

**BACHELOR OF MIDWIFERY STUDENTS' EXPERIENCES OF
ACHIEVING COMPETENCY FOR BEGINNING PRACTICE**

**A thesis submitted in total fulfilment of the requirements for the award
of the degree**

DOCTOR OF PHILOSOPHY

by

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Statement of Authorship and Sources

This thesis contains no material published elsewhere or extracted in whole or part from a thesis by which I have been qualified or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgement in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant ethics committees

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ABSTRACT

This study, commencing in 2005, explored the experiences of Bachelor of Midwifery students' achievement of competency for beginning practice. Data were collected via interviews with nineteen final year Bachelor of Midwifery students, completed competency assessments and reflective journals, along with field observation of 5 of the students periodically during their final placement, for a total of 48 hours. Data were analysed using grounded theory methodology augmented by situational analysis.

Achievement of competency involved a number of social processes as the students adapted to a largely medically dominated system. The overarching process was termed assimilation, linked to which were realisation, adaptation and consolidation. Assimilation represents the processes of adjustment that occurred within the various clinical agencies where the students were learning to become midwives. During their final placement the students acknowledged what had been an ongoing realisation of the nature of midwifery practice and the midwife's role within a medically dominated system where medical discourse held sway, resulting in restrictive midwifery practise and autonomy. This was in direct contrast to an alternative midwifery discourse which underpinned the Bachelor of Midwifery curriculum.

Very few students worked with a preceptor on an ongoing basis and less than half worked with midwives who role modelled appropriate midwifery care; when this did occur it was usually in midwifery-led models of care such as caseload, birth centres, non-tertiary hospitals and community midwifery practice. Adaptation therefore involved modifying behaviour to appear to fit in and thus avoid disciplining practices, such as intimidation, social exclusion and criticism from the midwife preceptor. This enabled the students to gain the experience needed to achieve competency through practical application of knowledge, increasing independence and confidence in practice, so called consolidation.

Achievement of competency standards and confidence to practice was perceived to be made difficult because of the restricted nature of midwifery practice within the hospitals in which they were learning. This was linked to criticism of the competency assessment

process where the intense focus on achieving requirements for registration set by the regulatory bodies was often to the detriment of personal learning objectives.

This study raises awareness of a number of issues to be considered for those involved in the development and implementation of Bachelor of Midwifery curricula, namely competency assessment methods, clinical placement allocation and related student preceptorship needs. A critical review of the time frame for achievement of the requirements for practice is also needed as is provision of a variety of agencies to allow students to achieve professional competencies that promote autonomous midwifery practice, in partnership with women throughout the continuum of childbirth.

Statement of Dedication and Appreciation

I would like to convey my sincere gratitude to my supervisor, Dr Carmel Seibold, for her patient dedication and generous nature. Her invaluable support and guidance, constructive criticism, encouragement and belief in me pushed me to grow more than I ever expected throughout this journey. Also I would like to extend a sincere thank you to Dr. Fran McNerney, who came along at the perfect time to provide fantastic and valuable feedback as well as some great philosophical conversations.

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Finally, I dedicate this thesis to the Bachelor of Midwifery students who participated in this study, for graciously giving me their honesty and precious time. I also dedicate it to all the courageous midwives who juggle the 'everyday' tasks of caring for childbearing women, students, each other and the profession.

What about you? Are you brave enough for this future? For it is true we get in life what we have the courage to ask for. What do we as midwives have the courage to ask for?

Nelson Mandela said, 'our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light not our darkness that most frightens us ... and yet when we let our light shine, we unconsciously give people permission to do the same.'

As we are liberated from our own fears, our presence automatically liberates others.'
*As we stand at the edge of history with the future blowing wildly in our faces. As we see the air brightening at times and blinding us at others let us remember that we are powerful beyond measure and our greatest power is **we are midwives: we are with women!***

(Dahlen, 2006 p. 9)

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Chapter One

INTRODUCTION

The focus of the study reported in this thesis is how and when final year Bachelor of Midwifery students achieve competency for beginning practice, and explores midwifery students' experiences while achieving competency.

In 2002 the Bachelor of Midwifery commenced at three Victorian universities, providing a new direct entry learning pathway for aspiring midwives. The first cohort of students in the Bachelor of Midwifery graduated at the end of 2004. In 2005, after seven years working as a midwife in a variety of biomedical and community settings, I began teaching the Bachelor of Midwifery students at Australian Catholic University (ACU). While teaching within the course, I recognised that my own experiences had been somewhat different to the Bachelor of Midwifery students I was now teaching. I hold both nursing and midwifery qualifications, yet have worked just one year as a nurse – my graduate year in a women's hospital in 1997. The three year nursing degree had been a necessary stepping stone on my pathway to becoming a midwife – and, at that time in Victoria, the only avenue open to me.

I became increasingly interested in the experiences of the students, particularly as they began to voice concerns about the challenges they faced in relation to the requirements for course completion as well as the challenges that awaited them at the end of their three year course. One of the challenges the first cohort of students had identified was the obligation to meet more extensive requirements for course completion by the Nurses Board of Victoria (NBV) than their Graduate Diploma counterparts (Seibold, 2005). Additional challenges appeared to stem from an apparent uncertainty by midwives that the new course would adequately produce competent graduates. While hearing the concerns of the students, I was also aware of professional concerns being expressed, namely that that graduates of the Bachelor of Midwifery would be less competent than graduates from the previous Graduate Diploma of Midwifery because they had not studied nursing prior to midwifery.

In 2005, as part of my further education via a Masters of Midwifery (Research), I was offered the opportunity study the experiences of final year Bachelor of Midwifery students as they achieved competencies. Based on my understanding of the issues facing students, and the profession of midwifery at that time, I took on the challenge. This thesis details my research journey, initially as a Masters of Midwifery (Research) student and then as a PhD student.

The Development of a Bachelor of Midwifery

Australia, along with other western countries including the United Kingdom (UK), New Zealand (NZ), Canada and the United States (US), was by 1999 experiencing a shift in midwifery philosophy which demanded midwifery be seen as a profession distinct from nursing, with consequent changes to midwifery education. This debate had been raging for at least a decade prior to 1999 when the midwifery profession in Australia had sought to establish itself as a profession separate from nursing (Cutts et al., 2003; Seibold, 2005). In concert with these professional changes, women were voicing the need for change, and they had begun to demand services that better met their needs. Mounting research evidence, demonstrating positive outcomes for women when midwifery care was not governed by obstetrics, was used to fuel campaigns by midwives and consumers who demanded government-provided services which offered continuity of midwifery care from a known midwife in a community setting (Maternity Coalition, 2002; Leap et al., 2002; Cutts et al., 2003).

The role and scope of midwifery practice in Australia was broadening and a “move away from the biomedical, hospital centric focus of pregnancy to one emphasising a ‘new midwifery’ based on a midwife-woman partnership and evidence based practice” (Seibold, 2005 p. 10) began to emerge. However while things were changing, the philosophical separation of midwifery from nursing was not being reflected in the education of Australian midwives. The Graduate Diploma of Midwifery, the only entry into midwifery practice in Australia prior to the Bachelor of Midwifery, required applicants to: a hold degree in nursing or equivalent; be licensed to practise within the state where the course was undertaken; and, most courses, also required them to have some nursing experience post graduation from a Bachelor of Nursing (Leap, 2002).

These requirements were in contrast to the Australian College of Midwives' (ACM) position that midwifery was a separate profession from nursing (Australian College of Midwives, 2002b).

Around the same time as this philosophical shift occurred, the Australian Government, Department of Education, Science and Training, (DEST), (2002) commissioned the 'Australian Midwifery Action Project' (AMAP) to review midwifery education. This review surveyed 27 Australian universities who were offering midwifery courses and found that the Graduate Diploma of Midwifery, which could be attained in one academic year, afforded insufficient time to prepare midwives to work within the full scope of practice as stipulated in both the International Confederation of Midwives' (ICM) (2002a) and the ACM *Competency Standards for the Midwife* (Leap, 2002). It was contented that it left graduates unable to provide the expected woman centred approach grounded in a social health and wellness framework because of the time constraints of a one year course (Leap, 2002).

The AMAP review also highlighted concerns around the clinical practicum experience of midwifery students in Australia, noting it was based primarily in hospitals that were dominated by biomedical perspectives of pregnancy and childbirth (Cutts et al., 2003). As a consequence of this, Australian midwifery students' lacked exposure to women-centred, midwifery-led care and continuity of care models thus limiting their competency for beginning practice. The AMAP findings informed a report which highlighted inconsistencies in midwifery education across all the Australian states, along with a lack of leadership and accountability. It also raised serious concerns about the standard of midwifery education in Australia (Leap et al., 2002) and called for significant change:

Midwives practising... [across]...the world face the same challenges as those in the UK and Europe: the challenges of re-humanising maternity care; of restoring the possibility of continuous and sensitive relationships between mothers and midwives from highly fragmented systems; of reducing high intervention rates; of restoring pride in the profession of midwifery. The basis of these reforms for all of us is the provision of appropriate education and preparation for modern day midwifery practice (Leap et al. 2002 p.14).

The report argued that many developed countries with similar demographics to Australia had already implemented three or four year direct entry midwifery courses, and these courses were producing graduates of a high standard (Fraser, 2000a; Fleming, Poat, Curzio, Douglas & Cheyne, 2002) with more initial experience than Australian graduates from post graduate midwifery courses (Cutts et al., 2003). Supporting this argument were evaluations of 'direct-entry' midwifery courses in Britain by Fraser (2000a; 2000b), and in Scotland by Fleming et al. (2002) which suggested that direct-entry graduates from overseas programs were competent for beginning practice.

Australian midwives graduating from the previous system were, in a global sense, being left behind. Furthermore, they were unable to register to practice midwifery in the UK without a formal period of supervised practice and education (Cutts et al., 2003). Leap (2002) suggested that Australia benchmark education standards against these aforementioned developed nations. It was further recommended that a three year degree in midwifery, if offered by Australian universities, be modelled upon the UK curriculum, with similar philosophical underpinnings relating to competency standards. The hope was that graduates would become midwives who could meet the needs of both women and the profession of midwifery.

Despite the issues described above, the ACM was still expecting midwives graduating from a one year Graduate Diploma of Midwifery to be competent to practice according to the 'new midwifery' (Seibold, 2005) as reflected in the ICM *Competency Standards for the Midwife* and endorsed by the ACM in 1998 as the benchmark for midwifery practice and education in Australia (Cutts et al., 2003; Pincombe, Thorogood & Kitschke, 2003).

Further justification for a change to midwifery education included workforce issues. These included the national shortage of practising midwives, an ageing midwifery workforce and poor recruitment and retention of practising midwives in rural and remote areas (Tracy, Barclay & Brodie, 2000). In addition to workforce issues, Leap, Barclay and Sheehan (2003) raised concerns about the high attrition rates of new graduates entering midwifery via the traditional educational route – in New South Wales alone up to 30% of graduates did not seek employment when they completed

their midwifery education program. The lack of support from preceptors, stress within the course and horizontal violence were cited as reasons for the high attrition rate (Leap et al., 2003). Leap et al. (2003) argued that improvements to midwifery education and a more expanded role, in terms of care provision across the continuum of childbirth in a variety of settings, would mean less graduates abandoning midwifery.

Midwives and the Australian Government were, at the same time, calling for a change to midwifery education, to bring Australia in line with global midwifery education standards. The ACM (Australia's professional body for midwives) had advocated from as early as 1999 for the establishment of a Bachelor of Midwifery Degree (Glover, 1999). As the AMAP report was being published, a working party of twenty experienced academics from across Australia were setting educational standards which were to become the *ACMI Standards for Accreditation of three year Bachelor of Midwifery programs* (Pincombe et al., 2003). The ACM planned that, by ensuring nationally consistent accreditation of Bachelor of Midwifery curricula and standards for course completion, graduates from Australian Bachelor of Midwifery programs would be internationally recognised and competent to practise according to the ICM definition of a midwife. The Bachelor of Midwifery graduates would therefore: be mindful of the context of childbirth and culturally safe; be capable of providing continuity of care and carer in a range of midwifery models of care and settings; provide evidence-based, woman-centred care with a primary health care focus; and remain lifelong learners (ACMI, 2002a; Pincombe et al., 2003).

In response to these initiatives in 2000, a consortium of midwifery academics from five (later three) Victorian universities came together to develop a three year Bachelor of Midwifery curriculum. The aims of this Bachelor of Midwifery course were to: educate midwives to a higher standard than the prevailing courses; provide opportunities to women from non-nursing backgrounds to become midwives; and address the shortage of midwives quickly and economically. It was also hoped that the Bachelor of Midwifery would provide graduates capable of practising within the full scope of midwifery practice (Cutts et al., 2003). The development of the curriculum was therefore informed by professional standards that reflected the philosophical climate at the time, the 'new midwifery' and feminist principles (Cutts et al., 2003; Seibold,

2005). The curriculum was approved by the NBV and commenced at ACU, Victoria University and Monash University in 2002.

Research Problem and Justification for the Research

The first graduates from the Bachelor of Midwifery course in Victoria entered the profession in 2004. When this study commenced in 2005 there had been no significant exploration of the Bachelor of Midwifery students' experiences of achieving competency in the maternity care system in Victoria, Australia. The timing of the study was crucial as the early challenges faced by the first cohort of Bachelor of Midwifery students at ACU had been identified within an existing less than perfect system, namely organisational issues in the clinical agencies, concerns about quality of clinical learning experiences and seemingly excessive requirements for graduation set by the NBV (Seibold, 2005). In addition, there was a need to further explore the overall experience of learning from the students' perspective. The purpose of this study therefore was to explore the Bachelor of Midwifery students' experiences of achieving competency during their final clinical placement. An exploration of the conceptualisations of competency, and the application to midwifery and nursing education, is provided in Chapter Two.

Exploring Bachelor of Midwifery students' perceptions of their experiences of achieving competency lends itself to a qualitative methodology which respects the individual experiences of each participant. A contemporary grounded theory methodology, underpinned by symbolic interactionist and poststructuralist theoretical perspectives and constructionist epistemology, was chosen to address the research problem.

Data were collected during in-depth interviews, field observation, and review of students' reflective journals and competency assessment tools. Data were analysed using grounded theory coding, constant comparative analysis, theoretical sampling and memoing. The analysis was furthered with 'situational analysis' (Clarke, 2005), which involved various mapping approaches which identified the actors, discourses and

positions taken in the data. Further explication of the methodology is provided in Chapter Three.

Overview of the thesis

The next chapter of this thesis presents prior literature relating to the field of study. The current context of midwifery practice, in particular the subordination of midwifery and medical dominance, are discussed as well as the operations of power in the learning environment and theory practice gap. There is also a critique of existing literature surrounding the conceptualisations of competency and competence and the application of competency conceptualisations to the education and assessment of student nurses and midwives. The chapter also presents a discussion of the research literature pertaining to the clinical learning environment for nursing and midwifery students.

Some grounded theorists believe that an in-depth literature review prior to data collection may negatively influence the inductive nature of the methodology. However contemporary grounded theorists, such as Clarke (2005) and Charmaz (2006), undertake grounded theory from a constructionist epistemological standpoint and argue that literature review prior to data collection can be beneficial. Further clarification of how this standpoint influences the research process is provided in Chapter Three. In particular, Clarke (2005) argues that preconceptions about the field of study are inevitable if the researcher has a previous connection to the field of study – which, in this case, I do. The research presented in Chapter Two is not used to intentionally formulate hypotheses, rather to provide an explanation of concepts relevant to the study, and to provide context. There had previously been no significant research study exploring, within an Australian context, the experiences of Bachelor of Midwifery students as they achieved competency, that could have specifically pre-empted the findings any more than my own preconceptions of the field of study, as identified in my reflexive memos.

The particular theoretical framework that underpins this methodology is discussed in Chapter Three. The method of participant recruitment, data collection and analysis are also detailed in Chapter Three, as is how I attended to the methodological requirements

of reflexivity and ethical conduct. Chapter Four presents the findings of the study and is divided into three sections. Each section discusses a social process as identified during data analysis namely, realisation, adaptation and consolidation. The data is presented as a narrative with quotes as exemplars, and pseudonyms used to maintain confidentiality of students, midwives and clinical agencies.

The final Chapter of this thesis, Chapter Five, reviews and concludes the study. An overview of the findings in relation to previous research is provided and I make recommendations to inform the profession, most particularly those involved in the education of Bachelor of Midwifery students and midwives. Finally, areas for further research are suggested and limitations of the study are reflected upon.

Chapter Two

LITERATURE REVIEW

The first section of this literature review provides an overview of the context of Australian midwifery practice, including dominant discourses and previous research into the influence of the environment on student midwives' learning. Such context is relevant to the study given that, in keeping with the constructionist epistemology which informs its methodology, knowledge and constructions of self are geographically, culturally and historically located (Burr, 1995; Clarke, 2005).

The second section explores literature related to the development of student competency. Conceptualisations of competency, competency based education and assessment, and the application to their Bachelor of Midwifery are addressed, as are the experiences of nursing and midwifery students in a range of clinical learning environments, as both can be understood through previous research on the topic.

Section One: The Context of Contemporary Australian Midwifery Practice

Contemporary Australian midwifery practice remains mostly situated in hospital - an environment generally subordinate to obstetrics (Callaghan, 1996; Fahy, 2007; Barclay, 2008; Newnham, 2010) – and most women living in Australia give birth in hospital (Davey, Taylor, Oats & Riley, 2008). In order to understand current midwifery practice in Australia, a brief overview of the history of midwifery in Victoria, Australia is provided.

Childbearing women in Australia have been attended by midwives since the convict era, when midwives were experienced women without formal training and midwifery was an unregulated profession (Fahy, 2007; Barclay, 2008; Purcal, 2008). More trained midwives became available during colonisation, when women either gave birth at home or at lying-in hospitals which were run by midwives. Women who could afford care were attended by a midwife. If not, they were attended by experienced relatives (Barclay, 2008). Midwives were respected in the community as:

Valuable friends, rich in common sense, experience, kindness and with skilful hands. They had families of their own which allowed them to share the problems, concerns and joys of the families they serviced. Their results [...] were excellent, and the doctor was well satisfied to leave all normal midwifery to their care (Barclay, 2008 p.5).

The history of Australian midwifery practice and regulation highlights that midwifery practice has become progressively subsumed by nursing, increasingly supervised by obstetrics, and has been the target of professional rivalry from the medical profession (Rhodes, 1995; Callaghan, 1996; Lecky-Thompson, 1996; Reiger, 1999a; Harris, 2000; Robinson, 2002; Fahy, 2007; Barclay, 2008; Purcal, 2008; McColl, 2008; Benoit, Zadoroznyj, Hallgrimsdottir, Treloar & Taylor, 2010).

From 1920 through to 1970, a period described by Willis (1983) as a 'golden age for medical dominance', the medical profession enjoyed unquestioned societal support. This can be attributed to several factors including the enhancement of medical technology, which was increasingly able to improve outcomes for women (Benoit et al., 2010), and changes in legislative policy enabling the medical professionals to govern other health service providers, including midwives.

In 1915 the Australian parliament passed the Midwives Registration Bill and created the Midwives Registration Board (Fahy, 2007). The passing of the Bill was the first step in regulating what had been, until then, an autonomous profession whose practice was largely ungoverned. In 1916 a government inquiry recommended that only suitably trained midwives, under the supervision of doctors, could attend women giving birth (Fahy, 2007). In 1923 the Nurses Act was passed and the Midwives Registration Board was dissolved, meaning that midwives had to be registered by nursing registration boards. As nurse-midwives they were restricted to practising midwifery under supervision of a doctor, with the exception of rural areas where there was a shortage of doctors (Fahy, 2007). Midwives became subordinated and their practice largely restricted to hospitals, which were at that time operating under the 'Nightingale system' which dictated that nurses and midwives were to "follow doctor's orders" (Fahy, 2007 p.27).

The Influence of Medical Dominance upon Midwifery Practice

The medical profession, supported by government and assisted by technological advances (Reiger, 1999a), were over time able to control not only where women could give birth, but where and how midwives practised (Newnham, 2010), a situation which continues to this day. Such medical dominance allowed control of healthcare on “various levels: over the content of their own work (characterised as autonomy); over the work of other health care occupations (authority); and as institutionalised experts in all matters relating to health in the wider society (sovereignty)” (Willis, 2006 p.422) and is still reflected in the experience of maternity care and childbearing women in Australia.

Examples of authoritative and sovereign medical dominance over midwifery practice within Australia include: obstruction - via lobbying of government - of independent midwives' ability to acquire publically funded rebates for service provision (restricting clientele to those who can pay for service) (Newnham, 2010); verbal abuse of independent midwives by medical professionals; refusal by obstetricians to care for women who transfer from homebirths; reporting independent midwives to the regulatory body; and restricting legal representation of independent midwives through pressure on collegial legal organizations (Lecky-Thompson, 1996; Reiger, 1999b).

Evidence suggests that the obstetric viewpoint values technology, surveillance and intervention and is informed by a belief that pregnancy and childbirth is inherently risky (Callaghan, 1996; Wilson, 2002; Jordan & Aitkins Murphy, 2009). This standpoint has dominated maternity care provision in Australia during the last four decades, and has been fuelled by both historical and political-economic factors (Fahy, 2007; Barclay, 2008; Purcal, 2008; Newnham, 2010).

It has become generally accepted in society that childbirth should be medically managed to prevent risk and improve outcomes. This view is in sharp contrast to the midwifery perspective, where woman-centeredness, empowerment and normalisation of childbirth are valued (Australian Nursing & Midwifery Council (ANMC), 2006a). The dominant medical discourse has created a perception that hospital is the best and safest place for a baby to be born (Cahill, 2001) with 97.3% of Australian women opting to give birth in a

hospital (Davey et al., 2008). Prevailing medical discourse thus promotes the belief that childbirth without obstetric care and technology is dangerous or risky (Callaghan, 1996; Wagner, 2001; Wilson, 2002; Barclay, 2008), which is perpetuated by societal acceptance of scientific medicine and obstetric technology (Callaghan, 1996; Reiger, 1999a; Barclay, 2008; Benoit et al., 2010).

Examples of the dominance of medical discourse can be seen in written and visual representations of pregnancy and childbirth in Australian literature, the media and even in the textbooks recommended for the Bachelor of Midwifery students in this study (Henderson & McDonald, 2004). For example, Mayes' Midwifery (Henderson & McDonald, 2004), a recommended text for the Bachelor of Midwifery students in this study, provided mechanistic pictorial representations of pregnant women, such as those used in medical textbooks (McGrath, 2002). McGrath (2002) traces these pictorial representations back to 17th Century London, where William Smellie, who considered the birthing body a reproductive machine, commissioned anatomical drawings which displayed headless and bodiless reproductive parts of women and their unborn babies. McGrath (2002) argues that these types of unemotional and detached images provide a mechanistic representation of women's bodies and reinforce medicine's clinical detachment from women (McGrath, 2002).

The popular media is also a vehicle for communication of discourse in society. Australian researchers Williams and Fahy (2004) explored discourse surrounding pregnancy and childbirth in popular Australian mass media. They reviewed 69 articles about pregnancy and childbirth in four popular Australian women's magazines using feminist content analysis, via Barthes' Semiology, and found that, in general, Australian media portrays pregnancy and childbirth as risky, painful and requiring medical surveillance. Williams and Fahy argued that patriarchal interests are served in representations of pregnancy and childbirth in Australia's popular media, the medical model is promoted and midwifery partnerships are silenced.

Australian journalist Jennifer Keyte's *Australian Women's Weekly* magazine interview is one of 69 articles analysed in the Williams and Fahy paper. In this article, Ms Keyte is portrayed as good, moral and compliant, thus fitting the 'Madonna stereotype'. She is

married and overjoyed at her first pregnancy. Furthermore, having worked on the television program *Good Medicine*, she states that although childbirth is 'natural' women should be realistic about their expectations. Keyte says, "in an ideal world, wouldn't we all love to do it naturally - no drugs, no assisted birth and just as nature intended. But I'm realistic enough to know that it doesn't always work that way" (Williams & Fahy, 2004, p.14). Williams and Fahy (2004) contend that Keyte's comments imply that she views women who hope to birth naturally as potentially idealistic and unrealistic, and believes medical assistance and monitoring should be at hand for all women who give birth. Keyte's beliefs, reflecting the dominant discourse, were also identified in the 68 other articles reviewed.

Associate Professor and past president of the Australian College of Midwives (ACM), Hannah Dahlen, also explored the representations of women's childbirth experiences in the Australian media by comparing two birth stories reported in the news. One woman died after an elective caesarean section (for breech presentation) and the other had a stillborn baby after a planned unassisted birth at home (Dahlen, 2010). Dahlen's presentation of these two extremes of childbirth loss was not a research paper, rather a reflection of how fear from caregivers, society and women themselves is influencing women's perceptions of childbirth. One woman was fearful of the baby's wellbeing if she proceeded with a vaginal birth, while the other was fearful of intervention by the 'system'. Both women's experiences ended in tragedy, yet the woman who gave birth at home was judged harshly in the popular media and people were unsympathetic because they believed she had risked her baby's life by birthing at home unassisted. Her story was "sensationalised and used as evidence against home birth" (Dahlen, 2010 p.157). On the other hand, the death of the woman after an elective caesarean was blamed on recovery room nurses. This paper highlights the uneven attribution of blame suggesting absence of community and media expectation of obstetric accountability.

The influence of the dominant medical discourse surrounding risk is that women tend to fear childbirth and view obstetric technology as necessary to achieve a safe and satisfying birth experience. Interventions such as epidurals, instrumental births and caesarean sections are commonplace and therefore normalised (Waldenstrom, 2007). Dahlen (2006) has described Australia's maternity system as being an "industry of fear"

where “fear runs as an undercurrent through birth” and is “robbing women of power” (p.7). Dahlen (2006) compares the search for Weapons of Mass Destruction (WMDs) in the Iraq War to some Australian maternity care providers search “for WMDs or Women Who May be Dangerous” (p.7):

We invade their bodies with ultrasounds and tests, strapping them to monitors, breaking their waters to see the colour of their liquor. When we are not sure we take no chances. We see danger, danger everywhere. Like in Iraq we often find empty sheds, empty fields and the odd chicken farm. But our response is often to ignore the evidence and continue to do what was always intended. Invade and keep looking for those WMDs (Dahlen, 2006, p.7).

Women's Fears about Childbirth

Studies in various countries (Ryding, Wijma, Wijma & Rydhstrom 1998; Zar, Wijma & Wijma, 2002; Geissbuehler & Eberhard, 2002; Melender, 2002; Fisher et al., 2006; Waldenstrom Hildingsson & Ryding, 2006; Fenwick et al., 2009) have explored both the influence of women's fear upon the childbirth experience and the level of fear reported by childbearing women. Several studies found the percentage of women who are fearful of childbirth varies between countries, with Australian women reporting comparatively high amounts of fear (Fenwick et al., 2009). Approximately 25% of Australian women in the study by Fenwick et al. (2009) reported low levels of fear about childbirth, 50% reported moderate levels and 25% reported high levels of fear (Fenwick et al., 2009).

A wide range of specific fears have been explored by researchers, which can be summarised as: fearing for the safety of the baby during labour (Melender, 2002; Fisher et al., 2006; Waldenstrom et al., 2006; Fenwick et al., 2009); fear of a loss of control over the birth experience (Geissbuehler & Eberhard, 2002; Fisher et al., 2006; Fenwick et al., 2009); fear of the ‘unknown’ (Fisher et al., 2006); fear of obstetric procedures (Geissbuehler & Eberhard, 2002; Melender, 2002); and fear of pain, which has been reported to be as high as 40% of women (Geissbuehler & Eberhard, 2002; Fisher et al., 2006). Sources of fear reported include both past personal history and other women's stories about their negative experiences of childbirth (Melender, 2002; Fisher et al., 2006; Fenwick et al., 2009). There is also evidence of the ‘fear undercurrent’ in

Australian maternity services, as mentioned previously, as being another source of women's fears.

A qualitative, exploratory study of 22 Australian women by Fisher et al. (2006) found that fears can be prospective or retrospective. Retrospective fears arise from a previous traumatic birth experience, while prospective fears arise from social factors including hearing "horror stories" from other women (Fisher et al., 2006 p.65). Fisher et al. attributes much of the fear to disciplining practices of the medical profession and surveillance of pregnant women and the unborn child. Fisher et al. views disciplining practices and surveillance as disempowering influences which create both fearfulness around the wellbeing of the baby and loss of control during childbirth. One could presume that women who are fearful of childbirth would be more likely to choose to give birth in hospital, rather than a homelike environment, as common fears such as for the wellbeing of the baby (50%) and fear of pain (40%) would be motivating factors given that a hospital environment can provide technology and pain relief if required.

Influence of Maternity Care Provision and Practise Location upon Midwifery Practice and Birth Outcomes

The differences between maternity care provision in Australia and that of other similar countries are also worth noting. In New Zealand, for example, 75% of women have a midwife as their 'lead maternity carer' (LMC) while Australian women cannot choose a midwife as their LMC unless they are allocated a midwife within a 'caseload' model of care or can afford to pay for a private midwife (Callaghan, 1996; Newnham, 2010). The options for such models of care are limited in Victoria, with only a relatively small number of publically funded caseload models of care available.

The previous barriers to autonomous midwifery practice in Australia, highlighted throughout this literature review, are persisting despite lobbying of government by midwives and women. Recent national maternity care reforms in Australia brought about changes to the National Health Insurance Act, so that women receiving care from midwives are able to receive Medicare rebates, however there is a condition that their midwife obtain written evidence of a 'collaborative arrangement' with an obstetrician (Commonwealth of Australia, 2009). There has been a reluctance on the part of

obstetricians to sign agreements unless they are directly involved in the woman's care. There have also been concerns expressed by obstetricians about midwives' lack of indemnity insurance for intrapartum care as well as the safety of homebirth (Dahlen, 2011; McNamara, 2011; Medew, 2011). Only 37 of the 1760 Australian registered midwives have Medicare eligibility (McNamara, 2011). It has been estimated that only 3 privately practicing Australian midwives have been able to secure the necessary collaborative arrangements with obstetricians (Dahlen, 2011). Privately practicing midwives remain unable to provide midwifery care to their clients in hospitals because of difficulties obtaining practice arrangements and admitting rights to Australian hospitals (Dahlen, 2011; Medew, 2011).

In contrast, New Zealand midwives are endorsed as Lead Maternity Carers (LMC) and are able to provide publically funded care to women throughout their pregnancy, labour and birth despite the woman's chosen place of birth. New Zealand has a 'normal' vaginal birth rate of 66%, compared to 55% of women in Victoria, Australia. New Zealand also reports a significantly lower induction rate of 20% compared to 63% of Victorian women (New Zealand Ministry of Health, 2007; Davey et al., 2008). The statistics suggest that where midwives are able to work autonomously to provide maternity care, they may be more likely to be able to facilitate normal birth. Australian midwives were found to be more autonomous when they provided private midwifery care to women in the community compared to those working in hospitals (Callaghan, 1996).

The lack of professional indemnity insurance for private midwives providing intrapartum care (since 2002), lack of confidence in the safety of homebirth and medical opposition (Reiger, 1999b; Reiger, 2001; Benoit et al., 2010; Sweet, 2010; Medew, 2011) all seem to contribute to the low homebirth rate in Australia. Victorian perinatal data shows that the number of Victorian women who planned to birth at home in 2005-2006 was very small, at around 0.3% and this percentage is similar to previous years (Davey et al., 2008). 85% of these women gave birth at home, whilst the remaining 15% transferred to hospital where 60% of required a medically assisted birth, either via Ventouse (a method of instrumental birth where a vacuum suction device is applied upon the foetal head and traction is used with maternal effort (Henderson & McDonald,

2004)), Obstetric Forceps or Caesarean Section (Davey et al., 2008). Overall, 73% of the women who planned a homebirth, including those who transferred to hospital with complications, had a normal vaginal birth (Davey et al., 2008). These statistics suggest that planning hospital birth in Victoria allows women a 55% chance of a normal vaginal birth, whereas planning to birth at home allow a 73% chance, even if the woman becomes 'high risk' and transfers into hospital. Birth outcomes in Australia therefore appear to be influenced by midwifery practice location and philosophy.

There is further evidence that the setting in which a midwife works – for the vast majority of Australian midwives this is a hospital – significantly influences midwifery practice. A large survey of midwives working in eleven midwifery units across the United Kingdom (UK) by Mead and Kornbrot (2004) found that midwives working in 'higher intervention units' generally perceived that intra-partum risks were higher than those working in 'lower intervention units'. Across the board, however these midwives were intervening more than the evidence suggested was necessary: Hospital midwives were found to underestimate women's abilities to give birth normally and overestimate the necessity of medical interventions (Mead & Kornbrot, 2004).

Australian studies also provide evidence to support the notion that the culture of medical dominance of childbearing influences midwifery practice. Callaghan's (1996) study explored how Australian midwives perceive the care they provide to women and Fahy's (2002) explored how power operates in medical encounters with women as well as the role of the midwife in empowerment of women. Callaghan's (1996) qualitative, grounded theory study compared two groups of Australian midwives' perceptions of care provision in hospital-based and homebirth situations. While the study is now 14 years old, little has changed in that time according to a number of midwifery scholars (Fahy, 2002; Dahlen, 2006; Parsons & Griffiths, 2007; Homer et al., 2009; Smith, Leap & Homer, 2010).

Callaghan (1996) identified two care models that dominated midwifery practice – the "medical model" and "midwifery model" (p.55). She defined the medical model of midwifery care as characterized by: a negative or fearful attitude towards childbirth; practices that dehumanised and classified women; care dominated by routines and time

limits; a high utilisation of technology and interventions; a disempowerment and subordination of both women and midwives; fear of litigation; and a desired outcome of physically healthy mother and baby regardless of what it takes. The midwifery model, on the other hand, was characterized by a low level of intervention and use of technology; an individualised and holistic approach to care; and minimal control over what was seen as the normal process of pregnancy and birth.

The majority of midwives in Callaghan's (1996) study worked in hospitals and accepted the values and beliefs of the medical model. A small minority of these midwives said that they wished they could work within a midwifery model but they enacted the medical model to avoid conflict – perpetuating medical domination and midwifery subordination. Only a small minority of midwives, who did not work in hospitals, worked within a midwifery model (Callaghan, 1996). Callaghan's (1996) findings suggest that most midwives working in hospitals in Australia are heavily influenced by a biomedical model which is not only disempowering for midwives but also for birthing women.

Fahy (2002) had similar findings in a later study, and further suggested that midwives collude in the disempowerment of women by supporting medically dominated obstetric care. The study explored the experiences of thirty three young pregnant women within the Australian maternity system, using feminist post praxis research methodology. The aim of the study was to understand how power operates in medical encounters with women, and how midwives can empower women to have control over what happens to them during pregnancy and birth. Fahy's methodology drew on Michel Foucault's poststructuralist theories, particularly concepts of discipline, surveillance and the relationships between knowledge and power. Fahy (2002) found that obstetric discourse dominates within Australian society, which had learnt to trust the technology and science upon which obstetric practice is based. Furthermore, she found that medical power is usually invisible until resistance is met. If resistance is met, the obstetricians use rewards and punishments to gain compliance or submission of women, reflecting Foucault's theories of disciplinary power (Fahy, 2002). Fahy also found that medical power operates most efficiently with the co-operation of the midwife, where hospital-

employed midwives promote birthing woman's compliance with medical orders (Fahy, 2002).

The notion of midwife compliance, or obedience, has also been discussed by Australian authors Parsons and Griffiths (2007), who argued that Australian midwives are socialised into being obedient within their workplace. The authors suggest a generation of midwives who hold a nursing qualification have taken on nursing's legacy of obedience and conformity. Parsons and Griffiths also suggest midwives are reluctant to adopt changes recommended by evidence, and that they instead adopt practices occurring in their individual workplace. Change in practice is slow to occur, according to Parsons and Griffiths (2007), because the consequences of questioning practice include alienation by management and peers in the workplace via verbal intimidation, abuse, humiliation and exclusion. Parsons and Griffiths (2007) also believe that midwifery professionals themselves are regulating their own and each other's behaviour as they avoid punishment for non-conformity in the hospital workplace. If midwives are instrumental in the operations of medical power in Australian maternity hospitals (Fahy, 2002) while working within a medical model of midwifery practice (Callaghan, 1996) then, it can be argued, they may be working in conflict with professional standards for midwifery practice.

Despite the medical dominance of childbirth, the influence of the fear discourse, and midwifery practice that occurs predominantly in hospitals, Australian midwives are expected to meet competency standards which require them to be an "accountable professional" working in "partnership with women" to promote "normal birth" within a "women centred framework" (ANMC, 2006a; ANMC, 2006b p.1). ANMC (2006a) guidelines for contemporary midwifery professionalism in Australia, endorsed and adopted by the Australian College of Midwives and the Australian Nursing Federation, are informed by midwifery discourse. Their *Competency Standards for Midwives* (ANMC, 2006a) are based on a woman-centred, social view of pregnancy and birth - reflecting Callaghan's (1996) midwifery model. They value partnerships with women, professional autonomy, and facilitation of a normal life process (ANMC, 2006a), describing a midwifery role that is the antithesis of medical model - in which the majority of midwives were working in Callaghan's (1996) and Fahy's (2002) studies.

The ANMC *Definition of the Midwife* (2006a) emphasizes professional autonomy with the midwife working in 'partnership' with women to promote normal birth and seek medical assistance when complications arise (ANMC, 2006a). Furthermore, the *Code of Ethics for Midwives in Australia* (ANMC, 2008) describes ethical standards which require Australian midwives to value informed decision making and respectful relationships with women, play an advocacy role and provide care which takes into consideration the physical, emotional, cultural and spiritual needs of women. The following quote from the *Code of Ethics for Midwives in Australia* (ANMC, 2008) highlights the professional responsibilities of midwives according to the professional body:

Midwives have a responsibility not to interfere with the normal process of pregnancy and childbirth unless it is necessary for the safety of the women and infant(s). Quality midwifery care also necessitates midwives being accountable for the standard of care they provide; helping to raise the standard; and taking action when they consider, on reasonable grounds, the standard to be unacceptable. This includes a responsibility to question and report unethical behaviour or treatment (p.5).

Yet where midwives are predominantly working in hospitals they are constrained to operate within the embedded practices within those hospitals.

The 2002 the Australian Midwifery Action Project (AMAP) (Leap et al., 2003) identified significant barriers to midwives working in the full scope of practice including; a lack of awareness of the role of the midwife in the community, the institutionalisation of maternity care and associated medical dominance; lack of opportunities to work in an autonomous capacity; and workforce shortages (Leap et al., 2003; Homer et al., 2009). According to Homer et al. (2009) and Smith et al. (2010), the issues highlighted in the AMAP study have not been sufficiently resolved, despite changes to government legislation in 2010 (Benoit et al, 2010). There remains a lack of government funding and local implementation of midwifery models of care, along with an inability of most midwives to prescribe routine or emergency medications related to childbirth or order 'routine' tests for women (Benoit et al.). These issues need to be addressed in order for Australian midwives to practise autonomously (Homer, 2006). Furthermore, a clear articulation of the role of the midwife needs to be conveyed to the community (Homer et al., 2009).

The disparity between professional standards and the realities of practice was described by Australian midwifery Professor Nicky Leap (2002) as a “philosophy conflict” (p.20). This issue has also been identified by North American researchers who described it as a “theory-practice gap” (Jordan & Farley, 2008 p.413; Lange & Powell Kennedy, 2006). Australian midwives have some work to do to close this theory-practice gap and to address the philosophy conflict. In the meantime, Australian midwifery practice has been described as being in a “transition phase” (Smith et al., 2010 p.3) and “at the edge of history” (Dahlen, 2006, p.3) until the full scope of midwifery practice, according to professional standards, is realized (Homer, 2006; Homer et al., 2009).

Associate Professor Hannah Dahlen identified the greatest challenge for Australian midwifery profession to be “managing the great medical/midwifery divide” (Dahlen, 2006 p.6). This divide exists in a world where midwifery is contained within a culture of medical dominance and valuing technology and medical expertise. She and others have suggested that strong midwifery leadership and effective education of midwives is required to address these disparities and empower midwives to enact their professional role according to their competency standards (Dahlen, 2006; Keating & Fleming, 2009).

Dahlen (2006) calls upon midwives to actively promote midwifery, work towards change and be “politically active and dare to challenge the world” (p.3). This may be quite a challenge given the entrenchment of medical dominance and midwifery subordination in Australia and the midwifery profession’s history of obedience and conformity (Parsons & Griffiths, 2007). Furthermore, it seems that the medical model has become so ‘normal’ in Australia that midwives predominantly see birth from a technological, hospital-based, high interventionist perspective (Wagner, 2000). As Wagner succinctly puts it, Australian maternity care providers are like “fish [who] can’t see the water they swim in” (Wagner, 2000 n.p.).

The current situation begs the following questions: How do midwives promote normal childbirth while working in fragmented care models with, in the majority of cases, little or no relationship with the women they care for? How can midwives role model the ideal midwifery practice as defined in the professional standards? What *type* of midwives do students become?

Influence of Midwifery Practise Context upon Student Midwife Competency

Studies that explore midwifery students' perceptions of midwifery care, most pertinent to this study, highlight a perceived lack of midwifery philosophy influencing maternity care units within the hospital system. Studies in Australia, North America and the United Kingdom have found that both undergraduate and postgraduate midwifery students experience conflict between their vision of midwifery, or the philosophy/theory underpinning their ideal midwifery practice, and the reality of that practice in medicalised maternity units (Seibold, 2005; McCall, Wray & McKenna, 2007; Lange & Powell Kennedy, 2006; Jordan & Farley, 2008; Fraser & Hughes, 2009). It has been argued that this theory practice gap affects midwifery students' practice and professional development (Lange & Powell Kennedy, 2006; Jordan & Farley, 2008).

Lange and Powell-Kennedy (2006) examined the perceptions of 245 North American midwifery graduates about the theory-practice gap in midwifery and found an incongruity between ideal and actual midwifery practice, particularly related to interventions in normal labour, such as "using low technology approaches when possible" and "intervening only if necessary and appropriate" (p.75). Graduates were surveyed via a postal questionnaire which, using a Likert scale, asked them to reflect on their observations, during clinical placement, of 'ideal' and 'actual' midwifery practice. Various components of midwifery practice were broadly grouped into 'therapeutic', 'caring' and 'professional' traits. Lange and Powell-Kennedy (2006) described as particularly concerning the low congruence between ideal and actual midwifery practice of supporting normal birth in a hospital setting.

Jordan and Farley (2008) surveyed 125 North American midwifery students, asking them to rate self-efficacy for therapeutic presence and non-intervention in the absence of complications. They had similar findings to Lange and Powell Kennedy (2006). Students in the study reported that hospital midwives frequently used technology and intervened during uncomplicated labour (Jordan & Farley, 2008). The high use of technology and intervention in hospital settings identified by both of these studies adds to a body of knowledge that suggests medical dominance of birth in hospitals is a global

phenomenon. Australian researchers McCall et al. (2007) and Leap (2002) and UK researchers Fraser and Hughes (2009) had similar findings.

Jordan and Farley (2008) and Lange and Powell Kennedy (2006) suggested that midwifery students are socialized into the hospital environment because they rated the high level of intervention in 'normal labour' as appropriate (Jordan & Farley, 2008). Furthermore, students who were placed in a home-birth setting described the midwives as lacking vigilance (Lange & Powell Kennedy, 2006), suggesting they considered intervention in normal labour to be more appropriate than a more 'casual' approach. Despite this, those midwifery students exposed to low interventionist practices, such as in a birth centre or at homebirths, were more likely to practise in a low interventionist manner and those who were modelled high interventionist practices in hospitals were more likely to practice in a high interventionist manner (Lange & Powell Kennedy, 2006).

McCall, Wray and McKenna (2007) also found that Victorian Bachelor of Midwifery students conformed to the culture of midwifery practice during clinical placement. The researchers of this qualitative study interviewed, and held focus groups with, eleven Bachelor of Midwifery students. The interview questions focused on the student's career intentions and experiences during clinical placement. The study found that Australian undergraduate midwifery students conformed to the culture of care in the clinical environment and a very small number of students were 'weeded out' during the socialization process; they either withdrew from their course or were not practising midwifery after graduation. Those whose initial perceptions of midwifery were not congruent with what they saw during clinical experience blamed their own misconceptions about midwifery. For example, one student said that clinical placements "opened [her] eyes" to what the midwife's role "really is" (McCall et al., 2007 p.4).

Fraser and Hughes' (2009) qualitative study of 58 UK undergraduate midwives similarly found that midwifery students, prior to beginning their clinical placements, described the midwifery role as one that involved routine care practices, technology intervention and subject to medical dominance, despite some describing childbirth as "natural", "special" and "magic" (Fraser & Hughes, 2009 p.314). Conflicts between the

ideal and the reality of practice have been attributed to difficulties in retention of midwives post graduation (Fraser & Hughes, 2009).

The clinical learning environment therefore significantly influences student's competency as well as socialization into their profession (Lange & Powell Kennedy, 2006; Jordan & Farley, 2008). It appears that a theory-practice gap exists in midwifery practice in America and Australia as it has been suggested that professional standards, or philosophies of practice, are not being role modelled for students. Despite this recognition of the dichotomy between midwifery philosophy and midwifery practice, American and UK students' future practice tends to reflect that role modelled in practice.

Experiences during clinical practice have been shown to influence Australian graduates' future employment decisions as well as attrition rates (Leap, Barclay & Sheehan, 2003; McCall et al., 2007). Authors have, in recognising this issue, suggested strategies to bridge the 'theory-practice gap' for student midwives in the hope that contemporary standards for practice are role modelled to midwifery students during clinical placement.

Thomas (2007a) conducted a grounded theory study of midwifery graduates with the aim to generate an educational strategy enabling student midwives to become "woman-centred" (p. 23). She interviewed 14 midwives working within the National Health Service (NHS) in England and 9 midwives working outside the NHS (within caseload models of care in England, New Zealand, Australia and Canada). Thomas (2007a) found the midwives working outside the NHS had a strong belief in women's ability to birth without medical intervention and more capability to support normal childbirth than those midwives working in the NHS. These midwives' beliefs arose out of confidence and trust in women and their own ability; feeling equal to medical colleagues; a feminist ideology; a belief in the ability to change things; and working in a continuity of care model which facilitated positive relationships, where the midwife felt they knew what the women wanted. Those who chose to work in the NHS, on the other hand, were disempowered by medical colleagues and constrained by the system of hierarchy and a maternity service that did not place importance on the woman's needs (Thomas, 2007a).

Thomas (2007a) found that the midwives' learning environment as a student influenced their future beliefs, confidence and competency. The overall politics of the country's maternity services and specific units therefore influenced the way that midwives practiced in the future. For example, the confidence and competence of those midwives who chose not to work in the NHS was inspired by positive role models they encountered whilst learning to be midwives (Thomas, 2007a). Because of this Thomas (2007; 2007a) recommended that midwifery programs consider the influence of the environment on students learning. She emphasized the importance of a positive environment of practice that exposes students to strong role models and continuity of midwifery care models. Furthermore, she suggested that strong midwifery leadership and a supportive peer network would encourage students to have confidence and a strong belief in midwifery practice.

In summary, the literature relating to both the Australian midwifery practice context and student midwife practice indicates that it is situated mostly in hospitals and is dominated by medical discourse about childbirth (Callaghan, 1992; Fahy, 2007). Evidence reflects a disparity between professional standards for practice and the realities of midwifery practice in Australia. Overseas studies demonstrated that students tend to adopt the midwifery skills and attitudes role modelled within the clinical learning environment in which they are expected to achieve competency. The next section provides an overview of the literature related to student midwife competency.

Section Two: Competency, Assessment and the Clinical Learning Experience

Conceptualisations of competency in the literature and their application to competency-based education curricula and assessment are discussed. Following this is a review of research exploring the clinical learning experience and preceptorship.

Inconsistent conceptualisations of competence and competency in the literature have led to concerns about the use of competency standards in nursing and midwifery education and assessment of students. Competency has been a complex subject of debate, often misunderstood within the nursing and midwifery profession (McMullan et al., 2003; Girot, 2000; Watson, Stimpson, Topping & Porock, 2002; Bartlett, Simonite, Westcott

& Taylor, 2000; Zhang, Luk, Arthur & Wong, 2001; Chiarella, Thoms, Lau & McInnes, 2008). According to Girot (2000), attempts to “unravel the confusion” (p.331) surrounding nursing competence have been occurring since the 1980s. As recently as 2005 Cowan, Norman and Coopamah found, during a focussed review of the literature, that definitions of competency “lack consensus, being replete with ambiguity, confusion and contradiction” (p.358). Finding a reliable working definition of competency for a study which explores students' experiences of achieving competency was challenging, necessitating a thorough exploration of the conceptualisations of competency.

According to McMullan et al. (2003) and Watson et al. (2002), defining competency has been difficult because the terms competence, competency, and performance have been used interchangeably in literature. Watson et al. (2002) argued that if competency is to be used as the basis for education, and as a benchmark for assessment of student nurses and midwives, then a clear and consistent conceptualisation is essential. Conceptualisations of competence selected from literature studied highlight the inconsistencies suggested by McMullan et al. (2003) and Watson et al. (2002).

McMullan et al. (2003) conceptualise competence as: “the person's underlying characteristics and qualities that lead to an effective and/or superior performance in a job” (p.284). The second conceptualisation is provided by a UK nurse educator and researcher: “a performance capability needed by workers in a specific occupational area and may be cognitive, attitudinal and/or psychomotor” (Fearon, 1998 p.44). Finally, the definition of competency provided by the Australian Nursing & Midwifery Council in their midwifery competency standards (2006a), used to assess and benchmark nursing and midwifery practice in Australia, is: “The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area” (p.14)

Although each of these is a conceptualisation of competence, they could equally be applied as conceptualisations of competency when compared against McMullan et al.'s (2003) definitions of *competence* as an occupational attribute which includes nurse/midwife actions, behaviours and outcomes and *competency* encompassing the underlying qualities that indicate effective performance. McMullan et al. (2003) further

suggested that competency conceptualisations be classified into three groups: generic, behaviourist, and holistic; where generic conceptualisations being broad clusters of general abilities applicable to many situations, behaviourist conceptualisations are task-focussed, and holistic conceptualisations combine knowledge, skills and attitudes.

McMullan et al. (2003) found behaviourist conceptualisations to be most common in the UK and American nursing and midwifery literature, while holistic conceptualisations of competency were more common in Australian nursing literature. The following are examples of behaviourist conceptualisations of competency:

- a) "The skills and ability to practice safely and effectively without the need for direct supervision" (United Kingdom Central Council for Nursing and Midwifery and Health Visiting (UKCC) cited in Girot 2000 p.332).
- b) "An ability to perform a task with desirable outcomes" (Meretoja, Isoaho & Leino-Kilpi 2004 p.125).
- c) "An action, behaviour or outcome that a person should demonstrate in their [job] performance" (McMullan, et al., 2003 p.284).

