (5)• Adjusting to new ways of learning (6)• Work based learning (7)	<ul style="list-style-type: none">• Education – planning for university / career (5)• Life choice (5)• Exploration of career choices – influences (5)• Reflection on learning• Skills acquisition (6)• Coping with assessments• Maturity (6)• Non-midwifery placements

	<ul style="list-style-type: none"> • Accountability – a sense of uncertainty in their abilities to become midwives (8) 	<ul style="list-style-type: none"> • (7) • Self-doubt (7) • Relevance of placements (7) • Realisation of the role of the midwife (8) • Critical analysis of the course structure (8) • Self motivation (8)
2. The ideology of the role of the midwife	<ul style="list-style-type: none"> • Identifying with the role of the midwife (5) • Development – personal and professional (6) • Mentorship in clinical placements (7) • Sphere of the midwife's practice (8) 	<ul style="list-style-type: none"> • Identity – caring personality types (5) • Educational development (5) • Professionalism (5) • Cultural ideology of the birth process (5)) • Maturity (6) • Confidence in new abilities (6) • Coping with a new life style (6) • Approaches to midwifery education (6) • Supporting the student (7) • Building self-confidence (7) • Tri-partite support (7) • Taking the first step (8) • Ability to do the job (8)
3. The role of the midwife within the philosophy of the medical model of care within the NHS Trusts	<ul style="list-style-type: none"> • Decision making process (5) • Socialisation into the midwifery profession (6) • Phenomenon of midwifery within an NHS Trust (7) • Medicalisation of childbirth (8) 	<ul style="list-style-type: none"> • Birth experiences of family and friends (5) • Woman-centred care – relationship between woman and midwife (5) • The wonder of nature – development and birth processes (5) • Being a first year student midwife (6) • Midwives professional status (6) • Being a student in an NHS Trust (6) • High risk care (7) • Medical model of care (7) • Challenges facing normal midwifery (7) • Pressure to conform (8) • The role of the midwife in society (8) • Quiet confidence (8)

Table 7: The inter-relationship of the themes to emerge from the study

Understanding the education of student midwives is quite complex. As a result, the students' narratives cannot be written without reference to the wider professional discussions and commentary that exists throughout the world of education and the position of the maternity services within NHS Trusts. Many of these come from professional midwives and educators, offering historical and expert discussions including policies and research. In bringing these discussions together, it is possible to see how they are entwined. Some validity of the students' narratives is also established. Critical reflection takes place and a clearer understanding is constructed.

9.2 The students' experiences of their learning and development

Midwives are recognised as the professional providers of care to pregnant women. This was established in the students' narratives and is recognised in Statute. This responsibility is an accepted professional and social status, as no-one else, other than a doctor, can provide midwifery care to women (NMC, 2012). For society, this identification of the role of the midwife provides women with the opportunity to gain access to health care at an important time in their lives. This was previously discussed in Chapter 1. This important public health care role supports women and provides education to improve their health and that of their newborn babies. Therefore, pre-registration midwifery education has a pivotal social role to play in that it prepares students for the professional role of the midwife.

Within the professional and social discourses reviewed, student midwives are considered to be the future practitioners of the profession (Davis-Floyd, 2005). The current standards for pre-registration midwifery education prescribe the national

curricula (NMC, 2009). It supports the original educational philosophy of the transference of midwifery education into higher educational institutes (HEI) during the 1990s from local schools of midwifery within some District General Hospitals (Tew, 1995; Baird, 2007). This was previously discussed in Chapter 4, where I reflected on my journey of becoming a midwife. This supported my hermeneutic reflection of the interpretation of my experiences and my use of epoch as a reflective tool to set aside my pre-assumptions. It has been acknowledged by Tew (1995) and Baird (2007) that, prior to the changes in midwifery education, the focus was on traditional ways of working. The students were trained to provide care to the local population in keeping with the educational standards of the day (Tew, 1995). Student midwives were assessed on their acquisition of skills and the rationale for their use (Tew, 1995; Baird, 2007). The move into HEIs was designed to raise the professional profile of midwifery education and to encourage engagement with research to improve care, thereby reducing traditional ways of working (Baird, 2007). The results of this research revealed there is in fact an improvement in students' awareness of the need for research. It also revealed students had difficulties using research in practice. The education of student's falls short of preparing them for the role of the modern midwife; providing individual research-based care. The move of education into HEIs was viewed as a developmental course of action, bringing the focus of midwifery into a modern era to meet the needs of contemporary society. This was designed to support the students' learning in becoming equal partners in care within a multiprofessional team (Baird, 2007).

The work by Davis-Floyd (2005) defined modernism as a progressive process that encapsulates the need to change and adapt to modern society, which it can be

suggested was the rationale for the educational changes in midwifery. Her work focuses on traditional birth attendants (TBA) across North America, where many states do not recognise the role of the midwife that is acknowledged and accepted in the UK and other parts of the world. Davis-Floyd critically questions the role of the midwife within the medical model of care. She suggested that midwifery should be based around the needs of women and not directed by a medical model of care. Her comparison of the role of the midwife to TBAs is revealing, suggesting they provide a more woman-centred approach to care as they are not under the influence of others. They do experience some restrictions on their practice but they do also offer an alternative approach to birth and birth settings based on the woman's needs. They also receive varied forms of training which are based on their needs. It could be suggested that their philosophy of care is in keeping with the educational requirements of student midwives in the UK. In particular, the findings of the research revealed many students enjoyed their learning experiences alongside the community midwives.

'I think it all depends on where you work on community I think all the midwives are great, they are advocates for women' (University A, Group 1, No. 2).

'Quite a few people have said, 'you are lucky to have her,' she is a brilliant midwife and everyone compliments her' (University A, Group 1, No.2).

These comments reveal the commonality between the two cultures. They accept that childbirth is a human experience that acknowledges the sociological and cultural beliefs of women and their families. The students' interpretations of the role of the

community midwives suggested they were able to provide a more woman-centred approach to care which enhanced the students' education.

Davis-Floyd's (2005) reference to midwifery has an anthropological approach that supports her principles of humankind. Her work provokes serious thought regarding the purpose of midwifery education in the UK. In the current curricula students are taught the philosophy of midwifery care regarding women's physical, social and psychological needs, but it remains to be seen whether these aspects of care are being met. The results of this research demonstrate there is a lack of acknowledgement of a changing society that impacts on women's lives and their pregnancies within current practice. They further revealed that many women are denied their choice of care. Women have come to believe that the culture of birth in the UK is based on the provision of services with NHS Trusts. There were comparatively few women who experienced home birth, as statistics revealed (ONS, 2013). This was discussed in Chapter 1 of my thesis.

The results of this study revealed that students' education is based on their perceptions of birth being an established NHS-based culture, as they are placed within a Hospital Trust for their clinical education. Student midwives are educated to provide care to women residing in the UK who access maternity services in NHS Trusts. Towards the end of their studies the research findings revealed some students feared losing their newly found skills, as their interpretations of care and support within the Trusts were based on high risk interventions and not necessarily on informed choice for women. This was discussed in Chapter 8.

'Interventions are soaring again. I think our job is slowly being taken away. We are becoming recovery midwives we are expected to do things that are not really midwifery related' (University A, Group 2, No. 1).

'Now caesarean (C/S) birth is becoming such a demand. It makes you think, I have just done all this training and a woman walks through the door and demands a C/S. We are not able to do what midwives do, which is care for a normal labouring woman, but we can't if she demands a C/S' (University A, Group 2, No. 2).

The students' reflections were based on various media reports at the time, which suggested women could choose to have a caesarean section over a normal birth. The National Institute for Clinical Excellence (NICE) published its guidance on caesarean section in 2012. The media appeared to focus on two clauses under the heading 'Maternal Request for C/S' which suggested women could choose a C/S:

'1.2.9.6. For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS. [new 2011]

1.2.9.6 An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS. [new 2011]' (NICE, 2012, p15)¹⁹.

¹⁹ Permission to reproduce two excerpt has been granted by the NICE

The students' interpretations of this guidance caused them much distress. They appeared to see the role of the midwife being eroded as, in their understandings, the rates of C/S may rise.

The education of student midwives is also based on the requirements of UK universities preparing them for their award. The emphasis is now on modular teaching, learning and assessment (NMC, 2009). My research has found that the tripartite partnership between the university, student and the Trusts has departmentalised teaching and learning, with the students in between the two establishments. It can be argued that this separation has supported the concept of the medical model of care, as education is now separated into episodes of care: antenatal, intranatal and postnatal (Tew, 1995). The results of this research reveal they do not follow the women throughout their pregnancies and care is sporadic. This was discussed in Chapters 7 and 8. Tew (1995) argued that students are placed where there is available clinical space in NHS Trusts. It could be suggested that student learning is compromised, as continuity of care is difficult to achieve due to their experiences of short placements in the ward settings. The students in my study further revealed that this was not conducive to their learning, as they also encountered high risk incidents without prior theoretical learning, which resulted in task orientated learning; a surface approach to learning. This was revealed in Chapter 6 of my thesis. On the other hand, they also revealed that students experienced a longer, sustained period of time with a community midwife, which supported their learning. The continuity of learning allowed the students to become familiar with the changing needs of the woman within their environment and cultural background. The results of this study recommend a return to traditional community midwifery or a modern approach to case-loading to enhance students' learning.

Rawson (2011) supports the proposal of case-loading midwifery as she revealed that students are able to provide holistic care throughout pregnancy and birth. Her study suggested that students learn the values of the professional role of the midwife. They also gain valuable insights into the enormity of the autonomous role in decision making associated with their knowledge. My study supports a need for change.

The students' hermeneutic reflections within their focus groups supported their discussions on current media sensational exposure of the maternity services. They revealed their disquiet regarding the public's view of midwifery and birth, '*you see programmes on TV and they are terrible*' (University A, Group 1, No. 3). They stated that midwifery is not just about giving birth. Midwives also provided women and their families with support and education, preparing them for the enormous role of parenting. Some students suggested the future of the maternity services should return to a time when midwifery was based within the community. Reflecting on a current television programme 'Call the Midwife' which is based on the work of midwife Jennifer Worth in the 1950's, '*I would have loved to have been a midwife in the 1950s*' (University A, Group 2, No.1). This was discussed in Chapter 8 of my thesis. There appeared to be some nostalgia that possibly supported their need to become the midwives they originally wanted to be from their research of the role. They also revealed how some of the influences they experienced within the Trusts and with their mentors directed their education. They suggested that placing midwifery education within the community would enable them to follow the women throughout their pregnancies; both in low risk and high risk pregnancies. They further

suggested their education would be enhanced as the women would be the focus of care.

