MIDWIVES' EXPERIENCES WHEN WORKING WITH THIRD YEAR MIDWIFERY STUDENTS

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Abstract

Purpose: Midwifery students require appropriate and timely access to clinical learning opportunities during their education toward a Bachelor of Midwifery and the quality of this clinical experience influences the student's learning and confidence. To achieve this they must be supported by practising midwives. However at times midwives decline to work with students, citing a variety of reasons. To ensure the required quality and quantity of clinical placements the midwifery schools need to understand the barriers and enablers to midwives working effectively with third year midwifery students.

Method: Midwives on the midwifery school's database who regularly work with midwifery students were invited to participate in the research. Data was gathered through two focus groups of midwives who have worked with third year midwifery students. The transcripts were then thematically analysed.

Findings: The midwives described their experiences when working with students. The first theme describes the midwives' work with students and includes: *that confidence thing*, *it's not just about clinical skills* and *learning to be professional*. The second theme describes the implications for midwives' practice when working with students and includes: *we are responsible*, *what is expected of me* and *wanting a break*. Issues arising in professionalism weave through these themes.

Implications: Students with poor knowledge levels and unprofessional behaviour were regarded as problematic for the midwives working with them. The midwives were frustrated when students could not see the bigger picture and did not appear to understand the expected professional behaviours and boundaries. The midwives enjoyed regular contact with the midwifery school to support them when working with students particularly concerning assessment of students. They also enjoyed the learning they gained from working alongside students which they found beneficial to their own practice knowledge. At times there were tensions between the needs of women and students, and as the midwife moved between her role as teacher, supporter

and assessor of the student. However most placements were a positive experience for the midwives and they took pleasure in the student's progression through the programme.

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Chapter One – Establishing the context

Introduction

This thesis explores the experience of midwives when working alongside third year midwifery students in a New Zealand setting. In my role as a midwifery educator I became aware of issues with student placement when midwives declined to work with students, citing a variety of reasons. This is of concern to me given the requirement that midwifery students must have appropriate and timely access to clinical learning opportunities during their education toward a Bachelor of Midwifery, and to achieve this they must be supported by practising midwives. I sought to discover how midwives see their role in educating student midwives and what expectations they have regarding the preparedness of the students to undertake their clinical learning. In particular I wished to discover what contributed to a positive placement experience for the midwife.

Midwifery education in New Zealand is delivered in tertiary institutions with the clinical component undertaken in partnership with practising midwives in both hospital and community settings. The quality of this clinical relationship impacts on the student's learning and confidence as a midwifery student and subsequently as a midwife. A strong link is required between theory and practice to ensure students have the appropriate depth of understanding to enable their knowledge and skills to meet the required level for registration as a midwife. Students' experiences when undertaking clinical placement with midwives is described by students I am in contact with at the midwifery school and this is supported in overseas literature (Begley, 2000; Begley, 2001; Lange & Kennedy, 2006). While there is little describing the midwife's experience in New Zealand there is research undertaken in Britain which considers the experience of midwife mentors who work with midwifery students (Bray & Nettleton, 2007; Fisher & Webb, 2009; Fowler, 2008; Jones et al, 2001; Nettleton & Bray, 2008). In the New Zealand context the concept

of mentoring is usually applied to new graduate midwives and describes a negotiated relationship between two people (Kensington, 2006). By working closely with midwives as our partners in delivering midwifery education, and by developing a greater understanding of their experience, I hope to increase access to the required quality and quantity of clinical placements the midwifery students require to become competent and confident practitioners.

Midwifery education in New Zealand faces further challenges. To meet the current and projected shortage of midwives within New Zealand (due to the aging midwifery workforce), the Midwifery Council of New Zealand (MCNZ) is encouraging midwifery schools to increase their graduate numbers. This is supported by the introduction of the new curriculum which uses flexible delivery and is expected to "increase access to more midwifery students" (Pairman, 2009) however the number of clinical hours is increased significantly (from 1700 to 2400 hours). The combined effect of the increased clinical hours and the increased student numbers puts further pressure on clinical placements within a midwifery workforce already stressed due to chronic short staffing. Anecdotally midwives have expressed some concerns regarding how students are able to access quality placements successfully in an environment of short staffing, and higher student numbers and clinical requirements. To understand the midwives' anxiety I felt I first needed to understand what contributes to a successful student placement. This understanding could help the midwifery schools to reflect on their practices, and this could be used to support students and midwives in placements. The role of the midwifery school is important when working with such a diversity of midwifery practitioners and this includes preparing the students for clinical placement and supporting the students and midwives during the process.