Behaviourist conceptualisations focus on skills rather than thought processes, which arguably oversimplify the complex nature of nursing and midwifery competency. McMullan et al. (2003) argue that behaviourist conceptualisations reflect old-fashioned attitudes about nursing and the nurses' role, while others suggest such conceptualisations ignore critical thinking aspects of the nurses' role, which undermines the professionalism of nursing and midwifery (Watson et al., 2002; Cowan et al., 2005).

Holistic conceptualisations of competency, on the other hand, are said to integrate the essential qualities of knowledge, skills and attitudes (Watson et al., 2002). For example, according to Fearon (1998 p.44), "competency is the possession and development of sufficient skills, knowledge, appropriate attitudes and experience for successful performance in roles". Watson et al. (2002) and McMullan et al. (2003) suggest that the adoption of a holistic conceptualisation of competency, such as that described above, facilitates greater acceptance of the use of competency standards to inform nursing/midwifery practice and education.

Competency based education (CBE) was, during the 1990s, hailed by nursing leaders in North America and the UK as the vehicle to provide professional nurses who would be more able to meet workforce needs (Redfern, Norman, Calman, Watson & Murrells, 2002; Watson et al., 2002; McMullan et al., 2003; Cowan et al., 2005; Watson, 2002). Some authors in the Australian nursing literature have, however, consistently debated the merits of CBE and critics have been particularly concerned that skill focused, reductionist curriculums lacked respect for the complexity of performance and disregarded the role of professional judgement, intellectual processes and underlying attributes (Gonczi, 1994; Chapman, 1999). Chapman (1999) warns that behaviourist approaches “suppress aspirations for achievement” (p.133) because a narrow, skills focused assessment criteria focuses on skills and is overly “concerned with what people do rather [...] than know” (p.131) and Chiarella et al. (2008) argues that Australian nursing and midwifery competency standards require further refinement and development before they are successfully applied to education and practice.

Despite these concerns there is evidence that CBE curricula can effectively produce competent graduates. A study by Farrand, McMullan, Jowett & Humphries (2006), which surveyed 139 United Kingdom (UK) nursing students, compared graduate's outcomes of CBE curricula to non-competency-based curricula. They found students who graduated from the CBE curriculum reported a higher degree of confidence in their abilities than the graduates from the non-competency-based curriculum. Graduates from the CBE curriculum demonstrated more accountability for their own learning, practice and assessment (Farrand et al., 2006).

Graduates from UK midwifery undergraduate midwifery courses similar to the Australian Bachelor of Midwifery, who base their curricula on CBE, have been found to be competent for beginning practice. An action research study by Fraser (2000a; 2000b), which incorporated a case study evaluation commissioned by the English Nurses' Board (ENB), explored whether English direct-entry midwifery graduates were competent to begin practice. The ENB study participants – 39 students, newly qualified midwives, midwifery managers and midwifery academics from six universities throughout England – agreed that the direct-entry midwifery program did indeed provide graduates competent for beginning practice. There were some concerns raised

about the opportunities within the course for students to practice essential skills and the reliability of assessments (Fraser, 2000a). Students had little opportunity to practice episiotomies, urinary catheterisation and vaginal examinations. Consequently upon graduation they needed ongoing supervision and support when conducting such procedures. Their lack of experience in these skills, however, did not detract from their competency overall (Fraser, 2000a).

Fleming et al.'s (2002) study of Scottish midwifery students, commissioned by the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), had similar findings to Fraser's study in relation to direct entry midwifery graduates' competency in that they found the students needed ongoing support and mentorship post-graduation. The researchers utilised a mixed method to compare the competency of 95 direct-entry midwifery graduates to 35 post-graduate midwifery graduates. Both students' and supervisors' of midwives expectations of beginning competency were compared using the Glasgow Royal Maternity Hospital's skills inventory, a staff development tool. The post-graduate students were rated significantly higher in skills scores compared to the direct entry graduates by the midwifery supervisors, yet the higher rating of skills scores did not detract from the direct-entry students' competency overall. This study found that both the post graduate and direct entry students could safely care for a woman during normal labour and birth, but would require support when complications arose (Fleming et al., 2002).

There was, however, a potential for bias by the assessors who participated in the study which potentially influenced their assessments of the direct-entry midwives. The Fleming et al. (2002) study was commissioned by the NBS "after concerns [were raised] about the initial practice of the single registered midwife from both practicing midwives and managers of maternity services" (p.17). These previously identified professional concerns about direct-entry student midwives' competency related to their lack of nursing qualification and experience may explain the discrepancy between the lower skill ratings of the direct-entry midwives. Midwifery supervisors who participated in the study were registered with the NBS – which sent the letters inviting their participation. These supervisors were potentially those who voiced their concerns about

the direct entry students' competency. Fleming et al. (2002) make no mention of how they addressed this issue.

Fraser (2000a) and Fleming et al. (2002) both suggested that direct entry midwifery graduates are able to safely care for women throughout the childbearing continuum. And although they may need support as they develop certain skills post-graduation – such as episiotomy, vaginal examinations and urinary catheterisation – direct entry graduates are as competent as those with a nursing qualification and experience.

Application of CBE to the Bachelor of Midwifery Curriculum

Australian Bachelor of Midwifery curricula are underpinned by Australian midwifery competency standards which aim to provide a benchmark for practice and student assessment (ACU, 2001; ACM, 2002a; ACU, 2005; Australian Nursing and Midwifery Council, 2006a). These standards reflect a holistic conceptualisation of competency. The ACM (2002a) competency standards, which were used in the original curriculum, define competency as a “combination of attributes (knowledge, skills and attitudes) which result in effective performance” (p. 2). They aimed to enable the midwife to provide culturally relevant and high quality care for women throughout the childbearing continuum. The philosophical underpinnings of the ACM competencies emphasised the midwife working in partnership, valuing the woman's experience and possessing the “appropriate knowledge skills, attitudes and values in order to provide safe and satisfying care” (ACM, 2002 p.3). Competency categories included: professional accountability and responsibility; midwifery practice; health education and promotion; and legislation, policies and procedures.

In 2007, the Bachelor of Midwifery curriculum adopted the Australian Nursing and Midwifery Council's (ANMC) (2006a) *National Competency Standards for the Midwife*. These are organised into four domains: legal and professional practice; midwifery knowledge and practice; midwifery as primary health care; and reflective and ethical practice. Within each domain there is a cluster of competencies, under which sit competency elements and cues to assist assessment of competency (ANMC, 2006a). By using the ACM/ANMC competency standards, Victorian universities offering the Bachelor of Midwifery based their teachings on a holistic approach to the curriculum's

competency based education model, as they aimed to develop confident, politically and socially aware professionals, accountable for their own practice. Furthermore, the ACU curriculum was based on a teaching and learning model reflecting adult learning principles – including self-directed learning, critical thinking, reflection and practical involvement in learning (ACU, 2005).

As well as using principles of competency assessment, the ACM (2002b) *Standards for Bachelor of Midwifery Course Curriculum Accreditation* included specific requirements for numbers of experiences students were to achieve prior to registration as a midwife post graduation. Appendix I provides a copy of these requirements, which reflected the UK Nursing and Midwifery Council (NMC) (2009) and the Midwifery Council of New Zealand (2007). The source of these requirements was the European Parliament and of the Council (2005) *European Union Directive*. The ACM adopted these numbers in the hope that Australian Bachelor of Midwifery graduates would be comparable with UK and NZ midwifery graduates and therefore able to automatically be able register to practice as a midwife in those countries (Cutts et al., 2002). There is no research evidence available to substantiate that these numbers of experiences (suggested by the European Council – adopted by Australia, the UK and NZ) ensure a reasonable breadth of experience for midwifery students to develop their competency.

The ACM (2002a) standards also stipulated the number of clinical practicum hours provided by Australian curricula that should allow enough time for students to develop competency. According to the standards, Australian pre-registration (Bachelor) midwifery programs should be 156 weeks long (including leave) and 50% of this should be clinical practicum. This equates to approximately 78 weeks of clinical practicum (including annual leave), which is comparable to the overseas courses (Midwifery Council of New Zealand, 2007; NMC, 2009). Despite this, the 2005 ACU Bachelor of Midwifery Curriculum was approved by the Victorian Nurses Board with 42 weeks of clinical practicum (ACU, 2005), which was 38% less clinical practicum than their overseas counterparts. The 2008 ACU Bachelor of Midwifery Curriculum had even less hours of clinical practicum, at 30 weeks (ACU, 2008). A table comparing clinical practicum hours of these courses is provided in Appendix L. Why the NBV approved curricula which allowed significantly less clinical practicum than the hours

recommended by the ACM, and also those provided in other overseas courses with the same clinical requirements, is a mystery.

Additionally, these clinical practicum hours included 10 weeks of Follow Through Experience (FTE). The students were responsible for recruiting 10 pregnant women each year, totalling 30 women over the course of the degree. During the FTE the students were to be available 'on-call' to attend "at least half" (ACM, 2002b p.8) of these women's labours with the intention that they would experience continuity of midwifery care (ACM, 2002b).

There were barriers to students' ability to attend these women's labours and actively be involved in their care. It was the woman's choice if they wanted the student to attend the birth and the attendance was not to interfere with the students' compulsory university commitments or clinical practicum (ACU, 2005c). If the woman declined the students' presence or she gave birth when the student was at university or on placement then the student could not attend the labour. A number of hospitals would not allow the students to be actively involved in the woman's labour because they were not attending formal clinical practicum — and if the woman was birthing at home there was no indemnity insurance in place for the student, so they were forbidden by the university to be actively involved. The minimum requirement was an "average" (ACM, 2002b p.8) of 20 hours of time spent per woman, regardless of when the student was present throughout birthing experience. If the student did not attend the woman's labour they would be required to attend "at least 2 antenatal and 2 postnatal visits per woman" (ACM, 2002b p.8) to make up the 20 hours.

The minimum requirements of midwifery experiences standards changed somewhat when new accreditation standards and processes were developed via collaboration between the ACM and the ANMC (2009). In response to concerns from midwifery academics and students, the ANMC reduced the requirements for normal births from 40 to 30 (with attendance at a further 20 births with women experiencing complex needs) (ANMC, 2009). Concerns about the students' ability to achieve the number of FTEs were also expressed and the number of FTEs were reduced from 30 to 20 (ANMC,

2009; Gray, 2010). The reduction in requirements, however, occurred after data collection had ceased in this study.

Clinical practicum is an integral part of midwifery curricula. During clinical experience midwifery and nursing students apply theoretical knowledge, develop their skills and build competency (Tabari Khomeiran, Yekta, Kiger & Ahmadi, 2006; Benner, 2001; Burns & Patterson, 2005; Watkins, 2000) and develop their professional identity (Burns & Patterson, 2005; Watkins, 2000; Ulrich, 2004). During clinical practicum student nurses and midwives traditionally learn within a student-preceptor relationship.

The Role of the Preceptor in Student Competency Development

Studies exploring the student-preceptor relationship have found that preceptors have a significant influence on students' learning and future practice (Gray & Smith, 1999; Jackson & Mannix, 2001; Ulrich, 2004; McCall, Wray & McKenna, 2007; Jordan & Farley, 2008). This is because students' self-esteem and ability to learn depends on a supportive relationship with their preceptor (Gray & Smith, 2000; Randle, 2001; Begley 2002; Papp et al., 2003; Edwards et al., 2004; Tabari Khomeiran et al., 2006). Supportive student-preceptor relationships have been found to enhance both the quality of clinical placements (Clarke, Gibb & Ramprogus, 2003; Andrews, Brodie, Andrews, Wong & Thomas, 2005) and students' experience of learning during clinical placement (Jackson & Mannix, 2001; Begley, 2001a; 2001b; 2002; Lambert & Glacken, 2003; Clarke et al., 2003; Papp et al., 2003; Donaldson & Carter, 2004; Edwards et al., 2004; Burns & Paterson, 2005). Preceptors have been found to be instrumental in the provision of learning opportunities for students to develop clinical skills (Jackson & Mannix, 2001; Papp et al. 2003; Edwards et al., 2004; Khomeiran et al. 2006) and in providing students with a link between theory and practice (Jackson & Mannix, 2001; Lambert & Glacken, 2004; Burns & Paterson, 2005). Another significant aspect to the student-preceptor relationship is role-modelling (Gray & Smith, 1999; Jackson & Mannix, 2001; Donaldson & Carter, 2005) and socialisation into the profession (Papp et al., 2003; Edwards et al., 2004; Ullrich, 2004; Jordan & Farley, 2008).

Melia (1998 p.156) has theorised that student nurses are compelled to 'fit in' in nursing through a process of she called 'occupational socialisation'. She argued that student nurses gain "professional nursing rhetoric from the education sector and the practicalities of the service way of working" (Melia, 1998 p.156) and to progress through their course they align themselves with the preceptors in the 'service sector'. According to Melia's theory, students move between the education sector and the service sector and they come to accept two versions of their profession. They find that the best way to fit in is to align with the preceptors in the service sector, because they will eventually be working in that world. Nursing students also learn not to expose their differences when moving between the two worlds; instead they fit in to each world as necessary (Melia, 1998).

Expert preceptorship and clinical teaching is vital, therefore, in enabling nursing and midwifery students to develop skills and knowledge (Jackson & Mannix, 2001; Begley, 2001a; 2001b; 2002; Lee, Cholowski & Williams 2002; Thompson, 2002; Lambert & Glacken, 2003; Clarke et al., 2003; Burns & Paterson, 2005; Tabari Khomeiran et al., 2006). The positive or negative attributes of preceptors can have an influence on both students' learning and self-esteem development (Gray & Smith, 2000; Randle, 2001; Begley 2002; Papp et al., 2003).

Preceptors identified in the literature as supportive and helpful show interest in the student (Jackson & Mannix, 2001; Gray & Smith, 2000), have good interpersonal skills (Warren, 1996; Gray & Smith, 2000; Jackson & Mannix, 2001; Lee et al., 2002), are positive professional role models (Warren, 1996; Gray & Smith, 2000; Lee et al., 2002; Donaldson & Carter, 2005), involve the student in clinical learning activities (Warren, 1996; Gray & Smith, 2000), are realistic about expectations of students (Gray & Smith, 2000), and provide explanations about care (Jackson & Mannix, 2001). Furthermore, research findings demonstrate that students appreciate being preceptored by a clinician who values the student as member of the health care team (Begley, 2002; Papp et al., 2003; Edwards et al., 2004) and empowers them by promoting confidence and self-esteem (Randle, 2001; Edwards et al., 2004). Students also appreciate being provided with opportunities for diverse learning experiences (Edwards et al., 2004; Donaldson & Carter, 2004).

Jones and Wylie (2008) conducted focus groups of second and third year midwifery students from two UK universities and identified the factors that were considered stressful within their courses. The students identified feeling ignored and isolated by mentors, conflicts about non-evidence based practice, intimidation and bullying and lack of consistency of mentorship as stressful for their learning. Many other studies of midwifery and nursing students have identified both unhelpful preceptors and unhelpful preceptor behaviours which influence negatively upon students learning. Unhelpful preceptors excluded or ignored students (Jackson & Mannix, 2001), delegated unwanted jobs to the student (Gray & Smith, 2000), bullied or intimidated students (Randle, 2001), verbally abused students (Lash, Kulakac, Buldukoglu & Kukulu, 2006) and communicated poorly (Jackson & Mannix). Unhelpful preceptors lacked knowledge and expertise, had poor teaching skills (Gray & Smith, 2000) and showed a general lack of support by being unfriendly and unapproachable (Gray & Smith, 2000; Begley, 2002). Gray and Smith (2000) found that it is not uncommon for students to work with unhelpful preceptors - nine out of ten nursing students interviewed in their study worked with nurses whom they identified as "poor mentors" (p.1546).

Begley (2001a; 2001b; 2002) similarly found the majority of midwifery students' experiences working with midwife preceptors to be negative. Begley's (2001a; 2001b; 2002) phenomenological study exploring the clinical learning experiences of all 125 postgraduate student midwives in Ireland identified a hierarchical system and a lack of care shown to students by most senior midwives. The clinical situation was described by students as unwelcoming and they experienced rudeness and belittling from their preceptors which lead to lack of confidence, conflicts about role responsibilities and fear of doing the wrong thing. Despite this lack of support all students progressed through the course to graduation (Begley, 2001a; 2001b; 2002), which raises the question: How much better prepared for practice the students would have been if they had the opportunity to learn in a more supportive environment?

A more recent qualitative study of midwifery students by Seibold (2005) explored the first cohort (20 students) of Bachelor of Midwifery students' experiences and expectations. These students identified helpful mentors as those who provided debriefing and had the ability to offer appropriate guidance as needed. Less helpful

mentors were identified as those who did not understand the requirements of the university, nor provided adequate support (Seibold, 2005).

As the preceptorship relationship is significant to students' learning, some authors have suggested strategies to improve role modelling by preceptors. Thompson (2002) suggests that ethical teaching is required for effective role modelling with midwifery students. 'Ethical teaching' is described by Thompson as role modelling critical reflection to students, the aim being to assist students to put ethical thought into practice. Thompson also suggests that competent role models practice reflectively themselves and act as the "guardians of safe, respectful [and] competent midwifery care" (Thompson, 2002 p.259). Vedam, Goff & Marnin (2007) further suggested that students need preceptoring by midwives who role model autonomous midwifery practice and who work outside of hospital settings.

The NMC (2008) developed standards for mentors, practice teachers and teachers. These standards have been applied since 2007, with the intention to support midwifery students' learning in practice. The standards outline mentor, practice teachers and teacher definitions, responsibilities and competencies. According to the NMC (2008) mentors are primarily employed to provide care for women and are also required to supervise super-numerary midwifery students, either directly or indirectly, for at least 40% of their clinical time. They can, according to their professional judgement, determine when students can be safely delegated tasks and the level of supervision required. According to this definition, mentors are similar to 'preceptors' in this study. The NMC (2008) standards stipulate that mentors are a "mandatory requirement for pre-registration nursing and midwifery students" (p. 19) and need to "have successfully completed an NMC approved mentor preparation program" (p. 19). These programs are a minimum of 10 days and the setting is both academic and practicum.

UK mentorship has been shown to benefit students in terms of assessment, providing learning opportunities and continuity of preceptorship (Myall, Levett-Jones & Lathlean, 2008). Myall et al. (2008) found that 76% of nursing students worked three out of five shifts with their mentor and 87% of students reported having a good relationship with their mentor. The majority of students said that their mentors facilitated learning

experiences, provided constructive feedback and were good role models. The mentors themselves felt that, despite increasing their workload, it was a rewarding and satisfying experience mentoring students. They enjoyed sharing knowledge and learning from the students and felt a sense of pride in their mentee's development. They were, however, frustrated by staff shortages and lack of support from the university (Myall et al., 2008).

Student Competency Assessment

Issues of student competency assessment have been raised in a number of studies. The general challenges inherent in assessing student nurses and midwives have been debated, with concerns raised that the methods of assessment are subjective (Priest & Roberts, 1998; Bradshaw, 1997; Fraser, 2000a; Watson et al., 2002; Calman, Watson, Norman, Redfern & Murrells, 2002; Dolan, 2003; McMullan et al., 2003; Hand, 2006) and lack consistency (Bradshaw, 1997; Fraser, 2000a; 2000b; Watson, 2002; Hand, 2006). Furthermore, the unproven reliability and validity of competency assessment methods have been exposed (Priest & Roberts, 1998; Fraser, 2000a; 2000b; Watkins, 2000; Watson et al., 2002; Hand, 2006). Such challenges compound the lack of consensus about acceptable levels of competency for beginning practice (Watkins, 2000; Watson, et al., 2002) and lack of understanding about what competency actually entails (Bradshaw, 1997; Girot, 2000; Watson et al., 2002, Cowan et al., 2005; Clinton, Murrells & Robinson, 2005).

Nursing and midwifery students have traditionally been assessed on their ability to perform skills or tasks (Fearon, 1998), reflecting an arguably out-dated behaviourist conceptualisation of competency. A holistic conceptualisation is more appropriate, yet additional challenges have been identified in assessing nurse/midwife student competency from a holistic perspective. For example, Chapman (1999) argued that assessors find traditional nursing assessments - which evaluate how a student performs specific skills - easier than documenting the students' behaviour towards the client and their attitudes, yet acknowledged they were subject to assessor bias.

The lack of confidence in competency-based assessment (Fraser, 2000b; Calman et al., 2002) raises concerns about the reliability and validity of competency assessment methods (Watson et al., 2002; Calman et al., 2002). Difficulties include the ability of

assessors to objectively measure qualities such as attitudes, behaviours, interpersonal skills and communication (Chapman, 1999; Calman et al., 2002; Cowan et al., 2005). Furthermore, evidence suggests that assessors do not adequately understand assessment documentation and have insufficient preparation time and/or commitment to ensure reliable assessment of student competency (Calman et al., 2002; Dolan, 2003).

Dolan (2003) further found that poor continuity between student and assessor reduced the reliability of competency assessments. Fraser's (2000a) action research study found assessors were not confident in the assessment process and, for some assessors, reluctant to fail students. Poor continuity of preceptorship, and assessment by assessors lacking critical assessment skills, contributed to the universities' decision to give students the "benefit of the doubt" (Fraser, 2000a p.289) rather than failing them. However the decision may have been the best course of action taken by these universities given the general challenges and complexities of assessing student competency and the suggestion that direct entry midwifery students' were vulnerable to bias from assessors (Fleming et al., 2002). Girot (1993), while acknowledging the challenges of assessing attitudes, advised that assessors should exercise caution when using intuition as an assessment method because of its unproven reliability and subjective nature.

The ACU Bachelor of Midwifery curriculum uses a multi-method approach to competency assessment where both the student and assessor rate student competency according to professional competency standards, using a rating scale. Students reflect on how they met competency standards and record specific skills/experiences as a requirement for course completion and registration (ACU 2005b; ACU, 2006; ACU, 2007; ACU 2008).

A multi-method approach, using assessment tools with scales to assess sequential stages of competency (Benner, 2001), together with holistic methods such as continuous assessment and reflective practice, have been adopted by institutions in the UK to measure competency development in both nursing and midwifery students (Watkins, 2000; Redfern et al., 2002; Clinton et al., 2005; Hand, 2006). A detailed analysis of tools which have been tested for measuring competency for nursing and midwifery

students is provided in Appendix O. In summary, these tools have been tested as reliable however they are limited due to their quantitative nature. Further strategies, including adequate training and support of assessors and student self-ratings of competency, have been proposed to improve fairness and accuracy of assessments overall (Watkins, 2000; Norman et al., 2002; Redfern et al., 2002).

Gonczi (1994) also suggests the use of a combination of assessment methods is holistic and therefore a more reliable method of assessing competency. Gonczi (1994) explored competency assessments using case studies from Australian legal and medical professions to outline the comprehensive way in which these professions assess competency. Gonczi illustrated how the legal profession used written data, simulation, a mock file and review by peers and specialist medicine used eight methods comprising case commentaries, a three-hour multiple choice questionnaire, clinical interpretation test, computerized case studies, physical examination, diagnostic interview and case management viva as well as practice assessment. Despite such comprehensive methods assessing attitudinal components of competency remained difficult to quantify and Gonczi (1994) suggested competencies were just “inferred beyond a reasonable doubt” (p.32).

A (1993) study by Girot suggested that although a combination of assessment techniques were used by UK nurses to assess students, the majority (nine out of ten) said they relied on intuition to determine student competency, particularly for more subtle, attitudinal qualities. A reliable method for specifically assessing attitudinal aspects of competency was therefore not established.

Given that the multi-method approach to competency assessment has been suggested as helpful to measure attitudes (McMullan et al., 2003; Dolan, 2003; Meretoja et al., 2004; Clinton et al., 2005), assessors could use a range of techniques to gather evidence of student competency over and above tools that use that use rating or binary scales. Students' reflections have been suggested as one such technique (Hand, 2006). The reflective process has been described as an enlightening and empowering process, important for knowledge development and professional and personal growth (Johns 1995). Heath (1998) explains the benefits of reflection as exploration of knowledge that

has evolved within practice, enabling the student to examine decisions. Considering reflection is useful to highlight professional growth, using students' reflections to assess competency has the potential to expose students' attitudes and decision making processes. Reflection has therefore been suggested as useful for student assessment (Calman et al., 2002) despite claims of a lack of supportive evidence about reliability and validity (Burton, 2000).

Questions about the reliability of using student reflections to assess competency relate to the difficulties inherent in the reflective process. These difficulties include lack of time, inadequate reflective skills (Heath, 1998; Burton, 2000), inaccurate recall, lack of preparation of practitioners facilitating the reflective process, psychological distress and a general unwillingness to write reflections in journals (Burton, 2000). Furthermore, for the reflective process to be successful maturity, open-mindedness, critical analysis and self-awareness are required (Burton, 2000). Reflection may be a potentially valuable learning tool, yet its application for student competency assessment is limited until reliability is established.

A number of recommendations about how to support assessors and students to improve competency assessments have been identified by previous researchers. Several authors advised that universities should thoroughly prepare practice assessors, via preparatory courses, to avoid misunderstandings that potentially lead to inadequate competency assessments (Calman et al., 2002; Dolan 2003; Seldomridge & Walsh, 2006) or reluctance to fail students (Redfern et al., 2002). Others recommend preparing students for the competency assessment processes, particularly skills in gathering evidence, time management and keeping an assessment portfolio (Calman et al., 2002; Dolan 2003). Provision of clear competency statements and expectations of students was also highlighted as necessary (Calman et al., 2002; Dolan, 2003; Seldomridge & Walsh, 2006), as was adequate clinical support and feedback for students (Calman et al., 2002; Hand, 2006) and regular and constant supervision during clinical placements (Seldomridge & Walsh, 2006; Hand, 2006).

Reliability of assessments is increased when competency assessments are integrated and specific (Gonczi, 1994). Assessment methods should evaluate knowledge,

understanding, problem solving, technical skills, attitudes and ethics, and be direct and relevant to what is being assessed (Gonczi, 1994). Effective competency-based assessment requires a holistic framework which avoids using reductionist or behaviourist measurement approaches (Kerka, 1998; Clinton et al., 2005). A combination of assessment methods which test their ability to perform tasks as well as demonstrate the appropriate attitudes and behaviours (Fearon, 1998; Norman et al., 2002) is therefore required to allow students to demonstrate their competency.

Combined assessment methods which draw on reflective portfolios, and competency tools that allow student self-assessment compared with assessor ratings, can be used to improve reliability of competency assessments (McMullan et al., 2003). Assessment during real life situations, simulated conditions and patient assessments can all increase confidence in student's competency (Norman et al., 2002). Adequate support and preparation for assessors and students is essential, so principles of competency assessment should be clearly conveyed to students and adequate time allocated for evidence gathering and portfolio maintenance. Competency assessment is a significant issue for students and assessors alike, yet there is the opportunity to create a more consistent and fair measurement of student competency by drawing on the suggestions above.

A collaborative relationship, with links between the clinical practice environment and the university, are identified in several studies as important elements in facilitating students' learning and assessment (Papp, Markkanen & Von Borsdoff, 2003; Seibold, 2005). Highlighting the importance of a supportive environment for students (Watkins, 2000; Burns & Paterson, 2005), a supportive environment has been defined as one which conveys an attitude of respect towards students (Warren, 1996; Begley, 2001a; 2001b; 2002), nurtures students (Warren, 1996; Papp et al., 2003) and empowers them. Research has also found that student self-esteem and confidence is promoted in a supportive environment (Randle, 2001; Edwards, Smith, Courtney, Finlayson & Chapman, 2004) and good inter-personal relationships between preceptors and students essential to ensure students feel supported (Warren, 1996; Begley, 2001a; 2001b; 2002). Students' development of competency, particularly during clinical placement, is therefore strongly influenced by the student-preceptor relationship.

In summary, this review of the literature pertaining to both student nurse and midwife competency suggests the application of competency-based education principles and student assessment is influenced by the conceptualisation of competency. It is therefore suggested that a holistic conceptualisation of competency inform curricula to ensure confident and capable graduates. Behaviourist conceptualisations, on the other hand, are arguably out-dated and reductionist, and have poor expectations of students' intellectual capacity and critical analysis skills. Furthermore, they arguably pay little attention to the caring aspects of the nursing and midwifery role.

Competency assessments of nursing and midwifery students remain problematic, in terms of assessor subjectivity, difficulties inherent in assessing attitudes, and the only reliable assessment tools being quantitative in nature. Researchers have noted these difficulties which, when combined with a lack preparation of assessors, poor continuity with students, and time pressures, can result in a reduction in assessor's confidence in competency assessments and poor quality assessments. Further research is required to explore reliable methods of assessing competency from a holistic perspective, particularly since holistic competency standards are being used to inform midwifery curricula. In the meantime the most appropriate methodology is a multi-method approach as has been used in the UK and in the Australian Bachelor of Midwifery.

A positive learning environment is described as one which provides students with links between theory and practice, support and nurturing, positive role models, empowerment and good relationships with preceptors. Furthermore, a supportive student-preceptor relationship provides an ideal learning situation for midwifery students. Student midwives prefer to work with preceptors who are good role models, are supportive of them and value them as a part of the team. On the other hand, negative preceptor behaviours have been shown to negatively influence student midwives' learning experience.

This review of literature has highlighted the challenges and identified recommendations relating to competency education methods, assessment of competency and support in the clinical environment for student midwives, yet some questions remain unexplored. The methodology described in the next chapter provides a framework to explore the

complexities of the individual student's perspectives, experiences and social interactions in the context of the broader social situation, relevant actors and discourse – with the aim of addressing the questions of how and when Australian Bachelor of Midwifery students achieve competency for beginning practice.

Chapter Three

METHODOLOGY

This chapter describes the methodology chosen for this study of third year Bachelor of Midwifery students' achievement of competency. It is divided into two sections. The first section describes and justifies the chosen methodology – a contemporary approach to grounded theory as articulated by Adele Clarke (2005). The second section describes the methods and techniques used for data collection and analysis, as well as ethical issues. Finally, there is a discussion of researcher reflexivity.

In order to identify the research methodology for this study I was guided by Crotty's (1998) description of the four elements of the research process. Crotty (1998) defined *methods* as the procedures used to gather and analyse data; *methodology* as the strategy or plan of action or process underlying the chosen methods and linking them to the desired outcome; *theoretical perspective* as the philosophical stance informing the methodology which is linked to the epistemology; and *epistemology* as "an attempt to explain how we know what we know" (p.18). My epistemological stance is explained first, followed by the methodology, including its underpinning theories.

Constructionism as Epistemology

Constructionism underpins a number of qualitative research approaches. Unlike post-positivist assumptions that underpin most quantitative research, constructionist assumptions presume that truth is relative and subject to individual interpretation. It is believed that humans construct their world and make sense of experiences during interactions within it (Charmaz, 2000; Crotty, 1998). It is therefore believed that truth is relative and meaning is flexible and subject to change depending on the individual human social experience (Charmaz, 2000; Crotty, 1998; Schwandt, 2000).

Constructionism, as an epistemological perspective, also presumes that people are born into a culture which has already constructed meaning about the world, including its objects and symbols. These meanings are imparted to each human as they interact

within their world (Crotty, 1998; Schwandt, 2000). The human understanding of meaning is, therefore, shaped by socio-cultural influences that manipulate behaviour, experience and thinking (Crotty, 1998). This means that human beliefs about their world are both historically and culturally located (Burr, 1995).

The constructionist stance taken in this study was considered an “invitation for reinterpretation” (Crotty, 1998 p.51) of truth. The participant’s (student’s) ‘truth’ was therefore considered to be relative and constructed by the individual students, depending on how they saw their situation (Crotty, 1998; Schwandt, 2000). Fundamentally, these constructionist assumptions highlighted and validated the unique nature of the students’ reality and, in this study, I had a genuine intention to respect and represent each of the students’ unique experience. Furthermore, I accepted that the Bachelor of Midwifery students in this study would not be immune to the influences of how midwifery was practiced in the specific learning environment in Victoria, Australia. I expected that they would be influenced by preconceived cultural and social understandings as well as the ‘norms’ of both the role of the midwife and the role of a student. Despite this, I began the research recognizing the students’ unique and valuable constructions of meaning and beliefs as shaped by their interactions within the social and cultural situations they encountered during the university and their clinical experiences. Constructionism fits with grounded theory methodology because this methodology aims to understand individual human experience and the social processes involved in that experience.

Grounded Theory as Methodology

Grounded theory methodology was developed by sociologists Barney Glaser and Anslem Strauss (1967). Grounded theory was chosen as the methodology for this study partly because of its practical approach to understanding the human social experience through inductive, systematic and rigorous data analysis techniques (Strauss, 1987) and partly because it allowed theoretical flexibility.

Grounded theory is an inductive research process that allows the findings to arise from the data. The founders of grounded theory proposed that this qualitative method develop (substantive) theory of social action – firmly grounded within research participants’ data

(Glaser & Strauss, 1967). Originally, an integral part of the grounded theory process was that researchers avoided making preconceived assumptions by either researching previous theories or making hypotheses, because these activities are seen to be an influence on the findings (Glaser & Strauss, 1967). Many contemporary grounded theorists, however, clearly acknowledge their preconceptions. In fact, it is considered inevitable that researchers will have some preconceptions about the research area, the sources of which are previous research or a connection to the field of study (Clarke, 2005). It is now accepted that researchers use reflexivity to expose and explore researcher preconceptions (Clarke, 2005; Charmaz, 2006), which only adds to the rigour of the methodology. This was the case in this study as my connection to the field of research was my previous experience as a midwife and midwife academic teaching the Bachelor of Midwifery students.

Grounded theory uses certain approaches to data collection and analysis which are said to increase the rigour of the research process for qualitative researchers (Glaser & Strauss, 1967). For instance, data collection and analysis occur simultaneously to allow the researcher to identify theoretical questions whilst they are still in the field and able to explore them. Furthermore, the coding processes, theoretical sampling processes and contemporaneous memoing, or recording of thoughts during the research process (Glaser & Strauss, 1967; Strauss, 1987) also contribute to grounded theory's reliability as a qualitative research methodology. How I implemented these processes are discussed in detail in the data collection and analysis sections of this chapter.

One of the major debates by grounded theorists relates to the theoretical and epistemological underpinnings of the methodology. Originally Glaser and Strauss (1967) said their intention was for grounded theory to be theoretically flexible for researchers. In fact, the founders themselves came from opposing theoretical perspectives or paradigms. Strauss resided at the University of Chicago, where the sociological theory of symbolic interactionism (discussed later in this chapter) evolved, whereas Glaser had a predominantly positivist background. Glaser (2007) has consistently argued that grounded theory has no inherent theoretical perspective. Furthermore, he rejects the notion that researchers need identify a theoretical perspective as underpinning their approach. Strauss' methodology was, on the other

hand, obviously informed by the theoretical perspective of symbolic interactionism (Clarke, 2005; Strauss & Corbin, 1998). Glaser and Strauss' divergence of opinion is a great example of the flexibility of grounded theory in that the theoretical perspective can be either identified upfront, during the research process, or not be identified at all.

Nonetheless this debate has, over time, contributed to a division in the interpretation and application of the methodology. Generally, grounded theory researchers put themselves in either camp, and most clarify their methodologies as informed by 'Straussarean' or 'Glasarean' approaches. Glasarean grounded theory is often said to be informed by a post-positivist perspective whereas Straussarean grounded theory is clearly constructionist and informed by symbolic interactionism. It is not within the scope of this thesis to delve more deeply into this debate, except to acknowledge that my approach to grounded theory was influenced by Strauss' perspectives and furthered by contemporary grounded theorists' approaches, such as that of Clarke (2005) and Charmaz (2006).

Clarke (2005) and Charmaz (2006) have clearly identified symbolic interactionism as the theory underpinning their approach to grounded theory and constructionism as the epistemology embedded in symbolic interactionism. Furthermore, Clarke (2005), whose approach has significantly informed the research methodology for this study, situates herself as postmodernist, largely informed by the post-structuralist theories of Michel Foucault (Clarke, 2005), discussed later in this chapter. Firstly, however, it is important to explore the theoretical perspective of symbolic interactionism and the way that it has informed the methodology of this study.

Symbolic Interactionism

Symbolic interactionism is generally understood to have been historically and philosophically linked to American pragmatism. This is because George Herbert Mead, Dewey and Peirce, who were the major contributors to this theoretical perspective, were considered American pragmatists (Shalin, 1991). According to Shalin (1991), in short, American pragmatists challenged the notions of 'rationalist scientists' (or mechanical, non-participant observers of phenomenon) who believed there was a natural order in the world which was waiting to be discovered by them. Amongst other things the

pragmatists emphasised the role of individual human action in society and, therefore, the order of the world. They also emphasised the recognition of the inter-linkage between the human mind and the physical aspects of human life (Shalin, 1991). Symbolic interactionism was therefore proposed as a theory of human social life and conduct (Blumer, 1969 p.1). The theoretical perspective was based on the pragmatists' four basic assumptions about human behaviour:

- a. Reality is created as people exist in the world; there is no 'true' reality because reality is subject to individual interpretation.
- b. People accept information and therefore base their knowledge on what works for them and they disregard knowledge which is not useful.
- c. People define things in their world according to the use they have at the time.
- d. If we want to understand human behaviour we need to focus on what they do (Charon, 2000 pp. 29-30).

Although the original contributors to symbolic interactionism were said to be the American pragmatists affiliated with the University of Chicago (Mead, Dewey and Pierce), Blumer was a student of Mead's who later clarified the theories and further advanced symbolic interactionism as a sociological theory (Charon, 2000; Strauss, 1987). According to Blumer (1969), Mead's theories were most influential on the theoretical perspective of symbolic interactionism, particularly the theories about action, society and the mind. It is evident from Mead's (1934) writings that he felt that meaning emerges from the interaction between self and society. He suggested that the self, as well as the mind, emerges from a social process. Furthermore, he suggested that the concept of self is interpreted within social interactions, through self awareness as well as interpretation of the reactions of others (Mead, 1934).

Blumer (1969) coined the phrase 'symbolic interactionism' and therefore defined the theoretical perspective. He further clarified some fundamental assumptions about human action and interpretation of meaning, when he explained:

Human beings act towards things on the basis of the meaning that things have for them, the meanings of such things is derived from or arises out of social interactions with one's fellows, the meanings are handled in, and modified through an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969 p.2).

Blumer (1969) described the following six basic ideas which represent the way symbolic interactionists view human behaviour:

- a. Human society exists in action and this action is the starting point for analysis of society.
- b. Social interaction is significant as the process which forms individual and group behaviour.
- c. Human interaction occurs through non-symbolic and symbolic interaction.
- d. Social worlds are composed of objects (actors/actions) which are the products of symbolic interaction and each person's world has its own objects (actors/actions) which may or may not be shared with other people.
- e. Humans interpret their worlds and construct their actions based on symbolic interactions, both individually and collectively.
- f. Joint action is an inter-linkage of the separate acts of the participants within social groups.

In this study the theories of symbolic interactionism encouraged me to focus on the nature of social interaction and the social activities taking place within the students' social world. The focus of the analysis was therefore on students' interactions with others as well as their own internal thought processes. The focus was also upon the students' responses to the interactions in their world, which arose out of their interpretation of 'symbols'.

According to Blumer (1969), there are two forms of social interactions; the "conversation of gestures" (p. 8-9) and "use of significant symbols" (p.8-9) which were later re-named "non-symbolic interactions" and "symbolic interactions" (Blumer, 1969 pp 8-9). A non-symbolic interaction has been defined as kind of reflex response and symbolic interaction as a response to another's actions after an interpretation of meaning (Blumer, 1969). These social interactions and responses rely on the use of symbols, which are social objects used to represent whatever the user understands them to be (Charon, 2000). The human's individual sense of meaning is interpreted through an understanding of symbols (Charon, 2000 p.46-47). In this sense, symbols have been defined as social, meaningful and significant objects or acts used for social communication (Charon, 2000). Some examples of social symbols noted in this study

included smiling, frowning, eye contact, non-eye contact, hand gestures that represented scissors, and stroking. Language was another socio-cultural symbol observed in this study, both in verbal and written form.

According to Charon (2000), language allows humans to understand symbols. For example, verbal language is a powerful, immediate communication that is laden with socio-cultural symbols which are subject to interpretation. Written language has the potential to influence future generations through stories, the writing of texts and research papers. With respect to the power of language, I acknowledge that this study has the potential for influence over human action because it documents the students' stories. It therefore potentially harnesses the power of both verbal and written language. Furthermore, during the research process I was mindful of the influence of language on the students' development of their competency. I was aware that the students in this study learnt to become midwives via verbal and written language which was specific to the socio-cultural world they were operating within. The language assisted the students to construct and interpret their world and influenced how they did so (Charon, 2000). Analysis of language is also a significant feature of poststructuralism, which is another of the theoretical perspectives underpinning the methodology.

Poststructuralism

The poststructuralist theorist on whom Clarke (2005) (and therefore this research) particularly draws upon is Michel Foucault. While there is considerable debate as to what constitutes poststructural theory (Bordo, 1993), Michel Foucault's later work has been termed poststructural and as contributing to postmodernism (Bordo, 1993 p.38).

Postmodernism can be said to be informed by a number of social theorists (as well as Foucault) and yet it is possible to identify a number of unifying themes. In philosophical and sociological terms postmodernism rejects grand theories or projects of enlightenment (central to theories of modernism) such as Marxism. Postmodernism therefore throws into doubt objective and rational concepts of knowledge and truth, questions the enlightenment view of the human subject as rational, centred and purposive, and views subjectivity or self identity as a discursive construction (Bordo, 1993 pp.40-41; Barrett, 1992 pp.206-208). The poststructuralist movement is, as with

postmodernism, rooted in beliefs of plurality of meaning and subjectivity of interpretation.

It appears that Foucault's intellectual influences were phenomenologist Martin Heidegger, science philosopher Georges Canguilhem, philosopher Friedrich Nietzsche as well as structuralist, psychoanalytical theories and enlightenment theory (Danaher et al., 2000). Foucault's work consists of the early archaeological phase where he developed his theory of discourse and his later genealogical phase where he developed a theory of power/knowledge, with overlap between the two phases (Phillips & Jorgensen, 2002). In order to understand the theories of Michel Foucault a number of texts were explored. His seminal (germinal) writings were studied along with Danaher et al. (2003) and Clarke's (2005) interpretations of Foucault's theories.

Foucault's theories relevant to this thesis are those concerning discourse and power/knowledge. Foucault (1972) argued that discourse acts by influencing people within a historically constructed society; that discourse creates action by communicating a 'truth' that evolves from a set of internal rules, which may or may not be obvious to the person. He also argued that discourse acts by both influencing the construction of people's sense of self as well as influencing their actions which are motivated through and within the dominant discourse (Foucault, 1972).

Clarke (2005), drawing on Foucault, describes discourse as:

communication of any kind around/about/on a particularly socially or culturally recognizable theme — contemporary and/or historical. Discourse includes "word choice, arguments, warrants, claims, motives, and other purposeful, persuasive features of language, visuals and various artifacts"; discourse frames debates, influences perceptions, and creates objects of knowledge (p.148).

Discourse therefore essentially works by influencing human action by communicating rules and procedures which regulate behaviour and people's perceptions of truth. Morality and meaning are also constructed through discourse and discourse is the grounds for which people make sense of their world (Foucault, 1972). According to Foucault's (1972) theory of the discursive field, there are a number of competing discourses circulating within social institutions however certain discourses exert more power than others.

The relationships between discourse, power and knowledge were also explored by Foucault. He saw power as a fluid concept, dependent on dominant discourse and disciplining practices such as surveillance and punishment (Foucault, 1995). He explained that these practices are imparted by institutional systems, such as science and government, who authorise what is considered truth and normality (Foucault, 1995). This is particularly relevant to the situation of midwifery practice and education because related clinical practicum is mostly situated in hospitals which are arguably institutional systems governed by a dominant medical discourse.

Foucault therefore defines power as a circulating force; that is it enables people to do or achieve what they want as well as being used by institutions to get people to do what they want them to do (Foucault, 1995). Midwives in one sense exercise a degree of power as they adapt to work within the maternity care system and it can be assumed that student midwives would follow suit. The hospital or agency as an institution exercises power through requiring clinicians to act in certain ways, via 'disciplinary power' (Foucault, 1995). According to Foucault (1995), "all the mechanisms of power which, even today, are disposed around the abnormal individual, to brand him [her] and to alter him [her]" (p.199) and he therefore argued that there is regulation of people through surveillance by institutions and the punishment for deviant behaviour compels people to self regulate their behaviour and conform to 'normality'. This system essentially makes people both the subject of power and the facilitators of power (Foucault, 1995) as they are told what to do and do it to avoid punishments.

Foucault's theories challenge the notion that knowledge acquisition makes people more powerful. He supposed that people are not always empowered by gaining knowledge and, in fact, by gaining knowledge, people can become beholden to it as they "make sense of (them)selves by referring back to the various bodies of knowledge" (Danaher, 2003 p.50). It is almost as if they reinvent themselves through another discourse. This contention has attracted criticisms of his theory as it suggests that people have no agency, or choice, in their lives (McLaren, 2002).

These Foucauldian notions of agency reflect an influence from Freudian and Marxist theories (Danaher et al., 2003), who assert that the subject, or person, is constructed

within a social structure influenced by discourse, relations and institutions and dominated by social rules (Danaher et al., 2003 pp.122-123). However, Foucault (1995) also theorised that the subject is influenced by the social context they are operating in at the time and which can change at any time. This notion has some similarities to the symbolic interactionist perception of the self as socially influenced (Mead, 1934).

Some who have interpreted Foucault's theories, particularly feminist theorists, have argued that Foucault's early theories are fatalistic when it comes to the person's capacity for change, or agency, because they are "completely dominated and subject to power" (Danaher, 2003 p.4; McLaren, 2002) and perhaps this is because, as Foucault said, he "insisted too much on the technology of domination and power" (Foucault, Gutman, Hutton & Martin, 1988 n.p). It was not until his later seminars that Foucault explored the issue of agency in his seminars about the *Technologies of Domination and the Self* (Foucault et al., 1988 n.p). In these seminars Foucault theorised that people do not always remain as 'docile bodies', formed by the practices of discipline and discourse, but through particular self-examination practices, or 'technologies of the self' they can become active agents able to effect change in their lives. Foucault said:

Through these [self examination] practices which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity (and) wisdom... (Foucault et al., 1988 n.p)

Although people cannot escape the regulatory institutions and discourse within society, awareness of the influence of these as well as self awareness allows some potential for people's resistance and reinvention. I therefore saw the potential for resistance and agency for the midwifery students in this study.

Foucault's explorations of the social milieu led him to the conclusion that each social world has rules and procedures, roles and positions which regulate individual behaviours and language and produce hierarchies (Foucault, 1995; Danaher et al., 2003). This is very relevant for this study's methodology, particularly his theories about discourse. The application of Foucault's poststructuralist theories in this study exposed the discourses, surveillance and disciplining practices that dominate Australian midwifery practice and the Bachelor of Midwifery students' learning situation. As

other Australian researchers have argued, the medical gaze, via technologies and routine care, is the vehicle by which the Australian maternity system identifies deviance from normal and systematically disempowers Australian birthing women (Fahy, 2002; Sutton, 1996).

Surveillance of pregnancy and childbirth (by both individuals and institutions) and punishments for deviant behaviour compel women to self regulate their behaviour in order to conform (Foucault 1995). The inherent power of the medical gaze is only obvious when deviance is identified and/or resistance from the woman is met. In such situations obstetricians use rewards (i.e. safe, painless or assisted birth) or threaten punishments (i.e. death or damage to the baby or self) to achieve compliance from childbearing women (Fahy, 2002). Furthermore, the more physically vulnerable the woman becomes, the less able she is to subvert medical power (Fahy, 2002).

Surveillance of pregnancy and childbirth has been termed "Natal Panopticonism" (Terry, 1989 cited in Heckman, 1996), whereby healthy pregnant women are brought into hospitals for their pregnancy and births and are subjected to the "medical gaze" (Fahy, 2002 p.7). Using the term "medical gaze" (p.7), Fahy (2002) explains that women are subject to medical screening which is controlled by the medical institution and provides information that is interpreted by medicine and used to manipulate women's behaviour. I also considered that the students in this study were subject to surveillance, via assessments and their midwife preceptors, to identify 'failure' or deviance from normal. Disciplinary practices, via social exclusion or 'failure' of students, would then ensure that deviant students would modify behaviour to conform to expectations (Foucault, 1995).

There were also indications prior to data collection that language may be a significant construct to explore during this study. It has been argued that language around childbirth in Australia was heavily influenced by obstetric/medical terminology and that was disempowering of women (Cutts et al., 2003). The consortium of universities which developed the Bachelor of Midwifery made a conscious effort to move away from medical terminology (Cutts et al., 2003). The revolt against the use of disempowering language about the woman's body, baby or experience in midwifery curriculum was a

landmark change in the education of midwifery students in Australia (Cutts et al., 2003). Language was therefore a focus of analysis.

Foucault's theories also helped me to shift the analytical focus from the individual students to include the broader social world which they occupied (Danaher, et al, 2003; Clarke, 2005). Exploring the issues, behaviours and discourse within the broader social situation was assisted using grounded theory methodology, as guided by Adele Clarke's (2005) text: *Situational Analysis: Grounded theory After the Postmodern Turn*. The next section of this chapter describes the methods of data collection and analysis. Attention to ethical considerations and methodological rigour are also discussed.

Data Collection

The participants in this study were recruited from 2005-2008. They were purposively sampled from Bachelor of Midwifery students at Australian Catholic University who were enrolled in their final practice subject, *Preparing for Midwifery Practice*. With the intention that the participants would not feel coerced to participate in the study, an academic colleague informed the students of the study and advised them to contact me if they wanted to participate. Information letters and consent forms were provided to the students by my colleague, which were to be returned to me by mail. Copies of the information letter and consent form are provided in Appendix B.

The 2005 recruitment process yielded a minimal response; only two students consented to participate from a possible 13. Furthermore, both of the respondents were mature-aged students (who did not enter the course directly from secondary school). This lack of representation from secondary school leavers was noted at that time and addressed using the principles of theoretical sampling. Theoretical sampling is a grounded theory method which, according to Strauss (1967), is a process which aids the researcher to explore the theoretical questions arising during data collection and analysis.

Theoretical sampling assists identification of specific population groups, events or activities that will provide further data to assist with theory development (Strauss, 1987), as looking further afield provides rich data to nurture and strengthen a study.

Glaser and Strauss (1967) maintain that diversified sampling is an important strategy to ensure rich theoretical development of the theory, whereas sampling for verification risks limitation of the theory. With this in mind, I used theoretical sampling in an attempt to see if the experiences were different depending on the students' age or experiences prior to entering the course.