'On community you get to be with the women, you have your clinic which is always busy but the midwives make a bond with them. The women get excited to see you in the clinic and they come in with their latest family news and gossip. I think that is lovely' (University B, Group 1, no 2).

'I think there should be more experience working in the community; you would experience more continuity in your learning. There would be more emphasis on the skills that would be required as a midwife. On my first day a community midwife gave me a pinard and made me use it from the beginning. This was an invaluable skill which I will pass on to my students. Learning that skill is the art of midwifery, the science part is enabling you to apply the knowledge when doing a home birth or in any emergency situation' (University B, Group 3, No.3).

This form of learning supports the philosophy of woman-centred care as the midwife and student could provide individualised care based on the woman's needs; a humankind approach. The results of this research revealed that placing midwifery education within the community teaches the students the skills of the midwife. My research recommends that students' education should be based within the community. They would be able to follow the women throughout their pregnancies as their needs arise.

It has been suggested by Hunter (2004) that the ideology of midwifery is based on the concept of being 'with woman'. Many midwives practice midwifery based on their professional beliefs of midwifery care, which appears to direct where and how they work. This is not to suggest that only community midwives provide individualised care to women. The results of this research revealed there were midwives working in the wards and departments who held the same philosophy. They stated there was diversity between the two cultures; hospital and community. The students suggested there were two standards of woman-centred care. The community midwives offered continuity to their learning, whereas the hospital midwives focused on meeting targets associated with time constraints and the medical model of care. It is argued by Davis-Floyd (2005) that modern midwifery should re-claim its profession and offer diversity to women. Midwives need to take control of their practice and develop alternative approaches to providing safe and innovative care based on women's needs.

The original philosophy of pre-registration midwifery education was designed to support the students' learning (NMC, 2009). The results of this research demonstrated a duality to their learning; the needs to comply with learning and assessment in university, and learning within NHS Trusts. Students need to have contact with pregnant women in order to learn how to provide care (Spouse, 2003). The students' narratives suggested the two systems of learning did not interconnect. This was originally discussed in Chapter 6 under the theme 'approaches to midwifery education'. The students suggested, *'What I find most difficult is practice it is so different to theory. You get taught to do it one way but practice is nothing like we are taught'* (University A, Group 3, No. 2). The culture of the maternity services is

primarily based in NHS Trusts as most women expect to birth their babies on a labour ward. Therefore, the students' clinical education is based around the local provision of each Trust and not necessarily on women's choice. The students revealed there was no equality to their learning, as some were placed in large, research-focused Trusts and others were in smaller, local units. There was more diversity of risk status within the larger Trusts. This appeared to affect their preparedness for future practice, *'If I got a job at the Trust where I trained I would be fine'* (University A, Group 1, No.4). The students further revealed they had been socialised into the culture of the NHS Trusts where they had trained, *'I know the policies and guidelines and who I can trust'* (University A, Group 1, No. 2). Their hermeneutic phenomenological focus group discussions supported the students shared anticipation of their future careers. It appeared to relate to their futures within the Trusts only and not on widening their horizons to alternative care practices: homebirth, birthing centres, independent midwifery, midwifery-led units or free standing units.

Many theories of education reveal that the student must be at the centre of their learning (Ramsden, 2003). This was discussed in Chapter 2 of my thesis. Many approaches to learning enable the student to identify how they learn and this must be considered when students enter educational courses (Bloom, 1956). The pre-registration midwifery programme of study places students within the world of work-based learning (WBL) within NHS Trusts. Bosanquet (2002) argues that this structure has been adapted to comply with the service requirements of the maternity services. This service provision in fact only serves to provide a reference point for

the pre-registration educational structure for student midwives, as the culture of childbirth appears to be placed within the NHS.

The majority of women birth their babies in a labour ward and the majority of midwives in the UK are employed by the NHS Trusts. Students are socialised into the profession in order to provide a service, not necessarily to develop the profession (Davis-Floyd, 2005). It was not until recently that there was choice of place of birth for women: home birth, birthing centres, independent midwifery, midwifery-led units or free standing units. Therefore the structure of the programme is complex, as the ratio of theory to practice is 50% practice and at least 40% theory, with flexibility over the remaining 10% which may include simulation (NMC, 2009). The results of this research highlighted that students felt this structure was difficult to navigate as working in an NHS Trust reduced their time for study and enjoyment of family and social life, *'I question whether midwifery will be my forté or whether I am ready for that sort of career'* (University B, Group 1, No. 4). The students with children revealed the focus of their lives changed upon securing a place on the programme of study. This was revealed in Chapter 8 of my thesis. They were no longer primarily mothers, they became student midwives with children. The students' narratives suggest they learned to regret this change to their identity, as their children were no longer their priority; their care was shared with others. *'The course has consumed our lives I don't have much time for family'* (University B, Group 1, No. 3). Becoming a student midwife had added to their being which significantly impacted on their lives. Their sacrifice of time with the family was regrettable. Their hermeneutic reflections suggested they regretted prioritising their need to become midwives over their children. They revealed that they had missed many significant events their

children were participating in: school plays, sports events, award evenings. Their reflections suggested they would never re-gain this time again.

Many of the students revealed that the shift patterns of the Trusts and the commitment to providing care were overwhelming. This reduced their time to devote to their studies. The students' references to their socialisation into the working practices of the Trusts are closely related to the work of Foucault (1977). His work relating to prisoners and the imposition of timetabling provoked similarities to the students' socialisation into the workings of the maternity services. The students revealed they were expected to work alongside their mentors for a set number of shifts a week. This meant that they engaged with the mentors while off-duty, which at times imposed difficulties on their personal lives. For some, this could be negotiated, but for others there were many difficulties expressed as there were no other mentors available to work with.

'The timetable is an old inheritance. Its three great methods – establish rhythms, impose particular occupations, regulate the cycles of repetition – were soon to be found in schools, workshops and hospitals. The principle that underlay the timetable in its traditional form was essentially negative; it was the principle of non-idleness: it was forbidden to waste time' (Foucault, 1977 p149, p154)²⁰.

Bosanquet (2002) referred to women losing liberties on entering the maternity services but the students' narratives in my study further suggested they too left their previous lives to enter midwifery. Kirkham (1999) described this as 'service and

²⁰ Permission to reproduce this excerpt has been granted by Penguin Books

sacrifice.' It can be argued that midwives have become so habituated they no longer exist outside of the NHS Trusts. There are few independent midwives in the UK who could offer an alternative service to women. The results of this study reveal that in the UK the Trusts are the primary employer of midwives. The medical model of care appeared to direct how the midwives practiced in the hospital and the community settings. There is little evidence to suggest midwives are able to be innovative within the boundaries of care.

In Chapter 5 of my thesis the students readily accepted their need to develop psychomotor skills in practice, but struggled to cope with their cognitive development in university, *'I haven't felt particularly supported by university; I have wondered how I kept going. They treat you like naughty children'* (University A, Group 1, No. 2). My study further revealed the students had not anticipated the commitment needed to become a midwife, both physically and intellectually, *'it is such a hard going course'* (University A, Group 1, No. 3). The students' narratives revealed that many considered they were undertaking two separate courses as they were unable to unite the two learning structures. This became significant towards the end of their education, *'I have not once felt like a university student'* (University, A, Group 1, No.4). The students believed they were being trained to provide a service in accordance to Trust requirements, *'We are trained to provide a service'* (University A, Group 1, No. 1). They further revealed doubt regarding the significance of the classification of their degree qualification.

It has been recognised by Curtis et al. (2006) that service requirements of the Trust do impose restrictions on midwives' practice, which, it can be argued, ultimately affects students' learning. This can be related to the work of Foucault (1977):

'An architecture that is no longer built simply to be seen or to observe the external space but to permit an internal, articulated and detailed control – to render visible those who are inside it; in more general terms, an architecture that would operate to transform individuals, to act on those it shelters, to provide hold on their conduct, to carry the effects of power right to them, to alter them. Stones make people docile and knowable.' (Foucault, 1977 p172)²¹.

Midwifery attrition rates reflect midwives' frustrations at not being able to provide woman-centred care, which also affects students' educational experiences (Hughes, 2013). In fact, Curtis et al. (2006) further revealed that midwifery managers have limited powers to effect change in the system, as they too are answerable to the Trust Board. They describe their role as being 'piggy in the middle' through trying to placate the hierarchical structures and the midwives on the wards. The students' narratives revealed that the tri-partite relationship, which is promoted by the NMC, was not conducive to their learning. The students believed that they were not the main priority of the Trusts and, as such, they engaged with an apprenticeship model of education. Hughes and Fraser (2011) found many students used their mentors as role models who they wished to imitate. Problems existed when the midwife did not use research-based information in their practice, exposing what Lange and Powell-Kennedy (2007) described as a theory-practice gap. The results of this research

²¹ Permission to reproduce this excerpt has been granted by Penguin Books

revealed routine care had become normal practice thus exposing them to traditional ways of working *'I ask if we can get the woman off the bed, but then I tend to let the midwife do what she does... on the bed'* (University A, Group 2, No. 3). This was discussed in Chapter 7 of my thesis. My research further revealed that midwives need to reclaim their profession, but this can only be achieved through education and regular updating on current research. This is a recommendation from this study. The students further suggested that midwives need to learn how to challenge routine medical care that is failing to provide midwifery care. They believed the midwives were failing to support the future practitioners of midwifery: the students.

Previously it has been found that not all experiences of mentorship have a positive outcome. For some students it can be quite disappointing and confusing (Begley, 1999; Finnerty et al., 2006; Mulhall, 2005; Licqurish and Seibold, 2007). Results from this study revealed that a theory-practice gap remains, which is perpetuated by some authoritarian midwives. *'The booking interview - my mentor doesn't say anything about screening, nothing. Afterwards she says, 'why did you go into that?' She doesn't talk about breastfeeding either'* (University A, Group 2, No.4). The student's experience appeared to reflect her interpretation of the midwives' lack of interaction with the woman or possibly their lack of knowledge. Lange and Powell-Kennedy (2006) stated that the existence of the theory-practice gap does impact on the provision of care by the students, as the mentor controls what the student learns in practice.