Theoretical sampling therefore stimulated me to include secondary school leavers in the study as well as to broaden data collection methods to include field observation (which is discussed later in this chapter). When the question arose as to whether the learning experience is the same for students who were non-school leavers as it is for secondary school leavers there was an identified need to include secondary school leavers in the study.

The ongoing recruitment process occurred over four years (2005-2008) with four separate cohorts of final year Bachelor of Midwifery students completing their final placement. Over the four years, 19 students from a pool of approximately 80 students participated in the study, therefore representing 25% of the students completing their studies. The participants were aged between 21 and 47 years at their first interview. All were English speaking. Two were born overseas and had English as a second language. All of the participants were women. Five of the students were secondary school leavers and fourteen were mature age. The number of participants was appropriate for a qualitative research study of this type (Charmaz, 2006).

Multiple methods of data collection were used with the intention to gather a large amount of rich data. Until 2007 the data collection methods included two interviews (one at the beginning and one at the completion of the students' final placement were conducted with the intention to allow two opportunities for students to discuss their experiences), students' reflective journals and competency assessment tools used by clinicians to assess students' achievement of competency. At the time that I upgraded from a Masters of Midwifery (research) to a PhD (in 2007) data collection was expanded to include field observation of the students during clinical placement.

Interviews

The interview questions were developed to allow an exploration of the students' unique experiences. Open-ended questions were chosen which would facilitate description and reflection by the participants and allow their story to unfold. Initially an interview schedule comprising four open ended questions was used. A copy of the interview schedule is provided in Appendix A.

During early data analysis (which occurred concurrently with data collection) theoretical questions arose and were noted on later interview schedules and were used as probes. The probes were used as prompts that guided the questions in the subsequent interviews. Earlier probes related to the student-preceptor relationship and qualities of helpful and unhelpful preceptors and the students' perceptions of competency for beginning practice. As analysis continued more probes were identified which were added to the interview schedule. These later probes related to the relationship between competency and confidence, the cycle of learning when students perceived they had made a mistake and the concept of 'playing midwife'.

To minimise the inconvenience of the interviews for the students, I was flexible about the interview location. I offered to travel to students' private home or the clinical agency to conduct the interviews if they did not want to come to ACU. At each of these locations the interviews were conducted in private. Apart from six students, whose interviews took place in an office at the clinical agency and one at her home, the interviews took place in my office at ACU. Throughout the interviews I tried to create an environment that was as relaxed and non-intimidating as possible: I sat facing the student and there was no furniture between us; we sat on chairs of the same height; I tried to maintain an open body language; and a sign was placed on the door requesting privacy. There were, however, a number of things that may have been intimidating: my role as their lecturer had the potential to influence the students' responses to the questions (which is further discussed later in this chapter); the interviews were taped, with the recorder was in full view of the students, which may have made them feel uncomfortable; during earlier interviews there were occasional interruptions from a telephone ringing in the office which was silenced during later interviews.

Prior to each interview consent was revisited. The student was given the option to decline to be interviewed and confidentiality was discussed. Before the interview began I had a few minutes of general conversation with the participants in order to put them at ease. I also discussed the ethical aspects of confidentiality and reassurances about handling of data, as well as the purpose of the study. At recruitment the participants were given a written letter explaining the study and were asked to complete a consent form at the first interview (See Appendix B). The students were assured that pseudonyms would be used.

Some students appeared to be nervous at the beginning of their interviews but all appeared relax as time passed. The average length of interview was approximately one hour and the maximum length was one hour and forty minutes. Interviews were conducted as an informal flexible conversation and deliberately followed the participants' leads as to where they wanted to take the interview. This approach assisted the participants to recount their own experiences and uncovered new leads to be investigated further with subsequent interviews as well as encouraging an open and in-depth investigation of the experience. Throughout the interviews I maintained a sensitive and attentive manner. I had set open ended questions which were used to guide the interview however, with careful listening, concentration and flexibility I explored and clarified participants' descriptions of their experiences as they arose. The students appeared open and were quite frank during the interviews, which provided rich data for the study.

On occasion, after the interview was formally finished and recording stopped, I found myself re-commencing recording as some participants' continued to talk about their experiences, implying they had a lot more to say about this topic. Some positive feedback in relation to the non-hierarchical interview style was received after the interview from the participants; as one stated: "That wasn't an interview, it was a chat!" With further probing about my dual role as the interviewer and a teacher at the university, she [the participant] replied that she "trusted" me, because had been "taught" by me and that she could "relax" because she would have felt more "nervous" if the interview was conducted by someone else. I believe that my attitude of respect for the

students' views and experiences, together with flexibility during the interviews, allowed deep insight into their individual experiences.

Students' Documents

The student documents analysed during the study were their reflective journals and final competency assessment tools. The students were asked to keep a reflective journal throughout their final placement as part of the study. They were instructed to reflect on incidents that they felt were critical to their learning. The intention was that the reflective journals would be an opportunity for the students to share experiences that may not be expressed at interview due to shame, fear of failure or they had simply forgotten (Charmaz, 2006).

The participants were given a brief explanation of reflective writing. Critical reflection was already emphasised in the curriculum and was a component of the competency standards used to assess the students. A level of knowledge and experience of reflective writing was therefore presumed. I also presumed that they would be keeping a reflective journal during placement as a requirement of their final subject. The students were also provided with a model which they could use for their reflections; they were provided with a copy of the 'Gibbs Reflective Cycle' (Burns & Bulman, 2000) (See Appendix D).

One disadvantage of reflective journals as data is that they rely on the participant's motivation for writing their thoughts down (Burton, 2000). Unfortunately, there was a low return rate of the reflective journals; only 25% of students supplied a journal and most of these journals had minimal entries. I asked the students why they did not provide their reflective journal and most of them said that they did not have the time to write or they would prefer to verbally reflect on incidents during interviews. One participant was provided with a tape recorder at her request to record her journal entries.

Another data source was the students' final competency assessment tools (copies of the tools are provided in Appendix H). These tools documented the students' learning objectives and evidence for achievement of each of the ACM/ANMC competency standards for midwives. The students had a summative and formative assessment by

their clinical teacher or a midwife. The students' competency was rated according to a scale informed by the work of Benner and Bondy (ACU, 2005b; ACU, 2006; ACU, 2007; ACU, 2008). The scale rated students from 'independent' to 'unsatisfactory' and they had to achieve an 'independent' rating in order to pass (ACU, 2005b; ACU, 2006; ACU, 2007; ACU, 2008). The assessors also made comments about the students' competency on the tools. During analysis the students' self ratings of their competency were compared to the clinical educators' ratings and the students' learning objectives and assessor comments were examined.

Field Observation.

Observation of the students during their final placement was another source of data in this study. The decision to include observational data was made after theoretical questions relating to students' learning environment and interactions arose during the interviews, such as those relating to the interactions between students and their preceptors and aspects of the environment that influenced students' learning. For example, a number of students expressed concerns about the impact of preceptors' negative behaviours as well as medical dominance in the clinical environment on their learning experience. I decided that these theoretical questions were best explored by observing the students' learning environment first hand. Observation was an ideal process to do this because it allows exploration of social situations as they occur rather than recollections of situations given by participants during interview (Burgess, 1984).

Observation was conducted using the principles of naturalistic inquiry. During naturalistic inquiry, unlike observational techniques where the researcher aims to not interact in the environment, I worked to establish and sustain appropriate relationships with participants and other actors in their social world, whilst they were being studied in their natural environment (Lofland, Snow, Anderson & Lofland, 2006). During observation I observed and listened to social interactions. I also asked questions, similar to an interviewing process. In accordance with an ethical approach to observation my role as researcher/observer was made obvious to the people within the situation (Lofland et al., 2006). Although I had a dual role as observer and participant in

students' learning, as an academic from the same university as the student participants, I made it clearly known that my role was as a researcher whilst I was in the field.

Some limitations to observation as a data collection method were considered. One major issue is that the researcher's presence in the situation affects the actions of the researched. Some have argued, however that those being observed will, with time and appropriate action on the part of the researcher, continue with their natural actions (Burgess, 1984; Schatzman & Strauss, 1973). Furthermore, Schatzman & Strauss (1973) propose that people who work in a situation for a length of time lose sensitivity to common, recurrent experiences. The observer's presence therefore is eventually seen as no threat. They will then become normalized in the environment and life and work will go on as it did before.

Certain recommendations by Schatzman and Strauss (1973) were applied with the hope that I had minimal influence on the situation whilst I was observing the student's social situation and interactions. Firstly, I acknowledged that due to my presence, the field would be altered. Secondly, I tried to act socially appropriately or "humanly" (Schatzman & Strauss, 1973 p. 64) in the situation. I asked questions, explored questions, raised issues, used humour and took notes openly at times. I believed that these tactics helped me to more quickly become "a group member" (p. 64) and therefore my presence would be normalised.

Site Details

The specific site was chosen for observation because a large number of the Bachelor of Midwifery students in the study completed their final clinical placement there. 'The Hospital' (pseudonym used for confidentiality) is a women's health and maternity hospital which cares for approximately 30,000 women per year. It provides privately and publicly funded care to women throughout the childbearing continuum and as well as women experiencing gynaecological disorders. The Hospital averages around 5,800 births per year (The Hospital, 2008; Australian Catholic University, 2009). The birth suites were where the participant observation was carried out, however The Hospital also has a 62 bed Neonatal Intensive Care Unit and Special Care Nursery and a four bed High Dependency Unit. It is considered a tertiary centre and cares for women

experiencing both uncomplicated pregnancies and complex pregnancies and receives transfers of women and/or babies from other hospitals who require complex management (The Hospital, 2008; Australian Catholic University, 2009).

The Hospital caters for women of varied demographic and ethnic backgrounds. There are interpreter services and specialised multicultural clinics as well as Aboriginal and Torres Strait Islander and African liaison services. It is also a teaching hospital affiliated with the University of Melbourne and La Trobe University (Melbourne). It teaches specialist obstetrics, gynaecology, gynaecological oncology, neonatology and anaesthetics as well as midwifery and nursing (The Hospital, 2008).

Ethical approval for field observation was granted by the hospital's ethics committee as well as the ACU Human Research Ethics Committee. Students attending the hospital for their final placement were invited directly to be included in the research and five students consented to participate. They were observed while practicing in the Family Birth Centre, Birth Suite and Special Care Nursery between October and December 2007 and 2008 for a total of 48 hours. Each student was observed for a maximum of four hours, on a maximum of three occasions. The observations were staggered throughout the final placement, therefore occurring at different times for each student.

The broad focus of field observation was on areas identified during interview data analysis. Unlike other field observation methods, a checklist of specific behaviours or incidents to be observed was not used (Emerson, Fretz & Shaw, 2001; Mulhall, 2003). A broad focus approach allowed me to be open to what would be revealed in the field, which was in keeping with the inductive nature of grounded theory (Strauss & Corbin, 1998), rather than other approaches which may be checking to see that the interview data is proven in the field (Emerson et al., 2001).

Field notes were documented both during observation and immediately after. Formal interviews in the field were tape recorded (with permission from the participants), while and informal interviews were recorded in the field notes. My impressions of the site and the actors and discourses were documented whilst in the field via situational maps. I documented human action in a narrative description of scenarios. Reflections on my

thoughts, feelings and interpretations were recorded in theoretical memos in the field notes.

There was one difficulty related to field observation: not all students who had consented to participate were placed at The Hospital. In order to increase the number of students observed, therefore, those who were placed at that hospital were directly invited to participate in the study. Some of the students placed at that hospital said they were not comfortable with me observing them and were not part of observational component of the study. These issues account for why only 25% of the participants were being observed. In the end, however, the field observation contributed to theoretical sufficiency for the study overall, because the observed students were representative of the population of students and theoretical questions arising from the interviews were answered.

Theoretical Sufficiency

Data collection continued until “theoretical sufficiency” (Bryant & Charmaz, 2007 p.114) was achieved. According to Glaser and Strauss (1967) data collection continues until ‘theoretical saturation’ of the categories occurs, that is, no new data is discovered that will develop new categories or properties of categories. Theoretical saturation is achieved once the researcher sees the occurrences repeated over and over again (Glaser & Strauss, 1967). Contemporary grounded theorists such as Clarke (2005) and Charmaz (2006), however, argue that theoretical saturation is an unrealistic aim of traditional grounded theory. They propose that ‘theoretical sufficiency’ is a more realistic goal, whereby the researcher is confident the depth of coding and analysis has sufficiently explored the research question/s. Whatever the terminology, data collection ceased in this study when no new relevant data was being discovered in terms of the research question and the categories were sufficiently full of rich and meaningful data.

Data Analysis

The three data sources in this study (interviews, student documents and field observation) provided a large amount of rich data. I was confident therefore that,

through the use of these data sources and a rigorous data analysis process, the goal of theoretical sufficiency was achievable and a reliable substantive theory would emerge. At the beginning of the study it was expected that substantive theory would be induced via grounded theory data analysis (Strauss, 1987; Strauss & Corbin, 1998; Charmaz, 2006) and situational analysis (Clarke, 2005).

One of the characteristics of grounded theory is contemporaneous data collection and analysis. Interviews were therefore transcribed as soon as practicable to allow early analysis. The 2005 and 2006 interviews were personally transcribed by me using the Microsoft (MS) Word program. I was limited by my other work commitments and the part time nature of this study, so transcription occurred quite slowly however this allowed me to begin analysis as soon as practicable after the interviews. This process provided me with an opportunity to identify questions about the data that informed subsequent interviews and the observations of students in practice (Corbin & Strauss, 1990). This early analysis provided rich and specific information that further developed both the categories and the emerging theory.

The interview transcripts were analysed using grounded theory coding techniques. I was mindful of Clarke's (2005) statement "if action is at the heart of Strauss' [research] project, then power is at the heart of Foucault's" (p.52) during coding. This statement informed my focus during coding; I therefore searched for social action and interaction as well as power and discourse. Transcripts were studied line by line and significant quotes or issues relevant to the participants' achievement of competency were highlighted. To identify social action I searched for gerunds (or verbs ending in -ing that function as nouns) as well as other verbs that indicated action, for example: '*playing* midwife' and '*working* with midwives' were used as codes. To identify power and discourse I focused on the students' descriptions of the 'social rules' as well as representations of surveillance and disciplining practices. For example, one student said during interview that "the power gets readily handed over [by the midwife] to the doctor" and during field observation I noted a label on foetal monitoring equipment in The Hospital which read: "fetal surveillance – medical equipment".

To ensure reliability of the data, in-vivo codes were used. In-vivo codes are labelled using the student participants' words (Strauss & Corbin, 1998). I used three methods to code and store coded data: manual, NVivo 7 and MS Notebook. In 2005 I coded the interview transcripts manually. Codes were identified and the quotes were then cut out from a hard copy of the interview transcript. These cut out excerpts were physically grouped into similar themes or concepts. Concepts were then sorted, grouped and rearranged until preliminary categories emerged during constant comparative analysis. This process was time consuming but I feel it was valuable because it allowed me to formulate new questions to be explored during subsequent interviews.

During 2006-2008 the interview transcripts were imported into NVivo 7 program for coding. I encountered a number of difficulties with the program so I stopped using it. For one thing, the program would frequently freeze and my computer would require a reboot. Although the program was valuable for indexing and cross-referencing of data I found the process of coding counter-intuitive. In 2008-2009 I therefore re-coded all of the interview data into MS Notebook which was a much more effective program for me. I was able to use my own indexing system which was uncomplicated and allowed cross-referencing. MS Notebook allowed an excellent system for me to store the interview data along with all of the other data relevant to the research and the thesis including memos, meetings, coding, articles for literature review and situational maps. It also stored media files so I could store the audio recordings of the interview with the transcripts. Furthermore, and most importantly, electronic backup was automatic (via sync) and hard copy backup simple (via creation of a PDF of each 'page' and printing). During the analysis the codes were grouped under categories, which were then developed further, through collapsing and grouping, to become the final major categories. A summary of the final codes and categories is provided in Appendix E.

The consistency and reliability of analysis was facilitated using the 'constant comparative method' (Glaser & Strauss, 1967) of analysis and axial coding which allowed identification of similarities and differences between the categories. According to Glaser and Strauss (1967) the basic rule of the constant comparative method is: "while coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category" (p.106). To ensure a "good fit"

(Glaser & Strauss, 1967 p.105), the participants' statements were compared to other statements within the category and then statements in the other categories. According to Glaser and Strauss (1967), two elements of theory are generated by comparative analysis: categories and their properties, and the relationships between the categories and their properties. Relationships were conceptualised using memoing and by comparing categories and their properties. These categories were further refined and the properties and sub-categories developed by the use of axial coding (Strauss & Corbin, 1998; Charmaz, 2006). To facilitate axial coding I took the following steps, as outlined by Charmaz (2006):

1. Define the category.
2. Explicate the properties of the category.
3. Specify the conditions under which the category arises, is maintained and changes.
4. Describe its consequences.
5. Show how this category relates to other categories (p.92).

After the categories were developed to this point I used situational analysis (Clarke, 2005) to further explore the students' learning situation. Situational analysis was facilitated via three mapping approaches, which helped me navigate around the students' social world and the complexities of that world. These maps were modelled upon Clarke's (2005) 'situational maps', 'social worlds/arenas maps' and 'positional maps' (Clarke, 2006 p. xxii). Situational maps were used to identify the major human and non-human elements, the discourses circulating in the student midwives' social world and the relationships amongst these identified elements (See Appendix H). The social worlds/arenas map grouped these elements into smaller social arenas within the larger arena of their social world. For instance, the smaller arenas in the students' world included the university world, the hospital world, the midwives' world and nursing world (example provided in Appendix I). Positional maps identified the major positions taken (and not taken) by the student midwives and other human actors (example provided in Appendix J) (Clarke, 2005).

Data for situational maps and the social world/arenas maps was drawn from analysed interview and observational data. Furthermore, previous knowledge and research was

drawn upon, such as students' textbooks, consumer information, journal articles and university documentation. The maps were developed using MS Notebook software or hand drawn. The process was quite messy and, on occasions, challenging. Although Clarke (2005) provides detailed explanation of her processes, I could find few examples of situational maps in the literature. Other researchers, such as Mathar (2008) and Mills, Chapman, Bonner and Frances (2007) had critiqued or discussed the analysis method but had not provided examples of their maps. There was one electronic thesis I drew upon by Bergeron (2008) which provided a thorough example of the application of the methodology.

The situational maps were created by exploring a question suggested by Clarke (2005 p.94): 'Who and what are in the broader situation?' Once the messy situational map seemed complete the elements were put into an ordered situational map. Relations between the elements of the situation were then analysed using the messy map. To make the social worlds/arenas map I, again guided by Clarke (2005), asked the following series of questions: 'what are the patterns of collective commitment and what are the salient social worlds operating here?'; 'what are the social world's perspectives?'; 'what do they hope to achieve through collective action?'; 'which elements are the characteristics of each world?'; 'what constraints and opportunities do they provide in that world?' (Clarke, 2005 p.110). As with the coding described previously in this section, the analytical foci of the social worlds/arenas maps were action, power and discourse.

Positional maps were created by identifying the issues in the social arena on which people took different positions within the discourse. One example of discourse conflicts were the medical discourse of risk/safety versus midwifery discourse which normalise childbirth and promote women-centred care. These contested positions were then plotted on a linear graph with two axes. I found this to be more difficult than the social worlds/arenas and situational maps. The positional maps explored the positions not taken by the participants, which was an interesting process but required more abstract thought. Positions not taken needed to be theorised—they were not as obvious as the positions taken. Examples of two of the positional maps are provided as Appendix J.

The maps facilitated analysis and the findings; they were not a presentation of the findings. The process of mapping was an analytical tool. In recognition of the constructionist and post-structuralist perspectives that underpinned the methodology, I acknowledged that the maps were a construction that arose out of the research process. The maps stimulated deeper and more abstract thought about the issues within the area of study.

As recommended by Glaser and Strauss (1967), I documented my theoretical questions, along with my thoughts, conflicts and understandings about the data in the form of theoretical memoing. Theoretical memos showed the path to theory development, provided clarity and were my written 'memory' of the research process (Glaser & Strauss, 1967). They recoded my thoughts and ideas, highlighted gaps in data collection, documented questions of the data and clarified the connections between the categories during axial coding. They therefore recorded the development of the categories. Furthermore, these memos provided an 'audit trail' (Bryant & Charmaz, 2007) which was particularly helpful when I had long breaks in data analysis due to other commitments. My memos therefore provided methodological rigour and facilitated analysis as well as gave an opportunity for reflexivity (Charmaz, 2006).

Some of my memos were written in an informal flowing manner and without editing to preserve the natural flow of my thinking and encourage exploration of my ideas (Charmaz, 2006). Other memos were essentially concept maps and some were short questions or thoughts that I had whilst reading the transcripts or coding the quotes. Memo writing assisted my 'questioning' of the data and early theoretical questions arose from memo-writing relating to concepts of confidence and competency and the relationships between those concepts, as well as the student-midwife relationship and the cycle of learning experience. During later coding and analysis, memo writing recorded my thoughts about the categories and properties, to assist the increase in abstraction. Many of the memos would only make sense to me, however some more coherent examples been provided in Appendix C for explication purposes.

Reflexivity: Reflections on my Influence on the Research

Consistent with a constructionist approach to qualitative research, it was important for me to enter the field aware of any preconceived ideas about the area of study (Clarke, 2005; Charmaz, 2006). Throughout the research I was conscious of my influence over the whole of the research process, from choosing the research question to writing this thesis. Both my governance of the research process and my interpretations of the situation during analysis would mean that I had influence over the way that the findings would be interpreted. Furthermore, you as the reader will impose your own interpretation, and your interpretation may differ from my intended representations of the findings written in this thesis.

In agreement with Clarke (2005 p. xxiv), I consider “*all* knowledge (is) socially and culturally produced” making knowledge (and experience) produced, consumed and situated within groups of people who are historically and geographically located. Clarke (2005) further advocates that researchers acknowledge their embodiment. Embodiment has been defined as the understanding that “the body engages with the material world and is constantly mingled with the knowledge it produces” (Havelock cited in Bourdieu, 1992 p.73). Haraway (1998), whom Clarke (2005) cites when referring to embodiment, questions traditional assumptions of positivist science. She challenges both the notion that researchers are disembodied and therefore neutrally objective and the belief that a researcher can be an unobtrusive, stable and unbiased observer of phenomena. She argues that researchers cannot be objective because they bring with them their own constructed self through which they conduct their research and interpret the data (Haraway, 1988). Researchers therefore must take responsibility for their influence within the research project by clearly documenting who/why/what they bring and how they influenced the study. According to Hoy (1999), as late as the mid-1970’s, cognitive scientific theory regarded the mind as disembodied; concepts and reasoning were considered literal and logic-like, he offered a metaphor of the “mind as a computer program’ (p. 84) to illustrate how cognition was perceived.

These scholars highlighted for me the way that science has traditionally conducted research. They have given me permission to acknowledge what I already had suspected;

I could not just go out and objectively research these students and come back and present the data without having significant influence throughout the research process. After consideration of these theories I acknowledged the fact that I am a human, embodied being who interprets through my body. I therefore accept that “knowers [researchers] are embodied, regardless of denial strategies” (Clarke, 2005 p.21). I now see that my understanding and reasoning arises from my mind, which is encased in and interpreted through my bodily experiences and my history. Furthermore, the notions of embodiment recognise that the students are embodied too. Their learning, and achievement of competency, is interpreted through their bodies during interactions with others in their world. The students' understanding of meaning and reasoning will be therefore be interpreted through cognitive mechanisms, patterns of bodily movement, activities and experiences during their interactions with people and objects in their world.

Reflexive memoing was used to expose my preconceived ideas, knowledge and beliefs about this research phenomenon. In my case previous published research, hypotheses and judgements from academic colleagues, midwives and students as well as my previous personal experiences were identified as some sources of preconceived knowledge. In order to document this process I kept these thoughts in a reflexive journal. The journaling process was also helpful for me to reflect on my emotional responses during the research. Listening to some student's stories was emotionally challenging for me. For example, when one student emotionally and angrily recounted a bullying experience, I had to work to regain my composure whilst trying not to affecting the flow of the interview. I did, however, tell her how her experience saddened me. This student told me that, despite her completing the course, she will not work in the midwifery profession and described midwives as ‘bitches’. She declined the counselling or support that I offered from the university.

Another student disclosed that she had self-harmed because of an incident during clinical placement. During her interview we were discussing the influence of midwives' behaviours on her self-esteem when she revealed a pink 10cm scar on her leg. She said that she slashed her leg using a stitch cutter she took from the hospital. When I saw that I was shocked and saddened. At the time I am sure my genuine concern for her was

obvious. I ascertained she had sought medical care. She said that her mother took her to her general practitioner who sutured the wound and organised mental health services. She said that she did not intend to harm herself again and is under the care of a psychiatrist. Reflecting back I see that my feelings were normal, due to my situation as researcher and teacher with a connection to the student. This incident also highlighted some ethical considerations.

Ethical Considerations

Certain steps were taken during the research to ensure it was conducted in an ethical manner. Approval for the research was granted by the Australian Catholic University Human Research Ethics Committee (ACU HREC) on the 3rd October 2005 (See Appendix N). After the observational component of the research was added, additional ethical approval was granted via modification to the original approval from ACU HREC (See Appendix N). Ethical approval was also sought and granted from 'The Hospital' Human Research Ethics Committee on the 7th September 2007 (further details are withheld to maintain confidentiality).

Throughout the study I aimed to protect the wellbeing of participants by upholding the established ethical principles of autonomy, beneficence and justice (Orb, Eisenhauer & Wynaden, 2001). Potential ethical issues relevant to this study were informed consent, confidentiality of data, data gathering methods, researcher/participant relationships, reporting of data and ensuring the wellbeing of participants who disclosed they had some psychological trauma resulting from their learning experiences (as discussed above).

To ensure consent was obtained ethically, the participants were informed about their right to decide to participate without being coerced. They were also advised of their right to withdraw from the study at any time. These rights were communicated both in writing (before the first interview) and verbally (at each contact). To reduce coercion the participants were invited into the study via a third party who did not have a vested interest in the study. Consent was considered a number of times during the research process. For example, I asked students' consent prior to tape recording the interviews.

Confidentiality was addressed by using pseudonyms for the students and removing identifying information. The students were advised, in writing, that the study would be published as part of a thesis and there may be publications in journals arising out of the study. They were also advised, however, that any identifying information would be removed. Furthermore, to maintain confidentiality, consent forms were stored securely in a locked filing cabinet. Only one of the students reaffirmed the confidentiality issue during interview. She was the student who disclosed to me her deliberate self-harm. I offered her the option of withdrawing from the study or, at least, choosing the information which she wanted excluded. She declined both options and was satisfied with the confidentiality processes in place. I also recognise that this raises an issue about publication of findings; with a small number of participants she could potentially be identified despite my attempts at confidentiality. Her freely given consent, however, reassured me that I had met the principles of confidentiality to a satisfactory degree.

Other issues that could have raised ethical concerns were related to my connection to the students. For instance, coercion was also a potential ethical issue in this study because I had been teaching the students participating in the study. The other issue was my responsibility for ensuring the students were competent. As an academic I relied on reports from clinical assessors that deemed students to be competent. Now I was about to go and observe them in practice and therefore I would have more insight into their practice. The challenge for me was to maintain the balance between the positive and negative aspects of this relationship. According to the feedback from students our established teacher-student relationship helped them to feel comfortable to discuss their experiences openly during the interviews. To ensure that students were not disadvantaged by my dual role of researcher and teacher I arranged for the midwifery course co-ordinator to be responsible for the students' assessments. I was, therefore, not involved with assessing students' competency or supervising them during clinical placement. The students who participated in the participant observation component of the study were made aware of this when they were recruited.

Summary and Conclusion

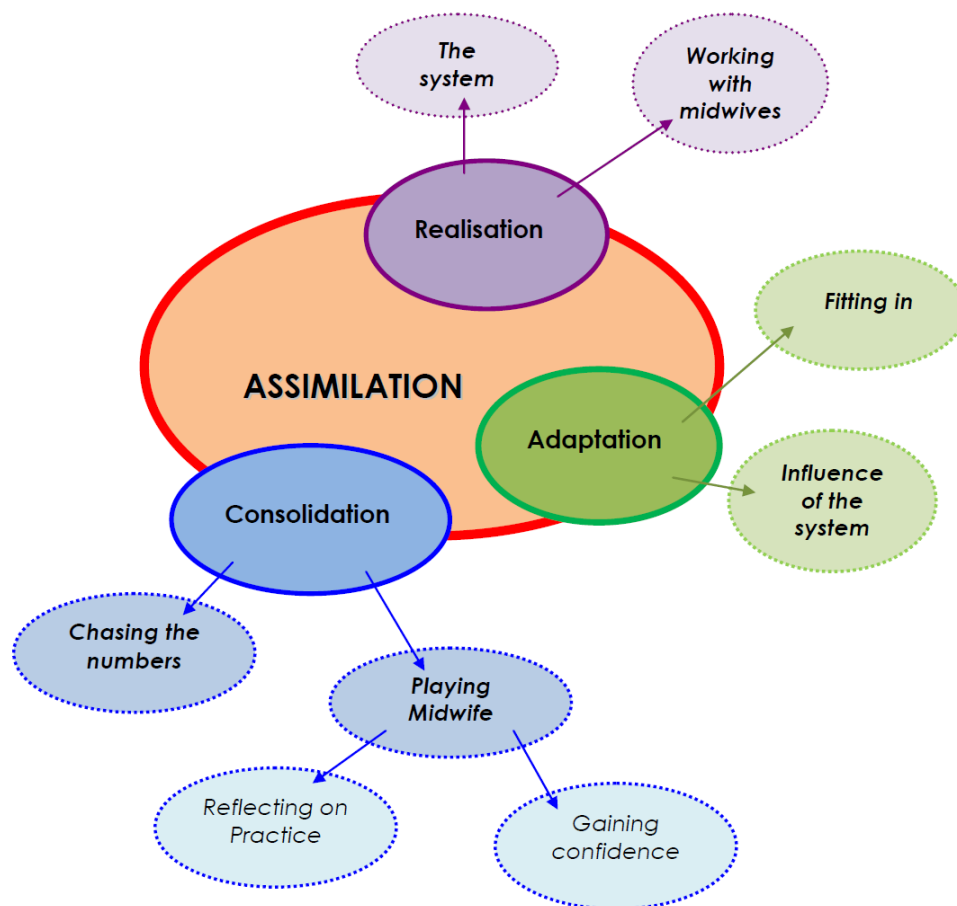
This research problem was addressed using a contemporary grounded theory methodology which was explained and justified throughout this chapter. I consider it was appropriate because it allowed in-depth, rigorous, analysis of the data, as well as analysis of the factors and discourse influencing the students' learning experience. The following chapter presents the findings.

Chapter Four

FINDINGS

This chapter presents the findings of the study and is divided into three sections related to each of the identified major categories, namely; 'realisation', 'adaptation' and 'consolidation'. These categories are linked to the core category 'assimilation'. The categories were derived via grounded theory analysis methods of open coding, constant comparative analysis and axial coding, as detailed in Chapter Three. The following figure illustrates the relationships between the core category, major categories and their subcategories:

Figure 4.1: Conceptual Map of Findings



Assimilation

The concept of assimilation represents the processes of adjustment that occurred within the various clinical agencies where the students were learning to become midwives. The Cambridge Dictionary's (2008) definition of assimilation – “to take in, fit into, or become similar” – is an accurate representation of the processes the students underwent. One of these was their realisation (or taking-in) of how ‘the system’ worked, another was their ongoing adaptation (or fitting-in) to ‘the system’. A further process was the students’ consolidation of the knowledge and skills necessary for beginning practice within ‘the system’, part of which was meeting the requirements for registration. Cindy reflected the majority of the students’ thoughts, in relation to consolidation of knowledge and skills, when she said:

When I had assimilated a whole lot of skills and I’m doing something without thinking and feeling anxious about it then I feel confident. It happens because I’m not thinking and stressing about it. It’s like being left in the room alone to do things that have to be done. Suddenly you realise ‘you did that and you did it reasonably well, and then I think ‘that’s okay, I’m on track’. There is a level of confidence.

Assimilation, however, meant more than just achieving a sense of competence and confidence; it was a combination of interrelated social processes as described above. The first of these, realisation, was a big step on the students’ journey to achieving competency for beginning practice.

Realisation

Realisation represents the students’ increasing awareness of ‘the system’ in operation and their (the students), the woman and her family, as well as the midwives’ and doctors’ positions within it. For the purpose of this study ‘the system’ refers to a pervasive organisational structure of maternity care provision in which the students were achieving competency - one which was dominated by medical discourse. All the hospitals where the students were placed for clinical experience were, to some degree, subject to medical dominance. The students’ recollections of ‘the system’ changed little from the first to the second interviews and they were further explored during field observation.

'The System'

Public hospitals in Victoria are classified by the level of obstetric care they provide and the degree of complexity of medical conditions they are able to manage. Primary level hospitals are generally regional and provide care to low risk women. Secondary level hospitals can provide care to women experiencing low risk and moderate risk pregnancies, and tertiary can provide care for women experiencing high risk pregnancies (State Government of Victoria, 2010). The students' clinical placements were in all of these levels of hospitals, as well as private hospitals where obstetricians largely managed the care of women. There was a great deal of variation in the expectations of the Bachelor of Midwifery students, depending on the hospitals they learnt within:

I think it's really good to do some private and some public system because they're hugely varied. They [the hospitals] are very different in what a student midwife is, what's expected of her, and how they're allowing you to practice. It varies heaps from public to private and also small regional hospital to a great big one (Eliza).

Medical dominance was, to varying degrees, influential within all the hospitals and was assisted by medical discourse that projected a belief that pregnancy and childbirth is inherently risky for both mother and baby. Medical supervision and surveillance was therefore seen as necessary to identify risk factors, which then required swift intervention to ensure physical safety. Furthermore, from the students' perspective, the woman and baby's physical safety seemed to be valued more highly than the woman's psychological wellbeing. Anna explained:

I think from what I've seen at [tertiary hospital] that so often the woman's experience is not even up there with being an area of concern for people. I know that they all want a good outcome...which, I think, is a healthy baby and a healthy mother but...sometimes it's like it doesn't matter what it takes to get that. Sometimes it seems that the actual journey from being in labour to having the baby doesn't matter and the woman has no say or no control over her situation at all...It's just taken away from her until that baby is born.

Anna, similarly to the majority of the students interviewed, increasingly saw that the medical discourse operated to control women and midwives, with subsequent disempowerment. The doctor's status and knowledge afforded them particular authority

to exert power over women and midwives as their surveillance and disciplining practices were used to manipulate behaviour. The competing midwifery discourse, which promoted female autonomy of both midwives and women, while emphasised in the Bachelor of Midwifery curriculum and the professional competency standards, was seen as very much an alternative discourse in a system dominated by medical discourse.

The students' increasing awareness of a medically dominated system across all the hospitals they attended for clinical experience, particularly tertiary hospitals, was confirmed during field observation at 'The Hospital' where the majority of ACU Bachelor of Midwifery students completed their final placement.

The medical discourse was observed to be reflected first in the physical environment of the birthing suites, with the ambiance and location of equipment in the birth spaces giving an impression of the clinical nature of care provision. The surfaces and colour schemes were cold, there were minimal soft furnishings, a lack of privacy (people entered at any time and there were no locks on the doors), medical machines were obvious and there was a large hospital bed in the centre of the room. Resuscitation equipment was obvious (even though there was a cupboard available to conceal it). This gave a clear message that that birth is risky and the hospital is prepared for any emergency.

Overall there was a clinical feel to the birth space, reflecting a belief that birth should occur in a hospital environment and that it is not – as midwifery discourse would argue – a normal life process. Women were subject to routine surveillance to detect abnormalities of blood pressure, pulse, temperature, frequency and duration of contractions, vaginal loss, urine output, cervical dilatation, foetal descent and duration of labour. The findings were noted on a 'Partograph' so that any deviations from normal could be diagnosed and rectified. Care was routine and women were managed within a system which, according to the students, seemed uncaring and mechanical:

There is no trust in there and its management, its birth management is all it is very clinical. It's like [there is an attitude of] 'we will sum this woman up, she is this, she is a that, we will compartmentalise her. She is probably not going to push that baby out and we will help her.' [...] I haven't seen a lot of inspiring midwifery [...] a lot of them have just categorised woman and they're just working in there like it's a supermarket (Kelly)

Many of the students alluded to the fact that the environment became even less woman focused when caregivers were responding to stressful situations. For example, when referring to the change in environment when caregivers became concerned about the wellbeing of the baby, Kelly said: "you can just taste it [the fear], it sort of all builds in the room and then it just goes bang! It's like someone just changes the dial on the thing...", as if the environment itself is a machine where the dial moves up and down, depending on the situation.

The notion of natal-panopticonism (Terry, 1989 cited in Heckman, 1996; Fahy, 2002), as defined in a previous chapter was pervasive, with medical surveillance in the birth space obvious to both the woman and the midwife. The foetal heart rate and woman's contractions were observed with continuous electronic foetal monitoring (CEFM) via Cardiotocograph (CTG) or intermittent monitoring using the CTG. The results of the CTG were sent via telemetry to a computer located outside of the room on the midwives/medical staff desk labelled: 'Fetal surveillance – medical equipment – this is not a computer'. Each time the foetal heart was auscultated, therefore, it was recorded and transmitted outside the room for the doctors to observe.

In this study, women and midwives knew they were under surveillance by doctors who could intervene at any time on the basis of the computer screen or print out of foetal heart rate patterns interpreted as foetal distress. According to some midwives spoken to during field observation, this contributed to their sense of disempowerment as well as the creation of a situation where they felt ignored in decision making. Decision making was therefore given over to a machine and often quite distant medical staff.

This widespread approach to care in labour had a significant influence on midwives' practice as they were not always consulted when decisions were being made. During field observation doctors were observed discussing the woman's CEFM results at the desk and not in the presence of the woman or the midwife attending her. On one occasion a doctor was observed making a decision to do an instrumental birth – without discussing it with the woman or midwife – based solely on what she saw on the computer screen.

As part of the process of field observation two midwives were questioned as to the influence of this CEFM surveillance on their midwifery practice: they were asked what is like working somewhere that has the CEFM trace beamed to the desk. These midwives expressed mixed feelings about it, but both agreed that it increased intervention and decreased midwifery autonomy. Midwife 1 said "it's good for the midwife in charge to see"; and Midwife 2 said that she felt the midwives are "not trusted, especially by the professor" [who was the head of obstetrics] and "doctors just rush in when there are decels [foetal heart rate decelerations]". Midwife 1 agreed with her, saying: "yeah, you could be doing intermittent monitoring and the CTG is on the bed and the doctors rush in with their gloves on and take over!" and "the doctors come when the woman is having normal second stage decels....it's increasing the number of instrumentals [instrumental births via Obstetric Forceps or Ventouse]".

After this conversation, almost as if on cue, I observed a doctor glancing at the computer and asking a midwife for "size 6 and a half [gloves] please" then heading into a woman's room. The student later returned from that room and explained that there was a vacuum extraction and the foetal "heart rate went down to 70" but the "baby is fine and the woman is being sutured". At the time I noted in my field observation notes that: "I can't believe my luck having this scenario played out in front of me", as it was a demonstration of the way in which midwives in 'the system' lacked autonomy, were not treated as colleagues, and were therefore subordinated to doctors. Although the midwives spent the majority of time with women and were mostly consulted during decision making, the ultimate decision was always made by the doctor.

The students also described a hierarchical structure of maternity care in 'the system' and felt they were positioned very low in that hierarchy. Kelly said she was "right down at the bottom, with the woman", adding:

The power just gets handed over so readily to a doctor. Not a 'let's step out of the room and discuss it and work it out together, because primarily I have been looking after the woman and they have just seen the CTG'. It's all done at the bedside, it's all ... 'in tongues' and the woman doesn't know what is happening (Kelly).

In 'the system', as described by the students, women were not adequately involved in decision making and therefore had limited autonomy. There were also ethical issues

regarding informed consent to be considered, which were further explored during field observation. On a number of occasions, caregivers did not adequately obtain informed consent, for instance they: gave inaccurate information; withheld information; used coercion; and did not always gain consent for procedures. During one incident a midwife cut an episiotomy without the woman's consent and without anaesthesia. These actions were incongruent with the midwifery competency standards and ethical standards previously discussed in Chapter Two.

Medical dominance, surveillance, disciplining practices and lack of informed consent led to a high degree of intervention. A minority of women experienced physiological birth without intervention and it was rare for the students to be involved in a labour where the midwife worked with the woman to achieve physiological birth. This was particularly the case in a tertiary or private hospital. Interventions such as epidurals or inductions of labour were commonplace in these hospitals and there was sometimes a complete disregard of women's aspirations for normal birth. Anna said:

I still wonder why women aren't allowed to give birth anymore? Or why are they induced at an early stage? Or why, why does this happen all the time? Why are most women induced? Why do most women choose epidurals? Why does it happen all the time? Why can't women just have babies anymore? Also why, when the women do say they want to have a normal birth, do the midwives think it's hilarious? I just find, you know, I find that really difficult. How are women meant to have normal births if the midwives laugh at them when they say that they want to have no drugs? It's just shocking....

On the rare occasion students had the opportunity to be present at a homebirth with an independent midwife, care was described as a "different world" (Tania) to the care provided in 'the system'. Many of the students believed that autonomous midwifery practice and women-centred care was more achievable in community and homebirth settings and wanted the opportunity to have their clinical placements with independent midwives. Unfortunately, at the time, independent midwives were unable to obtain indemnity insurance and therefore the students were unable to have clinical placements with them.

Those who did attend homebirths, in a purely observational role as part of their 'follow through experience' (FTE), highly valued the experience. As Kelly said:

I really, really think that a huge element of this course needs to come out of the hospital and that every single student needs to experience birthing outside of the hospital.

Other students mentioned how the FTE allowed them to see birth in various settings and develop relationships with women, which was positive to their learning. During the FTE the students made initial contact with women in early pregnancy and maintained contact until the end of the postnatal period. This enabled students to experience continuity with women and reflected the principles of the Bachelor of Midwifery which valued midwifery partnerships and continuity of midwifery care (ACM, 2002). Anna noted that the FTE allowed her to see a broad scope of midwifery practice and care models:

the follow through journey women have probably had a lot to do with it as they expose you to all different [experiences]...wherever they give birth, whether it's at home or in a private hospital or by caesarean section or whatever way they have their baby. I think that has a lot to do with it, I think that really broadens your knowledge. I think it also it also makes you realise that continuity of care and that model that the B Mid [Bachelor of Midwifery] is based on isn't just about normal birth and women having a spontaneous labour with no drugs and that... it's not about that at all. It's about whatever the woman...whatever happens for that woman in her labour and birth. I think that having so many different follow through experiences helps you become more open to all that stuff as well. It really adds to all you different competencies and accepting the woman's differences, wherever they're coming from or wherever they're going to.

A hospital praised by the students for its relatively midwifery-led, woman-centred approach, was a non-tertiary metropolitan hospital. This hospital had strong midwifery leadership and greater midwifery autonomy than other hospitals and also supported the Bachelor of Midwifery students. Other hospitals which the students said were women-centred were one outer metropolitan hospital, some regional hospitals and birth centres. Students enjoyed working in these environments because they were role modelled the type of midwifery practice they aspired to. When describing her experience in a regional hospital, Cindy said:

Birth is no drama up there. The women on the whole are sort of prepared to take responsibility. There is not as much intervention I think on the whole. The screening is not as intensive for them, they don't do GBS testing. The

doctors are there and very much involved but they are not sort of taking over.

Private obstetric hospitals were the most criticized for their lack of midwifery-led care, followed by metropolitan tertiary hospitals. In private hospitals the midwife's role was seen to be assisting the obstetrician:

I really find that in private hospitals you are more of an obstetric nurse. You are definitely an assistant to an obstetrician, although it depends on the private hospital as well. But yeah you don't, for instance pain management, you know, there are so many things we learn what you can do but you don't dare to offer this non-pharmacological pain relief in a private hospitals because that is just not the way it is there (Maree).

Private hospitals were also more restrictive of students' learning than public hospitals. Some obstetricians were reluctant to let them be the Primary Accoucheur (the person assisting the woman giving birth, also known as 'delivering' the baby) and for these reasons students preferred to have their final placement in a public hospital. Indigo explained:

I think it's just easier just not going through that whole negotiation of the relationship between the women and her obstetrician, and all of that, if you're in public [hospital]. It's just expected that you will do the birth there if you are a student....I think probably in public hospitals they are used to having students there all the time and that it's just a given that is what happens. They seem to be more relaxed and open about having students.

Furthermore, midwives working in private hospitals were more critical of the Bachelor of Midwifery students' lack of nursing qualification. Most of the students were told by midwives, at various times throughout their course, they were inferior midwives because they did not hold a nursing qualification. These attitudes were more common in private hospitals, compared with hospitals which provided midwifery-led models of care:

I have experienced less need to justify the course in public hospital than I did in private. There was a lot more questioning of and grilling me about what we did. One midwife came and said, "I've got a good question for you, when you finished will you be able to give drugs?" and I am like, "well I am going to be a midwife so, can you give drugs as a midwife? Well, yes, I am going to be a registered midwife and just, yes!" People [were] constantly questioning you and giving you their opinion about whether or not the course is a good idea. I just don't really care what [they] think but that was tiring to always think that people would initially, immediately think of you

as being not as good as if you...were a nurse already because you wouldn't have a lot of those background clinical skills, I guess (Indigo).

About the midwives who were critical of the Bachelor of Midwifery students, Nora said:

I feel like they are putting you in your place. They make you feel like you will never be on their level, and you never can be, because you are not a nurse. They even tell you that. A student is a student and there is that hierarchy, but I was told on my first placement that Bachelor of Midwifery is nowhere near as important as a double degree and why would I do a bachelor of midwifery because that's not a real midwife. You have to be a nurse first.

Many other students felt that the Bachelor of Midwifery course was subject to criticism within the profession and this negatively influenced their learning experience. Some felt that they did not want to be seen to be "too big for [their] boots" (Eliza) and others believed that the midwives were more critical of them because of their lack of nursing experience. As Anna said: "As B Mids [Bachelor of Midwifery students] the midwives we work with are always, well not all of them but some of them, on our backs about being clinically spot-on" and Eliza said:

In some ways I wish I had started B Mid [Bachelor of Midwifery] when it had been running for 10 or 15 years. So no one batted an eyelid, no one really cared how you had come to train. I just found myself constantly defending the course and not just even defending myself personally for me it was the concept of a direct entry course full stop. I mean you spend a lot of time doing that that you could be spending doing blood pressures in first year. It would have been great to go on placement where people knew what B Mid was and they knew what to expect. They're still used to students who are nurses and who have great clinical nursing skills. That can be really embarrassing. It's not that we are incompetent as people; it's that we've had no chance to practice this until now, standing in that hospital in the maternity unit somewhere.

There were some broader circumstances which may explain why midwives were cautious about the Bachelor of Midwifery courses ability produce competent graduates as well as the variation in the influence of medical dominance in hospitals within 'the system'.

At the time of this study the midwifery profession was calling for an expanded role, however government and local factors were inhibiting midwives' ability to work in a

more autonomous capacity. There were a few funded midwifery-led and continuity of midwifery care models in Victoria which catered for a relatively small number of women. The majority of Victorian women, however, gave birth in hospitals where midwifery practice was subjected to medical supervision and control. These issues are discussed further in Chapter Two of this thesis.

Many of the students said that tertiary hospitals were understaffed and busy, and this negatively influenced the care of women. The high number of births meant that staff was under pressure to free up beds to accommodate incoming women. Some of the students felt that women may not have experienced such a high degree of intervention if there was not this pressure. Yvonne explained:

All of those big centres have a medical angle to everything, they're all very business orientated towards their costs and their numbers and everything, their funding and their finance. The organisation doesn't focus so much on the job at hand... I don't have a problem with the people who need medical interventions. But I find the medicalisation of [...] low risk non-problematic people. They don't have the time to wait for them in labour. They have to get them in and out. That was actually said to me by one of the midwives, they don't have time....Government are also responsible and the people who run the hospitals, there are not enough people to do the jobs and people are having babies like crazy and women are having babies in hospital when they don't need to go there.

Individual caregiver's practices within these hospitals were influenced by their philosophical standpoint, the restrictions of hospital protocols, workload issues and funding. The midwives observed noted that they and medical staff working in busy hospital birthing suites were under pressure to provide quality care to a large number of women and the students felt that intervention sometimes made the job easier. Some students acknowledged that it was easier for a midwife to care for a woman with an epidural because they required less intensive labour support. Others said that women's labours would be augmented without valid indication, so even within the medical discourse some interventions were unwarranted. These interventions highlighted the pressure under which midwives and doctors in the hospital environment were under.

Maree explained:

I feel that some midwives - I don't know if they are just sucked into a system that they just surrender and go with the flow too often - I have the

impression it is easier for the midwives as well to look after a woman who has an epidural, you're continuing your obs but you don't have a screaming demanding woman who needs more of your attention.

There was a significant theory practice gap in terms of what the students were being taught at the university and what type of care was being provided to women in 'the system', as Dahlia said:

At the start, when you first start on placement a lot of things happen and you are shocked by it, and I suppose coming into uni and working on women centered care and continuity of care, you get in your mind the way it should be. Then you try to practice that as much as you can, but I think after a while you just realise that it [a woman-centered approach to practice] is not going to work that way, and that's been something that I've really had to accept.

Faced with this theory-practice gap, the students felt disappointed, conflicted and confused. Their feelings arose out of their preconceived perceptions about how women should be treated in childbirth and the role of the midwife, which were either informed by past experience or the theory of midwifery practice taught at ACU. Midwifery discourse framed the Bachelor of Midwifery curriculum and the theory of practice taught at Australian Catholic University (ACU). Midwifery discourse valued woman-centred care, supporting normal childbirth, continuity of midwifery care and midwifery autonomy within a feminist theoretical framework (discussed in Chapter Two), which was contrary to the way that midwifery was generally practiced within 'the system'. Many students said they appreciated the theory of practice taught at ACU, however they wished they saw more of it in practice. Cindy said:

The conflict of between, the discrepancy between, what we have been taught and what we see has a potential for a huge conflict, you know internal conflict for students and how you cope with that [...] I have had some moments of thinking it is unfair to teach us you know this philosophy you know this woman centred philosophy when where when actually you are fighting an uphill battle to practice it or to see anybody practice it.

The dominance of medical discourse within 'the system' was therefore a considerable source of frustration for the Bachelor of Midwifery students. They were disappointed with the way that women and midwives were disempowered and the use of intervention. The students were realistic about the need for intervention in some labours, however the way that intervention was conducted was often criticised. Dahlia's recollection of a

birth represents the anger students felt about how some women were treated when intervention was required:

All was going well until Dr Crazy Hair turns up and everything goes to shit...before I knew it there was a large Epis[iotomy] and abusive yelling to push harder! Then a 3rd degree tear, rude communication to midwives and PPH with every Oxytocin given under the Sun causing extremely painful after-pains, therefore Voltaren and pain relief and Maxolon given, so mum threw up and never really got to hold or bond with her baby....So I was glad when it was 3.30pm and I left never to return to the [tertiary hospital] Butcher Shop.

Many of the students were traumatised from witnessing the way that some women were treated in 'the system'. Some students expressed how they could not come to grips with why women would choose to give birth in a system that treated women and students like that. As Kelly said:

It's traumatic. I found every, every hospital, every clinical has had an element of trauma in it for me. [It was] draining [and] incredibly exhausting just suppressing the feelings all the time, because no one really wants to hear about it and there is no point. I take it incredibly personally. I come home, and I think it's awful, it's so awful I feel so sad for all the women who have chosen that model of care and that don't know it could be different and are accepting of it and there not necessarily as devastated about their birth as I am but that makes me sad as well that they don't even know that it [normal birth] exists.

The students' trauma was compounded by inconsistent support and lack of formal debriefing. Apart from the occasional supportive midwife or clinical teacher many of the students did not have adequate debriefing. Many suppressed their feelings of despair until they went home and spoke to family members, other students or, occasionally, they sought counselling from professionals. The main reason that students did not debrief during clinical was because they were concerned about confidentiality, they did not want to make 'trouble' or be seen to be questioning practice or they simply felt that the midwives did not care. The lack of continuity of preceptorship compounded this issue as the students did not trust that the midwife or clinical teacher would not 'punish' them for criticising care. As one student said she just had to 'grin and bear it'

The students described women 'screaming in pain' and 'being butchered'. One tertiary hospital was called the 'Butcher Shop' (Dahlia) and a 'Supermarket' (Kelly), suggesting that women were de-humanised and treated as commodities. Women's experiences

were described as a 'crime' and a 'violation', which suggests that in other circumstances the actions of the caregivers' would be illegal. There were many examples that represented the students' trauma however two, by Maree and Olivia, are provided below.

When reflecting upon a birth that she described as traumatic, Maree said:

She was fully dilated already at 12.00 and then they tried a vacuum and the vacuum didn't work so they let her labour for another 3 hours, then they let her push for an hour and this woman was really in agony. She was a small, tiny [...] woman. Then 3 hours later they started another vacuum [extraction].

The vacuum slipped off twice... and [they] did an episiotomy without any local and she screamed. They didn't really wait until the perineum was nice and wide, when she might not have felt anything... There was screaming and then they [saw] no progress and then they pulled the forceps out.

It was really like butchering a woman, it just really awful. Then the forceps didn't work and then [they did an] emergency caesarean section. The baby was completely flat.

Olivia similarly recalled how she felt when a midwife did not consider one woman's needs:

She [the midwife] didn't infiltrate [with anaesthetic] she got the scissors and she didn't ask the consent from the woman. She cut really deep, long episiotomy that was pouring blood out because it has been cut too early.

She gave this almighty scream when she cut it [...] and I could feel her hanging onto the bed [...] I was just continuing to try and talk to her [...] so I got the packs and holding the epis[iotomy] cause it was pouring blood out (Olivia) .

The students had varying responses to this trauma and their own sense of powerlessness, ranging from detachment to overwhelming emotion. Occasionally the students felt responsible for the actions of the midwife. For example, after the above scenario, Olivia felt a "party to the crime" when the midwife cut the episiotomy because she misled the woman by reassuring her everything would be okay and it was not. Nora was emotionally distressed witnessing a traumatic birth, which happened to be the first that she ever saw. The effect of her experience was ongoing:

I was looking after a woman the next day [after witnessing a traumatic birth] and when she was in pain I kept crying in the corner. I couldn't look after anyone all week because I felt like something was going to happen to them like really scary and traumatic that I didn't have any control over.

[after the traumatic birth] I chucked up [vomited] in the toilet and that night I howled [cried] myself to sleep and [her partner] just came home from work and said 'what is going on?' and I told him, and he just held me, and I howled myself to sleep - I was just howling.

I felt physically like I'd been party to this horrible thing that was happening to this woman and I physically had pain in my stomach and I had a shooting headache and I felt sensitive all over and felt like vomiting all the time. That howling [...] it just wracked my body.

Nora's anxiety continued throughout the rest of her placements. In second year she saw a counsellor. Her grief was compounded by her feelings of powerlessness to change the situation or help the woman and the lack of support from the midwives she was working with:

I think they loved it – that I was hurt by it. I think they like you to do it the hard way. I felt like they wanted me to see all the gory stories and see all the forceps and [sigh] 'because that's what it's all about' [sarcastically].

I saw another student who cut an episiotomy under the watchful eye of a midwife and when she came out of the room they all [midwives] said "oh now you are becoming a *real* [emphasis by student] midwife" – as if an episiotomy means you are initiated into being a midwife!

Some other students were placed in non-tertiary, public metropolitan hospitals with midwifery-led models of care. Indigo was one student who said that she worked with midwives in these settings who appeared to be aligned with her philosophy of midwifery practice:

I have come across midwives that share a similar philosophy to [the Bachelor of Midwifery]. Particularly either midwives who are younger and chosen to go and work in a public hospital and, more particularly, in a low risk public hospital than a high risk where it is a much more medicalised culture. Some of the midwives in their late 30s early 40s who are really experienced and competent and have seen a lot and but [are] not...old school but they...seem to realise that birth is generally a normal process and we shouldn't interfere so much.

The students' realisations of 'the system' extended to the midwives they were working with as they achieved competency. Midwife preceptors' behaviours were defined by

students as helpful or unhelpful. Working with helpful midwife preceptors could mitigate the negative aspects of a medicalised hospital culture, whereas unhelpful midwife preceptors could accentuate it.

Working with Midwives

Whilst learning in this system the students were allocated a midwife preceptor. To clarify, the term 'preceptor' has been used in nursing and midwifery education literature to describe the nurse or midwife who supervises students during clinical placement (Licqurish & Seibold, 2008). For the purposes of this thesis, the preceptors are defined as: "midwives who work in a teaching or supervisory capacity with a student, for a minimum of a day, and has ongoing contact with that student at the clinical agency" (Licqurish & Seibold, 2008 p.481).

During each shift on clinical placement the students said they were allocated a midwife as a preceptor. Their midwife preceptors were responsible for the care of women and the family, as well as supporting the student midwives' learning. The students in this study described in-depth the qualities of helpful and unhelpful midwife preceptors they encountered in 'the system'.

Helpful midwife preceptors were defined as those preceptors whose behaviours were supportive and facilitative of the students' competency development. The students in this study emphasised the importance of a helpful midwife preceptor and how they had a significant, positive influence on the students' learning and confidence. Anna explained:

I think your confidence has a lot to do with how competent you feel and that comes back to who you work with. Because some midwives can crush your confidence and you just feel like you can't do it anymore and others can make you feel really good and make you feel like you can do it and it's going to be all right. It depends on the day and who you are working with.

Working with a supportive midwife could offset the negative aspects of an unsupportive or medicalised hospital culture. Supportive midwives were valued by all of the students who described helpful midwives as those who: allowed or encouraged hands on practice

and relative independence in practice; included the student as a valued member of the team; showed interest in the student; were empathetic; and were positive role models.

Helpful midwife preceptors allowed the students the space to develop their competency by letting or encouraging them to apply their knowledge through practicing skills. On the other hand, if midwives were impatient with the students they might take over which was not very helpful for the students' learning. Midwives' impatience could have been related to workload issues, which were identified as a problem in major hospitals. Renee said:

It's really hard when midwives don't actually let you do it even though it takes you a while. Like you would be doing something and then the next thing you know they will just grab something out of your hand! Like the other day, this midwife and I were drawing up something that was little bit thicker. Because they are in a one mil[ilitre] syringe you get the bubble of air at the end and so I was just trying to get this bubble out of this syringe and the midwife just grabbed it out of my hand and flicked it this special way so the bubbles disappeared and I thought 'oh for god sake let me play with the bubble!'

Helpful midwife preceptors would let the students provide the majority of care for women whilst being available as a supportive resource, which helped increase the students' competency for beginning practice. As Tania said:

They would really just leave me to my own devices and just hang out [with the woman]. There was one midwife who came in and introduced me to the couple and then she left and would get an update from me. She would come in every hour just to double check.

The need for the students to have increasing independence throughout their final placement is further discussed later in this chapter.

Helpful midwife preceptors were also inclusive with the students and showed appreciation for their contributions to the care of the woman. These helpful midwives made students feel valued as part of the team by consulting them about the care of women and seeking their input. Feeling included as part of the team had a positive influence on the student-preceptor relationships as well as the student's self esteem and confidence. Olivia explained:

I think the good midwives are the midwives who really treat you as almost a midwife, so often the midwives will say well you are a midwife now what

do you think and so bring you up and it is much easier to push people down and keep them back than draw them in and build them up. So the good midwives are the ones that will show that they have confidence in you, whether it's unfounded or not because they have never clapped eyes on you before. So maybe it's a personality too but so the good midwives are the midwives who talk to you and discuss the care of the woman and so make it inclusive.

Helpful midwife preceptors were generally described as caring and supportive by the students. Support was particularly valued when the students made mistakes. They also helped the students to feel relaxed, which was important for their confidence and competency.

As Kelly said, "when I stop feeling relaxed I start to feel like 'oh I am going to do something wrong - and all that overrides my confidence and the knowledge I already have'", she is then more likely to make mistakes. Greta elaborated:

this was a particular midwife that was really nice and I was so glad she was there at the birth doing the birth with me because she has a way of telling you that you made a mistake without making you feel like a complete idiot.

Recently graduated midwives were sometimes helpful preceptors because they showed empathy towards some students. On the other hand it appeared that some midwife preceptors had "forgotten what it was like to be a student" (Greta). Furthermore, the students appreciated working with recent Bachelor of Midwifery graduates because they were more likely to have similar philosophy and care practices. Some students even felt more empowered when working with recent graduates because they had a less experience and knowledge than the more experienced midwives.

On the whole the midwife preceptors did not have teaching training yet they were expected to teach the students during placement. Some students felt that the motivations and support from some preceptors overcame that barrier however it would have been desirable that midwife preceptors had some degree of training to preceptor student midwives more effectively. The helpful midwife preceptors actions that suggested they were motivated teachers were described as being approachable, taking the time to answer students questions and debriefing after the birth with them. Motivated midwife preceptors showed a willingness to get to know the students and their learning objectives as well as work with the students' learning styles. They could also adequately

ascertain the students' competency and what they needed to do to achieve the Nurses Board of Victoria (NBV) requirements for registration. As the NBV requirements were a major focus of the students' learning objectives for their final placement, the students valued someone who was interested in what they needed to do to achieve the requirements and provided the opportunities for them to do so.

Helpful midwife preceptors demonstrated the type of midwifery practice students aspired towards. They reflected the midwifery competency standards, were women-centred and worked towards autonomous, professional, ethical and competent practice (ACM, 2005; ANMC, 2007). It is important to reiterate at this point that the Australian Competency Standards for the Midwife were used by ACU as a framework to assess the students' competency. These competency standards therefore, as the theoretical benchmark for desirable practice, formed the basis of their students' perceptions of the role and competency of a midwife. These standards and the midwifery theory underpinning them are detailed in Chapter Two of this thesis. The students' perceptions about who was a positive role model or a 'good midwife' seemed to be informed by these standards, as much as the negative role models (as discussed later in this chapter) were compared against them.

The ANMC (2006a) and ACM (2005) midwifery competency standards promoted midwifery autonomy, continuity of care, woman-centred and ethical practice as well as a primary health and social model of care, which are concepts strongly rooted in midwifery discourse. As ascertained previously in this chapter, the students' learning environment was heavily influenced by medical discourse. The competing midwifery discourse not entirely silenced however, as students did have the opportunity to work with positive role models, it was just less common.

Beth was one of the students who discussed the qualities of a positive role model being rooted in midwifery discourse and the ANMC (2006a) competency standards. She said they were "inspiring, in terms of being an advocate and seeing midwifery as a professional, skilled profession". Although the students did not use the term 'woman-centred' specifically, their descriptions of the ideal role model reflected the principles of woman-centeredness as defined in the literature (ANMC, 2007). For example, Cindy

said “it's good to work with someone who was really conscious of the woman's experience”. Maree's discussion of a ‘good midwife’ was more in-depth:

the good midwife is really in tune with the woman, the good midwife establishes a good relationship with the woman and listens to the woman and her need what does this woman need ...she [the midwife] is really in contact with the woman and that she can guide women through strong pain or you know distressing moments and just make her feel safe.

As mentioned previously in this chapter, students had limited opportunities to work with positive midwifery role models. The opportunity to work with positive role models was dependent on the clinical agency and its associated dominant discourse, which influenced the philosophy of care and midwifery practice. In general, the less medically dominated the clinical agency was, the more likely students had an opportunity to work with midwives that they described as positive role models.

Olivia said that there were only a couple of midwives who she worked with who could successfully marry together sound clinical skills with a caring, woman-centred approach to care. Maree also said that it was rare to work with a positive role model. In fact throughout all of her placements she had only worked with two midwives whom she admired:

There was [sic] just two midwives I really admired because they were very respectful with the woman's space. They were very quiet when the woman had contractions, they didn't speak. That is something most midwives really, don't care about a lot. Although...most of them have really good clinical skills and are into natural birth and everything, all these fine subtle things of you know respecting the woman's space and so on....I don't know maybe it's very much the hospital environment.

Whilst helpful midwife preceptors positively affected the students' learning experiences, confidence and competency, unhelpful midwife preceptors inevitably had a negative influence. Unhelpful midwife preceptors were those whose behaviours had a negative influence on students' learning and confidence. The significance of the negative influence of unhelpful midwife preceptors was strongly evident in some students' stories. Cindy's opinion that “the hardest thing to deal with during clinical was [...] not necessarily being supported as a student by certain midwives” was representative of how the students felt when they were unsupported by their preceptor.

Various unsupportive behaviours were identified and generally ranged from subtle to more obvious and/or aggressive. The subtly unsupportive behaviours were showing a disinterest in teaching, ignoring the student, demonstrating lack of trust, taking over unnecessarily or being a poor role model. The aggressive behaviours identified by the students included intimidation, overt criticism and humiliation.

The preceptor allocation process could expose students to unhelpful preceptors who were not motivated to precept students. As Dahlia explained, during placement at handover, with all of the midwives on that shift present, some midwives in charge would ask “who wants the student?” and there would be no reply. This led to her feeling “deflated” (or humiliated) and she would then be allocated someone whom she felt was reluctant to work with her. This combined with her being told by other students that certain staff members at that agency had said they “hate” working with students made her feel:

Unsure because you really have to think about what you are doing when you are around these people, and you can't ever feel relaxed. You are constantly trying to get out of their way or you ask them stupid questions....They make you feel like they're too busy, or I should know it, or I should ask somebody else.

Unhelpful midwife preceptors would behave as if they did not want to precept students and this was not helpful because it exposed the students to unsupportive behaviours and was detrimental to their learning. Anna said:

Some of them don't mind being allocated a student but some of them give you a really hard time if they don't want to...like they do that challenging thing. They're challenging you to do things but they don't explain what they want you to do, so they're very picky and they make you feel very inadequate. You don't learn stuff then, you just feel, you just lose your confidence and you lose your faith.

Some students were told directly by their midwife preceptors that they did not want to work with them, whereas other unhelpful midwife preceptors were less direct; their behaviour subtly suggested to students they were not happy with the situation. The students recognised that these preceptors may not be motivated teachers and they begrudgingly precepted students because it was “part of their job” (Beth). They also could see that having to precept a student increased the midwife's workload and was therefore might be an added burden in a busy hospital. Some students felt that the

midwives were not passionate about teaching or just saw their role as a midwife and not a teacher. The students were not overly critical of these midwives as they realised the workload pressures. Cindy said:

They are feeling overworked and undervalued and are working to get through their days, and have lost touch with a lot of the issues, with the way they can be more human. I don't want to be too harsh about that.

Unmotivated midwives tended to just go about their business caring for women and the students would follow them around. There was little interaction between the student and preceptor. Regardless of the workload pressures or personality clashes, unmotivated preceptors did not effectively facilitate learning opportunities for the students and were therefore unhelpful for students' competency development.

Some midwife preceptors had obvious uncertainty about the students' competency. This may have been related to the poor continuity of preceptorship because, as discussed earlier, continuity of preceptorship facilitated trusting relationships and an awareness of the students' competency and learning needs. It also may have been because midwives had worked with students who were not competent. Because of this uncertainty they would test the students' level of competency. Unhelpful preceptors, however, would test the students in a particular way which undermined the students' confidence.

Greta worked with one particular midwife who continually rechecked every one of the vital signs she had taken, who got the same results as her each time. The preceptor's actions made Greta feel like she was incompetent, which undermined her confidence, even though she was getting the same results. These actions made Greta feel frustrated and angry, she said: "I just wanted to chuck her out a window when every time I did something she would re-do it, like taking a pulse or a blood pressure".

The manner in which unhelpful midwife preceptors tested the students' knowledge or observed their practice was intimidating. Some students felt that midwives were trying to outwit them to expose a lack of knowledge. The students were under almost constant surveillance by the midwives in the hospital and they were cognisant of that. Some midwives, however, through their body language and manner projected a critical attitude, rather than a supportive attitude, toward the student. Ulla said that these

midwives: “would be watching out and just waiting for something to pounce on [...] they really want to test you, or even want to trick you and look for something bad”.

Nora's reaction to the behaviour of one of her preceptors in her first placement continued to influence her practice to the end of her final placement. This midwife re-checked blood pressure that Nora had taken and had a slightly different finding than Nora, then she criticised her in front of the woman. Nora explained the influence of the midwife's behaviour on her learning, saying “It affected the way that I learn. I clam up – I get really stressed”.

Other unhelpful midwives would not allow students to have ‘hands on practice’ in their final placement which undermined the students' confidence and restricted their ability to develop their competency. The students had limited time to achieve competencies and meet the NBV requirements for registration and they needed to have hands-on practice. Indigo, Eliza and Beth's comments represent how the students felt when their practice was limited by unhelpful preceptors:

When you are kind of being undermined, not by someone saying anything mean to you or being nasty to you, but just not letting you do anything. That it sort of implies that they don't think that you're capable, that they don't trust your judgement....[that] didn't really help [my] confidence. It kind of made me feel like I didn't really know what to do...and I couldn't relate to (the) woman (Indigo).

You feel like you were being babysat and a bit of a pain in the arse and you are expected even in third year, to observe for 8 hours [whilst] thinking “I'm on limited time, I could be practicing doing that myself” (Eliza)

Some midwives that we are working with will just take over and not let us do anything whereas some other midwives will be out at the desk, call us or buzz us if you need anything. It's hard for us to asses where they're at and what they're going to let us do compared to whether or not they're willing to let us do anything (Beth).

Other preceptors expected students to do menial tasks, which the students did not see as relevant for their learning, such as cleaning and running errands. These tasks may have been part of the midwives' role and in a busy tertiary hospital the student may have been helping the midwife. The students, however, felt that they did these things to the detriment of other more beneficial learning experiences. Helen explained:

I have just really felt like I was a bit of a 'gofer' really and not actually getting to do a lot at all. Like, [they would say] 'go and get the doctor' or 'can you go and get a bucket?', or whatever it might be...rather than [me] actually being the one doing all of the obs[servations] and doing the assessment and speaking to the woman and encouraging her.

Unhelpful midwife preceptors' unsupportive and unhelpful behaviours negatively influenced students' confidence, as Anna said: "some midwives can crush your confidence and you just feel like you can't do it anymore".

Aggressive behaviours from "nasty" (Dahlia) midwives or "bullies" (Dahlia; Helen; Greta) influenced some students' self esteem to the point they were emotionally and psychologically at risk. All of the students were in a vulnerable position; they were relatively disempowered by 'the system' and were easily intimidated due to their level of knowledge and experience. Three students, however, experienced bullying from midwives that significantly influenced their learning and self esteem. Notably, these three students were criticised by midwives in front of other people; Helen was criticised in front of other midwives and Greta and Nora were criticised in the presence of the woman and family. This common theme suggests that the negative influence on students' self esteem increased when the student was criticised in front of others. Furthermore, Greta's bullying occurred on numerous occasions which may be why she reacted so dramatically.

Helen recalled an incident that she described as bullying:

I had a run in with the midwife in charge at this hospital. She screamed at me "how dare you question me!" - screaming in my face and in a really violent kind of way, really intimidating and getting in my face and like waving her arms around in the air: [she said] "how dare you question me! When I tell you to do something, you do it!" "next time you'll get nothing!" screaming "go...just leave...get...GO!" I thought, 'oh my god! What's happening? Why are you screaming at me?' She was so violent I didn't know what to do. I went into the bathroom, I was crying in the bathroom and I came back and I walked around the corner and I could hear her... bitching about me to all of the other midwives that I'm "sooking in the bathroom" and I'm "so pathetic" and everything like that and then she wouldn't even look at me or didn't apologise to me at all.

She said that the influence of this midwife's behavior on her learning was significant:

It just affected my whole placement, because I'm...scared almost to come back and to face her again. I don't think I would have been able to do my job properly. I didn't want to take it any further. I don't even feel like I want to do it anymore. I felt so shook up by it. It was so like shook me completely, my pride, it was almost like I was a stunned mullet. It was really bad because none of the other midwives stood up for me. It was really inappropriate behaviour and no one said just "you know, actually, she's right!" I keep thinking 'it'll be different when I'm a midwife, it'll be different when I'm a midwife'. But to have to deal with that every day when you come in, I just can't do it!

Helen did return to placement to finish the course. Although she spoke of making a formal complaint about that midwife's actions during her interview she did not do so. After she graduated she moved interstate and did not work as a midwife.

Greta said that she experienced repeated incidences of bullying throughout the three years of her course. The serious influence of these experiences came to a head during her final placement. She said that over the years of her midwifery degree she had experienced midwives belittling her which had influenced her self esteem. She said:

I don't think I have any self esteem left. It's been horrible really...I'm um seeing my psychologist just much more frequently now because [clears throat, tears in her eyes] just the whole thing has made me feel so upset and so angry at people. I just would come home and I'd be crying because of things people had said to me [pause]. I did that [lifts pants leg to reveal a 10cm scar on her leg from a self inflicted wound which required medical attention and suturing].

When she revealed the scar I ceased the interview to ask her permission to continue recording and reiterate her right for her to withdraw. She said that she wanted to continue the interview. She explained the incident that led to her self-harm:

I was really upset after a hard day....that was the day after the midwife had put me down for not knowing what to put on the tray for the suturing [...]

There was one woman who needed to be sutured, it wasn't me who did the birth, I did the reception and she [the midwife preceptor] said "I want you to set up the trolley for what the doctor is going to need to suture the woman up" and I said to the doctor "do you want to let me know what you'll need?" Then the midwife started laughing at me and said "don't worry, she's just a student she doesn't know what she's doing". And I mean... I could have just slapped her - thanks for insulting me in front of someone, that was really nice of you [...] she made me stay back and I was really tired and [she] had been giving me a hard time all day and I just felt really horrible.

Nora similarly had a significantly negative reaction to the behaviour of one of her preceptors in her first placement, which continued to influence her practice even at the end of her final placement. This particular midwife re-checked the blood pressures Nora had taken. She had a slightly different finding than Nora and the midwife berated her in front of the woman. Nora explained:

Since that [incident] in first year, that's affected how I work and how confident I am (starts crying). It just really affects how you learn and how, thinking about going to be a grad[uate midwife], you always feel like you are going to be checked up on. I couldn't actually face going into a room and doing a blood pressure. You feel stupid when that happens; you don't trust yourself. That placement nearly killed me.

The students felt that many of the midwives were unhelpful because they were poor role models; they did not practice according to the ACM (2005) and ANMC (2006a) competencies, or the theory of midwifery practice taught at ACU. As previously established in this chapter 'the system' severely restricted the midwives' ability to practice according to these professional standards. Sadly, this meant that many of the students felt uninspired and unimpressed with midwifery care provision within the hospitals. Kelly said: "I wouldn't say I have been inspired by many midwives I have come across" and Maree said: "there were not a lot of midwives [she] was completely [...] impressed with". These comments were representative of how many students felt.

Students were critical of midwife preceptors who did not facilitate the woman's birth plans for normal childbirth. Beth sarcastically said that unhelpful midwife preceptors "teach you how to give a woman pethidine when she [the woman] first arrives in the hospital". Her comment was representative of many of the students; they did not find it a helpful learning experience to work with a preceptor who did not try and facilitate natural childbirth. The students were comfortable working with midwives who were supportive of women and their choices. Some midwives, however, seemed uncaring and disinterested which made the students feel uncomfortable. Olivia explained:

I am always much more at ease with the midwives who have an easy way with women who treat the woman like it's their body and their baby and their birth and all that sort of stuff rather than [...] talking to the bed or the door or looking away or just sort of barking orders at the women.

The actions of midwife preceptors significantly influenced the students' learning experiences and confidence. Helpful midwife preceptor support could offset some aspects of a negative hospital culture whereas unhelpful midwives' lack of support compounded students' stress and distress as they realised how the 'the system' worked.

Summary of Realisation

Realisation represents the students' ongoing recognition that 'the system' in which they were learning was dominated by medical discourse, that was in conflict with the midwifery discourse that underpinned the Bachelor of Midwifery curriculum which promoted feminist principles of women-centeredness and empowerment; continuity of care; and autonomous midwifery practice. The majority of hospitals in 'the system' were dominated by medical discourse which facilitated medical dominance and restriction of midwifery practice and autonomy. However there were several hospitals where medical discourse had less influence over care provision and individual midwives' practices within the hospitals.

Whilst on clinical placement the students were working with midwives and the midwife preceptors had significant influence on the students' learning and competency development as well as their self esteem and confidence. Helpful preceptors appeared to be motivated teachers who facilitated the students' learning, were supportive and positive role models. Unhelpful preceptors on the other hand appeared to be unmotivated teachers and were unsupportive of student learning and for some students this had serious consequences for their learning.

As the students approached the end of their three year Bachelor of Midwifery course they became aware of the severe restrictions placed on the way midwives and they as students were able to practice. All of the students realised that they would need to learn to work within 'the system'. The next section of this chapter, adaptation, explores the social processes students used whilst adapting to work within 'the system' to achieve competency for beginning practice.

Adaptation

'The system' as previously identified was a source of conflict for students, however, they all realized that they needed to compromise to adapt – or fit into – 'the system' to achieve competency. 'Adaptation' represents the ongoing adjustments the Bachelor of Midwifery students' made to fit in to 'the system'. The Cambridge dictionary (2008) further defines adaptation as the "process of changing to suit different conditions" and is a perfect description of the students' actions to fit in to the system. As Helen explained:

You do have to pretend, like you have to mould yourself and try and pick up on what they want you to do [in relation to the care of women] and who they want you to be and when you do, you say to yourself 'that's pretty bad'.

The students' awareness of the need to adapt to the system was discussed in both the first and second interviews. The students' relative lack of knowledge and experience made them feel powerless and vulnerable, encouraging adaptation and making them susceptible to the influences of medical discourse which dominated 'the system'. They were also compelled to adapt because they were reliant upon the system to get the experience required to achieve competencies and meet the Nurses Board of Victoria (NBV) requirements for registration.

All of the students in this study modified their behaviour to adapt to 'the system' or, as Yvonne stated, acted like "chameleons", meaning they changed their persona and practice to fit in with each facilities' modus operandi and each midwife preceptor they worked with. The students felt it was necessary to behave in a certain way to facilitate positive relationships with the midwives they were working with so that they felt accepted as "part of the team" (Maree). As Nora said, "you want to impress, you want to be in the crew and you want to do what other people are doing". The students tried to flexible to each midwife preceptor's expectations. As Indigo explained:

I really think that a lot of your relationship with the people you are working with has to do with how you behave, because basically... they don't need you, you know, you need them. So you're the one that needs to kind of...they're not kind of going to alter their behaviour to keep you happy, because it's no skin off their nose if you go home without having done everything you wanted to do ... just even things like, just phrasing something [how you phrase things].

The students were also dependent on their midwife preceptors to teach them the practical aspects of midwifery and facilitate learning experiences. They believed that if they did not behave, or adapt to the system, they may not get the experiences they needed to achieve competency. Vera noted that if she refused to do what she was asked to do “then you don’t get the birth the next time and its tension the whole time. They are in the tea room having a word about it saying ‘bloody student doesn’t do what she is told!’” Helen, in a similar vein, said:

I’m like in this situation now that I’m vulnerable and at your [the midwives’] mercy. I just need my births, I need you to allocate me to women that are going to deliver and not end up a caesarean [...] I think ‘oh God I just have to put up with this?’

Students did not want to be seen as “trouble makers” (Helen) or get a reputation for being confrontational or aggressive. They were made aware of their low position within the hierarchy and felt powerless to challenge the system and, when students had personal issues with their midwife preceptors they did not raise them for fear of being ‘punished’. The punishments identified by the students were lack of support, being excluded from learning experiences, social isolation, criticism and intimidation. Helen, who considered she was bullied (as discussed earlier in this chapter) in her final placement, explained that she did not complain because:

I thought it would jeopardise my placement and I’ll get a reputation like ‘oh that student just causes trouble’, because that’s already happened to a few other girls that did the course, they had problems with the same midwives in charge and then the clinical educator said something to them and they got that reputation and as a result they are behind. In a way you just have to grin and bear it because you have to get through.

The students were also cautious about questioning the midwives’ or doctors’ practice for fear of being seen to be critical. Honest debriefing about the woman’s care was rare which, in the students’ eyes, limited their learning. From their perspective the emphasis during debriefing was on explaining or justifying the actions of the midwife or doctor. Students therefore sought debriefing with others about their concerns about the treatment of women such as clinical teachers, mentors, other students, family members, friends and counsellors.

While these people may have been helpful, they were not present during the incidents of concern and may not always have had the knowledge and/or experience to counsel the students about midwifery clinical decision making. At the same time there were some students who internalised their concerns and this was not helpful for their emotional wellbeing. Helen said that questioning the midwife or doctors' decisions or practice was futile because "it's not going to get me anywhere and it's not going to change anything"; questioning practice risked offending the midwives and exposed the students to punishments as mentioned above. Maree emphasised:

You have to be very careful that you don't open your mouth too far with your colleagues as well because it's just a culture you have to adjust in a way and if you, if you come with different ideas you become an outsider and you can get bullied and stuff like that.

Indigo similarly noted:

If you rub people up the wrong way they are not going to help you, and when I do have a bad experience they are not going to be that sympathetic; they are not going to be as supportive to me and I am going to feel like I am arguing with everyone and that's not going to help me.

In fear of these punishments, and respecting the knowledge and experience the midwife preceptors could share with them, the students took a subservient role within the system. They recognised they had a lot to learn and the midwife preceptors' support, knowledge and experience was crucial for their learning. Those students who were construed as critical, inflexible, confrontational and overly assertive were not as well supported as students who were seen as flexible, respectful and had an enthusiastic attitude. Indigo's description of her attitude was representative of the latter:

I am here to learn everything I can and I will do everything you want me to do. You tell me where you want me to go and what experience you want me to have today and I will do it. ...I feel like that is going to get me what I want.

The students' adaptations reflect the operation of Foucault's (1995) theory of disciplining practices, along with his theories of discourse, power and knowledge (Foucault, 1972; Danaher et al., 2000). The previously identified dominant medical discourse within 'the system' emphasised pregnancy and childbirth as risky, medical surveillance as imperative and swift intervention to protect the health of mother and/or child the aim. Within this system both the women's and midwives' autonomy was

restricted due to medical dominance which was often accompanied by paternalistic attitudes. The alternative midwifery discourse, taught within the Bachelor of Midwifery curriculum, promoted: women-centred care; female autonomy and empowerment and a wellness/primary health care; and a model of maternity care with an emphasis on evidence based midwifery and consultation with obstetricians when complexities arose.

The students felt compelled to conform to the dominant medical discourse and social norms and did so via self-regulation of behaviour. This behaviour was such as not to cause conflict by questioning the knowledge or expertise of the midwives or doctors as well as always being enthusiastic and appreciative learners, as Maree explained:

There is a hierarchy and you just have to adjust to that, and even if I am 44 (years of age) I am just a little student you know. Even if there was 25 year old experienced midwife, she is much more experienced than I. I think you have to adapt to the environment and you know, I have never got insulted if someone tells me, or told me, that I should ... empty whatever or clean something. So I guess you have to adjust and be sensitive to the moment and just do it. I guess some students just don't do that. They [think], 'you know I am here to this and to do this and to learn that' and I guess they have an attitude which is sometimes a bit, yeah which can annoy some midwives...especially those midwives who like to find a victim for bullying anyway.

As well as influencing the students' actions within the learning environment, the system and its prevailing discourse insidiously influenced the students' learning as they sought to achieve competency. Beth said:

It's a bit of shock when during my placement, because I'd heard it so many times when a woman said "this is too hard what else is there?" I thought to myself, there was a little voice that said, 'do you want some gas?' Because that's what you hear all the time. It's hard to fight that off and go against that, and offer a shower or change of position etc. etc. I think that working in that environment makes you the person that you are and that's why all the midwives work in a similar way.

The system influenced the students' behaviour in other ways.

The Influence of the System

The influence of the dominant medical discourse on the students was also evident in their language and one could argue subsequent actions. Despite deliberate attempts

within the Bachelor of Midwifery curriculum to use positive feminist language as a means of empowering women (Cutts et al., 2003), all of the students, at various times, used language that reflected medical discourse, such as calling women 'patients', births 'deliveries', or midwives 'nurses'.

Several students, following the example of others in the system also categorised women by referring to them by their diagnoses. For example Greta noted: "I had a PPH [post partum haemorrhage]" and said "give me all the gestational diabetics, give me [allocate me] all the twins and all the epidurals". By doing this she did not acknowledge the woman but rather she portrayed women as a medical condition to be treated or managed.

Sometimes students used colloquialisms which reflected a medical risk discourse by highlighting the potentials for disaster in childbirth, e.g. "the baby that everyone thinks is happy as Larry [demonstrating normal heart rate patterns] is usually the one that comes out flat [and needing resuscitation]" (Tania) and "you know those [umbilical] cords can be dodgy" (Tania). Furthermore, Kelly, when referring to her perceptions about the change in the birthing environment when intervention was imminent, said: "you can just taste it, it sort of all builds in the room and then it just goes bang! It's like someone just changes the dial on the thing..." The 'dial on the thing' she was referring to was the birthing environment, which creates a sense that the birthing environment within the system was akin to a machine - a machine that was constantly monitoring and on alert for danger.

There were also some contradictions between the students' philosophical stance as reflected in interviews and their observed practice. Their philosophy of practice was aligned with midwifery discourse and while they would criticise care they observed, they were also observed (not unreasonably) practicing similarly to the way that midwives did within the system. For example, the students were observed (contrary to best practices) directing women to hold their breath and push, 'flexing' the baby's head and 'guarding' the woman's perineum in second stage. When I asked them about the evidence to support these practices they said they knew the research evidence did not support it, but if they "didn't do it the midwife would anyway" and many said they were

not confident practicing according to theoretical evidence if they had not seen it implemented in practice.

The students also said that there were many inconsistencies in midwives' practice and, because of little continuity of preceptorship, they were often adapting and readapting to each midwife preceptors' practice and expectations. Due to this situation students became confused about their own beliefs, their sources of knowledge and the 'right way' to do things. For example, when referring to the sources of knowledge which influenced her midwifery practice, Xena said, "You try to think back for something to say [to women] and you think 'have I just learnt that from another midwife? Or have I learnt that at uni? Or is that evidence based? Or is that just something my mum has told me and is really random?'"

By the end of their final placement the pervasiveness of a system dominated by medical discourse began to influence the students' philosophical beliefs. They became 'worn down by the system' and some said they began to lose confidence in women's ability to give birth normally. As Anna explained, "you get to a point where you almost feel like you don't trust that women can give birth anymore..."

The discourse was powerful because it communicated knowledge or 'truth' about the expectations of student behaviour and midwifery practice within the system. Within 'the system', the knowledge and experience of the midwives and doctors afforded them power, whereas the students (as well as women) were disempowered by their comparative lack of knowledge. Midwives' and doctors' practice and beliefs, therefore had significant influence on the students. As Wendy said, the midwife "is the person who is teaching you and they are the knowledgeable person in the room so of course you are going to pick up what they say."

Power was exercised within the system via disciplining practices (Foucault, 1995). The disciplining practices identified in this study were social exclusion, restriction of relevant learning experiences, intimidation and criticism. The students' awareness, or personal experiences, of these practices compelled them to modify their behaviour to meet the expectations of the system, and conform to practices heavily influenced by medical discourse. The students were fearful of challenging practice and, although they

would criticise care with others outside the hospital, they would not honestly discuss their concerns with their midwife preceptor. As Helen said:

It's [questioning practice] not going to get me anywhere. It's not going to change hospital policy. I'm not going to go in there as a student midwife and say 'this is how you do it' because people are just not going to go 'oh, really?' [...]

Helen went on to give an example of what could happen if you did question the system:

When I was working in one hospital doing my final birthing placement...the midwife in charge said, 'quick come in here and meet this woman' and she quickly introduced me. There was head on view and the midwife said 'this is supposed to be so and so's [another student's] birth but we don't like her so we are letting you do it' ...I got two of her women's births that day! They did not like her because she 'rocked the boat'.

In keeping with Foucault's (1995) notion of all participating in a network of power, despite their relative lack of power within the system, the students did have had some limited power, or agency. Through learning how the 'system' worked and adapting to it they were able to manipulate it in order to get the experiences they needed to achieve competency. Being seen to be flexible and non-confrontational improved students' relationships with their midwife preceptors and this meant that they were trusted, which afforded them more freedom.

The students believed that when their midwife preceptors trusted them they were more likely to leave them to care for women (or 'play midwife' – which is discussed later in this chapter), whilst acting as a supportive resource. This then gave students the opportunity for more independence and less surveillance of their practice. As Vera said:

If you feel confident that the midwife has confidence in you as a student or trusts you with the woman I think that makes a big difference. If you feel someone is looking over your shoulder all the time and double checking everything you do and like you take a blood pressure and they do it again to check it's kind of a bit disempowering.

The students then gained more practical experience and felt like a valued member of the workforce and increased their competency. As Maree explained:

[When] you have built up [...] a relationship with your preceptor knows where you are and they trust you and they give you more and more things to do. She trusts you so much, she helps your confidence in showing you the

trust to do it [play midwife]. She says 'I trust you and I know that you can do this'

Trust was more readily achieved when there was continuity of preceptor, however the general lack of continuity of preceptor identified in this study was a significant challenge to students establishing trusting relationships with their preceptor. Despite this, most of the students were able to work with the situation and reassure their preceptors that they were trustworthy enough to 'play midwife' by the end of their final placement.

In the absence of continuity of preceptorship, the students used various strategies to convey their trustworthiness to the midwife preceptors. One of these was through conveying enthusiasm for learning as the students believed that the midwives wanted them to be motivated learners. Dahlia said that she thought that midwives would "end up trusting you a bit more, and will support you more if you show that you want to make the most of your time with them.." and Indigo similarly said "I kind of show them that they can trust me and that I am competent so I try to be a little bit enthusiastic".

Effective communication between the midwife and student also helped to build trust. The students often initiated conversations with the midwives about the care of the woman to reassure the midwife they were caring for the woman appropriately. All of the students would "double check" (Anna) with the midwife when they were unsure about something. The midwives told the student that they wanted them to ask questions and report back to them midwife frequently whilst caring for women, to let them know what was happening when they were not in the room. They would therefore initiate discussions with the midwife both demonstrate their competency and put the midwife at ease. For example, Dahlia explained:

When they really don't trust me I kind of cue them like 'I can check the resus[citation equipment] do you want to check it as well?' I suppose just talking to them as if everything is under control and that you've got everything ready and then just giving them a quick summary of how your lady is going.

Casual conversations extending beyond the professional also helped students to build trusting relationships with the midwife preceptors, as they got to know each other on a more personal level. The student would initiate discussions about things other than

midwifery to find common interests. For example, Cindy said she would relate to her preceptors by “talking about animals and pets and things”. She believed her ability to relate socially helped her to successfully build trusting relationships with preceptors that other students did not get along with. This highlights how individual personalities also played a part in how students were socially accepted in the system, not to mention students’ awareness of social conventions being a route into smoother working relationships.

Most of the mature-aged students felt socially included and trusted to care for women with minimal supervision during their final placement, whereas some of the students felt, because of their age, they were treated as “young whippersnappers” (Nora) by the midwives. As Maree explained: “because I am mature I am already over 40 so I guess, unfortunately, people respect you in a different way than when you are a 20 year old student on placement”. A few of the other mature aged students also felt that their professional and life experience afforded them a greater degree of respect.

The degree of trust also varied with each student-preceptor relationship. Sometimes the level of trust was high and the students were able to have a greater degree of independence and a broad scope of practice, whereas at other times the degree of trust was low and the midwives would closely supervise and guide the students’ practice. Indigo explained how her confidence increased when her preceptor trusted her:

When she didn’t check it [a vaginal examination] it really made me feel much more confident and it made me feel that I could relate to them [the midwife] on a much more on a professional level and like collaborate with them in her [the woman's] care.

Greta, on the other hand, worked with a midwife preceptor who obviously did not have a great degree of trust in her competency in her final placement because she rechecked every one of the vital signs Greta had performed. The preceptor’ actions made Greta feel like she was incompetent, which undermined her confidence. Greta became frustrated and angry, saying: “I just wanted to chuck her out a window when every time I did something she would re-do it, like taking a pulse or a blood pressure”.

The students’ agency or ability to practise as they would have wished was influenced by the prevailing discourse within the hospital and/or the midwife preceptor’s individual

philosophy. All, to a greater or lesser degree, critically reflected upon the influence of medical dominance within the system and, as they aspired towards midwifery practice rooted in midwifery discourse, attempted to resist the influence of the medical discourse upon their ideal of midwifery practice. Approximately half of the students said that they worked with positive or inspirational midwifery role models at least once during clinical placement throughout their three years of the course. These role models were more common in certain hospitals (or settings) and they more closely reflected an ideal of midwifery care. They also helped the students to see that midwifery practice could be closely aligned with the philosophy of the course. As Indigo said:

I think if you spend too much time somewhere like the [hospital name removed] it would wear [me] down. For me it would anyway, because I just wouldn't have the energy to fight it all the time. But there are ... other times where...you keep getting reminded, through various...ways of how things can be. I remember when I went to [hospital name removed]...it was like a breath of fresh air because I felt like I could actually practice more or less what we were being taught.

This type of exposure and critical reflection allowed students some agency to develop a midwifery-self which was informed by the alternative midwifery discourse. Many of the students also said they used critical reflection as an opportunity for learning from negative experiences. Anna said:

I really struggle with that [the care of women]. I put myself in her position and wonder what that birth must have been like for that woman. She has a healthy baby but is she going to be reflecting on that birth for the weeks and months to come and just wonder why it happened that way...I think some births are really horrible in hospital and I think that's something that will be a real focus for me to make sure that that woman's experience is not one that she would look back on and think that was a really horrible experience. Because I've seen lots of them...it's horrible.

Kelly, as a reaction to a negative experience, decided she was going to be a midwife who provides information for women and empowers them to make informed decisions about their care:

I don't think I am going to easily adopt a lazy practice [upon graduation] and just sort of go 'oh, look that is just protocol or that's just this'. I just think I still feel really committed to telling women this is the protocol of the hospital it's your right to say no you need to be informed about it.

Students generally acknowledged that, while they were still students, they would “go with the flow” (Olivia) and bide their time until they graduated. After graduation they hoped to have more power to advocate for women and freedom “to do what they want” (Olivia). Several students said they managed to advocate for women towards the end of their final placement as they gained confidence. For example, Indigo reflected upon a situation where a midwife was being disparaging about a woman in labour:

The midwife went up at handover [to the new midwife on shift] and said "oh, you know so and so? She's just a miserable little one" and I kind of looked at her. I didn't back her up. That was my way of disagreeing with her was to not say "yeah"... I just looked at her like, blank - not going there and she looked at me and she said "well I am sorry but she is!" and I just didn't say anything and then as we walked down the hall...I said [to the new midwife] "oh, come and I will introduce you" - cause that is what midwives do and I was being midwife - I said to her "look she is not a miserable little woman she is lovely, she is just quiet. She has come in she is just labouring away. She is just she is really nice you know. This other midwife had been in for about 5 minutes come in to tell her she was holding on to her contractions" The midwife said "oh yeah I am sure she has just been on night shift she is grumpy" and I thought 'well I have just been on night shift too!' Then I warned all the other girls about her and then they all had stories about her as well.

Kelly similarly advocated for a women in her care by questioning the midwife's suggestion to artificially rupture the woman's membranes:

I kind of just stood there and said [to the midwife] "what is the indication to rupture the membranes?" I said "she has progressed, she has gone from seven centimetres to nearly fully in four hours and the membranes are still intact. She is labouring well, she is working with it beautifully, she is active, she doesn't have an epidural, hallelujah! Let's just leave her alone".

Summary of Adaptation

Adaptation represented the processes the Bachelor of Midwifery students used to fit in to the system and the influence of the dominant medical discourse upon the students midwifery competency development. Essentially, the students socially adapted to the system by taking a subservient position, motivated by the need to feel socially accepted and to have the necessary practical experience in order to achieve their learning objectives. The strategies they used to fit in were modifying their behaviour, avoiding conflict and building trusting relationships.

As the students became acculturated in the medical environment their beliefs and practice were adapted to fit in to the system to the point where some felt a lack of trust in normal birth. The students did, however, have potential for resistance, as they critically reflected upon the practices within the hospitals. These students hoped that they would have more agency post graduation and would be able to practice in the manner to which they aspired. Whilst the students were realising the way that the system worked and were adapting to this system they were also consolidating their knowledge and skills to build their competency.

Consolidation

Consolidation represents the social processes and related strategies the students used to bring together their knowledge and skills for competent beginning practice. Competency was essentially a combination of knowledge and skills gained and development of their midwifery identity, one which was consolidated within the context of 'the system'. The students' level of competency was evaluated via competency assessments, using preceptor/clinical teacher ratings and student self ratings of competency according to the ACM (2002) or ANMC (2006a) competency standards for the midwife, and documentation of specific experiences required for registration as a midwife with the Nurses Board of Victoria (NBV).

Whilst trying to maintain a woman-centred focus, the students practically applied their theoretical knowledge and, through repetition, consolidated their practice. Toward the end of their final placement they were able to extend their practical experience to case-manage women under the supervision of a midwife preceptor, a process where they attempted to put the woman at the centre, or make them the focus of their care. Indigo called this 'playing midwife'

Playing Midwife

Playing midwife represented all of the students' experiences of increased independence in practice that occurred towards the end of their final placement. Olivia, describing

how 'playing midwife' occurred, explained how students would often spend time with women whilst the midwife preceptor was not present and, in the midwife's absence, begin to take on the some professional responsibility:

Being a student often you spend the most time with the woman - more than the midwife - because they might have another woman that they are looking after and fairly often they say "well you stay with this woman". So I might be in the room for most of the time and so you do have that kind of professional role. But at the same time you don't have the responsibility that the midwife has. I don't feel as responsible for the outcome of her labour and birth as I think I would if I were her midwife. [...] So I try and behave like I would if I were a midwife, or as if I am a midwife with the woman. But you always know you know that the midwife, the real midwife, might walk in at any moment and say "right, well, we are going to do this now" and you just go "okay" and you have to kind of step back and do what they say. So when they are not there you can play midwife and when they are there you play student.

'Playing midwife' usually occurred later in the students' final placement with "straight-forward labours" (Indigo) where the midwife preceptor would be available outside the room for longer periods of time, rather than constantly supervising the student. As the students were close to graduation the midwife preceptors and students felt competent enough to play midwife. As Maree said, "they know that you are a third year student and that you are on your last placement. So they really let you do more things and give you more responsibility". This role was initiated by the midwife preceptors who, the students believed, were supporting their learning. As Helen said:

They [midwife preceptors] want you to learn - not just bludge through [not do enough work] and kind of just walk through the course. They still help you to learn by kind of saying "now, you do everything, and they kind of push you off to do it." That's a good thing, it's kind of nerve racking in a way because it kind of forces you to be independent. [...] Then you are more independent, then you say 'well, I did it myself today' and 'I wrote all the notes and I did the delivery and she (the midwife) was more just watching me and was there if I needed her. It was more, like, just me.

The students believed that they were subjected to a high degree of surveillance from their midwife preceptors and that a certain degree of trust was required for this surveillance to lessen. Playing midwife therefore allowed the students a unique opportunity to care for women without feeling observed. Many of the students said that the decreased level of surveillance by the midwife whilst they were 'playing midwife'

allowed them more space to learn and care for women without feeling “under pressure to perform” (Wendy). The students suggested that they felt more relaxed when they were not under scrutiny. As Ulla explained:

I think that, for me, I work better not watched. So if I've got a bit of space to go [...] and care for a particular woman. I do a much better job than when I'm watched.

The midwife preceptors' surveillance and presence in the room had a significant influence on the students' practice. Many students said that in the presence of a midwife they would 'step back' from taking greater responsibility and such an active role in the care of the woman. As Maree explained:

It's a very different atmosphere than if the midwife is with you because you know in a way you want to respect that she is the midwife you are just a student and you don't want to be too pushy. So do you always, you step back a little bit and at the same time when we step back we you rely on the midwife.

Maree's comment alluded to how all of the students deferred responsibility for the woman's care when the midwife preceptor was present. When deferring responsibility the students relied upon the midwife preceptor to monitor the woman's labour and birth. As Indigo said “if the midwife is in the room, even if she lets you do things and trusts you, she is still [...] the one who looks more after the woman than you as a student.” Although they could learn a great deal from the midwife's actions and decision making when she was present, during their final placement they wanted to practice making these decisions whilst still a student in a supportive environment. They could then test their own knowledge and skills safely, as the midwife preceptor was available to support them whenever necessary.

During field observation the students often 'played midwife' in birth suite and I had many opportunities to observe the influence of the presence (and absence) of the midwife preceptor on the students' behaviour and engagement with the women/family. The students did act differently when the midwife preceptor was present. When the midwife preceptor was absent the students seemed more able to build and maintain a rapport with the family. When the midwife preceptor was present, however, the student would be quieter, and interact less with the woman and family, and would interact more

with the midwife. Furthermore, students would defer responsibility when the midwife preceptor was present.

One scenario which highlighted this was when a student was attending a woman whilst she was pushing. When the midwife was absent the student was very attentive to the woman, she talked to her about her birth plan and wiped a damp face washer over the woman's brow. When she was pushing the student remained engaged with her and her partner, quietly encouraging her whilst also observing her vagina for signs of crowning. I noticed that when the midwife preceptor returned to the room the student moved away from the woman.