Previous research suggested many factors that impinged on the practice of the students' mentors. These were discussed in Chapter 2 of my thesis. They were

highlighted as pressures from the Trusts internal structures, which again reflect the institutionalisation imposed by the NHS Trusts (Cavanagh and Snape, 1997; Finnerty et al., 2006). It can be argued that these structures, policies and guidelines are in place to provide standardisation to all patients within an NHS Trust. My study suggests they do not necessarily support women's choices when accessing the maternity services. They also do not support the students' educational requirements, which are based on providing individualised woman-centred care, *'She doesn't focus on the women's needs at all. The booking takes 20 minutes'* (University B, Group 1, No. 1). In fact, the students' narratives revealed many guidelines that appeared to place barriers in the provision of research-based care. The students considered that many policies and guidelines were not based on research findings, as they imposed restrictions on women's choice. My study further revealed that many of their mentors' practices reflected the need to comply with the Trust's needs rather than those of the women. *'It's sad they [midwives] don't get the chance to be midwives they'd want to be.'* (University A, Group 2, No. 4). The students suggested there was an innate fear of litigation in some midwives' practice which prevented them from being 'with woman'. *'The midwives I worked with revealed their fear of being sued if something went wrong.'* (University B, Group 1, No. 2). This can be related to the work of Hobbs (2012), who suggested that many newly qualified midwives found the transition from student to midwife difficult. The pressure of complying with the needs of the Trust appeared to be detrimental to the midwives' development.

Even though my study revealed the experiences of student midwives throughout their education, it was interesting to read the work of Hobbs (2012) regarding the experiences of newly qualified midwives. It would appear that socialisation into the

maternity services takes longer than the students in my study anticipated. Hobbs (2012) suggested the indoctrination process continued upon qualification as the newly qualified midwives in her study struggled to find support from their peers. Hobbs does, however, reflect on the medical model of care and how it appears to dominate the practices of some midwives within NHS Trusts. This is particularly relevant to the aims and results of my study.

My study highlights that students' education is placed within the NHS Trusts because they need access to pregnant women. The structure of their education is focused on service provision in the UK, but the definition of a midwife suggests a more flexible approach to care and education. The results of this research suggest that confining midwifery education to the NHS structures stymies midwifery education. It can be argued that this prevents further development of maternity services and the provision of alternative practices such as community based midwifery or case-loading midwifery. The results of this research further suggested that midwifery is a profession that is disappearing as the medical model of care becomes more dominant.

Bluff and Holloway (2008) revealed some midwives were content to follow the rules dictated by the Trusts and were happy to comply with the medical model of care. The students' reflections on their experiences appeared to support this theory but further add that there is a lack of support for midwives who use research in their practice. *'I see the role of the midwife is diminishing, you get the odd midwife who really does try on the wards and on delivery suite; they can be shot down by others, especially on delivery suite'* (University A, Group 2, No. 1). This was revealed in Chapters 7

and 8 of my thesis. This is consistent with the findings of Davis-Floyd (2005) who argued that medicine has become the dominating factor within the maternity services. The findings of my study suggest midwives are becoming maternity nurses who are not embracing their autonomous role, which may affect the education of student midwives. Women are being denied choice in the current service which could be based on the midwifery model of care.

The results of this study also revealed their clinical education was based on a medical model of care and not on being prepared for the autonomous practice of the midwife. This was discussed in Chapters 6, 7 and 8. In fact, the students stated the role of the midwife was based on delegating their work to others, *'Our job is slowly being took off us, postnatal care is being given to assistant practitioners, they are doing community care, heel pricks and interventions are soaring. Our main midwifery role is no longer there, we are becoming recovery nurses with the demand for caesarean sections'* (University A, Group 2, No. 1). This delegation of work was previously documented by Lavender and Chapple (2004) who suggested support workers could enhance the role of the midwife by undertaking non-midwifery jobs. My study suggests it has now become a process for the delegation of midwifery practices, and has gone too far, with non midwifery personnel undertaking midwifery roles. The results of this study highlighted students' urgency to return to a more traditional role of midwifery. These discussions provoked the students to consider an alternative approach to their future careers as midwives *'I love normality, I want to work in a birth centre. It is heart-breaking, I think I will do further training in sexual health and care for young people'* (University B, Group 1, No. 1). My study further

highlighted how some students became disillusioned towards the end of their training and considered alternative employment options outside of midwifery.

The students acknowledged there were many good mentors who did use research in their practice. These were the midwives they wished to imitate, as it was considered they provided woman-centred care. Hughes and Fraser (2011) suggested mentors have a pivotal role to play in students' education in clinical practice. They stated having a good mentor enables the students to reflect on their future practice as midwives and as mentors. Bluff and Holloway (2008) previously suggested that role modelling does have positive and negative effects on students' learning. They argue role models must display the attributes that the midwifery profession encourages. These are based on a midwifery model of care, placing the woman at the forefront of care and not on the medical model of care. The results of their study revealed their learning experiences were dependent on the style of practice their mentors adopted. Some were exposed to an apprenticeship model of learning, '*...I don't feel like I'm studying... we are doing an apprenticeship...*' This was based on a traditional form of working which was mainly task-orientated. The students in my study revealed they were fearful of challenging the mentors' practice for fear of reprisals, which they believed would result in them failing the placement, '*you avoid certain midwives*' (University B, Group 3, No. 4). The findings of my study are consistent with the work of Bluff and Holloway (2008) and Hughes and Fraser (2011), in revealing that some students had negative experiences from their mentors but that they further identified how they would challenge practice in the future once they were qualified. The results also revealed that students felt they have no voice regarding their learning needs when undergoing their education: '*It does depend on which midwife you get, there*

should be one standard' (University B, Group 3, No. 1). They stated they would not treat women and students as they had experienced. They identified that clinical midwifery education needed to change.

In spite of their experiences, the students in my study were determined to continue with their studies. They had already decided what type of mentor they wished to be in the future. They wanted to support the students of the future in their education, '*will listen to my students'* (University B, Group 2, No. 2). They also stated they would improve the care women received once they were midwives. They considered they were powerless to effect change in their mentors' practices. They believed many midwives had become complacent by accepting the demands of the Trusts. The results of my study revealed that mentors appeared to direct the students' learning through their interpretations of the Trust's policies and guidelines. The students' hermeneutic interpretations of their experiences within their focus groups suggested there was a lack of consideration regarding their learning needs. This had affected their approach to their studies. In their shared discussions in Chapter 8, they outlined their future as mentors once they were qualified.

9.3. The students' ideology of the role of the midwife

Midwives are responsible for providing choice-based holistic midwifery care to women throughout their pregnancies and births (NMC, 2009; NMC, 2012). The students' ideology of the role of the midwife was originally based on their cultural perception of the work they had observed and researched prior to commencing their studies. This was discussed in Chapter 5 and further in Chapter 9. They chose midwifery for diverse reasons and some considered they had the attributes that are

needed to be a midwife. A study by Williams (2006) suggested there is a possible link between personality and cultural background. Considering the lived experiences of potential students it can be suggested that the four existential lived world themes, as described by van Manen (1990), have an important function in their choice of midwifery.

Lived world experiences provide a plethora of experiences that shape the personality and people's lives (Erikson, 1974). Experiences with the outside world are considered responsible for motivating actions (Berger and Luckman, 1996; Hillman, 1996; Roesler, 2000). The students' narratives suggested they, too, entered midwifery for a variety of reasons, which it can be argued were based on their experiences and personalities. These were quite diverse and included the possibility of having a life-changing career for themselves and their families. The results of this study further revealed that some of the older students considered it was now their time to take stock of their lives and change direction, *'It makes you think what you want for yourself a bit more, rather than living for other people like your kids and family and doing what they want'* (University B, Group 1, No. 1). They considered their previous lives had been dedicated to other activities, possibly due to outside influences and personal choices at the time. These they believed were due to their social and educational lives at a younger age.

Other influences that effected change were their previous life/birthing experiences; both personal and that of friends and also their own identification with the role of the midwife, *'My midwife was lovely, I want to be able to give women what I received from her'* (University B, Group 2, No. 4). Considering the themes to emerge from my

study it can be suggested that there is some linkage with the work of Williams (2006). In stage one of my studies I wanted to explore why the student wanted to be midwives, this was discussed in Chapter 5. My search of the literature discovered a similar study to the first stage of my study. Williams conducted a small exploratory study regarding why students wanted to become midwives. The themes to emerge from the data were similar to mine, which included a *sense of inevitability*. This can be supported by similar quotes from both studies '*My mum... always thought I'd go into some sort of caring, because she always thought that was kind of me*' (Williams, 2006 p48). A student from my study stated '*I want to do a job where I come home and feel I have done a good job and helped people out*' (University B, Group 3, No.3). Another similar finding was *not nursing*. '*I knew I wanted to be a health care professional but I knew I didn't want to be a nurse.*' (University A, Group 2, No.4). Similar themes to emerge from the study by Williams were interpreted as '*it sounds really horrible but I'm not very good with old people and I just don't want to do men*' (Williams, 2006 p 49). Another familiar theme was *making a difference*. This theme was demonstrated as a sense of altruism '*The things I've seen from the midwives that I've been working with, they're very dedicated. It's not a job you go into for money. The NHS is run on good will and the dedication of the staff in it.*' (Williams, 2006, p 50). A more personal quote from my study revealed individual dedication '*Why can't I be the person who changes peoples' lives in a nice way?*' (University B, Group 2, No.1). The findings from my study and those of Williams reveal that students view midwifery as a separate profession to nursing. Their vocation to midwifery is based on caring for women. Those students who had experienced pregnancy and birth wanted to improve the care for women within the maternity services. Considering the work of Williams it provided a snap-shot view of the

students' decisions of becoming midwives. My study further explored the students' journeys throughout their programme of study, to discover their experiences of becoming midwives. Considering the themes to emerge from both studies there is a gap in the literature. Further research is needed to explore the students' views of the impact of care on the women and also why do some students, if any, leave their chosen career upon qualification.