When the next contraction came, the midwife and the student moved together and stood at the end of the bed, staring at the woman's vagina and chanting "push...push...push!", which was not how the student was interacting with her before that. "Hold your breath" commanded the midwife "No! Hold your breath!" After the contraction the woman asked "would having my legs further back help?" Nobody, including the student, answered her. The midwife and student stayed at the end of the bed. The student motioned with her hand towards the stirrups, looking at the midwife questioningly. The midwife ignored her then turned the overhead light on, shining it on the woman's vagina.

Essentially, the student acted in the way the midwife preceptor did and therefore became less attentive to the woman and more attentive to the midwife. This type of behaviour was frequently observed. Students commonly moved away from the woman when the midwife preceptor entered the room. During the interviews the students also said that midwife's presence influenced how they related with women. As Anna explained, "when a midwife comes into the room and takes over they destroy the relationship you have built up with the woman".

When the midwife was not present and the students were 'playing midwife' they felt more responsible for the care of the woman, which had a positive benefit for the students' competency development. It allowed the students an opportunity to have increased responsibility for the care of women whilst still supported by a preceptor. As Maree said:

Being on your own with a woman is how you learn the best, because you are kind of stepping into the midwife role in the midwife's absence. Even though you know that she is outside the room and at any moment that you can get her support. So it is like being thrown in the deep end supported - with a life raft.

The increase in responsibility meant that students were challenged to concentrate and think critically about what was happening in the room. They had to be alert for any change in the woman or babies' condition and seek help if required. 'Playing midwife' therefore refined the students' diagnostic and complex care management skills:

As an example...if we're sitting next to a woman and the CTG's on for whatever reason and there's dips, rather than just saying "help!"[...] I try all the things and then buzz, or buzz as I'm doing the things... (Beth)

I'm in the room and suddenly the heart rate goes down to 60 and stays there and it's like...I can't go out and like "can you help me?" I need to do things in the mean time. While you press the [call assist] buzzer and get people to come and like kind of everything goes in slow motion and I'm like 'okay, do this, this and this' and I'm like doing what I need to do (Helen).

Additionally, 'playing midwife' was beneficial because, in the midwives' absence, students developed independence in practice as they took on a greater role and felt more autonomous. Playing midwife also significantly contributed to students' critical thinking skills and sense of responsibility. The sense of increased responsibility motivated students to identify and address gaps in their knowledge and/or skills because, as Maree said, "when you work a little bit more autonomously [...] that is where you learn and that is where you find out where your weaknesses are and where you have to do more study".

The increase in responsibility also helped students to consolidate their assessment and critical thinking skills because they assessed and managed the woman's care whilst the midwife was absent and referred to her when decided it was necessary. As Cindy said:

When the midwife is there you are not in control and you don't have so much responsibility. Whereas when you look after the woman on your own you just, you just concentrate differently you just have the responsibility that is how you learn. Like suddenly [...] there are some changes in the CTG. You have to be switched on you have to just be alert of things, how things are changing.

'Playing midwife' also allowed students the opportunity to integrate the skills they had learnt over the past three years and to practice the whole experience of caring for women rather than just performing a task in isolation; as Cindy said, it allowed students to "think about the bigger picture rather than just that one little task". Furthermore, according to Helen, it allowed students to have a greater understanding of their role and responsibilities upon graduation:

there's all these little things that sometimes you don't even realise the midwives do...but that's still part of your job so you need to know how to do it and if they [the midwives] give you that opportunity [to play midwife] it's really good [for your learning]. (Helen)

The increase in students' responsibility and autonomy, and reduced supervision from the midwife preceptor, meant there was potential that students might be put in situations where they were not competent to manage. To ensure that 'playing midwife' occurred in a safe manner, there were certain mechanisms in place; Maree likened it to a "life raft". This life raft encompassed both students' and preceptors' attitudes and behaviours that, on the whole, ensured that women's wellbeing was not jeopardised whilst students were learning through 'playing midwife'.

The students were responsible for being aware and honest about their own limitations in regards to what situations they could handle and when they needed support. Most of the students in this study demonstrated that they were aware of their limitations; they all discussed scenarios where they sought and received help from the midwife preceptor in appropriate circumstances. Students were always allocated a midwife preceptor who oversaw their practice and provided support when needed.

When 'playing midwife' the students said they always had a supportive midwife preceptor who was available as a resource if they needed them and this made them feel like 'playing midwife' was safe. When a complex situation arose or the birth was imminent the midwife was present and took an active role. Students were however less supervised during care of the woman in first stage labour and during the immediate postnatal period.

During field observation the students were left alone for periods of time, but not during critical times such as an imminent birth or emergency situation. They also appropriately

liaised with their midwife preceptors about the care of the women. Furthermore, all of the women were monitored via CEFM and the data was available at the midwives' desk outside the room, which afforded the midwives more surveillance of the woman than if this was not available.

Many of the students recalled situations where they recognised the need for the midwife preceptor to come in and take over, and all of the students said they sought help during emergency or complex situations. In these situations the midwives or medical staff would appropriately "take over" (Dahlia) from the student. The following are two examples:

I was doing a set of obs[ervations] and I checked her [uterine] fundus and she had a bit of a gush [of blood per vaginum] at the time. I had a look and was rubbing her up and it was still trickling so I went out. I was right opposite the nurse's station so I just popped my head out to see who was out there and ask that midwife to come in. She came in and rubbed up the [uterine] fundus and she said to go and get the other midwife (Indigo).

I'd been...just completely by myself with the woman and her partner and the midwife I was working with said, "you're going to do the whole birth and just call me if you need to". Then there was Mec [Meconium present in the amniotic fluid] and she came in and took over [the care] (Greta).

Regular communication of the status of the woman and family was also encouraged and students would confer with the midwife preceptors about how they were caring for the women. As Greta said, "people would much rather you ask questions for fear of looking like a dill and stuffing it up, particularly if it's something that could be dangerous", which again highlighted the presence of the medical discourse. She also said:

She [the midwife] would say "you've got to make sure that you are talking to everyone out here and letting everyone out there know what's going on in there". I said "oh I thought I was doing that" and she said "you were, but just remember to keep on doing it".

There was only one occasion identified where inadequate communication and supervision was noted during field observation. In this instance the student was left alone whilst the woman was giving birth, despite her attempts to call for her preceptor to help. The student, informally interviewed during field observation, explained that she was 'playing midwife' and the woman had a rapid labour. When the birth was imminent she rang the buzzer but her preceptor did not return in time; the baby was born with

only the student in attendance. The student said that she was happy because the baby and mother were fine and she felt confident that she managed the birth well in the absence of her preceptor. However, this situation highlights the need for students to have a preceptor available at all times.

This was an isolated incident and there were no other examples of lack of student supervision in this study. The example does, however, highlight the fact that whilst 'playing midwife' there is the potential for students to be exposed to professionally difficult situations. If there is was a negative outcome related to the students' inexperience then this would be unacceptable for the woman and family and professionally detrimental for the student.

A major challenge was the lack of preceptor continuity when students were 'playing midwife'. This made it difficult for the preceptors to adequately ascertain if the students were competent to be left for periods of time to care for women. Most of the students acknowledged during interview that their midwife preceptors needed to assess their competency before allowing them to 'play midwife' and that it takes time to build a trusting relationship. Helen explained that midwife preceptors were only comfortable letting her play midwife after they had adequate time to assess her practice. In some circumstances, midwives would say to her "you've seen me do it, you've been here a week, now you can go and take care of that woman and do all the notes".

The midwives who were informally interviewed during field observation also said that they felt more comfortable to allow students to 'play midwife' if they worked with the same student on more than one occasion. The lack of continuity was therefore a barrier to them adequately assessing the students' capability to 'play midwife' and if they couldn't adequately assess students' ability to care for women they were not comfortable leaving the student in the room on their own.

One midwife said "it's usually just a fluke if you work with the same student twice and if I work with her again I'll feel more comfortable" letting the student play midwife. Most of the midwives seemed to err on the side of caution when leaving a student that they did not know well unsupervised in the room. As another midwife explained to me, she tells students "not to take it personally but she will supervise their practice" because

she has “worked with students who were confident in their practice and say that they don’t need supervision when they do”.

When students were ‘playing midwife’ they felt valued for the contributions they could make to the team which increased their confidence. As Eliza said:

I’d like to be useful...I’m not saying give me a patient load but surely I can do something I can learn from, but will also benefit your unit for the day. Like don’t sort of think like you have to baby-sit me. I hate being ‘well what do I do?’ standing around like an idiot with hands and not doing anything with them.

The midwives informally interviewed during field observation agreed that a capable student in their final placement was appreciated because they could practice more independently. Furthermore, because they were not constrained by work pressures, they could provide one-on-one support for women in birth suite. Feeling valued by the midwife preceptors increased the students’ self-esteem and confidence in their practice.

The students’ confidence was also increased when they were able to prove to themselves, via ‘playing midwife’, that they could provide care for women in a more independent capacity. ‘Playing midwife’ was also opportunity for them to prove to themselves that they were capable to practice as a midwife after graduation. As Helen said, she felt like “if I can do it today then I can do it next year when I’m doing my grad year” and Vera described how her confidence increased when ‘playing midwife’:

If you feel confident that the midwife has confidence in you as a student or trusts you with the woman I think that makes a big difference. If you feel someone is looking over your shoulder all the time and double checking everything you do and like you take a blood pressure and they do it again to check it’s kind of a bit disempowering.

The students strongly emphasised their need to gain confidence in their practice and there was a relationship between students’ feelings of confidence and their competency development.

Gaining Confidence

Gaining confidence was described as a “big issue” (Cindy) for the students because, when confident, they were more inclined to seek opportunities to practice their skills

and therefore develop their competency for beginning practice. Furthermore, many students said that confidence and competency were interrelated concepts. Their perceptions of their competency relied on their confidence in their practice, and their confidence was increased when they felt competent. As Anna said, achieving competency was “definitely a confidence building thing” and “your confidence has a lot to do with how competent you feel.”

Many other students said that gaining confidence was a significant aspect of their competency development. For instance, Beth defined competency for beginning practice as: “personal development and having the confidence as a student midwife, or as a midwife, to be able to say I can do it”. Cindy concurred:

I reckon I'll feel competent when I've assimilated a whole lot of skills and I'm doing something without thinking and feeling anxious about it, and then I feel confident. It happens because I'm not thinking and stressing about it. It's like being left in the room alone to do things that have to be done. Suddenly you realise 'you did that, and you did it reasonably well', and then I think 'that's okay, I'm on track'. There is a level of confidence.

Students said that they needed to gain confidence in themselves in order to practice the necessary skills to achieve competency:

If you are not confident in doing something how would you want to gain the competence? You have to practice it and [...] to gain the competence you have to practice it a few times and you need the self confidence that you can do that [...] or at least you can achieve that by practicing it (Maree).

The students relied on two aspects of confidence: self-confidence and practice confidence (that is, their ability to practice as a midwife, or competency). They needed a certain degree of self confidence - arising out of support from the midwife preceptor, prior knowledge, positive practice experiences and self-esteem - to step in and practice to become competent. Once they felt competent they became more confident in themselves. As Dahlia explained:

It's not until you feel like you are learning it and you think 'no, I can do this, it's not as bad as I thought it was'. Once you've got that confidence um...you can tick it off that you are competent in that area.

With practice the students' level of confidence and competency increased. As Maree explained; “you are already a bit confident, then you do it” and the students wanted to

repeat their skills to increase their confidence in their competency. Furthermore positive learning experiences, or “having a few wins along the way” (Cindy), such as thinking ahead, remembering what to do and meeting the needs of the woman and the midwife preceptor all contributed to students' feelings of confidence.

Continuity of preceptorship and familiarity within the clinical environment also increased students' feelings of confidence. This again highlights how consistency of hospital placement and preceptorship was important for students' competency development. For example, Beth said that “knowing the ropes, knowing the routine of the hospital and the staff, getting to know the staff” helped her to feel more confident, while Anna said:

When you start again in a new place and competence that you had, or feeling of competency, goes back to some kind of base level. I suppose it's like you're at the basic level that you have and then it takes a while to build it back up again. [...] knowing about routines and knowing where to get things in a hurry and things like that affect how confident and also more competent you feel.

Previous life experience also increased students' feelings of confidence. Some of the mature-entry students said that their experiences with home-birthing, before they commenced the course, contributed to their confidence. Others said their age afforded them greater “life experience” (Cindy; Olivia) and “maturity” (Cindy), which gave them confidence. As Olivia explained:

I feel as though my age has given me an advantage because you know [then] I have got like other things to bring to it [midwifery], other life experiences and years of evolving thought processes about myself and about other people.

Maree felt that her previous experience as a nurse was helpful because she “had the advantage of doing already some of the clinical skills, like injections and stuff”. Dahlia, a younger student, felt she had the advantage of recent study:

I think that the other girls that came from year 12 found [the theoretical aspects of the course] it a lot easier if they had done bioscience subjects. Because it was so similar, and we knew our textbooks back to front in year 12. So it was probably easier for us than others in the course.

Factors which negatively affected the students' confidence were also indentified. Students' level of confidence was reduced by unsupportive environments and unhelpful

midwife preceptors and making mistakes, as discussed earlier in this chapter. Time between placements also reduced the students' confidence.

The students were placed in a clinical agency for a block of time during the year, rather than a number of days per week throughout the year, and these placements could be several months apart. These greater the length of time between clinical placements eroded students' confidence, some even said that when there is a big gap between placements, or the final placement and their graduate year they felt "back at square one" (Olivia). As Cindy said; "if there is more time between placements you feel your confidence slide a bit, you feel out of practice. You are not seeing and doing as much" and Anna explained:

Immediately after I finished placement I felt pretty good where I was at. As the weeks go by I start to feel less, probably not less competent, but less confident with what I'm about to step into [in the graduate year].

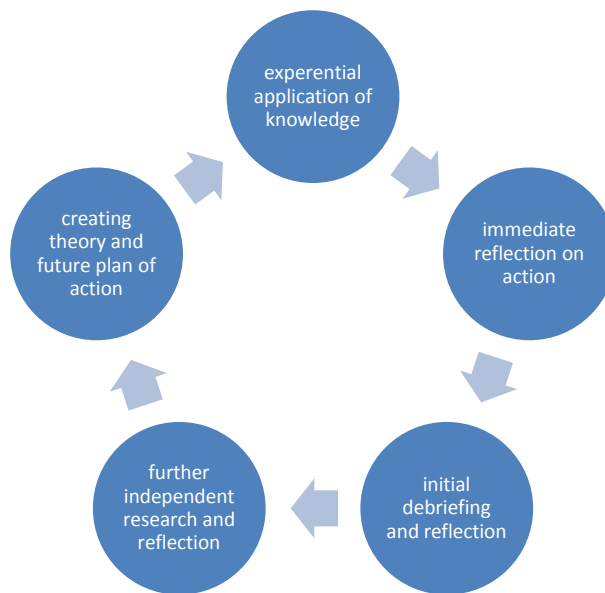
Whilst the students were 'playing midwife' they used reflective practice to guide their learning. Reflective practice was particularly useful for the students when they were involved in, or witnessed, scenarios where adverse outcomes occurred. Most students felt that they used reflective practice more often in these situations.

Reflecting On Practice: Learning from Mistakes

The majority (12 students) discussed the value of using reflection when involved in situations where the woman or baby's experience was negatively influenced by the actions or decisions of the midwife or doctor, or they felt they had made a mistake. Reflection was seen as an aid to developing competency. Cindy was one such student, who noted that she "learnt about all the bad outcomes, [and this helped her to know] what you want to avoid". She added:

It changes your practice and I guess that is where you learn the best - when you have situations and you notice, well that wasn't ideal how it all went. You need this little kick to stay on the ball and improve your knowledge and do more research about it.

In an attempt to model the students' reflective process the following is provided.

Figure 4.2 Students' Reflective Process

The influence of reflecting on mistakes was raised in the early interviews and was subsequently explored with each student through asking them to describe a scenario where they made a mistake and what they did afterwards: Dahlia and Greta recalled a situation where they clamped the umbilical cord too short; Dahlia and Cindy were the Primary Accoucheur for women who sustained 3rd degree perineal tears; and Indigo worried that she inappropriately cared for a woman experiencing a postpartum haemorrhage, when recalling the following incident:

I was looking after a woman and she had just had her baby....I checked her fundus and she had a bit of a gush at the time. I had a look and was rubbing her up and it was still trickling so I went out. I was right opposite the nurse's station so I just popped my head out to see who was out there and ask that midwife to come in.[...] I realised that I shouldn't have left her to walk to the door. I should have just pressed the call assist buzzer.

The students' initial reaction to their mistakes was self-criticism, which ranged from self-doubt to a sense of "devastation" (Cindy). The extent of the students' self-criticism was influenced by their perception of the potential harm to the woman and/or baby and the degree of support they received from the midwife preceptors. For example, Cindy was devastated because of the potential long term influence of a third degree perineal tear:

I felt really, really bad about that situation ... I just felt devastated that she had this experience and what were the long term problems that she would have because of this experience. So I had to hold back tears and I felt really terrible. With that third degree tear I was *shattered* [student's verbal emphasis]."

Lack of support during the incident increased the students' degree of stress and therefore their negativity about the situation. For example, Greta, reflecting on why she cut the baby's umbilical cord too short, said she "just kind of panicked because there were a lot of people in the room and there was mec liquor and everyone was just yelling at me". Indigo was alone in the room when the woman had the post-partum haemorrhage and she felt that she did not have the confidence to act, which made her feel afraid, stressed and lacking confidence:

I think for me it was upsetting cause I felt like even though I knew I should be rubbing up her fundus I didn't actually have the confidence to do that without anybody else being in the room. I didn't want to do anything to hurt her, even though she was bleeding, without anybody else being there. I thought 'what if I do something and all this blood gushes out and she is bloody dying and I don't know what to do about it [be]cause I have heard of those stories where you give a really hard rub and a litre of blood pours out. I was, sort of, scared of that happening without anybody there.

A supportive midwife preceptor was helpful when students made mistakes because they alleviated the students' stress and their degree of self-criticism. Also, they could debrief with the students about the incident. Supportive preceptors would say things like; "these things happen" and "we pretty much couldn't have stopped that, it was all too quick" (Cindy). This supportive debriefing started the students' critical reflection processes which helped them to learn how to avoid future incidents, if possible. Occasionally the midwife who was preceptoring the student at the time was not approachable so students would seek out others to debrief with such as other midwives, clinical teachers, student colleagues, lecturers, or even friends and family.

After debriefing about their mistake the students would further reflect on it to create a plan of action for the future. In order to improve their knowledge and skills when they made a mistake these students engaged in a reflective process. Most of the students would debrief with the midwife preceptor or their clinical teacher. Some of them discussed it with other students and some with family or friends. Furthermore, many of

the students would research texts or journals to identify ways in which they could improve their practice. Their reflections encouraged the students to identify what they would do if the situation arose again. For example, after the short cord scenario, Greta decided that she was never going to do that again. She explained that she was “more careful after that - I just made sure that I took a good look at where I needed to clamp the cord and get dad to cut it”. Dahlia also decided that she was not going to pull so hard on the umbilical cord during second stage:

After I snapped the cord, I wasn't delivering placentas after that because I wasn't pulling hard enough. They were just sitting there and I was just a bit worried about it [nervous laugh], but now I just use heaps of clamps and move them up really close.

Indigo said that after she did not act appropriately when the woman was bleeding she decided that in the future she would “would rub up her fundus and place a call if I was worried, so I would be doing something but getting help as well.”

One of the students, Cindy, said that she learned from the incident described that she would not always be able to control every situation. Although she wanted to avoid women having third degree tears in the future she realised that it might not be avoidable and was possibly due to a number of factors.

Cindy said that she held that situation in the back of her mind throughout her whole placement and planned to:

Work on my communication at that crowning stage to slow everything down and get a sense of what's happening there [...] how much is it stretching up, how much room is there, all of that stuff.

In summary, ‘playing midwife’ occurred whilst students were left largely unsupervised to care for a woman by their midwife preceptor, who nonetheless acted as a supportive resource. This was an opportunity for students to have increased independence and responsibility and allowed them to develop their assessment and critical thinking skills as well as their confidence. Whilst playing midwife the students tried to keep the woman at the centre of their care.

Certain conditions contributed to the safety of playing midwife; the students needed to recognise their own limitations, have a supportive preceptor who could provide help and

good communication skills. Furthermore, the midwife preceptor needed to be aware of the students' level of competency and when to take over. One challenge to 'playing midwife', identified by both students and preceptors, was the lack of continuity of preceptorship.

Playing midwife contributed to students' feelings of confidence in their practice and gaining confidence was identified to be an essential component of competency development. Furthermore, whilst playing midwife the students used reflection to develop their practice and they said that reflection was particularly useful when they made mistakes. When the students felt they made a mistake, they were self-critical, reflected on the situation and developed a plan for their future practice. Most students found that the opportunity to debrief with a supportive midwife was helpful and the support from the midwife made them feel better about the situation and began their critical reflective process.

Playing midwife was an important component of the students' practice consolidation, linked to which were being there for the woman, gaining confidence and reflecting on practice. The students were also expected to achieve certain requirements for registration as a midwife. 'Chasing the numbers' was a phrase one student used to describe their attempts to balance the expectations of achieving competency by attaining the necessary skills, knowledge and attitudes to be a woman-centred and capable beginning practitioner, within the regulatory requirements for assessment and registration as a midwife, as stipulated by the ACM (2002b) and the NBV.

Chasing the Numbers

Chasing the numbers refers to the students' perceptions of achieving the requirements set by the Nurses Board of Victoria (NBV) in order to register as a midwife. These requirements were based on the Australian College of Midwives (2002b) standards for the accreditation of Bachelor of Midwifery courses and mirrored the United Kingdom and New Zealand standards (Nursing & Midwifery Council, 2009; Midwifery Council of New Zealand, 2007).

Essentially, in order to register as a midwife the students were required to document that they had achieved certain numbers of experiences, or skills, set by the NBV (See Appendix I). The experiences were: at least 40 normal births as Primary Accoucheur; caring for 40 women experiencing complex pregnancy, birth or postnatal experiences; 100 antenatal and postnatal assessments and a minimum of 10 follow-through journey experiences per year. These requirements were additional to their competency assessments, which evaluated students according to the ACM (2002) and ANMC (2006a) competency standards for the midwife.

As discussed in Chapter Two, the length of Bachelor of Midwifery programs, as stipulated by the ACM (2002b), allowed 67.5 weeks of practical learning over three years, which was consistent with the UK and NZ course requirements of 67 weeks. However, the 2005 ACU Bachelor of Midwifery curriculum, approved by the Nurses Board of Victoria, provided 42 weeks of clinical practicum over three years (based on a 38 hour week) for the students (ACU, 2005). The subsequent 2008 curriculum provided only 30 weeks of clinical practicum, which was less than half the ACM recommended clinical hours. A table comparing the Victorian, UK and NZ curriculum clinical hours is provided in Appendix L.

The comparative lack of clinical practicum time has, according to their reports, significantly jeopardised the students' learning in their final placement. During their final placement, students were forced to prioritise 'chasing the numbers' over their individual learning needs. The students' major focus whilst 'chasing the numbers' was the normal vaginal births (NVBs) as Primary Accoucheur they needed to achieve to graduate.

Despite the students' and their preceptors' best efforts, there was therefore simply not enough time for the students to achieve the requirements in clinical settings within their allocated hours. Most midwives in charge and midwife preceptors tried their best to help the students to achieve them, however there were many factors that midwives in charge needed to consider in relation to student allocation of experiences, including competing students' needs, the midwife preceptor's experience and abilities, and the unpredictable nature of childbirth itself.

As discussed earlier in this chapter, individual hospitals' and caregivers' care practices also limited the chances of women experiencing normal births without intervention. As Anna, said "it just depends on the woman and the midwife and whether it's the right time" to get the experiences she needed. It was more difficult for students doing their clinical placement to get NVBs in private hospitals, a) because it was more likely that private obstetricians would not allow students to be the Primary Accoucheur, and b) because of the higher degree of intervention at birth.

The unpredictable nature of childbirth was also a challenge for students, both in terms of when babies come and also how birth journey can change during the course of a woman's labour. Maree lamented that she would often be caring for a woman who would then have epidural analgesia, which significantly reduced the chances of a normal birth; she said, "95% of them would end up with an instrumental or caesar" [Ventouse, Forceps or Caesarean birth] and Helen explained:

You don't control when babies come, that's the hardest bit. I've never taken a sick day in my life but babies come when babies come and you can go on a shift and it's slow...

Another hurdle was competing for experiences with midwifery and medical students, from various universities, who all wanted to 'count' the same thing – normal vaginal births. This caused competition between the students. For example, Helen was "shattered" when another student "snuck" into her room whilst she was on a short break:

I knocked on the door and the midwife came out and said 'there's already a student in here' and she didn't even apologise to me or didn't say anything to me and I was just shattered because I was so stressed out about getting my births and I was thinking 'now I don't have that opportunity'.

With only two weeks of experience in the birth suite allocated for their final placement, none of the students had documented more than 20 NVBs, prior to commencement of the placement. Helen had only documented 11, which meant that she had to attend NVBs in two weeks whilst placed in a tertiary hospital with a high intervention rate. Understandably she was anxious that this was unachievable.

Even at the end of their placement, after achieving competency according to their clinical assessors, all of the students had more NVBs to document. Cindy needed 14

NVBs, so she did three weeks extra placement. Greta did four extra weeks whilst Eliza considered herself “lucky” because she only had to do one and a half extra weeks. Helen, the student who had 29 NVBs to go at the beginning of her final placement, did seven days a week of placement for seven weeks. She drove, on her days off, from clinical practicum at a metropolitan hospital to a rural hospital:

I had to do [arrange] it myself. I was working seven days a week, on my days off I was driving to [a rural placement] to do extra placement. I've done 7 weeks of birthing and I've done it all myself!

She also went on call overnight after a shift, which raises the question of student safety and wellbeing during their final placement when placed under such pressure.

Most of the students, understandably, resented the situation and criticised what they saw as the Nurses' Board of Victoria's (NBV) unreasonable expectations. As Anna said, “I think...the course is too focussed on 40 normal births”. Others criticised the lack of time in birthing suite and were upset about the negative influence on their learning experience overall. As Kelly said, “I just had to get my births and it all comes down to the number and woman centeredness isn't the focus at that point. The focus is on getting your births”.

The extra placement influenced other aspects of the students' lives. Some of them were living on limited incomes whilst they tried to complete the course, making them resentful and angry. Their anger was often directed towards the university as they criticised their clinical allocation and the lack of support. Sometimes their anger was also directed at the midwives in the clinical agency. Cindy said:

I got to the point that I was resentful because I had not planned to be in that position over the years [...]. I had a bit of back luck in that I didn't get my births in [rural placement]. I got resentful because I couldn't work and this was the time where I thought I would be able to start earning money. I was broke and really exhausted and my health has been an issue. Probably the hardest thing was having to return to the [tertiary hospital] and not necessarily being supported by certain midwives [to get the requirements]. One wasn't championing us at all or working with us to get us into labours and births.

Cindy's reflections on this issue suggest that she felt midwives were unaware of the influence of the need for extra placement to meet the NBV requirements and to support

her whilst she did extra placement. It also highlights the financial strain which extra placement placed on students, many of whom needed to pay rent and utilities, as whilst on placement, they were unpaid and could not work part-time. Despite the pressure and stress, most students said that the number of births contributed to their competency:

I wouldn't dispute that I needed those 40 births I dispute how hard it was and I have said that to other people and they said "40 births is just crazy". A lot of us actually feel that we need 40. I don't want to be negative about it. I personally found it stressful though and I thought I had organised myself enough to avoid that situation (Cindy).

Maree disagreed, however. She felt that there could be other ways to attain competency than counting births or, as she called them, 'catches':

I think there is too much focus on catching the baby. Because catching the baby, to be honest, there are not a lot of skills you need and some women deliver the babies on their own, they birth the babies on their own. Hands on, hands off approach, I mean it all very controversial so I think the focus is too much on the delivering of the baby. I think it would be much better to, say, look after 100 women in labour with different needs. It would make much more sense for me and I guess then and it would make more sense from a learning point of view and you wouldn't have all this pressure about getting those 40 spontaneous births.

Because of the pressure to achieve the NBV requirements in a short time frame, many of the students' individual learning objectives for their final placement reflected the NBV requirements. As Kelly said:

I have just had to rush everything and pretty much my time has been allocated to the things where assessments have been allocated, so it hasn't been through my desire to know more about something necessarily.

Other valuable learning needs were not prioritised by the students because they could not be counted, such as caring for a woman in labour, vaginal examinations, medication administration, documentation, assisting with emergencies and so on. The NBV requirements, therefore, took priority over other learning experiences. As Indigo noted:

You can't count spending time with women in the way that you can count a catch, you know... It's like, we don't have anywhere in our green [clinical record] books to record that. You might have looked after a women and done two VE (Vaginal Examinations) but haven't got the catch and there is no where to put that, to put the VEs either!

This situation raises the question: How more prepared for beginning practice would students would be if they were allocated sufficient time over the three years to achieve the requirements and were then able to focus on personal learning objectives in their final placement?

The students' learning objectives were documented on their competency tools, which were used to assess their competency according to the ACM (2002) and ANMC (2006a) competency standards for the midwife. These objectives were grouped into four broad skills areas: medication administration; complications; assessments; and midwifery skills (Refer to Appendix M).

Because the requirements for 'births' took priority over these identified learning objectives, the students did not always have opportunities to develop their skills or knowledge in the areas where they had identified learning needs. As Eliza explained:

I will go into it [final placement in birthing] with some pretty clear objectives but I'm just very conscious that 10 shifts is not a lot of time, especially since you haven't been in [to birthing] since July. [...] I'll go in with clear objectives for consolidating [...] but at the same time you are wanting every catch. That's not ideal for confidence in the end, to be chasing the numbers now.

Students said, during interview, that they needed more experience with administration and paperwork. As Helen said, she felt "pretty good about my skills, looking after a woman and looking after her baby" but she was "just not 100% confident with the administration". During field observation I noticed that midwife preceptors frequently completed paperwork whilst the student was involved in more hands-on aspects of the woman's care.

Many of the students wanted more experience with complications and interventions. The conflict between needing to learn about caring for women experiencing interventions and the pressing NBV requirements was raised by Anna:

When I started [final placement] I felt like I really needed more experience with interventions. As much as I don't like the experience with interventions I know that's what I needed more. I started the placement with 21 or 20 births [...] and I've been averaging a birth a shift but up until this placement I'd only worked with two women with epidurals so I knew at the start that I needed more experience with that. But at the same time you because we

need 40 births you are usually allocated the women that are potentially going to give birth on your shift.

Paradoxically, the focus on normal births to the detriment of other learning experiences affected the students' competency right to the end of their final placement. For example, Indigo reflected on the influence of her effort to avoid caring for women with epidurals so she could maximise her chances of documenting a normal birth:

I think what scares me is just all the little things like knowing what to do when a doctor asks for this or that or where to get it from, or exactly how to prepare for an epidural and the things they need, just because I haven't done them very much.

On the other hand, two of the students said that they wanted more experience with normal childbirth. Beth said that she wanted experience with "normal vaginal birth without intervention and working with the women in pain" because she only ever did that once in her last 12 weeks of placement, and Cindy said:

I suppose I would have liked more experience in out of hospital situations. That would have been nice to be a bit more comfortable in the home birth situation. I had one of those, which was pretty awesome.

The NBV requirements for registration compartmentalised the care of women to a set of skills, rather than recognising the holistic nature of midwifery competency as expressed in the competency standards (ACM, 2002; ANCM, 2006a). They also effectively reinforced 'the system's' attitudes about midwifery practice by compartmentalising the women and baby so much that the students focussed on 'a catch' rather than the woman and baby's experience. This was to the detriment of women's experiences and the students' learning.

In summary, because of the time pressures, the students found themselves pressured to prioritise 'chasing the numbers' rather than learning through providing holistic midwifery care to women in various situations and addressing their own learning objectives. This caused considerable stress for the students as all of them needed to complete extra placement to get their numbers, despite them being deemed competent for beginning practice by their educators on their competency tools. There were, however, criticisms of the students' competency assessments and this study raised

questions about the applicability of the ACM (2002) and ANMC (2006a) competency standards to the assessments of the students.

The theory-practice gap between the reality of midwifery practice in 'the system' and the professional competency standards meant that students had difficulty achieving competency for beginning practice according to the standards. Students therefore had to re-define their expectations of their competency for beginning practice so they fit in with the system's expectations. Furthermore, the competency assessments were criticised by the students for being seemingly unrealistic. The students criticized the competency standards which they were being assessed with as unrealistic because they felt unable to meet some of the standards within the medically dominated clinical learning environment. As Indigo said, "some of the competencies [...] are not really what you would do as a midwife" and Kelly noted, her initial expectations of midwifery competency were not achievable within the system:

My expectations at the beginning of the course have changed along the way. Part of that is just naivety and not understanding enough about the real content of midwifery and the restrictiveness of it. I thought I would just sort of go and do the course and be an independent midwife and it doesn't feel quite that simple.

I feel like I am a fraud and I have spoken to other students and they have felt the same way it's hard to believe that what I have done over the past three years makes me a midwife. It feels very academic, it feels quite removed from the art of what midwifery is to me [...] I really, really think that a huge element of this course needs to come out of the hospital and that every single student needs to experience birthing outside of the hospital.

As previously noted, there was little opportunity for students to be role modelled, or encouraged to practice, according to some of the competency standards, particularly those related to: advocacy; providing or supporting midwifery continuity of care; and enhancing the professional development of others. As Wendy said, "often midwifery not practiced like that in a hospital...it depends on the organisation's rules."

As established earlier this chapter, most hospitals where the students completed their placements were medically dominated and quite restrictive of autonomous midwifery practice, however, the degree of medical dominance varied between hospitals. Students needed to have varied experiences, in various clinical agencies, in order to consolidate

their skills and knowledge, particularly in relation to normal birth and midwifery autonomy. As Beth said, “working in a hospital with a high intervention rate doesn’t allow you to work with women having normal births”, while Eliza observed:

I think it’s really good to do some private and some public system, because they’re hugely varied. They [the hospitals and midwives] are very different in what a student midwife is, what’s expected of her, and how they’re allowing you to practice. It varies heaps from public to private and also small regional hospital to a great big one.

The university’s expectation of student competency at the end of their final placement, as documented in the Midwifery Practice Competency Tool, was that the students would achieve an independent rating in each of the midwifery competency standards domains (ACU 2005; ACU 2006; ACU 2007; ACU, 2008). According to ACU (2005) an independent rating means that the student has been assessed as “practis[ing] in a woman centred, safe, accurate, co-ordinated & effective manner with occasional need for guiding cues” (ACU 2005 p.7). All of the students documented that they had achieved an independent rating and so had their assessor, therefore they were competent for beginning practice.

Despite all achieving an independent rating, both students and midwives expressed concerns about the reliability of the competency assessments for three reasons: the lack of continuity; lack of objectivity; and the applicability of the competency standards to midwifery (and student midwife) practice within ‘the system’. For example, Kelly described the competency assessment process as a “farce” and Wendy said:

I think people just pass you [in your competency tool] because they know, the clinical teachers work within the hospital system and they know that if you are ready or not to start working...they have to because otherwise you are not going to pass the unit and you can’t go on...there is not a lot of objectivity. [...]

In relation to the reality of achieving the competency standards within the system, Vera said:

I think the [competency] tool is good for us to have it for setting our goals about our placement it can be used for. But I don’t think it’s the best to assess competence because they’re [...] professional midwife based, not student midwife based. Like, you are not really in a role of educating fellow midwives. What you think their reaction would be? They’d say ‘who are you? Pull your head in you’re a student’

During field observation I inquired of midwife preceptors, students and clinical teachers how they felt about the method of competency assessments. The competency assessments were criticised heavily for being time consuming, repetitive, confusing and unachievable, as well as a difficult tool with which to adequately assess students. One of the clinical educators said that the competency tool made it difficult for her to identify students who might be failing in certain areas, so she had to rely on the midwives' comments or her own observations and notes.

One student that I spoke to confirmed the clinical teacher's concerns. She described the competency assessments as a "load of crap". She said that clinical teachers generally just observe the student a couple of times and if they have "filled out the 'green book' [record of clinical experiences] then they will sign the off [as competent in the competency assessment]". The same student said at interview:

It's impossible to do [meet the competencies] as a student because a lot of them you don't do until you practicing as a fully qualified midwife. How are you supposed to do that [become independent] in three years when you are doubling the whole time and you know you are just finding your feel and learning these skills as well as learning how to relate to women? You can't do it in three years and you can't do it as a student because you are not practising by yourself (Wendy).

The clinical teachers' workload at the clinical agency where field observation occurred was high; they were given a ratio of eight students per clinical teacher per day, which allowed approximately one hour per student per day. During this time they were expected to facilitate students' learning, debrief with the students, oversee clinical learning, address issues, liaise with midwife preceptors, mentor the students and assess the students' competency. In order to assess the students' competency, one of the clinical teachers said she mostly relied on the feedback from midwife preceptors.

Lack of continuity of preceptorship was also identified as an issue in regards to competency assessments. Most of the students who criticised the competency assessment methods felt the lack of continuity negatively influenced the reliability of their competency assessments. Vera explained that she did not feel that the midwives could adequately, or holistically, assess her because of the lack of continuity:

I found at some hospitals you have a dedicated person that you work with a lot of the time who comes around and assesses you and others [hospitals]

you are with a different person every day, so I found it a bit hard to get someone to properly assess you. I mean you might have a great birth that day but you're not competent in something else that they haven't seen.

The lack of continuity, as Kelly said, made the competency assessments "just a farce really I mean it's just a façade! Lots of people tick you off and they have got no idea what your level of competency is really". Indigo reinforced this view:

I actually hope it doesn't offend anyone but they're a bit irrelevant to me, I mean I kind of think that your competencies get assessed with the people that you work with day to day and you know your clinical educator is not there most of the time so how they would know? I mean they get feedback I suppose but....they are kind of a bit of a formality for me...

It was unrealistic for the students to achieve an independent rating for all of the professional competency standards as a student, particularly since the students were learning within a system where the philosophy was not always congruent with the underpinning philosophies of the competency standards themselves. Furthermore, the reliability and objectivity of the competency assessment methods was questioned. Despite this, the students and their assessors all rated them as independent in the competency tools. It was suggested that assessors relied on the students achieving the NBV requirements for registration as an indicator of competency. Confidence in the competency assessment tool being a true reflection of the students' competency for beginning practice was therefore questionable.

The students were able to define, or re-define their competency for beginning practice as they did meet the expectations of competency according to their clinical assessors. Their competency may not have mirrored all of the components of the ANMC (2006a) and ACM (2002) competency standards for the midwife however some of the components were similar. Competency for beginning practice was broadly (re)defined by some of the students as the combination of women-centred practice and safe practice because most of the students in this study maintained a perception of midwifery competency that valued both women-centeredness and safe practice. Students' references to 'safe practice' and 'safety' encompassed physical safety of the woman and baby as well as psycho-social needs. As Anna said:

I think you have to combine a lot of stuff. That is, for me, the first thing is the woman's experience. I don't know what the most important thing is...

[competency] is probably the combination of practicing within safe boundaries but also remembering that it's the woman's experience. When I work as a midwife that thing will always, well, I hope it will always be with me. I won't forget that space of birth...and the woman's experience and everything. I think it's a balance between safe practitioner and maintaining the woman and her partner's experience of birth being the best it can be.

The women-centred aspects of the midwife role which the students believed reflected competency was promoting informed choice, supporting or 'being with' women and autonomy. Cindy explained that she hoped to be able to facilitate women to "make choices rather than being told what she wants".

The students agreed that being woman-centred did not necessarily mean promoting natural childbirth but advocating for the woman's informed choices. For example, Helen said, midwifery is "not all about natural childbirth" and Anna said "I'm an advocate for natural un-drugged births and everything...but if it needs to happen it needs to happen" and Beth described competency as:

Knowing the ropes, knowing the routine of the hospital and the staff. Getting to know the staff; what they do, what they're like. How to fill in the paperwork. The little nitty gritty things that contribute to being able to complete the whole process of being with the woman.

The notion that birth was unpredictable and sometimes intervention was necessary for the safety of the baby or mother was also acknowledged by the students, as was the need to be caring and compassionate towards women whilst intervention was occurring. Some students also believed that competent midwives are brave, political advocates for the profession, when they saw a need to change it:

Someone who has a gentle caring woman-centred approach to care is important; respect and dignity for women; someone who's knowledgeable and quick thinking if an emergency should arise; and good communicative skills. I think someone who's got a bit of gung-ho about them, about change and wanting to change the system and that they're not completely happy with the way that things are. They will help to cause change or create change (Beth).

Most students felt confident with their midwifery skills and ability to care for women experiencing normal birth. For example, Helen said she was confident that she was adequately assessing women during vaginal examinations and that she was confident with supporting women during labour. Greta felt that during the last ten births she

attended she could manage the situation. Kelly similarly said she felt competent being with the woman, she explained:

I feel like the knowledge base is pretty strong and that I have got all the resources to access when I am not sure of something and that I know how to do that and that I would know how to read research and analyse whether its relevant and well done, that feels like a really good tool to have learnt [...] I suppose all the clinical stuff to me, the practical things are like doing a catheter or giving an injection or drawing up medication and yeah I [also] feel competent with all of the actual being with the woman and hanging out.

There were some situations, however, that students felt less confident about. These were usually those where the students had less experience, such as complex labour and birth as well as 'nursing skills'. For example, Dahila was worried about needing to cut an episiotomy and Eliza was more concerned about how her colleagues might react to her lack of 'nursing skills':

I still think there will be times in say, my first 6 months of practice... that people are going to raise their eyebrows a bit and think 'have you put a drip up before dear?'

Most students saw the real test of their competency would happen after graduation. Many expressed ambivalent feelings about how prepared they were and felt the real test of surety would be when they had commenced practice as a midwife. As Anna said:

I think it's prepared me, I don't know, maybe you need to do an interview a month after I've started to find out whether I'm well prepared or not. I don't think I can truly know that until I start my first shift. I really don't know, I mean I could say yeah now and get there and go 'oh my god! What the hell am I doing? Did I learn anything in the past 3 years?'

It seemed to the students to be a big leap between finishing as a student and the responsibility of practicing as a midwife and some students were concerned that they would not have the support of their midwife preceptor anymore. Others were concerned about expectations of their ability as well as the increasing responsibility. The transition from student to midwife was on the students' minds as they came to the end of their final placement. As Anna said:

Your role changes; you can still rely on other people, but as a student you always have that midwife there that you are working with, and next time I'm working in birthing or postnatal, or wherever, it's going to be me. It's a bit daunting.

Kelly had some anxiety about the transition, which was also reflected in statements by other students, she said:

I felt quite anxious and nervous and I think it was because I knew this was my last time as a student and it felt quite overwhelming to think that, even though it's what I've wanted for ages it all of a sudden felt a bit overwhelming.

Despite their concerns about the increasing responsibility, all of the students felt that they were as prepared as they could be for beginning practice. Some, such as Greta, even looked forward to the transition from student to midwife because it meant an increase in status. Although the students looked forward to moving on from their position as a student, they believed their learning would continue after graduation. As Maree said:

I'm pretty positive [...] I feel it's really time to start working now and I definitely gained lots of confidence at the last placement and everybody said 'oh you will see in your last semester at the end of the course everything comes together' and it really is like this.

I know that there are so many things I don't know, and in a way I think none of us are real midwives next year. But I guess that is the reality and I guess that is how we all start. That you start with so little or patchy knowledge and I guess the real learning starts [after graduation].

All of the students planned to work in a hospital 'graduate year program' after graduation because they wanted the support during their ongoing learning. Graduate year programs were government funded and provided by hospitals to support graduates during their first year as a midwife through mentoring and education programs. Graduate year programs gave students security and the confidence to take on a greater role in a supported environment. Indigo said:

I won't be solely responsible as a grad and there will always be, even when I am not a grad, you are always liaising with the midwife in charge so they know what is going on. They are always advising you. I don't feel that I would be confident if wasn't going into a graduate year because especially the girls I've spoken wouldn't have been able to do it without support from the midwives [...] I think after my grad year I'll be a lot more confident.

Some students alluded to how they would cope in their graduate year; as a novice they would continue to evaluate the working environment and then try and fit in, at least until they felt confident enough to practice in the way they aspired towards.

In summary, the students felt that practicing independently according to all of the ACM (2002), or ANMC (2006a), competency standards for the midwife was an unrealistic goal, considering their place and the realities of midwifery practice within 'the system'. The competency assessments were made difficult due to the lack of continuity of preceptorship and both the students and their preceptors criticised the competency standards; they considered them irrelevant, confusing, subjective, time consuming, repetitive and vague. The vagueness meant that it was difficult to identify students who were not competent without extra documentation, such as anecdotal records.

The students defined, or re-defined, competency for beginning practice within 'the system' as a combination of woman-centeredness and safe beginning practice. Students expected that they would be able to care for women compassionately and provide information so they could make informed choices and also provide care for them with support from more senior midwives and medical staff. They felt confident caring for women experiencing normal birth but they would need support to care for women experiencing complications.

Consolidation was an ongoing process during the students' final placement. The need to consolidate was identified as an objective for final placements in the first interviews with the students and was further emphasised in the second interviews. Consolidation and assimilation were complex, fluid and individual processes and therefore a specific time that students achieved competency was not determined. As the students' confidence in their competency for beginning practice was changeable, depending on the circumstances they were faced with, most of the students felt some degree of anxiety about their transition from student to midwife. They were, however, reassured by their plans to make that transition within a graduate year program where they would be mentored and supported. Furthermore, they did not expect to know everything and be able to manage every situation; they acknowledged that there would be ongoing learning during their graduate year and beyond.

Summary and Conclusion

The findings demonstrated that the students in this study achieved competency for beginning practice via a number of social processes. The overarching process identified

was assimilation. Assimilation essentially represented three major processes in which the students engaged in order to achieve competency for beginning practice: realisation, adaptation and consolidation.

During their final placement the students realised that 'the system' was dominated by medical discourse and restrictive of midwifery practice. Women were cared for in the system that appeared to value physical outcomes over women's psychological needs and this was in contrast to the midwifery discourse of woman-centeredness and midwifery autonomy. As discussed in Chapter Two, midwifery discourse was represented in the ANMC (2006a) competency standards used to assess the students' competency and the philosophical underpinnings of the Bachelor of Midwifery course. In saying this however, the degree of medical dominance depended upon both the clinical agency and individual staff within the agency. In general, private hospitals and major tertiary hospitals were identified as more medically dominated than rural and non-tertiary centres. Students were also more likely to be role modelled midwifery-led care in birth centres and, for two students, homebirth settings.

Whilst working within the system the students described how they worked with 'helpful midwife preceptors' and 'unhelpful midwife preceptors'. Helpful midwife preceptors were supportive and motivated teachers who facilitated or allowed the students to have hands-on practice and increasing independence in practice as they approached the end of their final placement. Furthermore, helpful midwife preceptors were inspiring role models for the students. On the other hand, students also worked with unhelpful midwife preceptors, who were described as poor role models for the students, unsupportive, unmotivated and not allowing enough relevant hands-on practice.

The students were compelled to adapt to the system in order to achieve competency for beginning practice. The process of adaptation to the system was described as 'fitting in'. Whilst fitting in the students took a position of relative powerlessness and used various strategies to adapt. They were compelled to fit in to avoid punishments of disallowance of clinical experience, social exclusion, intimidation and criticism. To fit in the students assessed the midwives' expectations of their practice, role and position and then externally adapted, or modified, themselves to become what the midwives/clinical

learning environment expected of them. This was done in order to be socially accepted as well as to get the necessary clinical experiences that would build their competency.

The students' competency was influenced by the system because they were mostly placed in hospitals which were medically dominated. They adapted to fit in to these environments and were therefore influenced by the dominant medical discourse within the system with the degree of this dependent on their particular experiences. All of the students were, however, influenced to some degree by dominant medical discourse within the system. Furthermore, the system influenced the students' emotional wellbeing and most, if not all, of the students witnessed what they saw or described as traumatic birth experiences.

During these ongoing processes of realisation and adaptation the students consolidated their knowledge and skills. The strategies students used to achieve this were to be there for the woman, having hands on practice and have increased responsibility by 'playing midwife'. The consequences of these strategies were that students felt confident in their competency. However, as students and midwives' practice was restricted within the medically dominated clinical learning environment, students did not feel that it was achievable for them to meet the ANMC (2006a) and ACM (2002) competency standards for the midwife. Furthermore, the lack of continuity of preceptorship and clinical assessments made students less confident in competency based assessment model used by the university.

Despite these challenges, the students felt they were competent for beginning practice, or safe to practice according to the expectations of the midwives assessing them, within the system. However, in order to meet the autonomous midwifery standards set by the ANMC (2006a), students needed to have much more exposure to midwifery practice which was informed by midwifery discourse, such as in the community or in midwifery-led models of care.

The students, therefore, felt prepared for beginning practice within the system. Despite some feeling that a graduate year would mean further consolidation of the type of midwifery practice occurring in the system, most wanted to have the support of a graduate year program. This was because many had a degree of trepidation about the

increase in responsibility and the transition from student to midwife. Despite their anxieties, all of the students felt it was time to make the next step into the “whole new world” (Beth) of being a midwife.

The final chapter of this thesis reviews the findings of the study in relation to previous research. Recommendations for stakeholders involved in educating midwifery students in the future are also presented and justified. Furthermore, some limitations of the study are discussed and suggestions for future research are made.

Chapter Five

REVIEW AND CONCLUSION

The focus of this thesis was the achievement of competency for beginning practice of Australian Bachelor of Midwifery students. In this chapter I briefly revisit the research process and main findings of the study. I then discuss the implications of the findings for midwifery education and practice, make recommendations, identify the limitations and conclude with some reflections upon the research process.

In Chapters One and Two I introduced the research problem and placed the research in the context of current Australian midwifery practice, discussed competency and its application to midwifery education and assessment and reviewed related research studies. I concluded that, despite a number of overseas studies of similar courses, when this study commenced in 2005, Australian Bachelor of Midwifery students' experiences had received little attention in the research literature. This study was therefore timely as the Bachelor of Midwifery was a relatively new model of midwifery education, developed in response to changing political, economic and workforce needs as well as expectations of the midwife's role in Australia. There were also issues, highlighted by the AMAP study, with the previous models of midwifery education which needed to be addressed (Leap et al., 2002). There were great aspirations from the profession that the new Bachelor of Midwifery graduates' would be able meet the Australian College of Midwives professional competency standards and their expectations of the role of the midwife.

In Chapter Four I described the methodology of the study. The particular grounded theory approach had not been previously applied to research exploring students' learning in the healthcare field. Applying the methodology was an interesting and creative experience. It allowed in-depth exploration of the students' experiences, as well as highlighted related social processes and interactions and provided context to their learning via identification of the dominant discourse which held sway.

Overview of Findings

Analysis of the data revealed an overarching social process of assimilation, and three related sub-processes named realisation, adaptation and consolidation. In summary, Assimilation represented the processes of adjustment that occurred within the various clinical agencies where the students were learning to become midwives.

During assimilation, the students experienced ongoing realisations about this system in which they were learning as well as the role of the midwife within the system. They also realised that they had to adapt to fit in to the system in order to meet their learning objectives and to avoid disciplining practices. Whilst adapting to the system they consolidated their competency through application of knowledge, practicing skills and meeting their learning objectives. A specific time when students achieved competency during their final placement was not determined as consolidation was found to be a complex, fluid and individual process.

During their final placement the students acknowledged what had been an ongoing realisation of the nature of midwifery practice and the midwife's role within a medically dominated system where medical discourse held sway, resulting in restrictive midwifery practice and autonomy. This was in direct contrast to an alternative midwifery discourse which underpinned the Bachelor of Midwifery curriculum. The findings of this study, detailed in Chapter Four, showed that these Bachelor of Midwifery students were learning within hospitals in a maternity system that was subject to medical dominance. This medical dominance was aided by prevailing medical discourse which portrayed childbirth as a risky and requiring obstetric surveillance and support through medical intervention. Within 'the system' midwives and women were subordinate to obstetrics. Midwives' autonomy was restricted and their practice was influenced by this medical discourse. In general, the findings showed that medical discourse was most dominant in private hospitals and larger metropolitan maternity hospitals. When students were placed in midwifery-led models of care the medical discourse was less dominant over care provision.

These findings are consistent with prior research which have highlighted how medical/obstetric discourse – which portrays a perspective that pregnancy and

childbirth is inherently risky – is consistently dominating care provision maternity hospitals in Australia (Callaghan, 1996; Fahy, 2007; McCall et al., 2007; Barclay, 2008; Newnham, 2010). It has also been argued that an obstetric approach to care, characterised by technology, surveillance and intervention, prevails in Australian hospitals (Wagner, 2000). The disempowerment of women and midwives within the medicalised system, as found in this study, is consistent with many studies from both Australia and overseas (Callaghan, 1996; Begley 2001a; Fahy, 2002; Leap, 2002; Bosanquet, 2002; Seibold, 2005; Baird, 2007; Fahy, 2007; McCall et al., 2007; Barclay, 2008; Newnham, 2010).

Some caregivers in this study were described by the students as: portraying a negative or fearful attitude towards childbirth; dehumanising and classifying women; providing care dominated by routines and time limits; using technology extensively, along with a high level of intervention; and reflecting an emphasis on a physically healthy mother and baby regardless of what it took. Aspects of these findings reflect those in other studies of the Victorian maternity care system (Callaghan, 1996; Fahy, 2002; Leap, 2002; Fahy, 2007; Barclay, 2008; Newnham, 2010).

In contrast to the way that midwifery was practiced and role modelled within 'the system', the Bachelor of Midwifery students had been taught theory of midwifery practice underpinned by midwifery discourse, which emphasised feminist principles such as empowerment, female autonomy and woman-centeredness. As discussed in Chapter Two, The Bachelor of Midwifery curriculum was based upon the 'new midwifery' (Page, 2000), which emphasises a wellness perspective, the midwife as a primary health carer and the midwife-woman relationship of non-hierarchical partnership formed and nurtured within a continuous relationship. The new midwifery was ideologically congruent with the aims of the Bachelor of Midwifery curriculum and the professional midwifery competencies used to assess the students. Aspects of the new midwifery were, however, found to be rarely role modelled in practice by the midwives in 'the system' because their autonomy and ability to provide continuity of midwifery care was severely restricted. This incongruity essentially exposed a theory-practice gap between midwifery theory taught at the university and midwifery practice within 'the system'. These findings are consistent with studies in Australia, North America and the

United Kingdom, which found that both undergraduate and postgraduate midwifery students experience a conflict between their vision of midwifery, or the philosophy/theory underpinning their ideal midwifery practice, and the reality of practice in medicalised maternity units (Seibold, 2005; Lange & Powell Kennedy, 2006; Baird, 2007; Fraser & Hughes, 2009; McCall et al., 2007; Jordan & Farley, 2008).

The findings of this study support concerns expressed by Bachelor of Midwifery course co-ordinators McKenna and Rolls (2007) as well as Carolan, Kruger and Brown (2007). The findings also indicate that the disparity between midwifery practice standards and the realities of practice identified in the AMAP study (Leap, 2002) continue to exist: Australian midwifery graduates are unable to provide a woman-centred approach grounded in a social health and wellness framework because of a lack of adequate preparation (Leap, 2002), despite a stated aim of the Bachelor of Midwifery being to provide midwives capable of practicing within the full scope of midwifery practice and within a continuity of care model (Cutts et al., 2002; Pincombe et al., 2003). The Bachelor of Midwifery students in this study learnt within a medically dominated environment and therefore may still have inadequate training in social health and wellness framework. I contend that as long as the Bachelor of Midwifery students' learning occurs predominantly in hospitals where midwifery autonomy is restricted and midwifery care is fragmented they are unlikely to be able to meet these expectations of graduate competency.

The findings of this study also highlighted the Bachelor of Midwifery students' relative powerlessness within the system and their need to adapt to the system in order to feel socially accepted and to 'fit in' to 'the system' to achieve competency for beginning practice. Adaptation involved students modifying their behaviour to appear to fit in and thus avoid disciplining practices. This enabled them to gain the experience needed to achieve competency through practical application of knowledge, increasing independence and confidence in practice, so called consolidation. The punishments for not 'fitting in' identified by the students in this study were social exclusion, restriction of learning experiences, criticism and lack of support. These findings were consistent with those of Parsons and Griffiths (2007), who also found that Australian midwives are

discouraged from questioning practice for fear of alienation, verbal intimidation, abuse, humiliation and exclusion.

The midwife preceptors students worked with had a significant influence upon the students' adaptation and competency development. The influence of the preceptor, both negative and positive, reflects the finding of previous studies exploring both nursing and midwifery students discussed in Chapter Two (Jackson & Mannix, 2001; Begley, 2002; Lee et al., 2002; Thompson, 2002; Clarke et al., 2003; Lambert & Glacken, 2004; Burns & Paterson, 2005; Tabari Khomeiran et al., 2006; Jones & Wiley, 2008; Jordan & Farley, 2008; Hughes & Fraser, 2011). In particular, the significant relationship between a positive relationship with preceptors and self esteem and confidence experienced by students is consistent with other studies appraised in Chapter Two, including those by Grey and Smith (2000), Randle (2001), Begley (2002), Papp et al. (2003), Edwards et al. (2004), Tabari Khomeiran et al. (2006) and also by Hughes and Fraser (2011).

The students in this study appreciated working with supportive preceptors who were motivated teachers, shared knowledge, answered questions fairly, provided feedback and facilitated reflection on practice as well as hands on practice. They also sought opportunities to work with midwife preceptors who were aligned with the course's philosophical basis of the 'new midwifery' (Page, 2000) and role modelled professional midwifery practice. The findings also revealed that students appreciated midwife preceptors who gave opportunities for 'playing midwife', which enabled them to practice critical thinking and put theory into practice. The students did not, however, appreciate working with unhelpful midwife preceptors who were poor role models, 'took over', were unsupportive or had a hierarchical attitude towards students, such as believing students should 'know their place' and not 'get too big for their boots'. The findings also highlighted unsupportive preceptor behaviours such as failing to communicate through ignoring or excluding students from learning experiences, being overly critical or intimidating students, and delegating unwanted jobs to the students, which were reflected in other studies (Gray & Smith, 2000; Jackson & Mannix, 2001; Begley, 2002).

Ignoring and excluding students was also identified by Jackson and Mannix (2001) as well as Jones and Wiley (2008). Delegating unwanted jobs was consistent with Gray and Smith's findings (2000). Bullying and intimidation was described by students in studies by Randle (2001), Begley (2002) as well as Jones and Wiley (2008). Preceptors verbally abusing students also occurred in studies by Begley (2002) and Lash et al. (2006). Poor communication was identified as characteristic of unhelpful preceptors by Jackson and Mannix (2001). Additionally, this study identified that unhelpful preceptors lacked knowledge and expertise and had poor teaching skills, as was the case in Gray and Smith's (2000) study. Unhelpful preceptors contributed to the unsupportive learning environments experienced by some students and made them feel humiliated, unwelcome and inadequate. These findings support those of Begley (2001a; 2001b; 2002), Randle (2001) and Lash et al. (2006). The students in this study were vulnerable to the lack of support from midwife preceptors because they negatively influenced their confidence. This finding reflects Randle's (2001 p. 294) claims that negative clinical learning environments affect students' self-esteem and ways that they "think, feel, motivate themselves, and act".

The findings from this study were not consistent, however, with studies of nursing students which found preceptors generally provided students with a link between theory and practice (Jackson & Mannix, 2001; Lambert & Glacken, 2004; Burns & Paterson, 2005). As mentioned previously in this chapter, the theory-practice gap was noted as a major challenge to competency development for the Bachelor of Midwifery students in this study, with less than half of the students saying that they worked with a positive role model throughout the duration of their course.

While acknowledging that working with caring and supportive midwife preceptors (even if only for one day) negated some issues related to inconsistent preceptor allocation, the findings indicated that students preferred to have continuity of practice with midwife preceptors. Continuity of midwife preceptors was seen to enhance relationship development, create awareness of student learning needs as well as provide consistency of practice and meet expectations of students. Additionally, continuity increased students' feelings of being a valued member of a 'team' and therefore improved the students' clinical experience and confidence, which reflects Edwards et

al.'s (2004) findings. The lack of continuity of preceptorship, identified in this study, caused many challenges to the students' learning. Working with different midwives meant difficulties in building trusting relationships, inconsistencies in practice and teaching as well as assessments. Inconsistencies in preceptors' practice meant students were vulnerable to criticism from the midwife preceptor; they often found themselves in situations where their midwife preceptor would tell the student they were doing something 'wrong' and insisting that they do it their way, or the 'right' way. Although Fraser (2000b) also found inconsistent preceptorship to affect reliability of student assessments, and Jones and Wiley (2008) found it was a source of stress for the students, they did not conclude that it made students vulnerable to criticism and compel them to adapt to each midwife's expectations to avoid conflict, as was the case in this study.

It could be argued that 'adaptation', as identified in this study, was essentially professional socialisation. The process, influence and prevalence of socialisation for nursing and midwifery students have been extensively discussed in the literature, and socialisation has frequently been identified as an aspect of learning for both nursing and midwifery students (Melia, 1998; Yearley, 1999; Gray & Smith, 1999; Papp et al., 2003; Edwards et al., 2004; Ullrich, 2004; Lange & Powell Kennedy, 2006; Thomas, 2007; McCall et al., 2007; Jordan & Farley, 2008). According to Melia (1998), nursing students align themselves with practitioners in the service sector. They learn not to expose their differences when moving between the two worlds, instead they fit in to each world as necessary – which is similar to being a “chameleon” as described by one of the students (Yvonne) in this study.

However, socialisation theory assumes that the Bachelor of Midwifery students entered the midwifery course as homogenous open vessels, ready to be filled with the information and experience to mould their final identity as a midwife (Olesen & Whittaker, 1998). The theory relies on the activities of hierarchical power and social norms within a specific social group, which construct a new member's self identity. I believe that socialisation theory therefore disregards the Bachelor of Midwifery students' own embodied experiences, identities, assumptions, beliefs and knowing. It also disregards the notion of personal agency and resistance to the operations of power.

I argue that labelling the students in this study's experience as 'socialisation' would over-simplify its complexity. The influence of the students' personalities and experiences and their responses to 'the system' should be considered. The students in this study said that they adapted to 'fit in' to *each* clinical learning environment as well as *each* midwife's preceptors' practice within that environment. They therefore took on differences and had multiple 'socialisation' experiences. They were also 'socialised' to varying degrees – some resisted the medical discourse more than others. Thus, to say that all of the students in this study underwent a specific and complete socialisation process, as articulated by other researchers and theorists (Melia, 1998; Olesen & Whittaker, 1998; Yearley, 1999; Gray & Smith, 1999; Papp et al., 2003; Edwards et al., 2004; Ullrich, 2004; Lange & Powell Kennedy, 2006; Thomas, 2007; McCall et al., 2007; Jordan & Farley, 2008), would be presumptuous. I have, therefore, labelled the students' process as *Adaptation* rather than socialisation.

The students in this study reacted to their adaptation experience with despondency and, rather than fully assimilate into a culture, sought opportunities to work with those midwife preceptors who imbued the philosophy of the course. This is different to other studies' findings, detailed in Chapter Two, which alluded to the socialisation experience of midwifery students (Begley, 2001a, 2001b; Lange & Powell Kennedy, 2006; McCall et al., 2007; Jordan & Farley, 2008), which found student midwives were successfully socialised into the culture of midwifery practice in the units where they were learning. Unlike the Bachelor of Midwifery students in this study, those in Fraser and Hughes's (2009) UK and Jordan and Farley's (2008) US study were socialised to the point that they rated the high level of intervention in 'normal labour' as appropriate and normal. The Bachelor of Midwifery students in this study, however, said that although they adapted, they were disappointed, shocked and saddened by the high level of intervention they witnessed on placement and they did not seem to accept it as either normal or appropriate.

McCall et al. (2007 p.4), who also interviewed Victorian Bachelor of Midwifery students, found that the students had preconceived "misconceptions" about midwifery, which were challenged within the clinical environment as they learnt about the "reality" of midwifery practice. The students in her study then reviewed their future careers and

many planned to work in large public hospitals upon graduation. Similar to McCall et al (2007), the Bachelor of Midwifery students in this study outwardly conformed to the culture of midwifery practice during clinical placement. They did however, upon reflection, have insight into the influence of medical dominance on the woman's experience. As Parsons and Griffiths (2007) suggested, Australian midwives may appear obedient because there is a generation of midwives who hold a nursing qualification and therefore midwives have taken on nursing's legacy of obedience and conformity. This outward conforming may have represented students' obedience to their subordinate position, not necessarily socialisation.

Although the Bachelor of Midwifery students in this study also planned to consolidate their practice within large hospitals, they hoped to be empowered to provide woman-centred practice upon graduation. They also remained critical of midwives or doctors who did not meet their ideals of maternity care, even at the end of their final placement. The persistence of the students' theoretical beliefs of woman-centred midwifery may be attributed to the theoretical focus on feminist principles and women-centred midwifery in the curriculum.

Whilst adapting to the clinical learning environment, the students in this study consolidated their practice and achieved competency via processes of 'playing midwife' and 'chasing the numbers'. As they were 'playing midwife' the students tried to keep the woman at the centre of their care and they were mindful of the need to be caring and supportive towards the woman and family. 'Playing midwife' gave the students the opportunity for hands on practice, which was essential for their competency development. Whilst 'playing midwife' the students used critical reflection to develop their competency. Reflection was particularly useful when the students made mistakes or were involved in situations where women had what they saw as undesirable experiences. The students craved opportunities for hands on learning of both nursing and midwifery tasks as well as supported responsibility for the care of women during their final placement. During their final placement the students experienced increasing levels of independence in practice, where they had the opportunity to develop critical thinking and management skills whilst being supported by their midwife preceptors.

During their placements these students were supernumerary as they were not employed within the clinical environment and, apart from one student, none had nursing experience prior to entry to the course. They therefore had different learning needs compared with previous studies of graduate midwifery students. For example, Begley's (2001a) study of graduate student midwives found that, as students were employed as part of the midwifery workforce, they often found themselves "thrown in the deep end" (Begley, 2001a p. 26) at the beginning of their course. They felt a high level of responsibility for the care of women without adequate support from their mentors.

Begley's (2001a) study also identified the need for increased supervision and support of the graduate students who were, from the beginning of their course, expected to contribute to caring for women to reduce the workload of the unit. Their own learning was disrupted by as they were "surviving as employees in the workplace" (Begley, 2001a p. 26). The Bachelor of Midwifery students in this study, however, felt their practice was restricted. They wanted more opportunities for hands on practice of skills and responsibility for the care of women. Their desire for hands on practice and playing midwife is consistent with experiential learning theory, described as the application of knowledge which is tested within practical learning experiences (Kolb, 1984).

The findings also demonstrated a link between students' confidence and competency. The students reported needing to feel confident in order to practice the skills necessary for the achievement of competency. Practice and repetition increased the students' confidence in their competency, as did support from their preceptors and their own self-confidence arising out of previous life experience and knowledge. This repetition of skills increased students' confidence as did 'playing midwife', contributing as a member of the healthcare team, positive feedback from midwife preceptors and women, and having positive clinical experiences. Students' confidence was, on the other hand, reduced by unsupportive clinical environments and making mistakes.

The Bachelor of Midwifery students consolidated their competency by 'chasing the numbers' during their final placement meeting the extensive numbers of requirements for registration as a midwife with the NBV. These 'numbers' were informed by the ACM (2002) standards for Bachelor of Midwifery course curriculum

accreditation, which are the same as the UK Nursing and Midwifery Council (NMC) (2009) and the Midwifery Council of New Zealand (2007) numbers. The source of these requirements was the European Parliament and of the Council (2005) *European Union Directive*. The ACM adopted these numbers in the hope that Australian Bachelor of Midwifery graduates would be comparable with UK and NZ midwifery graduates and therefore able to automatically be able register to practice as a midwife in those countries. The findings in this study showed that these requirements were a significant focus as well as a source of stress and anxiety for the Bachelor of Midwifery students during their final placement. All of the students described 'chasing the numbers' at the expense of personal learning needs and had to complete extra clinical hours to meet the requirements.

There is no evidence to suggest that midwifery students, in either the UK or NZ, have difficulty achieving these numbers. It is important to note, however, that students in these countries have a significantly greater number of clinical placement hours to achieve them. The ACU students had significantly less clinical placement allocation compared to UK and NZ midwifery students, yet they had the same numbers of requirements to achieve before graduation.

Due to the lack of formal clinical practicum hours it was challenging for the students in this study to achieve many of the requirements adopted by the NBV, particularly the requirements for normal births as Primary Accoucheur, within the time allocated for their final placement. Furthermore, the Follow Through Experience (FTE) was counted as clinical practicum, which was problematic in terms of exposure to experiences that would contribute to students' competency. Ideally, according to the ACM (2002), the FTE would allow students to experience continuity of midwifery care, as well as attend at least 15 women's labours and births over the three years of the course. This was not necessarily the case as there were restrictions upon both the students' ability to attend the labour/birth and be actively involved in the care of the woman.

The Bachelor of Midwifery students were therefore pressured to 'chase the numbers' during their final clinical placement to achieve the ACM/NBV requirements, to the detriment of their other personal learning objectives. Subsequently, students had a lack

of confidence in some aspects of their midwifery practice (Appendix M provides a table summarising the students' learning objectives prior to their final placement). Many of these aspects were not counted in the requirements (Refer to Appendix I), yet were arguably important areas of midwifery practice.

Consistent with Fraser's (2000b) study of UK direct entry midwifery students, the students in this study also identified a lack of confidence in performing episiotomies, urinary catheterisation and vaginal examinations. Furthermore, at the end of their final placement the students in this study identified ongoing learning needs, which perhaps related to their lack of prior nursing experience, such as administration and management of medications, perinatal emergencies and assisting doctors with medical procedures. The Bachelor of Midwifery students' lack of experience in these skills apparently did not detract from their competency overall because they were all assessed as competent by the end of their final placement. This was also the case for the students in Fraser's (2000a) study. There were, however, serious concerns raised by the students about the competency assessment process in this study.

Achievement of the ACM/ANMC competency standards and confidence to practice autonomously was perceived to be made difficult because of the restricted nature of midwifery practice within the hospitals in which the students were learning. The competency assessment process was criticised and students' intense focus on achieving requirements for registration set by the regulatory bodies, was felt to be to the detriment of personal learning objectives. There was a general lack of confidence in competency assessments because of the questionable subjectivity and reliability of competency assessment procedures. This finding is consistent with previous research (Watson et al., 2002; Calman et al., 2002). Furthermore, the students believed it was unrealistic to expect they would achieve all of the competency standards because of the clinical environment. There were a number of organisational issues which may have led to the lack of confidence in competency assessments found in this study. Students and midwife preceptors in this study both said that competency assessments were hampered by the lack of continuity of preceptorship, which is consistent with Dolan's (2003) findings.

Another issue identified was that the clinical teachers were responsible for students' competency assessments. They did not, however, spend significant time with the students; their workload allowed one hour per student, per day for teaching support, supervision of preceptorship, and assessment of the students. It was unrealistic, therefore, to expect that clinical teachers could adequately assess all aspects of the students' competency and they relied heavily upon midwife preceptor feedback and students' reflections for competency assessments. The midwife preceptors themselves had little preparation for competency assessments. Lack of preparation has been shown by previous research to negatively influence the reliability of competency assessments (Fraser, 2000b; Calman et al., 2002; Dolan, 2003). This issue, therefore, may also have reduced the reliability of the students' competency assessments in this study.

The students in the study also lacked confidence in their competency assessments, because they believed it was unrealistic to be rated as 'independent' for some of the midwifery competencies. They felt ill-prepared to be leaders in the profession, advocates for women and provide evidence-based practice when their practice was significantly constrained by the hierarchical system of maternity care in 'the system'. This finding is consistent with Baird (2007), who found that UK midwifery students close to graduation felt their practice had prepared them to be qualified midwives but not autonomous professionals, because they were not role modelled autonomous midwifery practice in medically dominated obstetric-led units.

Implications for Midwifery Education

In consideration of these findings, I make the following three major recommendations for midwifery education, particularly for Bachelor of Midwifery courses:

1. Review the clinical practicum hours provided by curricula, with a view to ensuring realistic timeframes for student achievement of regulatory requirements.
2. Improve student preceptorship experience via:
 - a. Improved preceptor preparation.
 - b. Increasing continuity of preceptorship.

- c. Providing greater opportunities for students to be role modelled autonomous midwifery practice.
3. Review competency assessment methods.

Recommendation 1: Review clinical practicum hours provided by curricula, with a view to ensuring realistic timeframes for student achievement of regulatory requirements.

One of the significant issues highlighted by this study was the influence of the lack of clinical hours, within the ACU curriculum, for students to achieve competency for beginning practice as well as the NBV requirements for registration. The lack of hours led students to feel like they were 'chasing the numbers' during their final placement, rather than focussing on individual learning needs. I recommend therefore there is attention paid to the discrepancy between the clinical hours according to the ACM, and the current ANMC (2009) standards, and hours provided in the university curriculum, with a view to increasing the clinical hours. This may also mean a review of other Bachelor of Midwifery curricula's clinical practicum hours in each state, as there is evidence to suggest that their hours are also significantly less than those recommended by the ANMC (2009) (Gray, 2010).

Future Bachelor of Midwifery curricula need to provide the recommended clinical practicum hours as stipulated originally by the ACM (2002), and subsequently the ANMC (2009), which are similar to the UK and NZ clinical practicum hours. I recognise that there are two major hurdles that need to be considered when increasing clinical hours. Firstly, the availability of clinical places for the numbers of students enrolled in midwifery courses within the state needs to be in balance. Secondly, the expense of clinical practicum incurred by the university making this change would mean a 50% increase in the numbers of clinical places required by the universities and 50% increase in costs associated with this increase.

Clinical placement for midwifery students is said anecdotally to be an expensive component of the Bachelor of Midwifery course. According to the ACU clinical office, the industry standard is for the university to pay the clinical agency \$50.69 per student, per day for clinical supervision (D'Antonio, 2011). This currently costs the university

approximately \$7,600 per student for clinical practicum. To increase this by 50% would mean it would cost over \$15,000 for each student. Understandably, universities may feel pressured to increase numbers so that they can 'lay off' these costs or abandon the Bachelor of Midwifery programs altogether. Government support of universities providing Bachelor of Midwifery courses is therefore essential to ensure continued viability if the clinical hours are increased. Either funding allowances for midwifery courses will need to be increased to reflect the increase in clinical practicum costs, or funding for clinical supervision be incorporated into government funding of hospitals. It is questionable whether universities should be paying for clinical supervision in hospitals which are government funded. Essentially, midwifery students' competency should cease to be determined, by fiscal politics between university and government.

If it is found that increasing clinical hours for midwifery students is not a viable option, then Bachelor of Midwifery students' requirements for registration must be reduced accordingly. They should not be expected to meet the same requirements as the UK and NZ students to register as a midwife in Australia if they are not allowed equal clinical practicum hours. Australia will therefore need to realistically accept that our midwifery education standards may not be on par with global standards.

Recommendation 2: Improve Student Preceptorship Experience

2a. Improve Preceptor Preparation

Most midwives in practice in Australia are, to some degree, involved in preceptoring midwifery students. The reality is that midwife preceptors spend the majority of time with students, not the clinical teachers who are allocated one hour per student, per day (D'Antonio, 2011). Midwife preceptors are therefore an integral part of midwifery student learning as they influence how the student applies their practical knowledge to develop their competency and confidence.

Despite this great responsibility midwives in Australia seem to have little, if any, formal preparation for this role. Being a midwife does not automatically make one an effective preceptor or teacher, and nor should effectiveness be expected without adequate preparation and support. As discussed in Chapter Two, in the UK preceptors are called

mentors and the UK Nursing and Midwifery Council (NMC, 2008) has developed standards for mentors which have been applied since 2007. The UK mentorship system has been shown to benefit students in terms of assessment, providing learning opportunities and continuity of preceptorship and UK mentors have found it to be a rewarding and satisfying experience (Myall et al., 2008). Myall et al. (2008) therefore provide evidence that preceptor/mentor preparation and continuity of preceptor/mentor, could significantly improve Bachelor of Midwifery students' learning as well as job satisfaction for preceptors/mentors.

My recommendation is, therefore, that all Australian midwives working with students should be mandated to participate in preceptor/mentor education programs. Incentives for participation could include Certified Professional Development (CPD) points (Nursing & Midwifery Board of Australia [NMBA], n.d). Further incentives could include a mentor allowance or increase in incremental pay level for being an accredited mentor. The courses could also provide credits or entry pathways into higher degrees for midwives, which already increase salaries for midwives in Australia. To increase links and support between universities and clinical agencies, these courses could be jointly run between universities providing midwifery education and the clinical agencies.

Implementing mandatory preceptor/mentor preparation and allocating students a named preceptor/mentor would help to address a number of clinical issues identified within this study, namely inconsistencies in preceptors' practice, the preceptor's awareness of the students' learning objectives and level of competency, assessments of the student's competency, and improving the relationship between the midwife preceptor/mentor and student.

2b. Increase Continuity of Preceptorship

A number of issues arose around poor continuity of preceptorship in this study which also related to student assessment, competency development and the student-preceptor relationship. Continuity of preceptorship could be improved by allocating each student a preceptor/mentor whom they follow on shifts throughout the year to meet their clinical requirements, rather than in blocks of placement. As the theoretical time would be

reduced by 50%, full-time students would have ample time during the semester to work shifts with their preceptor.

There are some limitations with this model that would need to be considered. The students and their preceptor/mentor may not be compatible, so there would need to be processes in place to address conflicts and change of mentor if required. Furthermore, not all midwives are suitably supported to be preceptor/mentors, however I again suggest that we look to the UK system, where mentors are accredited after completing a regulated education program provided by the university and the mentors are supervised and supported.

2c. Provide greater opportunities for students to be role modelled autonomous midwifery practice

Most of the students' placement occurred within hospitals, which exposed a significant theory-practice gap in relation to the ANMC (2006a) Australian Competency Standards for the Midwife and midwifery practice. This gap was particularly wide in busy tertiary maternity hospitals and private hospitals where midwives were constrained by traditional hierarchies of medical dominance. Furthermore, tertiary hospitals were often busy and understaffed, which further constrained the midwives' practice. The value of placements with midwives working autonomously outside of mainstream maternity settings has been established by prior research (Callaghan, 1996; Lange & Powell-Kennedy, 2006; Thomas, 2007a; Baird, 2007; Jordan & Farley, 2008).

This study also found that midwifery-led units and hospitals with continuity models of care and strong midwifery leadership were more likely to provide students with positive role models who were, in turn, more likely to emulate or encourage midwifery practice according to the competency standards, particularly in relation to leadership, autonomy and woman-centred care. Currently, the Bachelor of Midwifery students are rarely placed in such models of care. Furthermore, they are not placed with private practising midwives because of their lack of indemnity insurance.

A number of the students in this study expressed a desire for more exposure to community midwifery practice. I recommend, therefore, that the Bachelor of Midwifery

students be intentionally placed in community settings with independent midwives to get a broader experience, particularly those students who express an interest in working in that model of care. I acknowledge that the majority of midwifery students' clinical practicum will occur in hospitals because that is where the majority of midwives practice in Australia. There is an imperative, therefore, to create opportunities for students to be role modelled autonomous midwifery practice within 'the system', rather than just look to solutions outside of it. One of the major challenges is, however, that hospital midwives have been constrained by the politics of practice within their working environments and this significantly affects their practice. Competency standards that support autonomous midwifery practice do not guarantee the existence of autonomous midwifery practice.

I believe there needs to be serious attention paid to the discrepancy between the definition of the midwife's role, as defined by the ANMC (2006a), and the realities of their practice in medicalised maternity units. As it stands, the ANMC (2006a) expects that:

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 postpartum 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 appropriate assistance and the carrying out of emergency measures (ANMC, 2006a p.2).

Midwives may aspire towards this practice but are severely restricted by medical dominance when working in hospitals and this, in turn, influences students' practice.

It would make sense to assume that increasing models of care which promote midwifery autonomy and continuity of care would create more balance in relation to care provision and management within the system and the discourse underpinning care provision. There have been major barriers however, to midwives practicing within these models. Over time there have been attempts by midwives and women, via lobbying of government, to increase continuity of midwife models of care and midwifery autonomy in Australia. These have mostly been met with resistance from medical colleagues.

As recently as 2009, this issue was again raised in a national Maternity Services Review (MSR) (Commonwealth of Australia, 2009). Tens of thousands of submissions to the MSR by women and midwives suggested that medical dominance of care provision in public and private health sectors meant that women had little real choice of maternity care provider and place of birth because they had limited ability to access a midwife as their primary maternity caregiver. There were protests in each capital city and women and midwives joined together in Canberra to protest for the option to choose their own midwife and place of birth. Under pressure from the obstetric profession, the Australian Government ignored these requests over the “observed benefits to women and their families of collaborative care models” (Commonwealth of Australia, 2009, p. 20). Furthermore, the government reneged on a previous verbal agreement and election promise to facilitate indemnity insurance for private midwives attending homebirths; there was no provision in the new government legislation for midwifery care in labour, as they would not underwrite indemnity insurance for midwives’ provision of intrapartum care in any setting. They did, however, allow women to access publically funded rebates for midwifery care in the antenatal and postnatal periods as long as a proven ‘collaborative arrangement’ signed by a doctor was provided (Commonwealth of Australia, 2009).

The government asserted that collaborative models of care are the models of choice although “consideration [should be] given” (Commonwealth of Australia, 2009 p.21) for the demands for greater options including the provision of birthing centres to expand the role of the midwife within collaborative models. The obvious dominance of the obstetric profession upon government policy lies in the terminology – collaborative care models – used in the report. The report itself does not define the term ‘collaboration’ and Australian health practitioners’ interpretations of ‘collaboration’ differ (Heatley & Kruske, 2011; National Health & Medical Research Council [NHMRC], 2010). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (2009) state that:

Collaborative care between midwives and obstetricians (specialist or [general medical practitioner] GP) in a hospital setting is considered the best model of maternity care. This model provides the opportunity for close surveillance of mother and baby during labour and the implementation of

appropriate and timely interventions if problems arise. In the absence of complications, minimal intervention is required (p.2).

According to this definition, the obstetric profession see collaborative care models as essentially conventional hospital-based maternity care models. RANZCOG (2009 p.1) are clear that they do “not endorse” homebirth and they also discourage midwife-led care in home-like settings (i.e birth centres), citing a 1.83 relative risk of perinatal mortality compared to hospitals in these settings. They advocate that the ‘collaborative care models’ are the best for women and their babies.

The NHMRC (2010) developed guidelines for ‘collaboration’ after the MSR report, which have a broader definition of collaboration that is applicable across all levels of care provision and emphasise good inter-professional communication, women-centeredness and mutual respect for autonomy. Positive inter-professional collaboration in delivery suites in Australia, however, has been shown to be more influenced by organisational factors and discourse within the practice setting, rather than personal skills (Hastie & Fahy, 2011).

The RANZCOG position statement and MSR therefore have the potential to restrict effective implementation of collaborative care, as reflected in the NHMRC (2010) guidelines. Furthermore, midwifery-led care provision outside of the system will remain limited, because of the government’s lack of provision of structures to increase services and this reinforces medical dominance of maternity services in Australia. Independent midwives, who provide community based, midwifery-led care have been marginalised, as obstetricians are reluctant to enter collaborative models of care with them if they attend homebirths (Dahlen, 2011; McNamara, 2011; Medew, 2011).

Although there have recently been a number of increases in hospital-based continuity of midwifery care models, the availability of community-based models, which are more likely to role model autonomous midwifery practice than medically dominated hospital settings, have been restricted. The numbers of these models remain small compared to conventional models, and therefore midwifery students will continue to have limited exposure to midwifery role-models outside of the hospital system.

If government is not going to actively increase models which promote midwifery autonomy then the responsibility again lies with each individual midwife to effect change within their own practice within or outside hospitals – to ensure these professional standards are not professional rhetoric. Yet, if history is anything to go by, achieving this will be no mean feat as change within the system has proven difficult owing to the power dynamics that exist within the organisations where midwives work.

Strong midwifery leadership, effective mentorship, peer support of midwives and education to build midwives' confidence in women's abilities and their practice could be useful to help maintain midwives' motivation and resilience during the changes that need to be made (Thomas, 2007). Both the United Kingdom and New Zealand have formal mentorship and clinical supervision programs, which have been used to effectively develop the midwifery profession (Lennox, Skinner & Fourer, 2008). Australian midwives could benefit from more support in this area therefore it is up to Australian midwives to support each other to challenge this historical position as paraprofessionals and strive towards autonomy. Hopefully, with support, midwives could then work confidently and collaboratively with medical colleagues on a more equal footing. By breaking the traditional role of subservience, a regrettable legacy from midwifery's alignment with nursing, midwives can then be positive, autonomous, role models for the future midwives.

Ideally, the Bachelor of Midwifery curriculum will continue to create graduates who are motivated to effect change within 'the system'. Their desire to do so is like an unrealised potential and, if nurtured, I hope it will be manifested into practice. Current restrictions of the system and students' social adaptation however, will remain significant barriers if midwives are not empowered.

Recommendation 3: Review Competency Assessment Methods.

This study found that students' competency assessments were criticised for being unreliable and unrealistic because of the limitations both upon midwifery practice within the hospitals and the students' role. Some of these issues could be addressed by greater continuity and preparation of students' preceptors as well as professional

mentorship programs and support. Other aspects of the competency assessment process however, also need to be reviewed.

The current system of assessing student competency according to competency standards as well as requiring students to achieve certain numbers of midwifery practice experiences is theoretically a positive approach to competency assessment as it uses multi-method approaches, which have been shown by previous research to be reliable methods (McMullan et al., 2003). However, the pressure to achieve the requirements for registration overshadowed the competency assessments in this study. A balance must be achieved so that the principles of a holistic conceptualisation and approach to competency assessment are achieved. Behavioural conceptualisations, or assessing students according to a number of requirements, reduces midwifery competency to a set of skills. It does not respect the influence of midwives' knowledge, skills and attitudes upon their competency.

There needs to be, therefore, a significant philosophical shift in terms of competency assessment for student midwives in Australia. Rather than focussing on counting numbers of midwifery practice experiences, such as births, assessments and FTEs, students should also be legitimately assessed according to their competency. Furthermore, until the required number of midwifery practice experiences are validated by research to reliably demonstrate the relationship between them and competency for all students, the profession should be cautious about purely relying on these numbers to affirm student competency.

Midwife preceptors and assessors also need to be prepared for comprehensive competency assessments which draw on various sources of evidence for student competency. Currently, observations of practice as well as preceptors and students' reflections on how they achieved each competency appear to be the major sources of information to evaluate students. These should be extended to include simulated scenarios when students are unable to be directly observed in practice and feedback from the woman and family. To reduce subjectivity of assessments, students should have their competency evaluations confirmed by other prepared assessors and there

should be collaboration between the universities, clinical teachers and midwife preceptors to ensure that competency assessments are thorough and reliable.

Criticisms about the applicability of some of the ACM (2002) and ANMC (2006a) competency standards to student practice are potentially more difficult to address. The restriction of midwifery practice within 'the system' and the subordinate position of the students meant that it was unrealistic to expect students to be advocates for women and educate their midwifery colleagues. A review of the application of competency standards to student midwife practice and assessment, therefore, needs to be undertaken by the ANMC particularly in relation to the autonomous aspects of the midwife's role. Universities should also consider using a modified version of the competency standards to assess student competency. For example, competencies that expect students to demonstrate leadership within the profession could be modified to demonstrate leadership with their student peers.

Reflections and Limitations of the Research

In agreement with Clarke (2005), I consider "*all* knowledge [is] socially and culturally produced" (p. xxiv) making knowledge (and experience) produced, consumed and situated within groups of people who are historically and geographically located. I therefore acknowledge that the results of this study should be interpreted with caution in terms of transferability because the data was collected from a limited sample of students from one university offering the Bachelor of Midwifery. It is notable, however, that the students undertook clinical placement in a number of different hospitals in both Melbourne and regional areas, which broadened the context and some of the findings reflect other research exploring midwifery students' learning experiences, which supports some level of transferability. It remains to be validated by further research in other locations, however, whether this study's findings are applicable to different geographical, demographic and cultural contexts.

Drawing on my particular theoretical perspectives, as described in Chapter Four, the research aim was to shed some light on this particular situation. I believe my recommendations may indeed be able to be applied to midwifery education in Australia,

however, I believe that context is the key to this applicability; where stakeholders see similarities in their systems of maternity care provision and midwifery education strategies they may find the implications and conclusions useful.

Throughout this research project I was conscious of my influence over the whole of the research process, from choosing the research question to writing this thesis. The candour of responses from the students at interview suggested that students felt free to share their views and experiences, which was reassuring considering my position as an academic at ACU. Both my governance of the research process and my interpretations of the situation during analysis would mean that I had influence over the way that the findings would be interpreted. Furthermore, you as the reader will impose your own interpretation as your interpretation of meaning may differ from my own intention of the representation of the words written in this thesis.

Implications for Further Research

This study has highlighted the need for further research in a number of areas. A sampling approach which includes a wider population, to include Bachelor of Midwifery students from other universities, would add to the research findings' contribution to knowledge. Furthermore, extending the sample interstate or even internationally would provide additional rich data. Further longitudinal research exploring midwives' competency development post-graduation and throughout their early career years would also be useful. Research exploring other midwifery students (post-graduate students who have previous nursing experience as well as students completing a dual nursing and midwifery degree) experiences would be helpful to compare findings.

During the final placement, the students focussed more upon achieving the 'the numbers' (minimum midwifery experience requirements recommended by the ACM, 2002) than their competency assessments, and they expressed a lack of confidence in the competency assessment process. This may be interpreted as the students believing that 'the numbers' determined their competency and therefore warrants further exploration.

Research focussing on the academics', preceptors' and assessors' attitudes towards the competency assessment process and the ACM (2002) minimum requirements is recommended so that reliable methods of competency assessment can be developed and it can be determined whether others (such as clinical assessors, preceptors and academics) are relying upon the NBV requirements as a measure of student competency.

There also needs to be research into the number of midwifery practice experiences that affirm competency as well as competency assessment methods. To this point I have not been able to determine why the decision was made by the European Union to decide upon the number of experiences required to achieve competency as a midwife. This is concerning. I recommend also further research into the comparability between the ANMC/ACM competencies, which we used to assess the students, and the realities of practice. For instance, how do these competencies really inform practice and how can we create a midwifery profession which meets the competencies?

A study comparing the fitness for practice (or competency) of students graduating from competency based assessment compared to experience based assessment (i.e. the existing standards) is essential. If this does not occur then students' competency development is potentially at risk, as I found in this study that the students' learning goals during their final placement were to achieve these requirements and this was to the detriment of their own identified learning needs.

The influence of academics, and others, upon the process of assimilation could not be fully determined as this was not the primary focus of the study and academics involved in the midwifery program were not interviewed. Further research exploring the influence of academics and the curriculum content upon students' expectations of midwifery practice prior to entry into the clinical field may be helpful to determine their degree of influence upon the assimilation process.

Another area of research that is needed in Australia is into the methods of preceptorship and mentorship. We need to determine what education programs are required to ensure adequate preceptorship for students, in terms the length of such programs and what needs to be taught within them. We also need to determine how to effectively

restructure our clinical placement allocations to ensure continuity of and effective mentorship for students.

In conclusion, this study has demonstrated that the Bachelor of Midwifery students' achievement of competency for beginning practice within the system was not always congruent with the philosophical underpinnings of the Bachelor of Midwifery curriculum and Australian professional competency standards. They were compelled to fit in this system as they developed confidence in their competency for beginning practice. The negative aspects of the learning experience were somewhat diminished by the supportive preceptors and positive role models they encountered and the meaningful relationships they developed with women and their families.

During their final placement the students in this study would have benefitted from paying attention to personal learning objectives. They had very little time, however, to achieve the essential NBV requirements for registration as a midwife, so this took priority. Furthermore, the competency assessment process was criticised by the students.

I have, therefore, recommended that the clinical hours allocated within the curriculum need to be re-evaluated and validated through further research. Student preceptorship needs to be improved through mandated formal preparation of preceptors and student allocation processes that ensure continuity of preceptor and exposure to midwifery-led care. I further recommend that the student competency assessment processes are reviewed, with attention paid both to continuity and preparation of assessors as well as relevance of application of the standards to midwifery students.

The intention of the midwifery profession to shift midwifery practice in hospital settings to more closely reflect the competency standards should be formally supported through mentorship. It is neither appropriate, nor realistic, to hope that Bachelor of Midwifery graduates will alone be able to change the professionalism of midwifery and meet the needs of women if they are not supported to do so during their clinical practicum experience.

It is therefore the responsibility of all midwives graduates, midwives in working in hospitals, academics, researchers, leaders in the midwifery profession to effect this change. As Hannah Dahlen (2006 p.9) eloquently stated:

The challenge for us as midwives is to make the change happen, not wait for change to happen. The challenge for us is to begin hearing voices and to start having dreams and then be willing to make these dreams become a reality. Midwives are indeed standing at the edge of history. As we look to the past for guidance, the present for our realities and our tomorrows for our potential will we passively try and predict the future or will we actively try and create it. The future for midwives is the women we care for, the babies they are birthing and the society we are all creating.

We cannot leave the midwives of the future to shoulder this burden – the responsibility to be a supportive role model for our future midwives lies with each individual midwife today. It is a unique, honoured and responsible position we are in to 'midwife' each other as well as our future midwives.

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APPENDICES

Appendix A: Interview Schedule

Interview One

- I. Tell me about your reasons for undertaking a Bachelor of Midwifery course.
- II. Can you tell me about where you are going to be completing your final placement?
- III. At this time what do you think that your level of preparedness for practice as a graduate midwife is?
- IV. What do you hope to achieve during this placement?

Interview Two

- I. Have you been able to meet your expectations regarding your preparedness for practice during this placement?
- II. What do you think your level of preparedness is now?
- III. Is that the level that you anticipated being at?
- IV. Why do you feel that you did not or couldn't meet your expectations?

Probes

'how students perceived they had gained competency', 'when students gained competency', 'what is competency' and 'do students feel prepared for practice?'

Appendix B: Consent Form and Letter to Participants

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy VIC 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

CONSENT FORM**TITLE OF PROJECT:**

FINAL YEAR BACHELOR OF MIDWIFERY STUDENT'S ACHIEVEMENT OF CLINICAL COMPETENCY

NAMES OF STAFF INVESTIGATORS or SUPERVISORS:

DR CARMEL SEIBOLD

NAME OF STUDENT RESEARCHER:

SHARON LICQURISH

I..... have read and understand the information provided to me in the Information Letter. Any questions I have asked have been answered to my satisfaction. I agree to allow the student midwife involved in my care to be observed during clinical practicum realising that I can withdraw at any time. I agree the research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME
(Block letters)

SIGNATURE..... **DATE**.....

NAME OF WITNESS.....
(Block letters)

SIGNATURE..... **DATE**.....

SIGNATURE OF PRINCIPAL SUPERVISOR.....

DATE.....

SIGNATURE OF STUDENT RESEARCHER.....

DATE.....



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Information Letter to Participants

TITLE OF PROJECT: FINAL YEAR BACHELOR OF MIDWIFERY STUDENT'S ACHIEVEMENT OF CLINICAL COMPETENCY

NAMES OF SUPERVISOR: DR CARMEL SEIBOLD

NAME OF STUDENT RESEARCHER: SHARON LICQURISH

Dear participant,

You are invited to participate in this research project which is being conducted by student researcher Sharon Licqurish. Participation in this study may assist Sharon in obtaining a PhD and it may assist Sharon obtaining a PhD. You will be recruited into the study by a third party at ACU National and, as a final year Bachelor of Midwifery student, your involvement in this study would be greatly appreciated. You are, however, free to refuse consent without having to justify your decision, or withdraw consent and discontinue participation at any time without giving reasons.

The proposed study will investigate the third year Bachelor of Midwifery students' experiences of achieving competencies for beginning practice. Particular emphasis will be on how and when the students achieve competencies for beginning practice from their perspective and through observation during clinical practice. The focus will be on the student's final four week *preparation for practice* clinical placement.

Midwifery education in Melbourne, Australia recently experienced a significant change when the three-year, Bachelor of Midwifery course was developed and offered by a consortium of universities as an alternative to the Graduate Diploma of Midwifery. The first graduates of the Bachelor of Midwifery course at Australian Catholic University entered the profession in 2004, and to this point there has been no research into these graduate's experiences of achieving competency for registration.

This research will assist universities, midwifery educators, professional organisations and other stakeholders to understand the process of Midwifery student achievement of clinical competencies from the student's perspective. Universities could use the results to help them shape courses and curriculum.

Data collection will involve two audio taped interviews conducted prior to and after completion of the student's final *preparation for practice* clinical placement. Interviews will be conducted in a private location deemed convenient by the student and should

last approximately one hour. Students will also be asked to provide copies of competency assessment tools and reflective journal excerpts relevant to their learning experience.

A period of observation of students completing their clinical placement at the Mercy Hospital for Women will also be conducted by the student researcher, Sharon Licqurish, on a maximum of three (3) occasions for four (4) hour periods (totalling 12 hours maximum). Sharon will approach the woman whom you are caring for and seek her permission to observe the care delivered by you. To ensure confidentiality, pseudonyms will be used, and no individual identifying information will be published in any report or publication arising from the study.

If you choose to participate in this study the Bachelor of Midwifery Advisor, Colleen Rolls, will be responsible for processing your grade for the subject NRSG 342 *Preparing for Midwifery Practice* and liaise with your clinical teacher as necessary. This is to ensure your progress in the course is not disadvantaged by participating in this study.

In accordance with ACU National HREC guidelines, all data will be de-identified to ensure confidentiality and will be stored on a password protected computer and/ or in a locked filing cabinet in the office of the chief investigator during the project. Upon completion of the project, data will be stored for five years in the office of the Head of Nursing & Midwifery School, ACU National, St. Patrick's Campus and then destroyed.

Participants who wish to do so can obtain appropriate feedback from the chief investigator. Any questions regarding this project should be directed to the chief investigator at the following address:

Dr Carmel Seibold
ACU School of Nursing
St Patrick's Campus
Locked Bag 4115
FITZROY MDC, VIC 3065
Tel (03) 9953 3186
Email: carmel.siebold@acu.edu.au

This research project has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way that you have been treated during this study, or if you have any query that the Chief Investigator has not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee at:

Chair, HREC
C/o Research Services
Australian Catholic University
Locked Bag 2002
STRATHFIELD NSW 2135
Tel (02) 9701 4159

Observation of students completing clinical practicum at the Mercy Hospital for Women has also been approved by the Mercy Health and Aged Care Human Research Ethics Committee and any concerns or complaints can be referred to:

Vicky Karitinos

Secretary,

Mercy Health and Aged Care Human Research Ethics Committee

163 Studley Road

HEIDELBERG, VIC 3084

Tel. (03) 8458 4808

Any complaint or concern will be treated in confidence and fully investigated and you will be informed of the outcome. If you agree to participate in this project, you should sign both copies of the Consent Form, retain one copy for your records and return the other copy to the Chief Investigator.

Yours Sincerely,

Dr Carmel Seibold

Sharon Licqurish

Appendix C: Examples of Memos

Theoretical Memo

15/9/06: Completed the first round interviews of my second cohort of students.

When I asked the students if they felt competent or how competent they felt, they spoke about confidence. Does competence come from confidence? Does the student need to be confident in the early days to be able to develop competency?

My thoughts from today and previous data collection were that the building of confidence depends on factors such as:

1. Knowing the clinical area: "Different equipment is enough to throw you", "Not knowing the policies."
2. Working as a team with midwives; "Good midwives"; caring, supportive, enjoy being with students "Bad midwives"; "baby-sat", "I hope they don't think I'm incompetent"; "Feeling useful and learning at the same time, Making judgements."
3. The midwife feels that confident student is competent; testing them and then allowing them to care for women with minimal supervision: is there more data available about this?
4. Hands on practice/Doing it; "Being challenged"; "thrown in the deep end"; "Being able to make mistakes"; "Developing a relationship with women"; "Continuity of practice; not having long gaps between clinical placements."

When do student midwives achieve competency for beginning practice? When themselves (and others) feel confident in their ability to care for women. This seems to happen in third year when students want the opportunity to be 'thrown in the deep end'

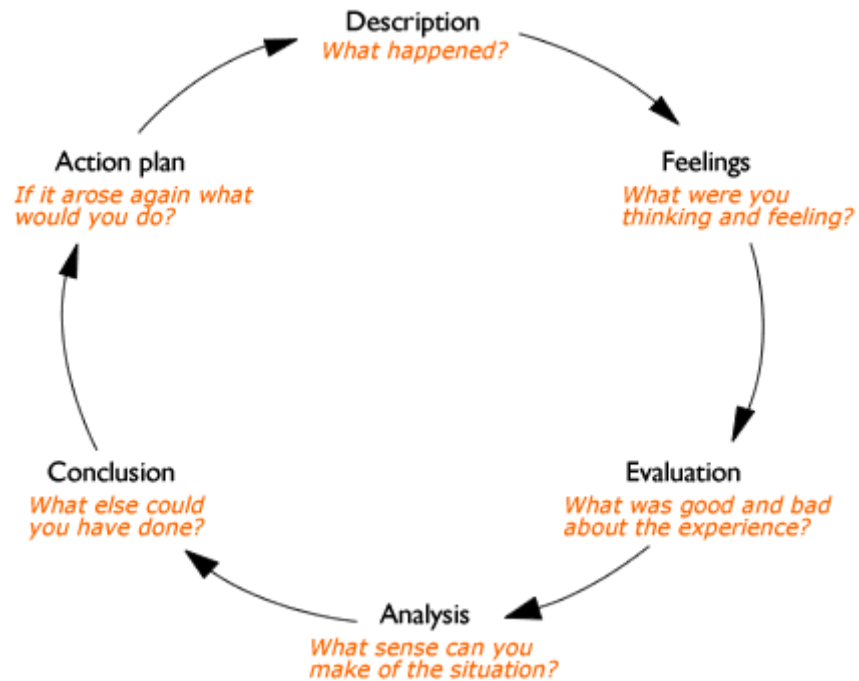
How do student midwives achieve competency for beginning practice? Through confidence building which is described as a process of; gaining hands on experience, knowing the clinical area, working with supportive midwives.