Exposure to the socialisation of the NHS Trusts as suggested by Bosanquet (2002) appeared to have affected the students in my study while they were on clinical placement. The students' narratives further revealed the role of the midwife held much disappointment, as their ideology of the autonomous role of the midwife was not evident within the hospital structures, *'Morale at the moment is low, litigation and defensive practice is not how I envisaged autonomy to be. As eager students you are brought down to earth seeing the reality. We are not taught it should be like this'* (University B, Group 1, No. 3). The students' reflections on the role of the midwife were based solely on their interpretations of the midwife employed by NHS Trusts. Their focus group discussion towards the end of their training, in Chapter 8, brought them to consider their future roles as midwives. The results of this study revealed there were many influential factors that affected the students' confidence and future status as midwives. Therefore, it is recommended that towards the end of their studies students should be placed in alternative placements for a substantial period of time such as a birthing unit, midwifery led units, with independent midwives in order to experience alternative approaches to midwifery led practices.

The students identified community midwives as having more autonomy, but even this was based on the students' perceptions of the midwife's personality and work ethic. It can be suggested that midwives choose where to work based on their ideals of midwifery and woman-centred care. Some midwives will also choose community midwifery for the flexibility it provides around their family lives. The work of Hunter (2004) supports this and suggests there are conflicting ideologies dependent on where the midwife works and their conceptual beliefs on woman-centred care. The results of my research support these findings, but in addition, they revealed that the students' learning was influenced by the midwife they were allocated to. Many students enjoyed working with the community midwives as they considered these midwives recognised their own autonomy. My study also revealed that, not only did the women receive individualised care, but that the students also received individualised teaching, *'The community midwives I have worked with encourage me to reflect on my practice'* (University B, Group 3, No. 2). Some considered community midwifery as a future career option, as the focus of their educational experiences was on the care of the woman and her family. They acknowledged the flexibility it afforded to support their studies. This reduced the time constraints that the Trusts' shift patterns imposed on their lives in general. The results of this research revealed placing midwifery education in the community not only supported the students' learning it also exposed them to a more flexible way of working. For some students, becoming a community midwife was a future career choice.

My study exposes autonomy within midwifery as a fluid concept within the structures of the NHS Trusts. The majority of midwives in the UK are employed by NHS Trusts which provide two distinct services that are part of the same structure; hospital and

community. The employment of midwives is broadly based on this dual approach to care. The students' experiences within this structure suggest midwives choose to work in either the community or hospital settings. Community midwives appear to have more autonomy than hospital based midwives (Hunter, 2004). Midwives who work in hospitals are more exposed to the medical influences of care in their daily practice. It would appear that community midwives have more control over the decisions they make concerning the choices offered to women (Hunter, 2004). The students revealed they learned more about the role of the midwife when on their community placements, *'We have had normal deliveries in community but their medical history hasn't been normal. My community midwife explained how care can be given based on their needs, it was really good'* (University, B, Group 1, No. 4). The students stated that these midwives knew the women and their families and were more woman-centred. They adapted their care to meet the needs of each woman they cared for.

The students described the midwives who worked in the hospital as employees providing a standard level of service, *'They too are brilliant, but they don't get the chance to be the midwives they want to be'* (University B, Group 3, No. 2). They considered whether the structures within the Trusts controlled how the midwives provided care in order to comply with its insurance policies. These included time constraints of working hours, which affected the midwives' and the students' lives in general.

Trust policies and guidelines appeared to restrict women's choice and the provision of care (Kirkham, 1999). Some of the students revealed midwives demonstrated their lack of autonomy by compliance to this structure. They further revealed some

midwives extended their lack of independent thinking to the women by refusing to acknowledge their choice of care, *'Midwives don't like it when women are informed, she is an awkward one, she has got a birth plan – she won't sit on the bed'* (University A, Group 1, No. 4). This was discussed in Chapters 7 and 8 of my thesis. Many of the students demonstrated their outrage when women who were experiencing a normal physiological labour were attached to a CTG monitor throughout their birthing experiences. They stated midwives were becoming *'Deskilled as the machines did all the work'* (University A, Group 1, No. 3). They believed they were being trained to use the machines and press the appropriate buttons, *'All we do is input the information onto a computer'* (University A, Group 1, No. 3). Their reflections revealed this impacted on their learning of how to support a woman in labour as their role was reduced.

Within the structures of the NHS it could be argued that compliance with the Trusts' desire to save money regarding insurance schemes and claims for malpractice has neglected the autonomy of the midwife. Many policies and guidelines were based on a medical model of care which provided a set standard of care. Many of these requirements were dictated by each level of the insurance scheme requirements (NHS Litigation Authority, 2012/13) (NHSLA). This scheme has since changed but many Trusts were required to reach level three so that their insurance premiums were reduced. This saved the Trusts money over the years (NHS Litigation Authority, 2012/13). The midwives were required to comply with NHSLA compliance which, it can be argued, impacted on their autonomous role, as the midwife's focus was based on being accountable to the Trust (Bosanquet, 2002). This in turn may have affected how the students were educated within the Trusts, which may have

attributed to the theory-practice gap previously discussed by Lange and Powell-Kennedy (2007).

Griffiths (2011) claims there are three dimensions to accountability; to the woman, to the NMC and to the employer. My study revealed some midwives were more focused on being accountable to their employer through their compliance with guidelines over the choices women make. The students' hermeneutic reflections revealed this impacted on their learning, as their mentors focus was on completing the work within time constraints. The students revealed there was a duality to their education. This was based on their ability to gain a degree at university and being trained to provide care at a service level in the Trusts. For the majority of the students the two systems did not meet their educational needs. They had the theoretical knowledge to provide research-based care but restrictions were in place which prevented them from using their knowledge, *'To some midwives it is just a job'* (University A, Group 1, No. 3). These barriers were put in place by some of the midwives/mentors in practice.

Bluff and Holloway (2008) argue that there are elements of covert bullying as midwives are expected to do as they are told as employees. They revealed some authoritarian midwives ensure the culture of their department is maintained. Covert bullying was masked by limitations within care provision. The students' narratives revealed some midwives have learned to conform rather than challenge care practices, *'They just kind of conform to the mould of being just one of the midwives'* (University B, Group 3, No.2). The students' interpretations of some midwives' practice suggested they appeared to comply with the status quo on each ward. The

students revealed their sadness, as this appeared to impact on their ideology of the role of the midwife. They suggested it also affected their education as the midwives practice was affected by others. This is supported by the work of Kirkham (1999) and her discussion on midwives being an oppressed group.

9.4 Midwifery within the philosophy of a medical model of care

Previously, Curtis et al (2006) found many managers believed baseline establishments (the number of midwives employed by a Trust) were the reasons for low staffing levels. These low levels of staff fuelled divisions between midwives as they impacted on their ability to provide care on a busy ward. Many of the midwives in their study stated they were stressed and overworked which they believed were at the heart of the Trusts' problems. My study further revealed staffing levels had a major impact on the education of the students. The students' hermeneutic discussions of this issue concluded that using traditional ways of working were actually giving the midwives more work, as they did not treat women as individuals. The students revealed some women did not receive their choice of care and were expected to comply with the midwife's way of working, *'we have normal postnatal women sitting on a ward; they should be at home'* (University B, Group 3, No. 3). This impacted on the students' perceptions of the women's birth experiences and their perceived quality of the care they provided. Many students were expected to comply with the oppressive culture of some midwives' ways of working. For some this was a traumatic experience, *'as an eager student who wants to change the world you are brought down to earth when you see the reality'* (University A, Group 1, No. 4). The students expressed their disappointment regarding the care women received from some midwives. From their phenomenological focus group

discussions the students revealed they wanted to learn how to provide women with their choice of care. This was a recurring theme throughout Chapters 6, 7 and 8. The results of this study suggested the students were trained to provide a standard of care that had become routine.

Kirkham (1999) revealed historic dialogue that suggested midwives have always been considered an oppressed group. In fact, Kirkham draws on the work of Freire (1972) regarding the internalisation of the values of the powerful group, which in turn devalues the characteristics of the oppressed group. It can be suggested that this is related to the midwives' acceptance of the medical model of care within the NHS Trust. As Richens (2002) revealed, obstetricians believe birth is normal only in retrospect. It can be argued that midwives are the professional lead providers for normal birth (NMC, 2012). However, it has become apparent that women accessing the maternity services in an NHS Trust are booked under an obstetrician. Midwives working in NHS Trusts have accepted this as a normal procedure. There are comparatively very few consultant midwives who book their own case-load of women within a Trust. Bluff and Holloway (2008) also propose that for some midwives, internalisation of the status of doctors results in their acceptance of the medical model of care. This could be suggestive of why some midwives do not challenge policies and guidelines that are not research-based. It can be argued that these midwives have learned submissive behaviour through the domination of the Trust's hierarchical structures and from their peers. In my study the students' reflections suggested sympathy for the midwives, who they considered were bullied, *'These midwives must have been enthusiastic as we are now'* (University A, Group 2, No. 2). Bluff and Holloway (2008) place a historic focus on their study, suggesting current

midwifery practice will have changed. My study revealed there has been little change for some midwives, as the medical model of care has become stronger within some Trusts. This was also previously discussed by Tew (1995), Kirkham (1999) and Baird (2007), discussed in Chapter 2 of my thesis

'When I first started I wanted to go and do all the things the midwife did. At the minute I feel things are being taken off us. Interventions are soaring again; I think our job is slowly being taken away. We are told to do more screening such as carbon monoxide screening. I understand the reason but anyone can do that' (University A, Group 2, No. 1).

It has been stated that people can only be dominated if they are prepared to be submissive (Freire, 1972). It has been suggested by Curtis et al. (2006) that, due to the shortages of staff, many midwives and managers cannot provide choice to women and often abide by hospital policies and guidelines in order to complete the work. Therefore it can be argued that placing student midwifery education within an NHS Trust perpetuates a submissive workforce. *'We are moving away from being 'with woman'. It does depend on the midwife, some are very much medicalised, there are very few who are pro-normal'* (University A, Group 2, No. 2). This is discussed in Chapter 8 under the theme 'medicalisation of childbirth'. There appeared to be very few midwives prepared to challenge the medical model of care perhaps through no fault of their own.

The Midwives Act of 1902 demonstrates how the medical profession began its control over midwives. Many midwives considered the Act was a defining moment for the education of midwives and the commencement of their professional status

(Kirkham, 1999). In fact, it was the commencement of supervision of midwifery when the regulation and supervision of the work midwives do came under the control of the medical profession (Tew, 1995). In time this role was given over to midwives and self regulation and supervision of practice became more of a supportive process for midwifery in the UK. Recent reports regarding poor practices by midwives within some Trusts have suggested there are flaws in this structure (Mellor, 2013). A review of its purpose and practice is currently being investigated. It has been suggested that the two processes of midwifery regulation and supervision should be separated and become more structured. This review is currently being discussed in the UK (Mellor, 2013).

Reviewing the work of Foucault (1977) and my students' narratives I found it easy to relate my findings to his study of carceral institutions. Foucault's (1977) reflections on 'docile bodies' appeared to match how my students believed women were treated. The students' narratives revealed women were expected to comply with how the midwives treated them, *'They think it is normal to get on the bed and have an epidural. Some don't get a choice.'* (University A, Group 1, No. 4). The students further revealed their own identities were removed on commencement of clinical practice, as they were required to wear a uniform, *'I am in a uniform, as a student midwife it is scary as women expect you to have knowledge. Doctors expect you to have knowledge also and are grumpy when you say, 'I don't know''* (University A, group 1, No. 2). The students reflected on the education of medical students suggesting they spent longer in university prior to being exposed to clinical practice, *'Medical students have three years in university we are expected to cope after a few weeks. I don't think doctors understand our training'* (University A, Group 1, No. 4).

This was discussed further in Chapter 5 under the theme 'professionalism'. The students' hermeneutic discussions within their focus groups revealed their interpretations of their experiences of being in a uniform. They revealed it denoted their status be not necessarily their level of knowledge. This caused them much distress and ultimately a comparison to the preparation of medical students for their practice.

Reflecting on the students' experiences, Foucault's (1977) work can be understood. Students were also expected to comply with the institutional structures through their compliance with Trusts guidelines and policies; the wearing of a uniform and compliance to a duty rota or 'timetable' just as Foucault (1977) described, '*We have no life outside of midwifery, I have lost friends who I used to be so close to when I was younger*' (University A, Group 2, No. 4). The physical structure of the delivery suite could be associated with Foucault's Panopticon (1977). Women were also exposed to a devaluation of their privacy during the most life-changing event in their lives; personal details on a board for all to view and there was centralised cardio tocograph (CTG) monitoring. Considering the students' narratives from my study it can be argued that they too were confined to a labour room, in the guise of learning, to provide one-to-one care to the women. But the students revealed how they enjoyed being on their own with the women particularly later in their training. They were able to provide research-based care based on the women needs. This form of practice was described as 'deceptive working' by Bluff and Holloway (2008). The students in my study believed the women appreciated their care, as they stated the women used them as interpreters when the midwife or doctor left the room, '*They always ask me questions when the midwife or doctor has left*' (University A, Group 2,

No. 2). The students viewed this as a confidence building exercise, suggesting an element of trust from the midwife, *'I enjoy being in the room with the woman. I can get to know her and build my confidence. If the midwife didn't trust me she wouldn't leave me alone'* (University B, Group 2, No. 1). The students' interpretations of being left alone to care for a woman in labour revealed it was accepted practice which allowed the mentor and the students to assess their ability to care for a woman in labour. The students suggested this provided a boost to their confidence and an insight into how they would practice in the future.

'It is starting to feel real now. I've just started back on labour ward and they are saying OK you can go to that admission or you can look after that lady in labour and I'll be out here if you need me. You question everything you do now, it's a bit scary but I quite like it' (University B, Group 3, No. 1).

'When you have a midwife with you constantly it provides reassurance but when you are on your own you realise that you do know what you are doing, that really helped. You are in charge of the situation rather than doing as you are told you are being in the situation of being a midwife, it's a step back and thinking what should I do and that helps' (University A, Group 3, No. 1).

The students' hermeneutic reflections on these experiences within their focus groups revealed their intentions of how they wished to practice in the future. They also believed they will be the midwife they want to be once qualified.

'I think the role of the midwife is a fabulous one when you are being a midwife. I don't think there is anything better. The buzz of it, even though it doesn't go according to plan, being there for that woman and not leaving her side for 12

hours, seeing her through that whole birthing experience is fantastic'
(University A, Group 2, No. 4).

This is supported by the work of Hobbs (2012) who revealed that, upon qualification, many midwives remain faithful to their ideals of being 'with woman', providing care that is based on the needs of the woman.

So far this chapter has discussed the discourses about pre-registration midwifery education. It has acknowledged the emerging themes of the students' understandings of their educational experiences using hermeneutic phenomenology. It has considered and discussed the students' experiences of becoming a midwife within the structures of the NHS Trusts. This has brought together the different aspects of experiences which offer an understanding into the current educational system. The following sections will discuss the wider issues that affect the provision of student midwives' education within NHS Trusts.

9.5 Implications for pre-registration midwifery education

This study set out to discover the nature of the students' experiences of becoming a midwife and to understand the influences of the working environment on the process. It is considered important to understand what their experiences are as they highlight the way in which people view and make sense of their lived world. It also reveals how they are influenced by factors which are beyond their control. There are implications for the findings of the study in terms of the culture of birth in the UK and the educational requirements of the current pre-registration standards for midwifery education which are prescribed by the NMC. These raise questions about the value

of the study, and some assessment of its strengths and limitations permits further debate. Discussion concerning these issues is considered below.

9.5.1 Health and Social Care Act 2012

The Health and Social Care Act of 2012 brought major changes to how health services are now delivered to the general population. It was designed to streamline its structure and remove much of the unnecessary autocracy that governed its management. Some of the power the Health Minister once had has now been removed (DoH, 2012). In its place there is now a more flattened structure. Central Government remains in control but there are now new bodies within its structure: public health England, NHS England and area health teams. It is interesting to note that the funding structures focus on primary care services, hospitals and other specialist providers.

A recent Public Accounts Report from the House of Commons stated that the provision of maternity services has not kept in line with the recent rise in the birth rate in the UK. Live births were at a new high of 700,000 in 2012 but there were no increases in the baseline establishments of midwives in the NHS Trusts; a shortage of 2,300 midwives across the UK (HoC, 2014). The Report suggests the tariff payments set for maternity services needs to be adjusted. When discussion regarding funding is raised, the focus tends to be on obstetric led care and the need for more consultant specialists. Perhaps future discussions could include the developing role of the Consultant Midwife who has specialist midwifery knowledge and skills that could enhance the role of the midwife and the education of the students. It has to be questioned as to why the professional status of midwives is ignored when the development of maternity services are discussed, this reveals a

gap in the literature. The Report also presents evidence from the National Federation of Women's Institutes and the NCT, which states women want to birth their babies in locations of their choice. The historic *Changing Childbirth Report* (DoH, 1993) highlighted this evidence and yet women are still forced to birth their babies in an NHS Trust due to the lack of choice and available alternatives. The evidence from these reports suggests there is a need to review the place of birth for all women. The money could be used to develop midwifery services outside of the Trusts in line with women's choices. This would also support the education of students, as they could follow the women throughout their pregnancies in the women's community.

Under the new structure it appears that maternity services have historically been underfunded and have often been subsidised through other NHS services. This has placed great strain on Trusts as they are constantly moving funds across departments (HoC, 2014). In 2013, a new tariff system was put in place which was based on a medical model of care and separated out each phase of pregnancy; antenatal, intranatal and postnatal care. Postnatal care appears to have received the least funding as the focus has been on antenatal and intranatal pathways (HoC, 2014). With this lack of funding there have been fewer midwives to support the education of student midwives. This has also impacted on some students achieving employment once qualified. Unfortunately, many Trusts are now employing a cheaper workforce: maternity support workers. Maternity Support Workers (MSW) only need to be educated to the level of national vocational qualification (NVQ) level 2 in comparison to a three year degree programme of study for student midwives. These posts were introduced to ease the burden of trying to work within the tariff

system (NHS, 2007). Of course, these posts are based on the needs of the NHS Trusts and not on the profession of midwifery.

The RCM's Position Statement (2010) on MSW sets out a clear framework in which they can work. The RCM make it clear that the professional status of the midwife cannot be impinged upon and that the work of the midwife in the intrantatal period remains in statute. Such a structure raises the crucial question of how much of the midwife's role can be delegated before the midwife starts to become de-skilled. The students in my study had mixed experiences when working alongside MSW. Their interpretation of the role revealed some confusion regarding the work the MSW were allowed to undertake. *'They are a diamond in our Trust we would not have got through the work without them.'* (University B, Group 3, No. 3). *'They are taking our jobs; they now do the postnatal care.'* (University A, Group 2, No. 1). Student midwives are required to work with their mentor at varying levels of competency as laid down by the NMC (2009). It will be interesting to see if MSW eventually start to provide task orientated training to the students.

In this research many of the students stated they only worked with a health care worker whilst they were undertaking their medical placement, *'I worked with a care worker for four weeks on my medical placement I can now make beds, do bed bath and stock cupboards. The nurses didn't know what to do with us'* (University B, Group 3, No. 2). This was previously discussed in Chapter 7 under the theme 'self-doubt'. This calls into question the relevance of the medical placements if the students are not being exposed to the pathology and management of illnesses. The students in my study believed these non-midwifery placements impacted on their

midwifery education as they were traditionally placed within their second year of their degree, *'Second year is all about high risk and we are working as health care assistants in outpatient clinics'* (University B, Group 3, No. 2). The students' interpretations of these non-midwifery placements revealed some did not see their relevance. There was an element of resentment at being taken out of their midwifery placements which they believed impacted on their midwifery learning.

9.5.2 Commissioning maternity services

Some of the studies from the literature I have reviewed are based on the provision of maternity care by the NHS. There is much discussion regarding the position of the midwife in the NHS Trusts and within the medical model of care. Midwifery education is based on Trust requirements. The midwife's ongoing learning is placed within an NHS setting. The majority of employed midwives attend a mandatory study day which consist of NHS 'drills and skills'. These consist of emergency scenarios and interpretations of cardio tocograph (CTG). The midwife receives a certificate of attendance and this is placed in their portfolio of evidence in compliance with their NMC post-registration education portfolio PREP requirements (NMC, 2008). For many midwives this is the total sum of education they will access once qualified. It may not necessarily be the midwife's fault, as the Trust expects them to be on duty to comply with their employment obligations. There is funding available to undertake further study. This is usually for an approved course which the Trust can benefit from, for example, examination of the new-born.