Reflexive Memo

I am concerned about the effect of my own beliefs on the data analysis. As their teacher, I will have preconceptions about this research question. Although...my own experience of studying midwifery as a registered nurse completing a Graduate Diploma was different than this course. As a teacher cannot presume to understand how an experience is for a student. I am a pretty curious person about people's experience. I need to be open to understanding the experiences of the student participants...a clean slate, I guess. I'm so curious about this and feel like the students have their own story to tell. In this case I'll try hard to see each story as separate to mine and each of the student's stories. Plus, I hope I can tell their story, I think that they have a limited voice here! (15/11/05)

Reflexive Memo: Ethical Issue 1.

This particular student related feelings of poor self esteem, stress and lack of support during clinical placement as her motivation for self harm. My offer to cease the interview was declined by the student. I felt genuine concern for this student. I asked if she had seen a psychiatrist and if she had experienced any feelings of harming herself since the incident. She reassured me that she was under the care of her psychologist and GP. I also followed the interview with a telephone call to further enquire about how she was feeling. I offered her the counselling service at the university, which she declined, saying she was under the care of her psychologist.

Appendix D: Gibbs (1998) Reflective Cycle

Gibbs, G. (1988). *Learning by Doing: A guide to teaching and learning methods*. Oxford Polytechnic: Oxford.

Appendix E: Codes & Categories List

Fitting in

- Seeing the reality
 - Non woman-centred care
 - The butcher shop
 - Unethical care
 - High intervention rates
- Being there for the woman
 - Having a positive role
- Feeling vulnerable
 - Being powerless
 - Putting up with it
 - Being worn down
- 'Rewards' of fitting in
 - Getting experience
 - Feeling supported
- Consequences of not fitting in
 - Not getting experience
 - Feeling bullied

Working with midwives

- Knowing each other
 - Building relationships
 - Wanting continuity
 - Picking a midwife
- Doing it their way
 - Ritualistic practice
 - 'Sussing out' the midwife
 - Readjusting
- Helpful midwives
 - Supportive
 - Good role models
 - 'good midwives'
 - Allow hands on practice
 - Inclusive and appreciative
- Unhelpful midwives
 - Take over
 - Unsupportive
 - Poor role model
 - Poor communicator
 - Bullying
 - Double Checking
 - Spot quizzes

Playing midwife

- Feeling 'left alone'
 - Having responsibility
 - Being thrown in the deep end
 - Doing the whole thing
- Asking for help
 - Being safe
- Feeling useful
 - Part of the team
 - Talking it through
 - Double checking
 - Communicating
- Being assessed as capable

- Overt assessment
- Covert assessment
- Being observed
- Confidence
- Identified learning needs
 - Gaps in knowledge
 - Gaps in experience

Building confidence

- Having some wins
- Experience
- Independence
- Knowing
 - Knowing the ropes
 - Knowing the routines
- Meeting other's needs
 - Needs of the team
 - Needs of the woman
 - Needs of the University

Becoming competent

- Making mistakes
 - Improves competency
 - Process of learning
- Good experiences
 - 'Wins along the way'
- Setting goals and objectives
 - 'Chasing the numbers'
- Transitioning
 - Looking forward
 - Feeling competent
 - Needing support
- Being assessed
 - Competency assessments
- Feeling confident

Appendix G: Examples of Situational Maps

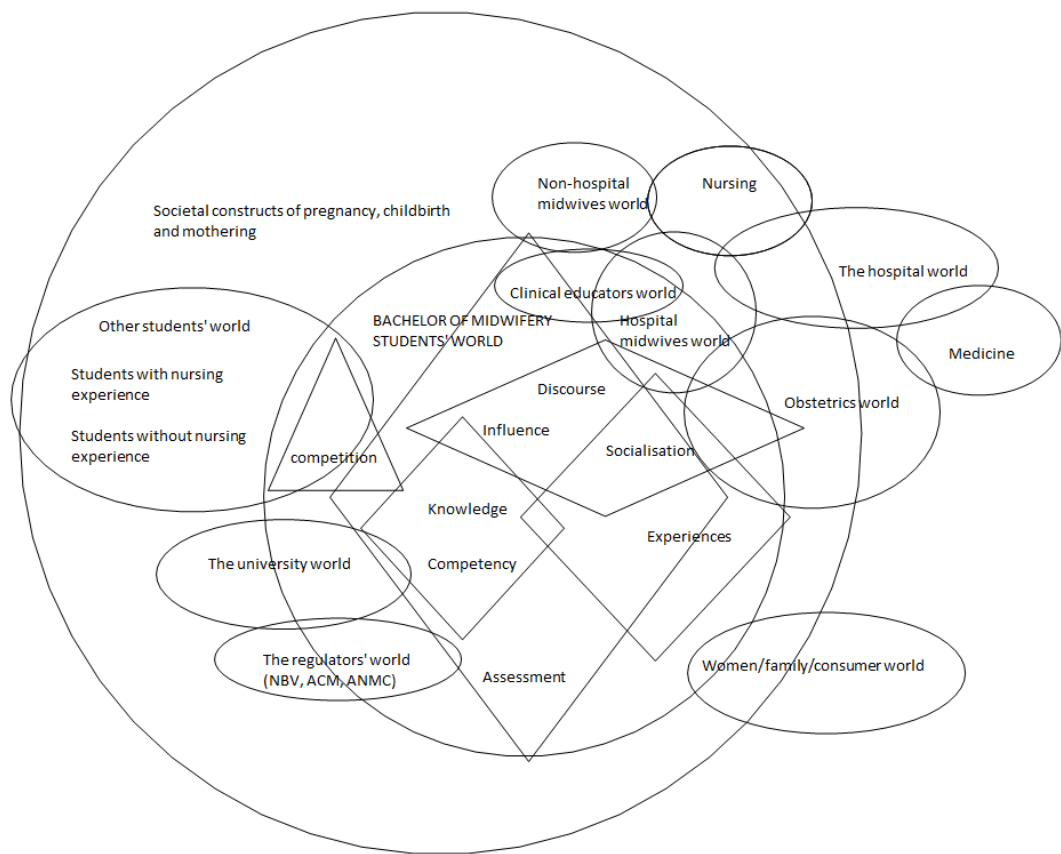
Example of Messy Situational Map



Example of Ordered Situational Map

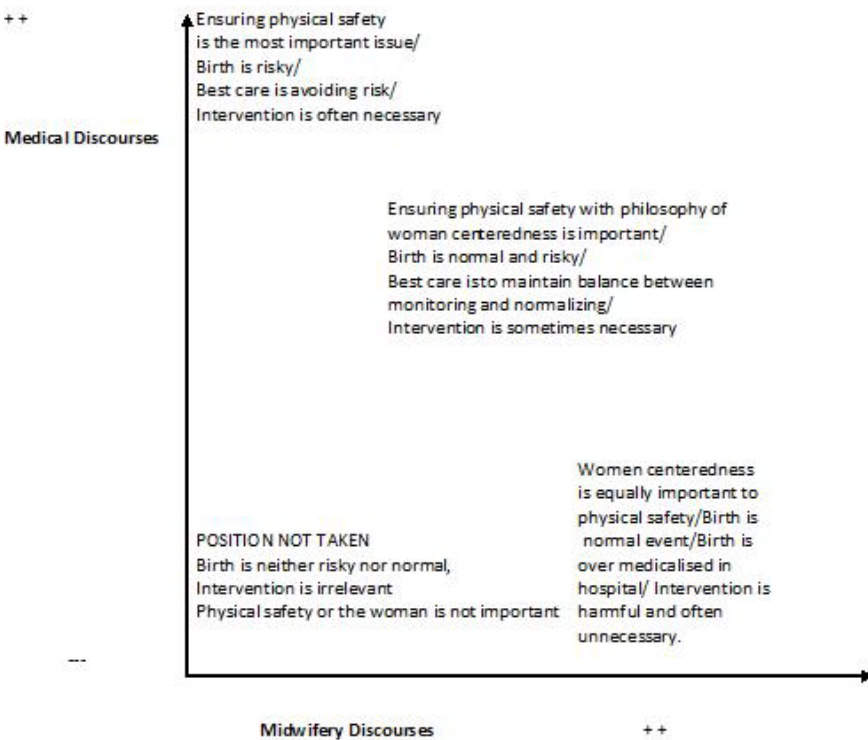
Individual human elements/actors	Nonhuman elements/actors
Midwifery students Midwives Doctors Women	Information technologies Medical technologies Surgical technologies Pharmacological technologies Surveillance Punishments Competency/competencies
Collective elements/actors	Implicated/silent actors
Midwives/doctors and other professional organisations Hospitals and hospital associations Medicare and private insurers Pharmaceutical and medical technology providers Media The university	Women Baby Father of baby Women's family and friends
Discursive constructions of individual and/or collective human actors	Discursive constructions of non human actants
Midwifery is an autonomous profession/Midwifery has a feminist perspective Hospital caregivers are not woman-centred Midwives should have a nursing qualification Pregnancy and childbirth is risky Midwifery and childbirth should be overseen/is dominated by obstetrics Best outcome is a healthy baby and healthy mum (physically) and it "doesn't matter what it takes to get that" Students are "a pain" Birth is horrible in hospital Students are socialised into the hospital/fit in Students need to do x number of activities to be competent Natural childbirth is desirable	Medical technologies as lifesaving Medical technologies as dehumanising Hospital guidelines as evidence based/policy/safe
Political/economic aspects	Socio/cultural aspects
Bachelor of midwifery/no prior nursing experience Recent introduction of bachelor of midwifery Ageing workforce Limitations to midwifery practice in Australia in current system Consumer demand for expansion of the midwife's role in the public health system Competency standards for the midwife did not reflect midwifery role	Traditional medical dominance of childbirth in Australia Midwifery registration requiring nursing qualification and experience
Temporal elements	Spatial elements
	Ward environment Work pressures; time, staffing, burnout, support
Major issues/debates	Related discourses
Students need to 'fit in' to the system Students 'play midwife' to achieve competencies Lack of continuity of practice and preceptorship Students need to complete a certain number of births to become 'competent' according to the NBV The midwife preceptor is an integral part of the learning experience Theory practice gap: Ritualistic practice is commonplace/lack of evidence based practice Bachelor of midwifery is not as good a graduate as those with a prior nursing qualification Students are punished for not fitting in Midwives are commonly not practicing according to the professional competencies Medical dominance of childbirth prevails and the students are socialised into this system	Crisis of maternity care in Australia Hospitals are a 'safe' place to have a baby Private hospitals provide superior care to public hospitals
	Other key elements
	Censorship Surveillance
	Punishment/Avoiding punishment Feeling traumatised Building relationships Helpful and unhelpful preceptors Trust Communication Theory practice gap Balancing safety and student practice

Example of Social World/Arena Map



Example of Positional Map (1)

Positional Map
‘Positions Taken Within Medical and Midwifery Discourses Circulating in the Social Arena’



Example of Positional Map (2)



Appendix H: Bachelor of Midwifery Student Competency Tools



**FACULTY OF HEALTH SCIENCES
VICTORIA**

BACHELOR OF MIDWIFERY

NRSG342 Preparing for midwifery practice
Semester Two 2005

Midwifery Practice Competency Tool

Student name:.....
Student ID:.....
Preceptor/s Name/s:.....
AGENCY:.....

PLEASE SUBMIT THIS TOOL TO LIC ON THE DATE SPECIFIED IN UNIT OUTLINE OR LATER WITH THE USUAL/OFFICIAL EXTENSION IF HOURS ARE NOT COMPLETE

RESPONSIBILITY FOR COMPLETION AND SUBMISSION OF THIS TOOL LIES WITH THE STUDENT. STUDENTS ARE REMINDED THAT ACADEMIC REGULATIONS WILL BE ADHERED TO REGARDING SUBMISSION DATE and PRESENTATION FOR THIS TOOL. THIS TOOL WILL BE HELD BY ACU IN YOUR FILE, THUS MAKE A CERTIFIED COPY (OF CERTAIN SECTIONS) IF YOU REQUIRE SAME. FOR FURTHER ADVICE PLEASE CONTACT THE LIC.

NRSG342 PREPARING FOR MIDWIFERY PRACTICE

DESCRIPTION:

This unit will prepare the student for the graduate midwifery role. It allows an intensive period of consolidation of midwifery knowledge and skills within midwifery practice settings through a preceptorship model of teaching and learning. During this experience, students will work with a Midwife.

UNIT OBJECTIVES:

On completion of this unit students should be able to:

1. demonstrate the ability to practice at a beginning level according to the Australian College of Midwifery Incorporated Competency Standards and Codes of Practice for Midwives (Victoria or Queensland);
2. reflect upon and critically examine their own values and beliefs;
3. demonstrate a receptivity to new ideas in midwifery;
4. consolidate midwifery knowledge and skills including collaborative care with other health professionals.

Midwifery Practice Strengths and Areas for Improvement:

In this final practice unit students are expected to identify individual and specific clinical practice objectives or learning needs to enhance clinical practice development prior to entering practice in their own right as a beginning level midwife. The course text by Cooper and Emden *Portfolio assessment: A guide for nurses and midwives* will be useful in the setting of individual learning objectives.

Identify below at least TWENTY midwifery practice goals/objectives/skills related to your specific learning needs and to the skills practised throughout the Bachelor of Midwifery course.

Write several objectives/goals/skills in pencil below and negotiate the possibility of achievement of same with your preceptor prior to firmly adopting. Record the final objectives in black ink. Set & negotiate further objectives as your practice competency progresses.

Objective or Skill to be achieved	Self-Evaluation (achieved/not achieved/date)
1.
2.

3.
4.
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20.
21.
22.

Midwife/Preceptor's Name: **Signature:**.....

&NBV ID: **Date:**

(verifying discussion about suitability of skill objectives/goals & achievement of same.)

CONFIDENTIALITY AGREEMENT

Various Australian codes for midwives and State legislation demand that midwives and midwife students maintain the privacy of information relating to the people for whom they care. Relevant codes and legislation include; the Health Services Act 1988, Health Records Act 2001, Information Privacy Act 2000, ACMI Code of Ethics and ACMI Competency Standards for Midwives, the NBV Code of Practice for Midwives in

Victoria, the Federal Privacy Principles and Human Services Victoria Health Privacy Principles 1998.

ACU National midwife students are required to abide by a practitioners or health care agency's confidentiality policy and procedures. Where a practitioner or an agency does not have an active confidentiality policy the following agreement is enacted. Students are expected to be aware of codes and legislation governing midwifery practice. If further information regarding this ACU National policy is required please contact the LIC or Course Coordinator.

Confidentiality Actions

- *I will abide by Australian and Victorian confidentiality and privacy laws, codes and policies in my practice as a midwife student.*
- *I will abide by legal and ethical confidentiality policies and procedures of the practitioner's business and the health care agencies in which I undertake midwifery practice and the follow through journey.*
- *I will seek to further my knowledge regarding laws, codes, policies and procedures relating to each setting in which I undertake midwifery practice and the follow through journey.*
- *I will ensure women & their families know why I am collecting information.*
- *I will treat all information about the people for whom I care as strictly private and I will only use information about the people for whom I care for the benefit of their clinical care and wellbeing.*
- *I will share information about the people for whom I care only with other health professionals involved in their care unless a court of law or the person themselves otherwise authorises.*
- *I will store securely the women's information I generate and protect it from unauthorised access*
- *When using a person's personal information for the purpose of study or research I will de-identify any records I make prior to removal from the agency.*
- *I will retain this agreement and make it available to women, to staff of the agency, my midwife teacher/mentor and or NBV upon request.*

My strategies to protect women's and families' personal information

Building on the strategies you have developed in earlier years add at least **five further** strategies below, related to midwifery practice.

My further strategies for ensuring confidentiality are:

1.
2.
3.
4.
5.
6.

Preceptor's Name/Signature/NBV ID verifying discussion & approval of strategies...... **Date**.....

ACU National is committed to ensuring the privacy of all information it collects. Personal information supplied to the University will only be used for administrative and educational purposes of the institution. Personal information collected by the University will only be disclosed to third parties with written consent of the person concerned, unless otherwise prescribed by law or by professional requirements for registration as a midwife in the State of Victoria. For further information please see the University's Statement on Privacy at <http://www.acu.edu.au>

CONFIDENTIALITY DECLARATION

I hereby declare that I have read the above agreement and I understand my responsibilities with regard to the privacy and protection of personal information of the people for whom I care.

STUDENT NAME: (block letters).....

STUDENT SIGNATURE:.....

STUDENT I.D.: DATE:.....

HEALTH PROTECTION DECLARATION

Midwife students are expected to maintain their own health in an optimum state for the protection of women and their families and also for their own wellbeing. Students are advised to consult their own practitioner regarding health matters including vaccinations and to make informed individual choices. Please see the relevant ACU National *Health Requirements* Policy in the Practice Information and Policy Book.

I have taken on the responsibility of maintaining my health status. I will make available my vaccination record or other documents in support of my health status when required by a woman, a woman's primary practitioner and when legally required by the health care agency's authorised staff member.

STUDENT SIGNATURE:.....DATE:.....

SECURITY: NATIONAL POLICE CERTIFICATE DECLARATION

As required by various legislation in Victoria and ACU National, I hold a current (annual) National Police Certificate and will make this original Certificate available to women with whom I work and to the authorised staff member of health care agencies.

STUDENT SIGNATURE:DATE:.....

ACU QUALITY PROCESSES DECLARATION

I have read and I understand midwifery practice policies and procedures in the current ACU National Practice Information and Policy Book.

STUDENT SIGNATURE:DATE:.....

PRECEPTOR FEEDBACK TO STUDENT REGARDING DECLARATIONS ABOVE & OTHER RELEVANT PROFESSIONAL BEHAVIOUR

Based on the broad and thorough notions of assessment underpinning ACMI Competency Standard specific skills lists are **not** appropriate. If a student has performed particularly well whilst undertaking for example, the psychomotor skills of listening and recording a woman's blood pressure or puncturing an infant's dorsal vein for collection of NST blood sample, they are advised to incorporate comment about such achievement with in the appropriate Competency Standard/s and or ask the supervising midwife to verify and or write accordingly.

Please note that the **MINIMUM COMPETENCY RATING** for NRSG342 Preparing for midwifery practice is **INDEPENDENT**, FOR EACH COMPETENCY UNIT (see explanation of ACU Competency Ratings below in next section).

Australian College of Midwives Inc Competency Standards for Midwives

Legend

Competency Rating	Criteria
Independent	Practices in a woman centred, safe, accurate, co-ordinated & effective manner with occasional need for guiding cues.
Capable	Practices in a woman centred, safe, accurate, co-ordinated and effective manner with some need for guiding cues.
Advanced Novice	Practices in a woman centred, safe, accurate and co-ordinated manner most of the time, with frequent cues required.
Novice	Practices in a woman centred, safe manner when continuous cues are given.
Unsatisfactory	Unable to demonstrate woman centred, safe practice, adequate knowledge base and /or appropriate professional behaviour.
Not Applicable	Not observed or not applicable.

(Adapted from Benner & Bondy)

MINIMUM COMPETENCY RATING: NRSG342 Preparing for midwifery practice

DOMAINS	Competency Rating Required
1. Professional Responsibility and Accountability	Independent
2. Midwifery Practice	Independent
3. Health Education and Promotion	Independent
4. Legislation, Policies and Procedures	Independent

COMPETENCY STANDARD 12	COMPETENCY RATING	
Fulfils the role of the midwife within the multidisciplinary health care team Performance criteria: <ul style="list-style-type: none"> Adopts a role congruent with the woman's needs Articulates the roles and interrelationships of members of the multidisciplinary health care team Facilitates access to the services of the health care team as required 	Student self rating	Precept or assessment <u>Interim</u> <u>Final</u>

COMMENTS by student (& preceptor prn) including mention of goals yet to be achieved by student:
Interim

Final

DOMAIN: HEALTH EDUCATION AND PROMOTION

COMPETENCY STANDARD 13	COMPETENCY RATING	
Offers formal and informal education that promotes women's and family health Performance criteria: <ul style="list-style-type: none"> Incorporates women's views in the development of prenatal, childbirth and early parenting education sessions Articulates accurate knowledge of women and family community health support services Participates in prenatal education Applies the principles of adult learning according to individual needs Acts as a source of accurate information for woman and their families Encourages the woman to accept responsibility for her own health Promotes independence of women in achieving optimum health 	Student self rating <u>Interim</u> <u>Final</u>	Preceptor assessment <u>Interim</u> <u>Final</u>
COMMENTS by student (& preceptor prn) including mention of goals yet to be achieved by student: Interim		
Final		

DOMAIN: LEGISLATION, POLICIES AND PROCEDURES

COMPETENCY STANDARD 14	COMPETENCY RATING	
Functions in accordance with legislation and common law affecting midwifery practice Performance criteria: <ul style="list-style-type: none"> • Articulates knowledge of policies and procedures that have legal implications for practice • Recognises and/or reports potential and/or actual child protection issues criminal violence in the home according to legislative requirements • Provides the woman with accurate information to allow her to give informed and valid consent • Fulfils duty of care in midwifery practice • Practises within the parameters of accepted midwifery practice and relevant legislation • Demonstrates accurate, contemporaneous and appropriate documentation as required by legislation 	Student self rating <u>Interim</u> <u>Final</u>	Precept or assessment <u>Interim</u> <u>Final</u>
COMMENTS by student (& preceptor prn) including mention of goals yet to be achieved by student: Interim		
Final		

NOTES:

OVERALL EVALUATIVE COMMENTS NRS342 Preparing for midwifery practice 2005***INTERIM***

Student Self-Evaluation:

Preceptor's Evaluation:

FINAL

Student Self-Evaluation:

Preceptor's Evaluation:

Assessment Grading (please place a tick in the appropriate box):**Satisfactory standard** ☐**Unsatisfactory standard** ☐

Date: _____

Name of Preceptor/Teacher: _____ Signature: _____

Preceptors/Teacher's NBV ID: _____

Name of Student: _____ Signature: _____

Student ID: _____ Date: _____

Date: _____

NB: Students please note that this Tool will be placed in your ACU file. It is recommended that you make a copy of relevant sections & have it certified for your own records/Portfolio.



FACULTY OF HEALTH SCIENCES VICTORIA

BACHELOR OF MIDWIFERY

NRSG342 Preparing for midwifery practice
Semester Two 2007

Midwifery Practice Competency Tool

Student name:.....
Student ID:.....
Preceptor/s Name/s:.....
AGENCY:.....

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NRSG 342 PREPARING FOR MIDWIFERY PRACTICE

DESCRIPTION:

This unit will prepare the student for the graduate midwifery role. It allows an intensive period of consolidation of midwifery knowledge and skills within midwifery practice settings through a preceptorship model of teaching and learning. During this experience, students will work with a Midwife.

UNIT OBJECTIVES:

On completion of this unit students should be able to:

5. demonstrate the ability to practice at a beginning level according to the Australian College of Midwifery Incorporated Competency Standards and Codes of Practice for Midwives (Victoria or Queensland);
6. reflect upon and critically examine their own values and beliefs;
7. demonstrate a receptivity to new ideas in midwifery;
8. consolidate midwifery knowledge and skills including collaborative care with other health professionals.

Midwifery Practice Strengths and Areas for Improvement:

In this final practice unit students are expected to identify individual and specific clinical practice objectives or learning needs to enhance clinical practice development prior to entering practice in their own right as a beginning level midwife. The course text by Cooper and Emden *Portfolio assessment: A guide for nurses and midwives* will be useful in the setting of individual learning objectives.

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&NBV ID: **Date:**

(verifying discussion about suitability of skill objectives/goals & achievement of same.)

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- *I will seek to further my knowledge regarding laws, codes, policies and procedures relating to each setting in which I undertake midwifery practice and the follow through journey.*
- *I will ensure women & their families know why I am collecting information.*
- *I will treat all information about the people for whom I care as strictly private and I will only use information about the people for whom I care for the benefit of their clinical care and wellbeing.*
- *I will share information about the people for whom I care only with other health professionals involved in their care unless a court of law or the person themselves otherwise authorises.*
- *I will store securely the women's information I generate and protect it from unauthorised access*
- *When using a person's personal information for the purpose of study or research I will de-identify any records I make prior to removal from the agency.*
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Preceptor's Name/Signature/NBV ID verifying discussion & approval of strategies.

..... **Date**.....

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STUDENT SIGNATURE:.....

STUDENT I.D.: DATE:.....

HEALTH PROTECTION DECLARATION

Midwife students are expected to maintain their own health in an optimum state for the protection of women and their families and also for their own wellbeing. Students are advised to consult their own practitioner regarding health matters including vaccinations and to make informed individual choices. Please see the relevant ACU National *Health Requirements Policy* in the Practice Information and Policy Book.

I have taken on the responsibility of maintaining my health status. I will make available my vaccination record or other documents in support of my health status when required by a woman, a woman's primary practitioner and when legally required by the health care agency's authorised staff member.

STUDENT SIGNATURE:.....DATE:.....

SECURITY: NATIONAL POLICE CERTIFICATE DECLARATION

As required by various legislation in Victoria and ACU National, I hold a current (annual) National Police Certificate and will make this original Certificate available to women with whom I work and to the authorised staff member of health care agencies.

STUDENT SIGNATURE:DATE:.....

ACU QUALITY PROCESSES DECLARATION

I have read and I understand midwifery practice policies and procedures in the current ACU National Practice Information and Policy Book.

STUDENT SIGNATURE:DATE:.....

PRECEPTOR FEEDBACK TO STUDENT REGARDING DECLARATIONS ABOVE & OTHER RELEVANT PROFESSIONAL BEHAVIOUR

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**MIDWIFE STUDENT ASSESSMENT IN THIS UNIT IS GOVERNED BY ANMC
COMPETENCY STANDARDS FOR THE MIDWIFE (2007) & PRINCIPLES OF
COMPETENCY ASSESSMENT**

The ACU National Clinical Education Information and Policy Book provides thorough policy directions regarding midwife student assessment. It is available via e-reserve via the ACU Library website <http://dlibrary.acu.edu.au/ereserve/patrick/NUR/GENERAL-NUR-perm1&2/index-GeneralNUR.htm>

Several performance criteria listed within each ANMC Competency Standard provide cues to assessors and students related to the type of performance each Competency Standard is assessing. These cues may forever change and are **EXAMPLES ONLY** of how a student may achieve the Competency Standard. Most importantly, principles of competency based assessment regards for the midwife or midwife teacher as expert, with the ability to appraise students in the wide variety of midwifery contexts. Students therefore should not be assessed on each and every cue but for the Competency Standard.

Based on the broad and thorough notions of assessment underpinning ANMC Competency Standard specific skills lists are not appropriate. If a student has performed particularly well whilst undertaking for example, the psychomotor skills of listening and recording a woman's blood pressure or puncturing an infant's dorsal vein for collection of NST blood sample, they are advised to incorporate comment about such achievement with in the appropriate Competency Standard/s and or ask the supervising midwife to verify and or write accordingly.

Please note that the MINIMUM COMPETENCY RATING for NRSG342 Preparing for midwifery practice is *INDEPENDENT*, FOR EACH COMPETENCY UNIT (see explanation of ACU Competency Ratings below in next section).

Australian Nursing and Midwifery Council Competency Standards for Midwives

Legend

Competency Rating	Criteria
Independent	Practices in a woman centred, safe, accurate, co-ordinated & effective manner with occasional need for guiding cues.
Capable	Practices in a woman centred, safe, accurate, co-ordinated and effective manner with some need for guiding cues.
Advanced Novice	Practices in a woman centred, safe, accurate and co-ordinated manner most of the time, with frequent cues required.
Novice	Practices in a woman centred, safe manner when continuous cues are given.
Unsatisfactory	Unable to demonstrate woman centred, safe practice, adequate knowledge base and /or appropriate professional behaviour.
Not Applicable	Not observed or not applicable.

(Adapted from Benner & Bondy)

MINIMUM COMPETENCY RATING: NRSG342 Preparing for midwifery practice

DOMAINS	Competency Rating Required
1. Legal & Professional Practice	Independent
2. Midwifery Knowledge & Practice	Independent
3. Midwifery as PHC	Independent
4. Reflective and ethical practice	Independent

DOMAIN: LEGAL & PROFESSIONAL PRACTICE

COMPETENCY STANDARD 1	COMPETENCY RATING	
Functions in accordance with legislation & common law affecting midwifery practice. <ul style="list-style-type: none"> <i>Element 1.1 Demonstrates and acts upon knowledge of legislation & common law pertinent to midwifery practice</i> <i>Element 1.2 Complies with policies & guidelines that have legal & professional implications for practice.</i> <i>Element 1.3 Formulates documentation according to legal & professional guidelines.</i> <i>Element 1.4 Fulfills the duty of care in the course of midwifery practice.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final

STUDENT'S COMMENTS supporting achievement of competence.

COMPETENCY STANDARD 2	COMPETENCY RATING	
<p>Accepts accountability and responsibility for own actions within midwifery practice.</p> <ul style="list-style-type: none"> • <i>Element 2.1 Recognises & acts within own knowledge base & scope of practice.</i> • <i>Element 2.2 Identifies unsafe practice & takes appropriate action.</i> • <i>Element 2.3 Consults with, & refers to, another midwife or appropriate health care provider when the needs of the woman & her baby fall outside own scope of practice or competence.</i> • <i>Element 2.4 Delegates, when necessary, activities matching abilities & scope of & provides appropriate supervision.</i> • <i>Element 2.5 Assumes responsibility for professional midwifery leadership functions.</i> 	<p>Student self rating</p> <p>Interim</p> <p>Final</p>	<p>Teacher /midwife assessment</p> <p>Interim</p> <p>Final</p>
STUDENT'S COMMENTS supporting achievement of competence.		

DOMAIN: MIDWIFERY KNOWLEDGE AND PRACTICE

COMPETENCY STANDARD 3	COMPETENCY RATING	
Communicates information facilitate decision making by the woman <ul style="list-style-type: none"> • <i>Element 3.1 Communicates effectively with the woman, her family & friends.</i> • <i>Element 3.2 Provides learning opportunities appropriate to the woman's needs.</i> • <i>Element 3.3 Plans & evaluates care in partnership with the woman.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 4	COMPETENCY RATING	
Promotes safe & effective midwifery care. <i>Element 4.1 Applies knowledge, skills & attitudes to enable woman centred care.</i> <i>Element 4.2 Provides or supports midwifery continuity of care.</i> <i>Element 4.3 Manages the midwifery care of woman & their babies.</i>	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 5	COMPETENCY RATING	
Assesses, plans provides & evaluates safe & effective midwifery care <i>Element 5.1 Utilises midwifery knowledge & skills to facilitate an optimal experience for the woman.</i> <i>Element 5.2 Assesses the health & wellbeing of the woman & her baby.</i> <i>Element 5.3 Plans, provides for, safe & effective midwifery care.</i> <i>Element 5.4 Protects, promotes & supports breastfeeding.</i> <i>Element 5.5 Demonstrates the ability to initiate, supply & administer relevant pharmacological substances in a safe & effective manner within relevant state or territory legislation.</i> <i>Element 5.6 Evaluates the midwifery care provided to the woman & her baby.</i>	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 6	COMPETENCY RATING	
Assesses, plans, provides & evaluates safe & effective midwifery care for the woman & /or baby with complex needs. <i>Element 6.1 Utilises a range of midwifery knowledge & skills to provide midwifery care for the woman & /or her baby with complex needs as part of a collaborative team.</i> <i>Element 6.2 Recognises & responds effectively in emergencies or urgent situations.</i>	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

DOMAIN: MIDWIFERY AS PRIMARY HEALTH CARE

COMPETENCY STANDARD 7	COMPETENCY RATING	
<i>Advocates to protect the rights of woman, families & communities in relation to maternity care.</i> <ul style="list-style-type: none"> <i>Element 7.1 Respects & supports woman & their families to be self-determining in promoting their own health & wellbeing.</i> <i>Element 7.2 Acts to ensure that the rights of woman receiving maternity care are respected.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 8	COMPETENCY RATING	
<i>Develops effective strategies to implement & support collaborative midwifery practice.</i> <ul style="list-style-type: none"> <i>Element 8.1 Demonstrates effective communication with midwives, health care providers & other professionals.</i> <i>Element 8.2 Establishes maintains & evaluates professional relationships with other health care providers.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 9	COMPETENCY RATING	
<i>Actively supports midwifery as a public health strategy</i> <ul style="list-style-type: none"> <i>Element 9.1 Advocates for, & promotes midwifery practice, within the context of public health policy.</i> <i>Element 9.2 Collaborates with, & refers women to, appropriate community agencies & support networks.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final

STUDENT'S COMMENTS supporting achievement of competence.

COMPETENCY STANDARD 10	COMPETENCY RATING	
Ensures midwifery practice is culturally safe. <ul style="list-style-type: none"> <i>Element 10.1 Plans, implements & evaluates strategies for providing culturally safe practice for woman, their families & colleagues.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

DOMAIN: REFLECTIVE AND ETHICAL PRACTICE

COMPETENCY STANDARD 11	COMPETENCY RATING	
Bases midwifery practice on ethical decision making. <ul style="list-style-type: none"> <i>Element 11.1 Practices in accordance with the endorsed Code of Ethics & relevant state/territory/commonwealth privacy obligations under law.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 12	COMPETENCY RATING	
Identifies personal beliefs & develops these in ways that enhance midwifery practice. <ul style="list-style-type: none"> • <i>Element 12.1 Addresses the influence of personal beliefs & experiences on the provision of midwifery care.</i> • <i>Element 12.2 Appraises & addresses the influence of power relations on midwifery practice.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 13	COMPETENCY RATING	
Acts to enhance the professional development of self & others. <ul style="list-style-type: none"> • <i>Element 13.1 Assesses & acts upon own professional development needs.</i> • <i>Element 13.2 Contributes to, & evaluates, the learning experiences & professional development of others.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final
STUDENT'S COMMENTS supporting achievement of competence.		

COMPETENCY STANDARD 14	COMPETENCY RATING	
Uses research to inform midwifery practice. <ul style="list-style-type: none"> • <i>Element 14.1 Ensures research evidence is incorporated not practice.</i> • <i>Element 14.2 Interprets evidence as a basis to inform practice & decision making.</i> 	Student self rating	Teacher /midwife assessment
	Interim	Interim
	Final	Final

STUDENT'S COMMENTS supporting achievement of competence.

NOTES:

OVERALL EVALUATIVE COMMENTS NRS342 Preparing for midwifery practice 2007***INTERIM***

Student Self-Evaluation:

Preceptor's Evaluation:

FINAL

Student Self-Evaluation:

Preceptor's Evaluation:

Assessment Grading (please place a tick in the appropriate box):**Satisfactory standard** ☐**Unsatisfactory standard** ☐

Date: _____

Name of Preceptor/Teacher: _____ Signature: _____

Preceptors/Teacher's NBV ID: _____

Name of Student: _____ Signature: _____

Student ID: _____ Date: _____

At least 160 hours required

Clearly record all details using block letters.

[illegible]

LICs signature verifying completion of required experiences.

Date:

Appendix I: ACMI Standard 2.6: Midwifery Practice Experience

Minimum requirements for midwifery practice experience are compatible with international standards for midwifery education.

Evidence that supports the measurement of this Standard is demonstrated where students experience:

- 2.6.1 practice in community organisations, both government and non-government
- 2.6.2 a minimum of 30 follow-through experiences (see footnote 3)
- 2.6.3 being with a minimum of 40 women giving birth as primary care giver, through labour and the immediate period following birth. This may include the 30 follow-through experiences referred to in 2.6.2.
- 2.6.4 attending a minimum of 100 antenatal visits. This may include the 30 follow-through experiences referred to in 2.6.2.
- 2.6.5 attending a minimum of 100 postnatal visits. This may include the 30 follow-through experiences referred to in 2.6.2.
- 2.6.6 midwifery practice placements in all areas of midwifery care provision in community and hospitals.
- 2.6.7 in appropriate acute care women's health settings
- 2.6.8 a placement in a special care baby unit.
- 2.6.9 opportunities to gain competence that include:
 - antenatal screening investigations
 - ordering and interpretation of laboratory tests
 - appropriate prescribing for midwifery practice
 - perineal suturing
 - examination of the newborn baby
 - community midwifery in the 4-6 weeks following birth

Reference: Australian College of Midwives Incorporated. (2002b). *Draft national standards for the accreditation of three year Bachelor of Midwifery education programs in Australia*. Melbourne, Victoria: Australian College of Midwives Inc.

Appendix J: Midwifery Publication (PDF)

Midwifery (2008) 24, 480–489



midwifery

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Bachelor of Midwifery students' experiences of achieving competencies: The role of the midwife preceptor

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Abstract

Objectives: to explore and describe Bachelor of Midwifery students' learning experiences, specifically the role of the midwifery preceptor in learning and development of competency, from the students' perspective. The findings reported are taken from a wider investigation into Bachelor of Midwifery student's achievement of competency.

Design: grounded theory methodology using in-depth interviews for data collection.

Setting: school of nursing and midwifery of one university, and associated clinical teaching hospitals in Victoria, Australia.

Participants: eight Bachelor of Midwifery students completing their final clinical placement.

Findings: data analysis in the broader study identified the categories of: hands-on practice; reflecting on practice; building confidence; gaining knowledge; working with midwives; and constructing a sense of self as a midwife. This paper focuses on one category 'working with midwives', which encompasses the therapeutic, interpersonal and clinical characteristics of the preceptor and their impact on student learning. Generally speaking, students identified midwife preceptors as helpful and unhelpful, and students indicated that they prefer to work with a caring midwife preceptor, who enjoys teaching, answers questions fairly and is philosophically similar. Students also felt that they benefited from opportunities for responsibility for care under supportive supervision, hands-on learning and debriefing. Midwife preceptors described as unhelpful were poor role models, did not allow the space for 'hands-on' practice or 'took over', were generally unsupportive and operated in a hierarchical system within the clinical agencies.

Key conclusions and implications for practice: a positive midwife preceptor–student relationship is an integral part of successful student midwife learning, and preceptors with helpful qualities enhance learning. Hands-on learning was emphasised as the most beneficial learning experience and students sought opportunities to work with midwives who imbued the philosophy they admired rather than becoming desensitised or socialised into a midwifery culture that was at odds with the course's philosophy. These findings are potentially useful to inform midwives and agencies teaching student midwives about preceptor behaviours helpful for student midwife learning.

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Keywords Student, midwifery; Education, midwifery; Preceptors; Education, competency-based; Clinical supervision

Introduction

In 2002, midwifery education in Australia experienced a significant change when 3-year Bachelor of Midwifery courses commenced in Victoria and South Australia. The Victorian course was offered by a consortium of universities including ACU National, Monash University and Victoria University and was based on a woman-centred philosophy embracing the 'New Midwifery' (Page, 2000, p. 4). The first graduates entered the profession in 2004 (Cutts et al., 2003). Prior to this, all students graduating from midwifery courses in Australia were experienced Division One Registered Nurses who completed a Graduate Diploma of Midwifery over 1 academic year. This paper reports on the role of midwife preceptors, which is one aspect of a larger study exploring Bachelor of Midwifery students' achievement of competency. For the purposes of this paper, the following definition of a preceptor has been adopted:

An identified experienced practitioner with responsibilities for a client group who enhances learning by teaching, instructing, supervising and role modelling.

(Morton-Cooper and Palmer, 1993, p. xx)

This definition includes all midwives who work in a teaching or supervisory capacity with a student, for a minimum of 1 day, and has ongoing contact with students placed in the agency.

The definitions of competency in the literature are generally inconsistent and lack clarity (Giro, 2000; McMullan et al., 2003). The following working definition of midwifery competency was adopted for this research:

A combination of attributes (knowledge, skill and attitude) which result in effective performance

(Australian College of Midwives Incorporated, 2002)

Literature review

A broad literature review was undertaken through OVID, Google scholar and CINAHL databases using the keywords 'midwifery student', 'nursing, student', 'education, midwifery' and 'midwifery competency'. There was paucity of literature available exploring Bachelor of Midwifery student's learning experiences and the role of their midwifery preceptor. There was, however, a considerable body of literature exploring the experiences of student nurses in terms of student-preceptor

relationships and learning, which has been drawn on for this paper. The following literature review is specific to the role of the preceptor in student development.

Preceptors were found to be central to the development of student competency in terms of: their influence on student self-esteem and confidence (Randle, 2001; Edwards et al., 2004); their ability to provide learning opportunities for development of clinical skills (Jackson and Mannix, 2001; Papp et al., 2003; Edwards et al., 2004; Tabari Khomeiran et al., 2006), linking theory and practice (Jackson and Mannix, 2001; Lambert and Glacken, 2004; Burns and Paterson, 2005) role modelling (Gray and Smith, 1999; Jackson and Mannix, 2001; Donaldson and Carter, 2005); and socialisation into the profession (Papp et al., 2003; Edwards et al., 2004; Ullrich, 2004).

Interactions between preceptors and students were found to impact on student learning, and expert clinical teaching was seen as vital for the development of skills and knowledge for nursing and midwifery students (Begley, 2001a, b, 2002; Jackson and Mannix, 2001; Lee et al., 2002; Thompson, 2002; Clarke et al., 2003; Lambert and Glacken, 2004; Burns and Paterson, 2005; Tabari Khomeiran et al., 2006). Two of the most influential factors for student learning and self-esteem development were the attributes of the preceptors they worked with (Gray and Smith, 2000; Randle, 2001; Begley, 2002; Papp et al., 2003) and the quality of their learning environment (Tabari Khomeiran et al., 2006).

Supportive student-preceptor relationships have been found to enhance both the quality of clinical placements (Clarke et al., 2003; Andrews et al., 2005) and students' learning during clinical placement (Begley, 2001a, b, 2002; Jackson and Mannix, 2001; Clarke et al., 2003; Papp et al., 2003; Donaldson and Carter, 2005; Edwards et al., 2004; Lambert and Glacken, 2004; Burns and Paterson, 2005).

Preceptors identified as supportive and helpful showed interest in the student (Gray and Smith, 2000; Jackson and Mannix, 2001), had good interpersonal skills (Warren, 1996; Gray and Smith, 2000; Jackson and Mannix, 2001; Lee et al., 2002), were positive professional role models (Warren, 1996; Gray and Smith, 2000; Lee et al., 2002; Donaldson and Carter, 2005), involved the student in clinical learning activities (Warren, 1996; Gray and Smith, 2000), were realistic about expectations of students (Gray and Smith, 2000), provided explanations about care (Jackson and Mannix, 2001), valued the student as a member of the health-care team (Begley, 2002; Papp et al., 2003;

Edwards et al., 2004) and empowered students by promoting confidence and self-esteem (Randle, 2001; Edwards et al., 2004). Students also appreciated being provided with opportunities for diverse learning experiences (Donaldson and Carter, 2005; Edwards et al., 2004).

Unhelpful preceptors displayed negative behaviours such as excluding or ignoring students (Jackson and Mannix, 2001), delegating unwanted jobs to the student (Gray and Smith, 2000), bullying or intimidating students (Randle, 2001), verbally abusing students (Lash et al., 2006) and being poor communicators (Jackson and Mannix, 2001). Additionally, unhelpful preceptors lacked knowledge and expertise, had poor teaching skills (Gray and Smith, 2000) and showed a general lack of support by being unfriendly and unapproachable (Gray and Smith, 2000; Begley, 2002). Sadly, nine out of 10 nursing students interviewed by Gray and Smith (2000) worked with nurses whom they identified as 'poor mentors' (p. 1546), and Begley (2001a, b, 2002) also found the majority of midwifery students' experiences working with midwife preceptors to be negative.

Begley's (2001a, b, 2002) study exploring the clinical learning experiences of 125 postgraduate student midwives in Ireland identified a hierarchical system and a lack of caring shown to students by most senior midwives. The clinical environment was described by students as unwelcoming; they experienced rudeness and belittling from their preceptors, leading to lack of confidence, conflicts about role responsibilities and fear of doing the wrong thing. Despite this lack of support, all students progressed through the course to graduate (Begley, 2001a, b, 2002), which begs the question of how much better prepared for practice the students would have been if they had been given the opportunity to learn in a more supportive environment.

A more recent study of midwifery students by Seibold (2005) explored a first cohort of Bachelor of Midwifery students' experiences and expectations. In relation to the mentor's/preceptor's role, students identified helpful mentors as those who provided debriefing and had the ability to offer appropriate guidance as needed. Less helpful mentors were identified as those who did not understand the requirements of the university or provide adequate support (Seibold, 2005).

The available literature identifies a positive clinical learning environment as one that provides links between the clinical practice environment and the university (Papp et al., 2003; Seibold, 2005), support for students (Watkins, 2000; Burns

and Paterson, 2005), an attitude of respect for students (Warren, 1996; Begley, 2001a, b, 2002), nurturing of students (Warren, 1996; Papp et al., 2003), empowerment in terms of student self-esteem and confidence (Randle, 2001; Edwards et al., 2004) and good interpersonal relationships between preceptors and students (Warren, 1996; Begley, 2001a, b, 2002).

Since much of the research has focused on the nursing preceptor's role in student learning, with little information available about the midwifery preceptor's role, there is a need for further studies that explore the experiences of Bachelor of Midwifery students in relation to the role of the preceptor, particularly within the Australian context.

Aims

The aim of the larger study was to explore how and when Bachelor of Midwifery students in a consortium programme achieve competency for beginning practice. One aspect of the findings, namely the impact of midwife preceptors on student learning and their achievement of competencies from the students' perspectives, is reported.

Methods

Research design

Grounded theory, developed by Glaser and Strauss (1967), was chosen for this study because it is a qualitative research method that uses interpretivist approaches and humanistic inquiry to facilitate understanding of the individual human experience and explain it to the world (Denzin and Lincoln, 2003). Generally, symbolic interactionism is the theoretical perspective that informs grounded theory methodology (McDonald and Schreiber, 2001; Charmaz, 2006).

Specifically, the epistemological approach of constructivism (Crotty, 1998; Charmaz, 2006) was chosen for this study. Constructivism focuses on how and why participants construct meanings through actions and experiences as well as the participants' interpretation of those experiences. Theory is constructed through the researcher's own interpretations of the data and the theory is acknowledged as an interpretation in itself (Charmaz, 2006). The participants' own interpretation and understanding of their world, sociocultural impacts on their world, and the specificity of subjective reality are fore grounded.

Grounded theory utilises qualitative methods of data collection and combines them concurrently with systematic coding methods of analysis to allow the researcher to 'follow leads as they emerge' (Charmaz, 2006, p. 14; Strauss and Corbin, 1998).

Participants and recruitment

After ethical approval was obtained from a University Human Research Ethics Committee, two cohorts of 2005 and 2006 final year Bachelor of Midwifery students in Melbourne, Australia and their clinical teachers were sent a letter informing them of the study, inviting their participation. Separate cohorts were chosen to gain sufficient numbers and further diversification of the data. Two student midwife participants and one clinical teacher from the 2005 cohort and six students from the 2006 cohort returned consent forms. Student participants included a combination of five mature entry and three secondary school leavers; they were all female aged between 20 and 40 years.

The interview process

In-depth interviews were conducted with the student midwives at the beginning and after completion of their final placement. Participants were open and willing to share their experiences during the interviews, which were conducted as an informal and flexible conversation. The interviews took place in a private office at the university or the clinical agency. Although the focus of the interviews was the student's final clinical placement, during the interviews, they reflected on past clinical experiences at various teaching hospitals in Victoria, Australia.

Eight questions were asked focusing on the clinical agency, students' self-rating of their competency, preparedness for practice and their expectations and learning objectives. Probes were used as necessary and focused on how students perceived that they achieved competency, when they achieved competency, what they view as competency, how prepared for practice they felt and their experiences of working with midwives.

The data analysis process

Transcription of data occurred soon after the completion of interviews which allowed data collection and analysis to occur simultaneously. Pseudonyms were allocated to ensure confidentiality. Data analysis techniques described by Glaser and Strauss (1967) and articulated by Strauss and

Corbin (1998) were used, including concurrent data collection, open and axial coding and constant comparative analysis. Coding and categorisation of data was assisted by QSR Nvivo 7 software.

Findings

Data analysis identified the categories of: hands-on practice; reflecting on practice; building confidence; gaining knowledge; working with midwives; and constructing a sense of self as a midwife. This paper focuses on the category 'working with midwives'. Pseudonyms have been used to present these findings to ensure confidentiality of the research participants.

Working with midwives

Working with midwives encompasses the therapeutic, interpersonal and clinical characteristics of the preceptor and their impact on student learning. Generally speaking, students identified midwife preceptors as helpful and unhelpful.

Helpful midwife preceptors

Helpful midwife preceptors were generally supportive, prepared to share their knowledge, facilitated hands-on practice, allowed mistakes, were positive role models, were motivated teachers and encouraged increasing responsibility and decision making.

Student midwife Cindy considered herself lucky to find supportive midwives in what was often an unsupportive environment: 'Having the luck to work with supportive midwives [was a bonus], because it [clinical placement] was in a hospital that wasn't necessarily supportive'. She also appreciated the midwife preceptor who was willing and able to share her knowledge and skills: 'It seemed to me [she had] assimilated a huge amount of knowledge and skills that she was willing to share'. Eliza also valued a midwife preceptor with the ability to provide constructive feedback: '...[the helpful preceptor was] willing to share and gave feedback.....and remembered what it was like as a student'.

The amount of feedback for students was inconsistent at times, and dependent on the midwife preceptor. Students expressed gratitude for the midwife preceptor who provided opportunities for debriefing:

Some of them will debrief a birth with you straight afterwards, some of them won't even bother, like they won't even, they won't even

check third stage with you. They'll just leave the trolley in the dirty room or whatever (Anna).

Students appreciated feeling valued as a member of the 'team' and contributing to care of the woman in a supportive environment. The team relationship was described by Anna as one where 'you share the load of the birth [with the midwife preceptor]', and Beth '[when] you work as a team [with the midwife preceptor]'.