The development of the midwife to undertake some of the duties of junior doctors commenced in 1996 with the development of working time regulations. It is an

interesting document, as it also highlights the educational needs of trainee doctors. The findings suggested that education should be embedded in the doctors' working lives and consultants and other senior doctors should support them in their learning (Morrow et al., 2012). Not surprisingly, this is not the case within the NHS, as the report acknowledges there is a deficit in support for students' learning. The results of my study further suggest that getting the work done is the prime objective that impedes student midwives' education.

Considering the current changes previously discussed in NHS England could midwifery consortia become CCGs which would incorporate midwifery education? The students' interpretations of their experiences of their education suggested the role of the midwife was diminishing, which they suggested was affecting their education

'I feel things are being taken off us. People are talking about postnatal care going to assistant practitioners, they are doing community care; heel pricks, they do everything' (University A, Group 2, No. 1).

Within the current framework of service provision it would appear that student midwives' education is not the main priority of the Trusts. There are some GP's in the North West of England who are developing community based services, of which midwifery is one (NHS England, 2013). This will be interesting to follow, but within their portfolio there is little evidence to support student midwives' education. Considering the findings of this study, the students' interpretations of their educational needs, and the needs of the women, it is recommended that midwives set up their own CCGs. They would be able to provide services to meet the needs of

women based on their geographical area. Midwifery CCGs could also provide educational support for students based on current research. The evidence from my study revealed student midwives should be educated to become autonomous practitioners of midwifery. It could be suggested that at present they are being trained to be employees of the NHS Trusts with a midwifery qualification. Considering the results of this study it is recommended that students' education be based within the community. The education of student midwives is designed to be woman-centred, which could be best achieved within the community where the women live. Case-loading is an option, as discussed by Rawnsion (2011) which supports a woman-centred approach to care and a student-centred approach to learning.

9.5.3 Subject benchmarks in midwifery education

It is acknowledged that subject benchmarks describe the nature and characteristics of programmes of study (QAA, 2010). These direct how programmes of study should be developed, focusing on learning outcomes associated with the profession. These benchmarks are sourced from external bodies and provide clear guidance. They are not necessarily prescriptive but provide a flexible approach to the development of curricula. Within midwifery there is much guidance that focuses on the professional role of the midwife. It also encapsulates the international definition of the midwife (ICM, 2005) and the midwives' rules and standards (NMC, 2012). Midwifery curricula promote the education of students to meet the changing needs of women in society. There is acknowledgement of the need to develop psychomotor skills, cognitive knowledge and professional affective skills. These are based on Bloom's (1956) taxonomies of learning, discussed in Chapter 2 of my thesis. Collaboration with

service providers should ensure the students are fit for practice on qualification (QAA, 2010). It can be argued that the needs of the NHS Trusts appear to misunderstand the purpose of student midwives' education. Many midwifery practices are governed by the medical model of care and its insistence on compliance with Trust policies and guidelines. It is acknowledged that higher education promotes a nation's strength in the global knowledge-based economy (Browne, 2010). In fact, England has a well recognised system of education. Midwifery education is a globally accepted qualification and UK trained midwives are much sought after.

The Browne Report (2010) stated there should be more investment in higher education. The proposals focused on an inclusion policy, for all to have access to higher education, regardless of income. The midwifery programme of study is currently funded by central Government but this may be questioned in future years as austerity is a current issue in the UK. Considering the results of this study and in light of the changes within the NHS structures and funding streams, it is recommended that the future of the midwifery services could be redirected back to a community setting as it was prior to the Peel Report (1970). The MINT Project (NMC, 2010) focused on the role of the midwifery lecturer and their position in the educational system. It also discovered many problems associated with the current structure of midwifery education (NMC, 2010). It describes how midwifery curricula have evolved to become a standard approach to education, the standard being students' progress through their learning, commencing with normality to high risk levels of care later in their training. The NMC published the standards for pre-registration midwifery in 2009, the year before the findings of the MINT Project were

published. The result may have given a different focus to midwifery education as it is today. One of the findings of the study suggested case-loading for students, as this supports their learning in the provision of woman-centred care (Rawnsdon, 2011). This was an area of practice the students in my study suggested supported their learning whilst placed with a community midwife

'I can now link everything, like what you do in antenatal influences the delivery and that influences postnatal, so now I have a continuum of care. Before I thought this was this and that was that' (University A, Group 2, No.2).

It is now four years since the findings of the Project (NMC, 2010) were published but there are no discussions regarding any future development. It is hoped the findings of my study will further support a review of the current system and a dialogue will commence. It is recommended that student midwifery clinical education be moved to the community considering case-loading as a focus to their learning.

9.6 Strengths and limitations of my study

9.6.1 The students' voices

I consider one of the strengths of this study is the way in which the students were able to tell me their experiences throughout their programme of study. This type of study has not been conducted in the past. Clancy (2013) stated that interpretive phenomenology provides an understanding of experiences through interpretation. Therefore it adds new knowledge to the social and professional discourses that have supported previous discussions of being a student midwife in NHS Trusts. It allowed the students to tell their stories relating to their experiences of becoming midwives. The inquiry process enabled an interpretation of experiences and allowed essential

themes to emerge from the students' narratives. The study has further provided an understanding of the position of student midwifery education within the complexities of the NHS structure. It also gives the students a voice regarding their experiences of learning within the current system of education in HEIs.

The study highlighted many factors that impact on the role of the midwife in practice. This in turn brings a focus on the position of midwives within NHS Trusts. It also demonstrates the impact of the medical model of care on their practice as autonomous midwives. The study reveals many Government reports support the role of the midwife but without the necessary funding there has been no support for change. The impact of the Ministry of Health Report (1970) remains strong today. The culture of midwifery is now hospital-based, governed by the medical model of care. Student midwifery education is influenced by the current structures of the Trusts. For many years, this has become an accepted process of training student midwives to become midwives. With support from previous discourses I have further highlighted the benefits of raising the educational standards of student midwifery education. The findings of my research revealed that towards the end of their studies the students expressed their delight at having someone to talk to about their experiences, *'We are going to miss our counselling sessions'* (University A, Group 1, No. 4). This supported my choice of using focus groups within hermeneutic phenomenology as discussed in Chapter 4 of my thesis. The students were able to discuss their experiences, which at times they revealed were familiar experiences to them all. It is recommended that hermeneutic phenomenologists consider my innovative use of focus groups as it has proved to be a successful methodological

approach for my study. I also recommend that focus group discussions be incorporated into future midwifery curricula.

It is only through the students' narratives that understandings of these issues emerged. My study showed the significance their education had on their lives as students. They willingly participated in my study and talked openly about their experiences. They expressed their appreciation of being able to talk about their experiences during their education. For many educationalists, this is a significant finding from my research. It is recommended that during the planning of future midwifery curricula, time and space is allocated to listening to the students regarding their experiences in a non-judgemental environment. This would enhance future programmes of study. Allowing the students to narrate their stories of their experiences provides a powerful basis to promote change in students' midwives education. Research is essential to promote change as this informs the future development of pre-registration education. It is envisaged that my research will support these changes.

From a constructivist point of view the strength of the study lies in the researcher and the research being co-constituted, which provided interpretation and meaning to their experiences. The students shared their interpretation of their experiences with me over the course of their programme of study. My decision to analyse the data within each separate year supports a constructivist point of view. The ontological position of constructivism is based on the belief that social phenomenon is based on social interaction. For the students, their social interaction was constantly being constructed over the course of the three years of their studies. This provided multiple

levels of interpretation (Guba, 1990; Grix, 2004). It was considered to be important to capture these multiple levels of their experiences. Their interpretation of their experiences added new insight into the phenomenon of becoming a midwife.

The students' narratives were about more than their education. They also outlined how socialisation into the midwifery profession significantly affected their lives and their developing self. This was discussed in Chapter 2 of my thesis. This promoted their development of many skills, including communication and social networking. My study made clear some of the issues that are of concern to the students between the partnership approach with the NHS Trusts and the HEIs. These two systems co-exist but function independently of each other. My study further revealed a rift between the systems of education. Bringing to light the dichotomy of learning suggests an alternative approach needs to be pursued. It is recommended that a new pathway to learning based on the students needs should be developed. I believe this has been highlighted as one of the strengths of my study as the students' voice suggested it is time for change.

9.7 Considering the aims of my research

- To discover the nature of the student's experiences of becoming a midwife
- To understand the influences of the working environment in the process

The aims of my study have been addressed throughout my thesis. It captured the student midwives' experiences of becoming midwives. I also discovered the influences of the working environment on their experiences. The findings of my study present new knowledge in regards to student midwives' educational experiences. I have to accept that the number of participants in my study was relatively small in

comparison to the number of students studying midwifery in the UK. I also acknowledge that these were the views of students training within one geographical area; North West of England. Their experiences were based on which NHS Trusts they were placed with and the influences of their mentors. These could be seen as limitations to the study. Within the analysis of my data I have to acknowledge that one group of students dropped out of the study at an early stage. However I believe this did not alter the focus of my research or the trustworthiness of the data. It has been suggested by Leonard et al. (2014) and Kim et al. (2014) that recruitment and retention of research participants can be problematic. They also found it was inevitable that some people would decide not to continue to participate in a research study. Despite the loss of four of my participants, my methodological approach and the results were relevant to informing my research. As a recommendation for future research, it would be an interesting follow-up study with my original students to discover their experiences once qualified.

9.8 Findings and recommendations

Table 8 lists findings and recommendations found from this study.

Findings	Recommendations
Tri-partite relationship does not support student midwifery education	The two systems need to work more closely together
Community midwifery supports continuity of learning	Education should be based in the community
Case-loading midwifery supports students' learning	Case-loading allows the students to follow the women throughout their pregnancies in both low and high risk
Exposure to the medical model of care is not supportive of students' learning	Students need to learn how to provide care in the midwifery model of care
Short placements do not support students' learning	Longer placements are essential for continuity of learning

The separation of the normal physiology of pregnancy and birth supports the medical model of care approach and not students' education	Students need to follow women throughout the continuum of pregnancy and birth
Clinical placements without theoretical supports does not support learning	The structure of the curricula needs to support students' learning
Students' education is compromised in regards to the role of autonomous practitioners of midwifery within NHS Trusts	Community midwifery demonstrates the autonomous role of the midwife. Student education should be based in the community
Midwives are becoming maternity nurses who are not embracing their autonomous role, which affects students' learning	Midwifery education should be removed from the influences of the medical model of care
Structures within the NHS Trusts devalue the role of the midwife, which affects students' learning	Student education needs to be re-evaluated and re-positioned among alternative providers of care
Students' learning is based on the provision of care within NHS Trusts	Students should be placed in alternative placements towards the end of their education
The structure of the programme of education affects students' personal lives, which affects their learning	The structure of the curricula needs to be more student friendly
NHS Trusts are the primary employers of midwives which may not focus on students education	Midwives should consider setting up CCGs as an alternative to working for the NHS
Confining midwifery education to the NHS stymies student education	Students should experience alternative practices and ways of working
Some mentors do not support students' learning due to their adherence to Trust policies and guidelines	Mentors need to be more flexible and support the students in their application of theory to practice. Mentors need to develop their own practice by using research based knowledge in order to challenge and develop Trust policies and guidelines. They will then be able to apply research to practice. This will support students learning.
Students receive individualised learning from community midwives	Student education should be placed within the community
Focus group discussions should be embedded in the curricula to support the students	Time should be allocated in the curriculum to enable the students to reflect on their learning and experiences

Table 8: Findings and recommendations

9.9 Implications for midwifery practices

It is important to consider the implications for discovering more about student midwives' experiences of their midwifery education, and to consider how relevant they are in preparing them for the role of the midwife in modern society. There has been much qualitative and quantitative research that has explored certain aspects of students' lived experiences of midwifery. Many qualitative research studies have been discussed regarding students' experiences of their education. Some of the professional discourses have included the work of Bluff and Holloway (2008) and the influences of role modelling on students' learning, Hughes and Fraser (2011) considered the role of the mentor and their impact on learning, and Begley (1999) and Currie (1999) critically analysed the treatment of post-registration student midwives. It is acknowledged there have been no longitudinal studies that have undertaken a hermeneutic phenomenological approach concerning the students' experiences of becoming midwives over their three year degree programme of study. There are also no longitudinal studies that have used focus groups within narrative inquiry within hermeneutic phenomenology. This is a unique study that gave the students a voice using narrative inquiry in focus group discussions. This approach explored new boundaries for discussion within phenomenology. Some researchers consider focus groups in phenomenology as an oxymoron (Bradbury et al., 2009). My hermeneutic reflections supported my unique approach to the collection of data as my analysis led me to consider that the students were all studying midwifery, which I viewed were similar experiences. This was supported by Krueger (1994) who suggested focus groups provide an interactive medium to hear others' stories. This longitudinal study offers insight into the students' experiences over the course of

their education. The implications from the findings of the study offer a radically new alternative approach to student midwifery education for the future.

Considering the education of student midwives it can be suggested that both quantitative and descriptive qualitative research will provide information that can be used to analyse different aspects of midwifery education. These may include student attrition rates, statistical analysis regarding the number of applicants to each university and successes and failure rates. These can be used as quantitative data which is useful for universities, potential applicants and the NMC in the planning of education provision. While this statistical knowledge is essential for people to have decisions regarding funding streams, application processes and the future number of students to be trained by each university, it does not provide information regarding students' interpretations of their experiences of their course of study. These data collection processes have become annual procedures. They do not take into account the experiences of the students on the programmes of study or whether the programme supports their learning. Considering the numbers of midwives currently on the midwifery part of the NMC register, it can be argued that the educational system does work on a service level. As technology advances it can be revealed that these quantitative statistics are readily available via the World Wide Web to anyone interested in becoming a midwife. They do not provide an insight into the lived experiences of becoming a midwife or the effects it has on the life-world of people undergoing their education. It does not provide information on the effects of institutional influences on the students' experiences of their education. This unique study provides new qualitative research knowledge that will support student midwifery education in the future.

It is important to ask what the implications are for trying to discover more about the students' experiences and understandings of becoming a midwife in modern times. Baird (2007) argued that the move of midwifery education would raise the professional profile of midwifery. It would provide midwives with the tools of critical analysis, discussion and reflection that would provide research-based care to women. Midwives would be able to enter into dialogue and debate with the multiprofessional teams on an equal basis (Baird, 2007). Student midwifery education is designed to support the students in their learning of the professional role of the midwife based on these concepts. Pre-registration midwifery education is directed by the NMC (NMC, 2009). The basis of the information for these educational standards was gained from quantitative and qualitative research data from women regarding their needs and preferences. The emphasis was on woman-centred care; offering choice to women (DoH, 1993; DoH, 2007). The current educational standards acknowledge the benefits of preparing students for research-based practice (NMC, 2009). This study found students were required to engage in research, learning and development as part of the requirements of learning within their HEIs. This raised their awareness of the need for information and good practice that protected the women from harm. The move into HEIs is now accepted as a positive transition for midwifery education as students are now educated to degree level (Fraser, 2008).

This study revealed the provision of midwifery education was on two levels as clinical midwifery education remained within the service provision of NHS Trusts. My study found this juxtaposition of these two institutions did not fully support the philosophy of student midwifery education. The students' interpretations of their experiences

revealed many inconsistencies in care practices and knowledge that placed barriers to their life-world of midwifery education. The findings and recommendations from this study can be seen in Table 8.

It is important that students remain the focus of their education. It must also be placed in a wider context and understanding about the factors that influence their education. This study found much of the professional discourse comes from sources that focus on social and political agendas on the provision of care to women. They do not incorporate students' personal interpretations of their experiences of midwifery education at the time of their writing. The students' narratives from my study added rich data to this dimension and provided a more complete view of the social and professional issues that affected their lives. This was important as it provided the students with a voice that can be heard within the professional arenas of midwifery education; the midwifery profession, HEIs, NHS Trusts, NMC, DoH, and NHS England.

The students' interpretations of their experiences brought life to their existence in midwifery education; they were no longer passive recipients of knowledge. This unique study acknowledged they belonged to the process providing meaning and understanding to a complex existence. Their stories of events that affected their lives should be shared against social accounts and research, giving insight into midwifery education from the students' points of view. Their stories told of being exposed to two different forms of education: theory within HEIs and a social form of learning based within NHS Trusts. This they revealed was dependent on the mentors they worked with and the mentors' work ethic. In addition the students were being

constantly judged through examinations and clinical assessment. This created a blending of evidence-based care with Trust policies and guidelines and their mentors' ways of working. These ways of working provided a mixed approach that was only relevant at the time and changed in time with experience and knowledge. For the students, this created a confused state and a need to be flexible in their education. This initially created challenges as to what was best practice when applying knowledge to practice.

As part of their education, students were encouraged to reflect on / in practice. However, this study revealed students needed time during their education to reflect on their lives during the course of their studies. This was considered by the students as an enhancement to the understanding of their knowledge and how it can be improved in the future. An example of a reflective cycle was originally developed by Gibbs (1988), below:

Table 9: The reflective cycle (Gibbs, 1988)²²

(²²The image originally presented here cannot be made freely available via LJMU Digital Collections because of copyright. The text was sourced from, Gibbs, G. (1988) Learning by Doing: A guide to teaching and learning methods. Further Education Unit. Oxford Polytechnic: Oxford (<https://www.brookes.ac.uk>)

The process of reflection should be a shared experience between the students and mentors, but this study revealed learning within a Trust was dependent on the workload activity of the ward. As employees, midwives have a contractual obligation to the Trust. As a midwife they are bound by their rules and standards to provide evidenced based care to women (NMC, 2012). This study revealed that placing student education within an NHS Trust presents many difficulties.

The education of students is designed to be supported by the learning and development of students. In midwifery, the provision of research-based care to women is the focus of the learning outcomes. Midwives working within the confines of a Trust had restrictions imposed on their autonomous practice. The medical model of care provided policies and guidelines that directed much of the care provided by midwives to women in the confines of the wards and departments. This study revealed that some midwives struggled to provide research-based care to women due to these impositions. This also affected their abilities to support the students' learning. Learning in the community provided continuous support to their learning as the midwives appeared to have more autonomy regarding their practice. It also provided learning into the wider issues of the public health role of the midwife, which included the education of women, families and issues of concern, lifestyles that impacted on pregnancy and medical disorders. This study provided insight into the students' shared cultural aspects of their learning. Using the findings of this study

provided an assessment and possible management of the problems raised by the students. This can only be done by providing the background in which the students experienced it.

The problems the students discussed were evident in relation to their learning. Therefore, it is important that the students' voice is heard and actions taken to address the disharmony between their learning of theory and practice.

9.10 A community approach to midwifery education

Women live and work within their communities. Pregnancy and birth can be an exciting time for some families (Kitzinger, 2000). Community midwifery is not new. Placing clinical midwifery education in the community places students in women's lives. Community midwifery provides education and support, which provides for the needs of the women within a shared community. The students would be exposed to public health promotional strategies and midwifery care that are specific to the local community. Parent education within local communities offers the students knowledge of local needs. It would provide education to the women, who could dispel many myths and misconceptions about pregnancy and birth.

Case-loading midwifery was discussed by Bluff and Holloway (2008) as an episode of care within the current programme of study. I recommend that a new midwifery curriculum could be developed based on working in the community using a case-loading approach to education. This would offer a new, diverse curriculum which would support the students learning. This could offer students the opportunity to follow groups of women throughout their education. The students could attend the

community appointments and, where needed, local Trust appointments accompanied by the students. Their education would be enhanced as there would be continuity of learning to care throughout. This would be in keeping with *Midwifery 2020* which focuses on the midwife being the professional lead for midwifery (DoH, 2010). I propose the ratio of theory to practice could be reviewed, a suggestion of 40% theory: 60% practice would support their learning. Research-based care would be enhanced, as the students would learn how to become an autonomous midwife within a midwifery model of care. The students would learn to place woman at the centre of care, providing them with a choice of place of birth. The students' education would be supported through continuity of learning alongside a midwife working in the community. This innovative new approach to education would reduce the students' exposure to the medical model of care. It places students at the centre of their learning. It has to be acknowledged from the students' narratives that there are some women who need obstetric care. They also revealed that the majority of women have pregnancies that progress uneventfully. Community student education could accommodate both types of learning. The women with complex needs would be identified during the booking appointment and referred onto an obstetrician. This could be accommodated by all women being booked within the community. This innovative approach to education would also improve the flexibility of learning for the students by reducing the need for duty rotas.