Continuity in the allocation of their midwife preceptor was important to some students and working with the same midwife preceptor contributed to relationship development, helped the midwife preceptor assess student learning needs and maximised opportunities for learning:

If you're lucky enough to get to work with them for a few shifts in a row...um...they'll make sure that if there's something going on that they think you need to know about they'll involve you in it....and then it comes down to the midwife that you are working with too, if you get to work with a midwife more than once, you get to know each other.....

.....I think that if there was the preceptorship thing going in every hospital, if you were able to work with one or two midwives for the whole placement, I think you would benefit so much from it. Because those midwives are actually prepared to be a preceptor and um there's definitely midwives who are really good at teaching (Anna).

All students felt that they needed to practice skills in order to feel competent and appreciated the midwife preceptor who 'allow(ed) you to do what you need to do as a third year student' (Eliza) by encouraging or providing the space for students to enhance skill acquisition.

Eliza also appreciated her preceptor who would initiate hands-on learning with appropriate direction: 'the nurse or midwife, depending on the environment that you are working in, um says 'can you do that for me?'. Likewise, Anna appreciated her preceptor's direction and support:

I think that it [achieving competency] really depends on the midwife you are working with, because some of them will actually get you to do it. They'll [helpful midwife preceptors] say 'all right, you do this and this, and if you need to ask questions, [then] ask questions'.

Cindy described her 'ideal [learning] situation' as:

working with someone who is caring, and also gives me the opportunity to make mistakes or practice the skills. And you know that if you do

make a mistake, it's going to be OK. Um... so yeah.... I suppose that's the way I learn best.

Preceptors who encouraged increasing responsibility and decision making, as the student demonstrated their readiness, were also highly valued. Some midwife preceptors demonstrated their confidence in the student's ability by leaving them in the room to care for the woman for a length of time. The experience of planning and implementing care, while feeling supported, was crucial for a third year student as it increased student confidence, allowed the space to further their competency by practicing their midwifery skills, enhanced critical thinking and gave students a sense of responsibility. Cindy described a situation where: 'The midwife felt confident enough in me to leave the room, not for long periods, but enough to leave me with the partogram and the woman and that felt great'.

Eliza felt that when 'people have faith that [she has] a certain amount of experience' they would demonstrate their confidence by allowing her such opportunities. A 'taste' of what it would be like as a midwife graduate challenged students to apply theoretical knowledge and practise decision making:

If I'm sitting next to a woman and the CTGs on for whatever reason and there's dips...rather than just saying 'help!'.... I'm challenged to therefore think what should I do in this situation, I'm not going to have someone there next year. What would I do, try all the things, and then buzz...or...buzz as I'm doing the things (Beth).

Integration of the practice experience with theoretical understanding therefore occurred with increasing responsibility for care. Cindy described this as 'working with' the midwife preceptor:

That is actually probably my very best learning space, where you have to do it. When I was working with [a particular] labour ward midwife I was able to keep up with the obs....note them on the partogram... and at the same time I was being with the couple and...yeah... assimilating a whole lot of things within the experience.

Learning under minimal supervision was described by some as being 'thrown into the deep end', and Beth felt she 'learn[t] heaps more [when] thrown into the deep end' (Beth). Eliza also preferred to be 'thrown into the deep end' in order to put theory into practice:

I'm one who personally would like to be thrown in at the deep end as long as I feel like I've exhausted the theory bit as much as I can, I'm

here to practise. So watch me once or twice and let me do it. That takes away the whole thing of 'I wonder what that person is going to be saying or thinking'. It's me and the woman (Eliza).

It is, however, worth noting that these students were 'thrown in the deep end' in the latter part of their course, arguably after adequate theoretical knowledge development and support from the midwife preceptor.

Students were also inspired when working with midwife preceptors who were philosophically aligned and role modelled the type of midwifery practice that the students had assimilated throughout their learning. When reflecting on working with a midwife she admired, Anna said: 'I think [the midwife was] inspiring in terms of being an advocate and seeing midwifery as a skilled profession'.

Beth sought opportunities to work with midwife preceptors who imbued the philosophy she admired and were able to facilitate an enjoyable learning experience: 'I pushed myself to work with specific midwives who I knew did have that approach to care, and eventually did end up having two beautiful births [because of that midwife's approach to care].'

Motivated midwife preceptors who seemed to enjoy teaching were beneficial to student learning. As Beth stated: 'if you are working with a midwife who really wants to teach you, it is so much more beneficial than just anyone [who isn't]'. Eliza felt that 'those midwives that were happy to have a student [working] with them would have been fabulous no matter where you came from'.

Cindy indicated she was well aware of her impact on the midwife preceptor's workload. She appreciated the midwife who supported her by answering questions without being made to feel intrusive or annoying, describing such a preceptor as easy to ask questions without feeling like you were being 'a pest'.

Unhelpful midwife preceptors

Unhelpful midwife preceptors were identified as poor role models, allowed working conditions to impact their care of the woman, did not provide opportunities for hands-on practice or 'took over' and were generally unsupportive. Additionally, students were frustrated by inconsistencies in advice and practice, which was often compounded by working with different midwife preceptors.

The Bachelor of Midwifery curriculum embraces the 'New Midwifery' which is a partnership model of care that advocates empowerment of women (Page, 2000). During clinical experiences, students

often witnessed a general lack of respect and disempowerment of childbearing women which they found emotionally challenging:

I know they all want a good outcome, which I think is a healthy baby and a healthy mother but sometimes it's like it doesn't matter what it takes to get that..... I think some births are really horrible in hospital.....from what I've see so often....the woman's experience is not even up there with being an area of concern for people. You go out on clinical... ..and that's...hard to see (Anna).

It's hard to manage actually because you have such a strong sense of this birthing experience being such an important thing....you want it to be the best experience for them and there's people who trample all over that....it's really upsetting (Beth).

The actual journey from being in labour to having the baby sometimes it seems like that doesn't matter and the woman has no say or no control over her situation at all, It's just taken away from her until that baby's born and sometimes I really struggle with that (Anna).

Cindy realised the possible long-term impact of negative working conditions for midwife preceptors and described working with some midwife preceptors who had been 'doing their job a long time [which made them] forget what it's like to be a student'. She perceived their lack of support as a result of being 'overworked and undervalued and are working to get through their days...and have lost touch with a lot of the issues...with the way they can be more human'.

Working with midwife preceptors who provided limited hands-on practice or explanation was also unhelpful to student learning, as Anna said: 'you could work in two really similar scenarios... and one midwife could just do their own thing and not even tell you what she's doing... and you wouldn't learn anything'. Beth reflected: 'If you work with a midwife who kind of goes about her business and you just follow her around, I don't really feel like you learn very much'.

Poor communication and lack of hands-on practice were seen as especially unhelpful in the final placement, as students realised that they had limited time before graduation to gain experience: 'you are expected, even in third year, expected to observe for eight hours...sort of thinking... "I'm on limited time! I could be practising doing that myself"' (Eliza).

Students identified a general lack of support, interest and encouragement from some unhelpful

midwife preceptors:

....a lot of them don't care...and they know that having a student is part of what they have to do, so they just kind of do their job and you follow them.... or... they do their job and you do most of the work for them (Beth).

[midwife preceptors] don't really have much interest [in teaching] and it's almost like a pain to have a student. It's either a pain..or it's good that the student can do their work but they don't actually teach them anything (Anna).

The above experiences also draw attention to the workload issues of midwife preceptors and the impact on student learning. These students emphasise the difference between working 'with' midwife preceptors and working 'for' midwife preceptors, as these students felt exploited at times by the midwife preceptor to the detriment of their learning.

Most students were aware of their impact on the midwife preceptor's workload and the unwillingness of some preceptors to have students assigned to them. This led to students feeling like an inconvenience:

I know students can be a pain in the bum sometimes, because.... they hinder.... the way you work and all that kind of stuff (Cindy).

...some of them don't mind, but some of them give you a really hard time if they don't want to [work with you] (Anna).

....just sort of at handover with someone going 'who wants the student' and no one saying anything is a bit deflating when you think... I've dragged myself up here, I'd like to be useful....I'm not saying give me a patient load but surely I can do something I can learn from which will also benefit your unit for the day. Don't think you have to baby-sit me. (Eliza)

Student midwives' confidence was vulnerable to midwife preceptor's negative behaviours, lack of support and inadequate understanding of educational principles. Midwife preceptors contributed to one student's feelings of incompetence by testing her aggressively: 'They [the midwives] do that "challenging thing"; they're challenging you to do things but they don't explain what they want you to do, so they're very picky and they make you feel very inadequate' (Anna). Anna also described working with midwives who '...crush[ed] [her] confidence, making [her] feel like [she] just can't do it anymore....'.

A hierarchical structure within some agencies contributed to disempowerment of students: 'B mid...or anyone really, that's been into a hospital, gets it drummed into them pretty quickly not to be too big for your boots clinically' (Eliza).

A general lack of consistency of midwifery philosophy, procedural practice and expectations of students was a source of frustration. For example, students could be chastised by midwives for doing things the 'wrong way' which was, in fact, taught as the 'right way' by a previous midwife preceptor. Students responded by accommodating the midwife preceptor they were working with at the time:

You want to try and make whatever you're doing.... the situation... as smooth as possible....because if you do something the way someone else told you... it might not be the way she [the current midwife] told you [how to do it] (Cindy).

Personally, I found that there seems to be a very fine line, and you just don't know until you are standing there working with that particular midwife how it's going to go.... I constantly evaluate 'If I do this will this person think that I've stepped outside what a student midwife should be doing?' (Eliza).

It seemed that learning as a Bachelor of Midwifery student had unique challenges, specifically, the need to defend the new direct entry Bachelor of Midwifery course:

In some ways I wish I had started B mid when it had been running for 10 or 15 years.....I just found myself constantly defending the course... and not just even defending myself personally.... For me, it was the concept of a direct entry course full stop. I mean, you spend a lot of time doing that when you could be doing blood pressures in first year (Cindy).

Overall, the midwife preceptor is viewed by students as an important factor impacting on confidence for practice and the quality and amount of valuable learning experiences:

...the midwives that you work with really depend [impacts] heaps on your competency and... how you feel about the way you practice (Anna).

...a lot of how much you learn, and the quality of what you learn, really depends on the midwife you are working with (Beth).

Discussion

The findings reported in this paper highlighted the important role the midwife preceptor plays in Bachelor of Midwifery students' learning experiences and development of competency. The value of the preceptor in student learning is not unique to this group of Bachelor of Midwifery students and it is reflected in previous studies exploring both nursing and midwifery students by Begley (2002), Burns and Paterson (2005), Jackson and Mannix (2001), Lambert and Glacken (2004), Clarke et al. (2003), Lee et al. (2002), Thompson (2002) and Tabari Khomeiran et al. (2006).

The students in this study appreciated working with caring and supportive midwife preceptors who were motivated teachers, shared knowledge, answered questions fairly, provided feedback, facilitated debriefing or reflection on practice and were positive role models. Students reported that they learnt best by hands-on practice of skills, provided by helpful midwife preceptors, which supports a previous study of nursing students by Papp et al. (2003). Furthermore, findings revealed that students appreciated midwife preceptors who gave them opportunities to direct the care of women, which enabled students to practice critical thinking and put theory into practice. This experience was especially valued by third year students as they prepared for practice post graduation.

Midwife preceptors described as unhelpful to student midwife learning were poor role models, did not allow the space for hands-on practice or 'took over' and were generally unsupportive. Unhelpful midwife preceptors operated in a hierarchical system within the clinical agencies, whereby students should 'know their place' and not 'get to big for their boots'. Arguably, this was a contributing factor to the unsupportive learning environment experienced by some students and made students feel humiliated, unwelcome and inadequate. These findings support those of Begley (2001a, b, 2002), Randle (2001) and Lash et al. (2006). Students expressed their vulnerability to the lack of support from midwife preceptors and the consequential negative impact on their confidence and motivation which supports Randle's (2001) claims that negative clinical learning environments affect students' self-esteem and way that they 'think, feel, motivate themselves, and act' in their future practice (p. 294).

Understandably, the Bachelor of Midwifery students in this study craved opportunities for hands-on learning of both nursing and midwifery tasks as well as supported responsibility for the care of women. They found the amount of purely observa-

tional learning provided by preceptors was limiting to their learning during their final placement. This suggests different learning needs of these Bachelor of Midwifery students compared with previous studies of graduate midwifery students. Begley's (2001a, b) study of graduate student midwives found that as students were employed as part of the midwifery workforce, they often found themselves 'thrown in the deep end' (Begley, 2001a, p. 26). They felt a high level of responsibility for the care of women without an adequate knowledge base, lack of supervision from qualified midwives and, as they were already experienced nurses, they found performing nursing tasks boring and unnecessary for their learning. Although both studies found support of students by preceptors to be important, the graduate students' identified learning needs emphasised adequate supervision, knowledge acquisition and 'surviving as employees in the workplace' (p. 26), whereas the Bachelor of Midwifery students in this study sought more opportunities for hands-on practice of skills and responsibility for the care of women.

Furthermore the findings demonstrated that students in this study sought opportunities to work with midwife preceptors who were aligned with the course's philosophical basis of the 'New Midwifery' (Page, 2000) and who role modelled professional midwifery practice. Students described emotional distress and disempowerment when faced with the reality of maternity care in some clinical learning environments that were not woman centred, or did not reflect the course's philosophical framework. Interestingly, one student attributed the midwife preceptor's lack of caring towards the student and childbearing women to her being 'overworked and undervalued'.

The issue of 'depersonalisation' (Begley, 2001a, p. 32) and disempowerment of women during childbirth was also evident in Begley's (2001a, b) and Seibold's (2005) studies. Begley (2001a, b) found the graduate student midwives were assimilated into the culture without any evident emotional distress, whereas the Bachelor of Midwifery student midwives in this study reacted with despondency and, rather than assimilate into the culture, would seek opportunities to work with those midwife preceptors who imbued the philosophy of the course.

Finally, while acknowledging that caring and supportive midwife preceptors often transcended situations of inconsistent or occasional supervision, the findings indicated that students preferred to have continuity of practice with midwife preceptors. Continuity of midwife preceptors was seen to enhance relationship development, create

awareness of student learning needs as well as provide consistency of practice and expectations of students. Additionally, students valued feeling part of the team by working together with the midwife preceptor to provide care for the woman, which reflects Edwards et al.'s (2004) findings that feeling part of a team was one of the most important aspects of a positive clinical learning experience.

Conclusion

This paper supports other studies' findings that a positive midwife preceptor–student relationship is an integral part of effective student midwife learning while also presenting the perspective of Bachelor of Midwifery students in an Australian context. The Bachelor of Midwifery students in this study identified that they prefer to work with a caring midwife preceptor, who enjoys teaching, answers questions fairly and is philosophically similar. Students also craved opportunities for responsibility for care under supportive supervision and discussion to develop their competency. Hands-on learning was emphasised as the most beneficial learning experience. It was also important for the midwife preceptor to provide opportunities for debriefing, assist clinical reflection and to recognise the impact of the woman's experience on the students' emotional well-being.

The Bachelor of Midwifery students were emotionally affected by their experiences on clinical placement, particularly if they encountered care of women contrary to the feminist philosophical framework of the course. Sadly, this was not an uncommon experience for the students, and they generally reacted by seeking opportunities to work with midwives who imbued the philosophy they admired rather than becoming desensitised or socialised into the midwifery culture. The students in this study were aware of a professional bias and found themselves defending the Bachelor of Midwifery course to some unsupportive preceptors. This suggests a lack of support within the profession in Victoria for the Bachelor of Midwifery programme, which impacted the students' learning experiences, confidence and motivation. It also highlights the difficulties encountered when implementing a midwifery education programme with a basis in community midwifery, which emphasises an empowering partnership model of care, while the majority of student placements are in hospital settings which are not necessarily aligned with this philosophy.

The limitations of this study include the small group of student midwives sampled from one university and lack of interview data from midwife preceptors. There is a need for further exploration of the issues raised. As this paper presents one aspect of an ongoing study, it is hoped that further data collection, including participant observation and interviews of midwives working in a preceptorship role, will strengthen the findings. Despite these limitations, these early findings offer valuable insight into the impact of midwife preceptor's behaviours and qualities on the Bachelor of Midwifery students' clinical learning environment. This study has the potential to contribute to the profession by providing information for clinical agencies and university programme about how to provide an optimal clinical learning environment for student midwives.

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Appendix K: Nurse Researcher Publication (scanned)

Nurse Researcher

Applying a contemporary grounded theory methodology

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Abstract

Aim The aim of this paper is to discuss the application of a contemporary grounded theory methodology to a research project exploring the experiences of students studying for a degree in midwifery.

Background Grounded theory is a qualitative research approach developed by Glaser and Strauss in the 1950s but the methodology for this study was modelled on Clarke's (2005) approach and was underpinned by a symbolic interactionist theoretical perspective, post-structuralist theories of Michel Foucault and a constructionist epistemology.

Review methods The study participants were 19 midwifery students completing their final placement. Data were collected through individual in-depth interviews and participant observation, and analysed using the grounded theory analysis techniques of coding, constant comparative analysis and theoretical sampling, as well as situational maps. The analysis

focused on social action and interaction and the operation of power in the students' environment. The social process in which the students were involved, as well as the actors and discourses that affected the students' competency development, were highlighted.

Conclusion The methodology allowed a thorough exploration of the students' experiences of achieving competency. However, some difficulties were encountered. One of the major issues related to the understanding and application of complex sociological theories that challenged positivist notions of truth and power. Furthermore, the mapping processes were complex. Despite these minor challenges, the authors recommend applying this methodology to other similar research projects.

Keywords

Grounded theory, post-structuralism, situational analysis, symbolic interactionism

Introduction

THIS ARTICLE discusses the application of a contemporary grounded theory methodology to a research project exploring the experiences of students studying for midwifery degrees in achieving competency. The methodology is modelled on Clarke's (2005) approach to grounded theory. The framework of this paper is based on the selection, exploration and implementation of the chosen methodology. To describe and defend the methodology, a comprehensive exploration of the theoretical and epistemological underpinnings is necessary.

As noted by Crotty (1998), confusion about research methodology, theoretical perspectives and epistemology is common for seasoned and fledgling

researchers alike. To overcome this confusion, he identified four elements to a research process that need to be understood, then articulated and justified. He provided these definitions of the four elements: 'methods' are the procedures used to gather and analyse data; 'methodology' is the overall strategy or research process; 'theoretical perspective' is the philosophical stance informing the methodology; and 'epistemology' is 'the theory of knowledge embedded in the theoretical perspective' or 'an attempt to explain how we know what we know'.

Constructionism as epistemology

Constructionism can underpin a number of qualitative research approaches and unlike the post-positivist epistemologies that inform most

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quantitative research approaches, presumes that people construct their world and make sense of experiences during interactions in it (Crotty 1998, Charmaz 2006). Meaning is constructed when an individual engages with the world, so truth is relative and meaning flexible. Truth and meaning are subject to change and tested in social experiences (Crotty 1998, Schwandt 2000, Charmaz 2006).

Constructionism assumes that people are born into cultures that have already constructed meaning about their objects and symbols. These meanings are imparted as people interact (Crotty 1998, Schwandt 2000). Individuals' understanding of meaning is, therefore, shaped by sociocultural influences that manipulate their behaviours, experiences and thinking (Crotty 1998). Constructionism fits with grounded theory methodology, which aims to understand human experience.

Grounded theory as methodology

The grounded theory method of qualitative research was developed by Glaser and Strauss (1967). It is mostly inductive, which means the researcher does not begin with a hypothesis about the phenomenon to be studied but instead remains open to whatever theory emerges from the data (Glaser and Strauss 1967, Strauss and Corbin 1990). To remain true to the inductive nature of the design, grounded theory has specific characteristics of project design, data collection and analysis, which will be explained later.

The theoretical underpinnings of grounded theory – if grounded theory method is informed by a specific theoretical perspective and if researchers' theoretical perspectives should be identified before they start collecting data – have been debated. Glaser and Strauss's (1967) description of the methodology suggested they originally intended grounded theory to be theoretically flexible. However, Strauss's later grounded theory methodology was informed by symbolic interactionism (Strauss and Corbin 1990). This is particularly evident in Strauss's later collaborations with Corbin, which suggested some differences from the original Glaser and Strauss (1967) methodology, symbolic interactionism implicitly being the theoretical perspective (Strauss and Corbin 1990).

Glaser (2007) later criticised Strauss's and Corbin's approaches. He argued that applying a preconceived theoretical framework to a grounded theory project is contrary to the inductive nature of the process. He maintained grounded theory in its original form did not have a particular theoretical perspective. However, some contemporary grounded theorists, such as Clarke (2005) and Charmaz (2006), identified symbolic interactionism as the

theoretical perspective underpinning their approach to grounded theory.

Symbolic interactionism is a theoretical perspective relevant to qualitative research that focuses on human experience. According to Blumer (1969), symbolic interactionism is a theory of 'human group life and human conduct'. The focus is on the social aspects of human action and interaction, meaning, and interpretation of meaning: 'Human beings act towards things on the basis of the meaning that things have for them; the meanings of such things is derived from or arises out of social interactions with one's fellows; the meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters' (Blumer 1969).

Blumer (1969) identified two forms of social interactions – the 'conversation of gestures' and the 'use of significant symbols'. Mead later termed them 'non-symbolic interactions' and 'symbolic interactions' (Blumer 1969).

Symbolic interactionists presume that someone's sense of meaning is interpreted through social interactions, and the communication and understanding of verbal and non-verbal sociocultural symbols. Language is an example of a sociocultural symbol in today's society (Charon 2001). Analysis of language is also a significant feature of post-structural theory, which is another of the theoretical perspectives underpinning the methodology.

While there is considerable debate as to what constitutes post-structural theory, Michel Foucault's later work has been described as post-structural and contributing to post-modernism (Bordo 1993). Post-modernism can be said to be informed by a number of social theorists – as well as Foucault – and yet it is possible to identify a number of unifying themes. Post-modernism rejects grand theories of the enlightenment period considered central to theories of modernism. Post-modernism therefore throws into doubt objective and rational concepts of knowledge and truth, questions the enlightenment view of the person as rational, centred and purposive, and views subjectivity or identity as a discursive construction (Barrett 1992, Bordo 1993).

The post-structuralist and post-modernist movements are rooted in beliefs about the plurality of meaning and the subjectivity of interpretation. The post-structuralist theorist on whom Clarke (2005) particularly drew is Foucault. Foucault's work consisted of an early 'archaeological' phase, in which he developed his theory of discourse, and his later 'genealogical' phase, in which he developed a theory of power and knowledge, with some overlap between the two phases (Phillips and Jørgensen 2002).

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Grounded theory as methodology

The grounded theory method of qualitative research was developed by Glaser and Strauss (1967). It is mostly inductive, which means the researcher does not begin with a hypothesis about the phenomenon to be studied but instead remains open to whatever theory emerges from the data (Glaser and Strauss 1967, Strauss and Corbin 1990). To remain true to the inductive nature of the design, grounded theory has specific characteristics of project design, data collection and analysis, which will be explained later.

The theoretical underpinnings of grounded theory - if grounded theory method is informed by a specific theoretical perspective and if researchers' theoretical perspectives should be identified before they start collecting data - have been debated. Glaser and Strauss's (1967) description of the methodology suggested they originally intended grounded theory to be theoretically flexible. However, Strauss's later grounded theory methodology was informed by symbolic interactionism (Strauss and Corbin 1990). This is particularly evident in Strauss's later collaborations with Corbin, which suggested some differences from the original Glaser and Strauss (1967) methodology, symbolic interactionism implicitly being the theoretical perspective (Strauss and Corbin 1990).

Glaser (2007) later criticised Strauss's and Corbin's approaches. He argued that applying a preconceived theoretical framework to a grounded theory project is contrary to the inductive nature of the process. He maintained grounded theory in its original form did not have a particular theoretical perspective. However, some contemporary grounded theorists, such as Clarke (2005) and Charmaz (2006), identified symbolic interactionism as the

theoretical perspective underpinning their approach to grounded theory.

Symbolic interactionism is a theoretical perspective relevant to qualitative research that focuses on human experience. According to Blumer (1969), symbolic interactionism is a theory of 'human group life and human conduct'. The focus is on the social aspects of human action and interaction, meaning, and interpretation of meaning. Human beings act towards things on the basis of the meaning that things have for them; the meanings of such things is derived from or arises out of social interactions with one's fellows; the meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters' (Blumer 1969).

Blumer (1969) identified two forms of social interactions - the 'conversation of gestures' and the 'use of significant symbols'. Mead later termed them 'non-symbolic interactions' and 'symbolic interactions' (Blumer 1969).

Symbolic interactionists presume that someone's sense of meaning is interpreted through social interactions, and the communication and understanding of verbal and non-verbal sociocultural symbols. Language is an example of a sociocultural symbol in today's society (Charon 2001). Analysis of language is also a significant feature of post-structural theory, which is another of the theoretical perspectives underpinning the methodology.

While there is considerable debate as to what constitutes post-structural theory, Michel Foucault's later work has been described as post-structural and contributing to post-modernism (Bordo 1993). Post-modernism can be said to be informed by a number of social theorists - as well as Foucault - and yet it is possible to identify a number of unifying themes. Post-modernism rejects grand theories of the enlightenment period considered central to theories of modernism. Post-modernism therefore throws into doubt objective and rational concepts of knowledge and truth, questions the enlightenment view of the person as rational, centred and purposive, and views subjectivity or identity as a discursive construction (Barrett 1992, Bordo 1993).

The post-structuralist and post-modernist movements are rooted in beliefs about the plurality of meaning and the subjectivity of interpretation. The post-structuralist theorist on whom Clarke (2005) particularly drew is Foucault. Foucault's work consisted of an early 'archaeological' phase, in which he developed his theory of discourse, and his later 'genealogical' phase, in which he developed a theory of power and knowledge, with some overlap between the two phases (Phillips and Jørgensen 2002).

Grounded theory

Clarke (2005), drawing on Foucault, described discourse as 'communication of any kind around/about/on a particularly socially or culturally recognizable theme - contemporary and/or historical. Discourse includes "word choice, arguments, warrants, claims, motives, and other purposeful, persuasive features of language, visuals and various artifacts"; discourse frames debates, influences perceptions, and creates objects of knowledge.'

Foucault's (1972) emphasis on how dominant discourses influence social interactions and human action is particularly applicable to a study of midwifery students. Medical discourse dominates maternity care provision in Australia (Fahy 2007). The author (SL) therefore contended that medical discourse influences how midwifery students develop their sense of self as midwives and affects the positions they take in relation to acceptance of, or resistance to, the dominant discourses in their learning environment. Although there are alternative midwifery discourses represented by philosophies of midwifery care present in this environment, the effect of the dominant medical discourse is significant.

Foucault's theory of discourse is linked with his later theories about power, knowledge, discipline and surveillance (Foucault 1995). He described power as 'a circulating force' - that is it enables people to do or achieve what they want, and is used by institutions to get people to do what they want (Foucault 1995). Midwives exercise a degree of power as they adapt to work in the maternity care system and it can be assumed that student midwives will follow suit. The hospital or agency as an institution uses 'disciplinary power' to require clinicians to act in certain ways (Foucault 1995).

Disciplinary power is further aided by surveillance practices, such as assessments and evaluations of student practice. Surveillance is used to detect whether students deviate from 'normal' expectations of practice, role and behaviour. Disciplinary practices, such as social exclusion or 'failure' of students, ensure that deviant students conform to expectations (Foucault 1995).

Childbearing women in Australia are also subject to disciplinary power through surveillance as a result of technology, such as the cardiotocograph (CTG), which records their contractions and the fetal heart rate. This has the effect of causing women to regulate themselves by conforming to ongoing fetal surveillance - in response to discourse, power, surveillance and disciplining practices, women have become observers and enforcers of disciplinary power (Heckman 1996). Along with Foucault's post-structuralist theories, Clarke's

Midwives exercise power as they adapt to work in the maternity care system and it can be assumed that students will follow suit

(2005) methodology was also informed by symbolic interactionism and a constructionist epistemology. As Clarke stated, 'if action is at the heart of Strauss's [research] project, then power is at the heart of Foucault's.' She suggested that a research project that employs this type of methodology has two focuses for analysis: social action and interaction; and power and discourse.

A significant feature of Clarke's (2005) methodology was the focus on discourse as an element of the social situation being researched.

Data analysis therefore shifts from identifying a basic social process as in traditional grounded theory to exploring the broader situation of the participants' social world, including the discourses that shape and condition them. Furthermore, Clarke (2005) advocated that the aim of contemporary grounded theory should be to illuminate a particular aspect of human interaction.

Clarke (2005) also suggested discarding positivist assumptions present in the original grounded theory method described by Glaser and Strauss (1967). Clarke identified these as a lack of emphasis on researcher reflexivity, the search for commonalities in the data, the oversimplification of social processes, discarding difference as 'negative cases' and the search for an overarching basic social process. Clarke (2005) advised that researchers acknowledge that the data will highlight the complexities and difference of human experience and that there will be multiple truths uncovered. She stated that 'claims of universality [of knowledge] are considered naïve at best' and suggested that difference, perspective, irregularity and ambiguity should be embraced. Clarke considered 'all knowledge (as being) socially and culturally produced' (Clarke 2005), making knowledge and experiences produced, consumed and situated in social groups influenced by particular cultural aspects of those groups. This constructionist stance informs the role of researcher as well as the research area.

'Embodiment' has been defined as the understanding that 'the body engages with the material world and is constantly mingled with the knowledge it produces' (Havelock 1963). Clarke (2005) advocated that researchers acknowledge their 'embodiment', as described by Haraway (1988). Haraway's position with respect to embodiment questions the traditional assumptions of positivist

Nurse Researcher

science - that researchers are disembodied and neutrally objective or that a researcher can be an unobtrusive, stable and unbiased observer of a phenomenon. She argued that researchers cannot be invisible, objective observers of phenomena and they bring with them their constructed selves through which they conduct their research and interpret the data (Haraway 1988). Researchers therefore must take responsibility for their influence in the research project by documenting who, why and what they bring to the research and how they influenced it. This is how the research process was approached with respect to the recognition of embodiment.

Application of the methodology

My chosen methodology was Clarke's (2005) approach to grounded theory. This helped 'elucidate the key elements of materialities, discourses, structures and conditions that characterise[d] the situation' (Clarke 2005) of learning for the students being studied.

At the beginning of the study, the author (SL) undertook a review of the literature relating to the concepts of competence and competency. In some traditional approaches to grounded theory, a literature review is avoided before collecting data so that the inductive nature of process is not influenced by the researcher's preconceptions about the area of study (Glaser and Strauss 1967, Clarke 2005). However, Clarke, along with other contemporary grounded theorists, such as Charmaz (2006), recommended a literature review as essential for establishing where the proposed study fits in the context of what is already known. The review informed the research proposal, in terms of the research question: 'How and when do Bachelor of Midwifery students achieve competency for beginning practice?' Further review of the literature occurred as a result of data collection and analysis.

After approval from a university human research ethics committee was obtained, a third party recruited 19 final-year midwifery students to the study over a period of three years. Initial data were collected through two individual in-depth interviews with each student: one at the beginning and one at the end of the student's final placement. Preliminary analysis of the interview data revealed that the students would have to be observed during their clinical placements. The author (SL) therefore observed them in their final areas of practice experience, focusing on the clinical learning environment, power discourse and students' interactions in that environment. The interview data and observational data from field notes were analysed using traditional grounded theory coding

techniques, as outlined by Strauss (1987) and Strauss and Corbin (1990), which identify human action and behaviours.

Coding involved examining the interview transcripts and field notes line by line to identify key issues or 'codes'. The focuses of coding were: action and interaction (in keeping with symbolic interactionism); and power and discourse (in keeping with Foucault's post-structuralist theories). Once the codes were identified, they were grouped and the categories were named.

The identification of categories and their properties was aided by the 'constant comparative method' (Glaser and Strauss 1967, Strauss and Corbin 1990). The basic rule of this is: 'While coding an incident for a category, compare it with previous incidences in the same and different groups coded in the same category' (Glaser and Strauss 1967). The author (SL) explored the causes, conditions and consequences of each category by asking questions such as 'When, how or why does this phenomenon or action occur?' and 'What are the consequences of this?' (Charmaz 2006).

The author (SL) used the constant comparative method together with 'theoretical sampling' (Strauss and Corbin 1990), which is a process in which the researcher engages in ongoing data analysis to identify emerging themes or leads in the data. These leads can then be followed up by choosing new research participants, environments or interview questions to gather specific data (Strauss and Corbin 1990). During my analysis of the early interviews, it became apparent that mature students were over-represented in the study, so school leaver entrants were recruited to the study. Interview questions and probes were also developed during data analysis to gather additional data about emerging themes. Questions that arose and that needed to be answered in subsequent interviews related to the relationships between student and preceptor, the relationship between confidence and competency, and the effect of 'negative' learning experiences on competency.

The author (SL) used situational analysis (Clarke 2005) concurrently with coding to provide more in-depth analysis of interview and observational data. According to Clarke (2005), situational analysis gives the researcher the tools to build on Strauss's situation-centred 'social worlds/arenas/negotiations' conceptual framework by using three mapping approaches. These allow the participant's social world and the complexities of that world to be explored. The three maps offered by Clarke (2005) are 'situational maps', 'social worlds/arenas maps' and 'positional maps'.

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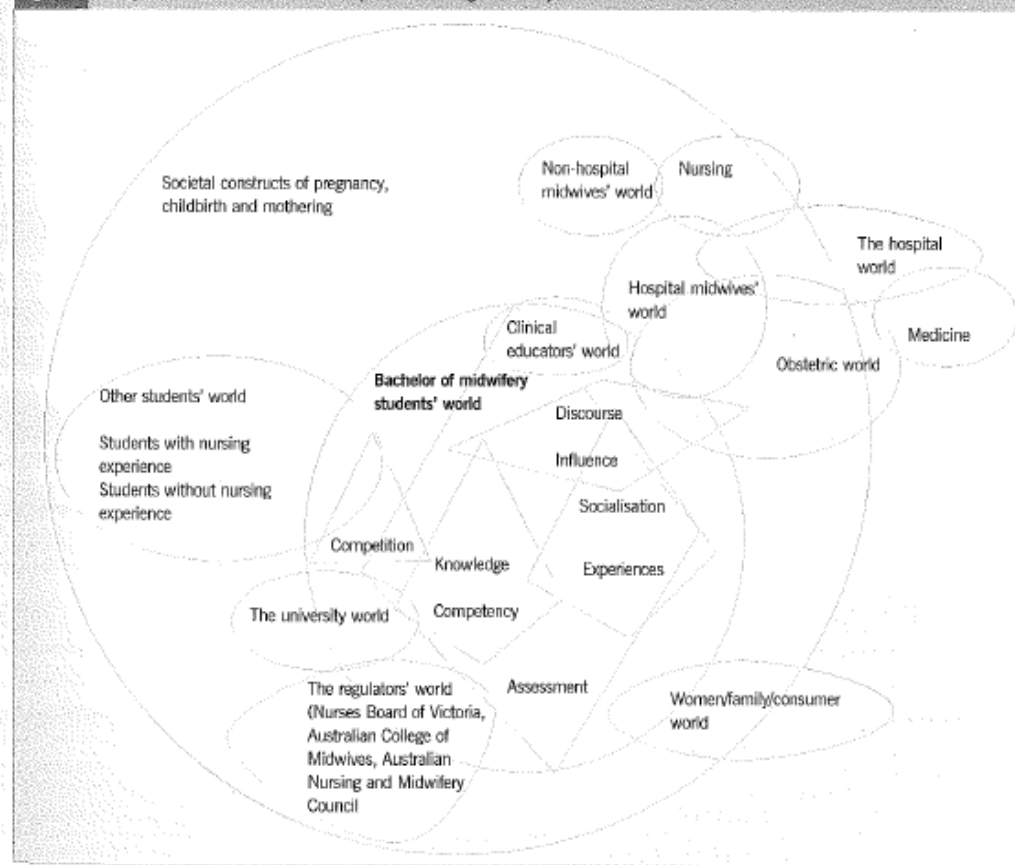
Grounded theory

The author (SL) produced situational maps in a creative process drawing on coded interview and observational data, and prior knowledge and research. These were used to identify the major human, non-human, discursive and other elements in the student midwives' situations, as well as the relationships among the identified elements. The social worlds/arenas maps identified the participants, non-human elements and the arenas of commitment and discourse in which the student midwives were engaged. Positional maps identified the major positions taken – and not taken – by the student midwives and others (Clarke 2005).

The positions not taken needed to be theorised since they were not as obvious as the positions taken.

Data for situational maps and the social world/arenas maps were drawn from interviews and observational data as well as texts and journal articles. Maps were initially hand drawn. Later maps were created using NVivo 7 and MS Notebook. The mapping process for me was quite messy, which has also been the case for other researchers using situational analysis (Mathar 2008). The maps were particularly helpful during observation or following an interview because they gave a quick visual representation of the situation. Further analysis could therefore occur spontaneously as the author (SL) could document thoughts without disrupting the flow of the interview or the observation. An example of a social worlds/arenas map created during data analysis is provided in Figure 1.

Figure 1. Example of a social worlds/arenas map created during data analysis



Nurse Researcher

The author (SL) identified a vast number of codes during data analysis. The codes were collapsed – so-called 'axial coding' – and three themes or major categories were identified under which the sub-categories fit. These were 'realisation', 'adaptation' and 'assimilation'. Realisation represents the students' recognition that the clinical learning environment is highly medicalised and interventionist; it also represents the students' recognition of the severe restrictions placed on the way midwives and students are able to practise and that they would need to work in that system.

Adaptation represents the students' responses in the clinical learning environment as they developed strategies to adapt to the situation and 'fit in' – the students modified their behaviour, avoided conflict, internalised their sometimes negative feelings and worked at building relationships with their midwife preceptors.

Assimilation represents the way in which the students developed competency by integrating and applying the knowledge and skills they had learnt throughout their course. This was a process that found the students needing a high degree of support and surveillance from the qualified midwife preceptors at the beginning of their final placements. However, they were given greater responsibility and had developed sufficient confidence and experience to care for women with minimal supervision towards

the end. Along with increased responsibility for care came the ability to build therapeutic relationships with women, practise clinical decision making and also realise the full role of the midwife.

Conclusion

The author (SL) believes the process of creating situational maps allowed for a more in-depth analysis of clinical learning environment experienced by the student midwives being studied – an analysis that would not have been possible with conventional grounded theory techniques. However, the methodology was challenging. It required a significant degree of acceptance of the complexity, difference and multiplicity of truth. Researchers hoping to find a tidy explanation of a phenomenon may be disappointed or frustrated by this type of analysis as it can raise more questions than answers.

Furthermore, analysis required a great degree of abstract thought about the situation, particularly when developing the positional maps. But, as an analytical tool that pushes the researcher to consider the 'silent' or unrepresented in the data – or even conceive that there are silent or unrepresented positions – the positional maps were very useful. Despite these challenges, this research approach allowed a thorough exploration of the students' experiences and the context in which they were learning to become midwives.

Online archive

For related information, visit our online archive of more than 6,000 articles and search using the keywords.

This article has been subject to a double-blind review and checked using antiplagiarism software

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Appendix L

Table 5.1: Comparison of Clinical Practicum of Undergraduate Midwifery Courses in Victoria, New Zealand and the United Kingdom

Location	Clinical weeks (based on 38 hour week)	Approximate population	Approximate number of births
ACU, Melbourne 2005-2007 students	42 weeks (includes Follow Through Experience (FTE))	22,000,000	300,000
ACU, Melbourne 2008 Students	30 weeks (includes FTE)		
United Kingdom	67 weeks	51,000,000	700,000
New Zealand	67 weeks	4,500,000	58,0000

Appendix M

Table of Students' Self-Identified Learning Objectives Prior to Final Placement

Medication administration	Complications	Assessments	Midwifery skills
Medication calculations Epidural management Intravenous therapy Intramuscular injections (adult and infant) Subcutaneous injections Nitrous Oxide administration Perineal infiltration with local anaesthetic Intravenous pump Management of magnesium sulphate infusion Syntocinon infusion management	Emergency Caesarean Section Premature labour Neonatal Jaundice Gestational Diabetes Haemorrhage Hypertension in pregnancy Pre-Eclampsia Shoulder Dystocia Cardiac conditions 'Traumatic birth' Neonatal resuscitation Instrumental birth (Forceps/Ventouse) Recognise and respond to emergency situations Neonatal hypothermia Neonatal hypoglycaemia Theatre preparation Removal of drain tube Removal of sutures	Intrapartum vaginal examinations, Neonatal assessments, Maternal abdominal palpation Postnatal Assessment of mother and baby Antenatal assessment Assessment during labour and birth	Urinary Catheterisation Management of blood transfusion Phlebotomy Use of water during labour Position changes Episiotomy Neonatal blood testing Suturing (assisting) Controlled cord traction Estimate blood loss Cord blood collection Debriefing with women Third stage management Fluid balance Fetal monitoring Artificial rupture of membranes Documentation Admission Hand-over Transfer Phone call advice Skin to skin contact Breastfeeding support Educating women Baby 'receptions' Listening skills Domiciliary Time management Antenatal booking Baby bath

Appendix N

Copies of Ethical Approval Documents from ACU HREC

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne



Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Dr Colleen Rolfs Melbourne Campus
Co-Investigators: Dr Carmel Scibold Melbourne Campus
Student Researcher: Sharon Licquish Melbourne Campus

Ethics approval has been granted for the following project:
Final year Bachelor of Midwifery students' achievement of clinical competency.
for the period: 3rd October 2005 to 30th November 2006
Human Research Ethics Committee (HREC) Register Number: V200508 12

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans (1999)* apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants


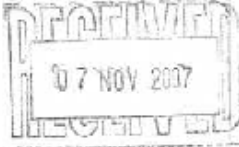
The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.


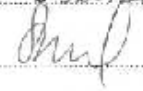
Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: by P. Rolfs
(Research Services Officer, Melbourne Campus)

Date: 27/9/05

 ACU National <small>Australian Catholic University Melbourne Sydney Canberra Adelaide Melbourne</small> Human Research Ethics Committee			
APPLICATION FOR APPROVAL TO MODIFY A RESEARCH PROJECT WITH HUMAN PARTICIPANTS			
<ol style="list-style-type: none"> 1. This form is available upon request via Email res.ethics@acu.edu.au or on the Internet at: http://www.acu.edu.au/research. All questions must be answered fully. If a question does not apply, indicate N/A. 2. It is a requirement of the <i>National Statement on Ethical Conduct in Human Research</i> (2007) that any changes to a research protocol which involves contact with human participants or access to their records or files must be subject to review and approval by a Human Research Ethics Committee. 3. The completed form should be signed and dated then lodged with the local Research Services Officer: <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 50%; vertical-align: top;"> VICTORIA Research Services Australian Catholic University Melbourne Campus Locked Bag 4115 FITZROY VIC 3065 Tel: 03 9953 5158 Fax: 03 9953 3315 </td> <td style="width: 50%; vertical-align: top;"> NEW SOUTH WALES, ACT AND QUEENSLAND Research Services Australian Catholic University Brisbane Campus PO Box 158 VIRGINIA QLD 4014 Tel: 07 3623 7128 Fax: 07 3623 7328 </td> </tr> </table> 4. The application will normally be processed within 20 working days. 		VICTORIA Research Services Australian Catholic University Melbourne Campus Locked Bag 4115 FITZROY VIC 3065 Tel: 03 9953 5158 Fax: 03 9953 3315	NEW SOUTH WALES, ACT AND QUEENSLAND Research Services Australian Catholic University Brisbane Campus PO Box 158 VIRGINIA QLD 4014 Tel: 07 3623 7128 Fax: 07 3623 7328
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NO modification to the protocol is permissible before written approval from the HREC has been received.			
<ol style="list-style-type: none"> 1. HREC Register No.: V200508 13 2. Approval End Date: 31st January 2008 3. Principal Investigator/Supervisor: Dr Carmel Seibold 4. Student Researcher (if applicable): Ms Sharon Licquish 5. Project Title: Bachelor of Midwifery Students Achievement of Competencies for Beginning Practice 6. Proposed Modifications to the Project <ol style="list-style-type: none"> 1. EXPANSION OF DATA COLLECTION METHODS TO INCLUDE A PHASE OF OBSERVATION OF THE STUDENTS DURING THEIR FINAL PLACEMENT. THIS WILL OCCUR AT THE MERCY HOSPITAL FOR WOMEN. STUDENTS WILL CONSENT TO THE OBSERVATION AND THE CLINICAL STAFF AND PATIENTS AT THE MERCY HOSPITAL FOR WOMEN WHO COME INTO CONTACT WITH THE STUDENT WILL BE INFORMED, VERBALLY AND IN WRITING, THAT THE STUDENT IS BEING OBSERVED AS PART OF A STUDY. INSTITUTIONAL CONSENT IS THE NORM FOR OBSERVATIONAL DATA COLLECTION. HOWEVER, STAFF AND PATIENTS WILL BE PROVIDED WITH AN INFORMATION LETTER AND VERBALLY CONSENTED, WITH THE OPTION TO NOT HAVE THE STUDENT OBSERVED. THE STUDENTS WILL BE OBSERVED FOR A MAXIMUM OF FOUR HOURS ON A MAXIMUM OF 3 OCCASIONS (12 HOURS MAXIMUM.) ALTERATIONS TO THE STUDENTS' CONSENT FORM AND LETTER TO PARTICIPANTS WILL BE MADE TO INCLUDE THE OBSERVATIONAL COMPONENT (SEE ATTACHED DOCUMENTS). <p style="margin-top: 10px;">AN EXPEDITED APPLICATION TO THE MERCY HOSPITAL FOR WOMEN RESEARCH ETHICS COMMITTEE IS CURRENTLY BEING PROCESSED FOR THE PROPOSED OBSERVATIONAL COMPONENT OF THIS STUDY. IT HAS BEEN CONDITIONALLY APPROVED PENDING A FULL MEETING OF THE ETHICS COMMITTEE.</p> 			
<div style="display: flex; justify-content: space-between;"> EMPHRETHics/ACU Modification of Ethics Clearance 5th november 2007.doc June 2007 Page 1 of 2 </div>			

8. Reasons for the Modifications		
No concerns have been expressed by the participants or adverse events have occurred. This modification is part of an expansion to further the study.		
9. Certification by Principal Investigator (or Supervisor) and Student Researcher		
I/We certify that the information provided above is an accurate and full account of the modification proposed to the protocols for this research project. I/We understand that the proposed modification is not to be introduced until the written approval of the Human Research Ethics Committee has been received.		
Name (block letters) Dr Carmel Seibold Principal Investigator / Supervisor Ms Sharon Lickurish Student Researcher	Signature  	Date 5/11/07 5/11/07
APPROVAL BY CHAIR / PANEL CHAIR OF HREC		
<input type="checkbox"/> Modification Approved.		
<input type="checkbox"/> The application needs to be referred to the next HREC meeting.		
<input type="checkbox"/> I approve the modification of the Research Project as described by the applicant subject to the following conditions:		
<hr/> <hr/> <hr/> <hr/> <hr/>		
Signed: _____ Date: _____		
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8. Reasons for the Modifications:

No concerns have been expressed by the Chair, panelists or other stakeholders have indicated. This modification is most often expected to further the study.

9. Certification by Principal Investigator (or Supervising) and Student Researcher:

I have verified that the information provided above is an accurate and full account of the modification proposed to the protocols of this research project. I AM understand that the proposed modification is not to be introduced until the written approval of the Human Research Ethics Committee has been received.

Name (Block letters)	Signature	Date
Dr Catherine Boland Principal Investigator/Supervisor	<i>[Signature]</i>	5/10/07
Ms Sharon Ligganish Student Researcher	<i>[Signature]</i>	5/10/07

APPROVAL BY CHAIR/PANEL CHAIR OF HREC

☒ Modification approved.

☐ This application needs to be referred to the next HREC meeting.

☐ Regarding the modification of the research Project as described on the application subject to the following conditions:

[Signature]
I approve modification

Signed *[Signature]* Date 15 (Nov) 2007
Action taken

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(Modification of Ethics Clearance Form 2006) Revised JTO 15 May 2007

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Appendix O

Summary of Evaluations of Nursing and Midwifery Competency Assessment Tools

The most commonly used quantitative competency assessment tool, which has been tested for reliability, is the North American *6D Scale of Nursing Performance* (6D scale) developed by Schwirian in 1978 (cited in Klein & Fowles, 2009). The 6D scale consists of 52 items grouped into six sections - leadership, critical care, teaching/collaboration, planning/evaluation, interpersonal relations/communication and professional development – which are plotted on a Likert-type scale (Schwirian, 1978 cited in Klein & Fowles, 2009). Despite the 6D scale having been developed in America and introduced more than 30 years ago, recent tools for measuring nurse competency were, to some degree, informed by the 6D Scale. Confidence in the scale seems to remain; even as recently as 2009 researchers Klein and Fowles used the 6D scale as a self-assessment tool to rate nurse competence.

Meretoja et al. (2004) developed their Nurse Competence Scale (NCS) measurement tool, using the 6D scale for comparison, and tested it to assess Finnish nurses' self-measurement of competency. The NCS was divided into seven categories, based on Benner's (1984) *From Novice to Expert* framework, covering: helping to role model; teaching-coaching; diagnostic functions; managing situations; therapeutic interventions; ensuring quality; and work role. Nurses self-assessed themselves by responding to a questionnaire using a visual analogue scale. Researchers found the NCS more reliable for testing levels of nurse competence when compared with the '6D scale' because it was more sensitive in differentiating nurses' positions on the novice to expert continuum (Meretoja et al. 2004).

Limitations of the NCS lie in its positivist nature. Relying on a quantitative scale alone risks ignoring the qualitative aspects of nursing competency. A quantitative visual analogue scale, particularly one that operates from a holistic conceptualization of competency, therefore has limited applicability to an education program for nurses or midwives. Furthermore, the tool was proven most reliable for assessing the progress of qualified nurses along the 'novice to expert' continuum and applying the 'novice to

expert' framework to nursing students. This arguably sets unrealistic expectations of student competency as they will unlikely graduate as 'experts'.

Scottish researchers Norman et al. (2002) developed and tested their competency assessment tool and applied it to test student nurses and midwives based on various methods being used in Scotland by the seven institutions teaching 300 nursing and midwifery students. The tool was a modified version of the UK *Nursing Competencies Questionnaire* (NCQ) which Norman et al. named the *Key Areas Assessment Instrument* (KAAI).

The KAAI consists of a self-rating scale with responses ranging from always to never. It assesses 18 practice areas, including clinical judgment and emotional respect, and considers psychosocial aspects of illness. As with Meretoja et al. (2004) the tool is limited by its purely quantitative approach to competency measurement. Norman et al. (2002) identified this limitation of the KAAI and recommended it be used as one part of a multi-method approach to assessing student competency which should include: measuring students against professional competency standards; skills assessments, both in a simulated environment and at the bedside; and student self ratings of competency via the KAAI. Their multi-method approach was the most comprehensive and holistic approach to competency assessment presented in the literature and arguably the most reliable.