The student midwives were provided with a pattern of placements that were primarily based within the Trusts. They spent a relatively short amount of time in the community. The unique findings of this study suggested midwifery education needed to be removed from the confines of the Trusts and placed in the community. The

students revealed working on delivery suite was both exciting and was necessary to experience high risk care. Within the proposed new curricula students could be placed on the delivery suite for a set amount of time. It cannot be predicted if the students would experience any high risk pregnancies as the outcomes of some labours are unknown. This study also revealed the students' medical and surgical experiences were not conducive to their learning. An alternative approach could be a placement with a community nurse, caring for patients in their homes.

The implications of this cultural movement of students' education would involve an increase in the diversity of midwifery in the community. Support would be needed during the transition in order to source more midwives within the community. This could include placing midwifery education with alternative clinical providers; midwifery-led units, stand-alone units, independent midwives and traditional community midwives. This would raise the profile of midwifery education, providing midwives who are the lead professionals of normal midwifery for the future.

Considering the new structures within NHS England, this study is quite timely. The development of CCGs in the community provides an ideal opportunity for midwives to develop their own practices. NHS England (2014) offers funding from Challenge Funds that support innovative practices that improve services within the community. The findings from my study offer an innovative approach to students' education. This unique study supports a change in midwifery education.

This study offers new knowledge in regards to student midwives' pre-registration midwifery education. The findings of the study suggested midwifery education has

remained within its traditional position and structure since its transfer from schools of midwifery to HEIs in the 1990s. The findings of this study suggested midwifery education needs to be removed from the imposing structures within NHS Trusts. Placing students' education within the community offers students insight into the needs of women in a modern society. There is much diversity within women's lives and students should be educated to provide for these differences in society. Exposing students to a flexible approach to learning will support their flexibility in their future practice as midwives. Continuity of learning supports a more supportive approach to their education. There needs to be a new focus that supports a modern society. My study suggested midwifery education needed to encompass a midwifery model of care approach to education. Future research is needed to discover how this new model of education could reduce the influences of the medical model of care within the maternity services. It is also acknowledged that the findings from this research are the interpretations of a relatively small number of students, but it provides insight into the experiences of student midwives in the current programmes of midwifery education. The findings of this study support a need for change. The students will then be able to become the midwives they want to be. This unique study offers new knowledge and an innovative approach for the future of midwifery education.

9.11 Gaps in the literature

There are many gaps in the literature regarding the students' experiences of becoming midwives and the influences of the working environment on the process. My research has explored some of these gaps. The structure of the tri-partite relationship with the university, student and the Trusts does not appear to support

their learning. My study suggests a new approach would be beneficial to their education such as community based learning or a modern approach to case-loading. This could provide continuity of learning, exposure to a midwifery model of care and experiences of alternative providers of care. Students could follow the women throughout their pregnancies and birth, which could enhance their learning. The maternity services are based within a medical model of care, the students are exposed to short placements which are not conducive to deep learning. It was also revealed many mentors focused on complying with Trusts policies and guidelines in preference to supporting the education of student. My study suggests mentors should be educated to provide research based care that will support the students to apply theory to practice. The mentors could then challenge traditional ways of working that are based on the medical model of care. My study also reveals there needs to be a new curriculum developed that is more student-friendly that could accommodate their lives outside of midwifery. Further research needs to be undertaken to explore alternative clinical providers that could support midwifery education. There should also be further exploration on how to support mentors to develop their research based knowledge in order to enhance students' clinical learning; applying theory to practice.

- Reflection on research journey

Reflecting on my research journey throughout the study I have gained many skills. My knowledge of hermeneutic phenomenology has improved immensely. Considering my position in the research I reflect back and think of the struggles I went through to separate my experiences from the students. My use of epoch as a reflective tool supported my journey through the collection and interpretation of the

data. Lincoln and Guba (1985 p84) suggested there are multiple constructions of experiences. 'Each may have a different meaning to each person, even though there may be some agreement on a possible definition that constitutes a partial description'. When applying this notion to my study I have to acknowledge that there is a definition of the role of the midwife (Appendix A). The students' experiences of their lived world as student midwives could not possibly be similar to mine. Each student's experiences will be different from their peers as we each experience life differently. As a researcher I wanted to interpret their interpretations of their experiences. Lincoln and Guba suggested this duality of interpretation may provide some idea of the reality of existences. I believe my research has provided the students with a voice that can now be heard.

9.10 Thesis summary

The aim of a hermeneutic phenomenological study is not to reach an ultimate result but rather to uncover a new understanding of the interpretation of the phenomena (Cohen and Omery, 1994). The study of experiences involves a process of reflection and constant movement within a circular process. This movement is pre-disposed to an ever-evolving interpretation of the method used. It also provides an understanding of the interpretation of the data as suggested by van Manen (1990). Within hermeneutic phenomenology, the journey through interpretation never ends, as the researcher's findings are their own interpretations of the data. Reflexivity on the part of the researcher plays an important part within the process of interpretation. This provides the researcher with the ability to become self-aware of their presence within the research. This provides a plausible explanation of the narratives from the students (Clancy, 2013).

The contributions my thesis offers to the phenomenon of becoming a midwife bring new knowledge to the education of student midwives in the UK.

My study used hermeneutic phenomenology as a way of investigating the students' experiences of becoming midwives. Pre-registration midwifery education is bounded by structures and regulations. My use of hermeneutic phenomenology allowed these boundaries to be set aside so that the phenomena were revealed. The students' understanding of their experiences allowed the essential themes to emerge that were previously unknown. Narrative inquiry gave the students the opportunity to relate their stories of their experiences. These experiences provided temporality which allowed the students to be situated within a time and place (Clandinin and Connolly, 2000). The student narratives are viewed as having value as they can be related to previous discourses of a similar nature. The importance of their experiences offers direction for future midwifery education.

The women in my study were from a variety of social backgrounds. Many had children of their own. Each had their own prior knowledge of what the role of the midwife was. The interpretation of their experiences generated themes of understandings of their lived experiences of being a student midwife. These were placed within the context of the duality of educational experiences. The variety of narratives created multiple sources of reality. An array of different perceptions, meanings and understandings emerged from these.

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Appendix A - Definition of a midwife

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has required the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the post-partum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospital, clinics or health units.

(Adopted at the International Confederation of Midwives Council meeting in Brisbane, Australia on 19th July, 2005) (NMC, 2009).

Appendix B – Letter of invitation to the students

Title of the study

Phenomenon of becoming a midwife

Research information sheet

Dear Student,

I am a researcher from Liverpool John Moores University, conducting a qualitative longitudinal study which looks at students' experiences of becoming midwives. Very little research has been done into pre-registration student midwives experiences of becoming midwives.

I would like to invite 12 students to participate in the research study. The 12 students will be divided into two focus groups; each containing six students. The study consists of a series of focus group interviews over your three year degree programme of study. The first focus group interview will focus on what brought you to midwifery; this will take place within your first year of study. The second focus group interview will take place within your second year of study. The third focus group interview will take place within your third year of study. The second and third group interviews will focus on the nature of your experiences throughout your programme.

It is anticipated that each interview will take approximately an hour; the interviews will be recorded and transcribed verbatim. The location of the interviews will be in your own HEI at a convenient time and location; this being within your own time.

If you do not wish to take part in the study your wishes will be respected. Whatever you decide will not affect your progress through your degree course.

All information you give will be treated in the strictest confidence. You will not be identified personally and your details will not be passed on to anyone else. You may withdraw from the study at any point without giving reason and without your rights being affected.

Thank you,

If you wish to take part in the study or for further information please contact:

Maria Forde Tel. 0151 231 8149 Email: M.Forde@ljmu.ac.uk

Researcher

Liverpool John Moores University,

L3 2AJ

Appendix C – Letter of support

Title of the Study

Phenomenon of becoming a midwife

At any point during the research study you highlight any practice issues that you are concerned about, there are mechanisms in place to support you.

Support available:

- Personal Tutor, Link Tutor and Lead Midwife for Education – practice issues that impinge on your learning
- Practice issues – contact the Trusts named Supervisor of Midwives for students, your Mentor, Personal Tutor, Link Tutor and Lead Midwife for Education

Your responsibility:

If you highlight any issues within your clinical or theoretical learning that needs addressing, support is available from your mentor, personal tutor, link tutor and module leader or you may wish to discuss your concerns with your LME or a SOM as outlined above.

Appendix D – Consent form EC3

**FORM OF CONSENT TO TAKE PART AS A SUBJECT IN A MAJOR
PROCEDURE OR RESEARCH PROJECT**

Title of project/procedure: Phenomenon of becoming a midwife

I, agree to take part in
(Subject's full name)*

the above named project/procedure, the details of which have been fully explained to me and described in writing.

Signed Date.....
(Subject)

I, certify that the details of
(Investigator's full name)*

this project/procedure have been fully explained and described in writing to the subject named above and have been understood by him/her.

Signed Date.....
(Investigator)

I, certify that the details of this project/procedure have been fully explained and described in writing to the subject named above and have been understood by him/her

(Witness' full name)

Signed **Date**
(Witness)

NB The witness must be an independent third party. * Please print in block capitals

Appendix E – Question schedule for the first focus group meetings

Reflecting on your experiences could you tell me what brought you to your decision to become student midwives?

Prompts:

- What influenced your decision?
- Was this your first choice of career?
- Did your level of education affect your choice of carer?
- Is midwifery in keeping with family tradition?
- What was your previous career?
- What made you want to change direction?
- Do you see midwifery as a career with a future?

Appendix F – Question schedule for the second focus group meetings

Could you tell me your experiences of being a first year student midwife?

Questions:

- Has your view of midwifery changed?
- Are there any factors that affect your training?
- Are you enjoying your training?

Appendix G – Question schedule for the third focus group meetings

Could you tell me your experiences of being a second year student midwife?

Questions:

- How are you feeling at the end of your second year of training?
- Are there any factors that have influenced your training so far?
- Within your experience of practice do you consider yourself to have sufficient knowledge?

Appendix H – Question schedule for the third focus group meetings

Could you tell me your experiences of being a third year student midwife?

Questions:

- Reflecting on your time as student midwives do you feel ready for your name to be placed on the midwifery register?
- Would you change anything within your training?
- How do you see the role of the midwife?