I believe that a greater understanding of the midwife's experience will help the midwifery school to provide a stronger partnership with midwives thereby supporting learning opportunities and increasing clinical placement options for

midwifery students. Within the New Zealand context there is no previous research exploring midwives' experience when working with midwifery students. Overseas research predominantly reports on the mentoring of midwifery students by a named midwife during their midwifery education however some of the findings are transferable. In New Zealand midwifery students work with a variety of midwives during their education in both community and hospital settings and do not always have a named mentor.

Positioning of author

I was initially educated as a nurse graduating in 1981 and then as a midwife in 1984. My midwifery education was undertaken in a polytechnic as part of the Advanced Diploma of Nursing (midwifery option). I first worked within a tertiary facility and was then introduced to homebirth and subsequently worked as a domiciliary midwife from 1988. Following the passing of the Nurses Amendment Act in 1990 I continued to work in the community as a Lead Maternity Carer (LMC) providing care for women choosing either homebirth or hospital birthing options. LMC midwives are self-employed midwives paid by the government funding agency to provide care autonomously to women throughout their pregnancy until four to six weeks after birth.

The years following the passing of the Nurses Amendment Act (1990) were exciting and turbulent times for midwifery, as our autonomy was exercised and midwifery developed as a profession. Direct entry midwifery education commenced, initially as a diploma and then as a degree, the New Zealand Midwifery Council was formed in response to the Health Practitioners Competency Assurance Act (2003), and the New Zealand College of Midwives(NZCOM) became the "professional organisation and recognised voice for midwives and student midwives in New Zealand" (NZCOM Inc, 2010).

A change in personal circumstances led to my employment as a nurse within an operating theatre setting and then within Plunket. Part of the attraction of this was due to the regular hours of work offered. However when a midwifery educator position became available I returned to my first passion of midwifery. In my current position as midwifery manager for the Bachelor of Midwifery programme in a regional polytechnic I work with a team of educators and am responsible for the quality of the graduates and to ensure our student numbers do not exceed the clinical placements that are available. The optimal use of available clinical placements is of paramount importance when planning a student's progression through the programme to ensure they access relevant and valuable learning opportunities in a timely manner.

Historical positioning of midwifery knowledge

Throughout history women have worked as autonomous lay healers, often working with the peasant population providing their only source of health care, with midwifery representing a part of this work (Ehrenreich & English, 1973: Squire, 2003). The eras of the witch hunts in the 14th to 17th centuries were regarded as "well organised campaigns, initiated, financed and executed by the Church and State" which targeted females, healers and midwives (Ehrenreich & English, 1973, p.9). The healers' and midwives' use of herbal remedies to manage illness and disease was not supported by the Church who instead saw these inflictions as evidence of the wrong doing and sins of those affected and instead advocated prayer for healing.

However the Church and State supported the care of the wealthy which included the university training of men as doctors (Ehrenreich & English, 1973). Until the early 19th century universities were closed to women, so midwifery education continued unregulated with apprenticeship methods of learning until the late 19th century. Over time the midwives gained considerable experience with a skilled midwife being highly regarded (Abel, 1997). Women continued to provide health care for the poor until this was

prevented by legislation which required health providers to be licensed to practice, something a lay carer could not achieve. By the beginning of the twentieth century legislation had reduced the role of the midwife to that of an assistant and births were increasingly undertaken in a hospital with a doctor supervising the care that was provided by a midwife.

Historically midwifery was seen as women's work as opposed to "a distinct job or profession" (Wickham, 2004, p 158). The knowledge acquired for this work was not valued by those in a patriarchal society. Wickham (2004) describes the development of this knowledge as empirical since midwives and healers built on their knowledge by trial and error ascertaining cause and effect, similar to the methods used by the emerging medical profession. How successful midwives and healers were compared to other medical workers is not documented however the witch hunts targeted midwives and this suggests their work was not valued by those who held the power (Ehrenreich & English, 1973; Wickham, 2004). There are many ways of knowing and what is recorded is determined by those who hold the dominant position within that society. Knowledge is socially constructed and what is regarded as truth is influenced by the context of that society (Belenky et al, 1986). While we have documentation of the witch hunters' experience there is nothing from the witches to describe their perspective. History tends to be written from the perspective of those who are prevailing and this bias in turn dominates our retrospective understanding of the events that took place and what is then recorded. The low status afforded to midwifery in the past casts a shadow on the claim of professional status as midwifery seeks to gain recognition for its unique ways of knowing.

The contested position of midwifery in New Zealand

At the beginning of the twentieth century midwives provided care for all birthing women in New Zealand, calling for assistance from medical practitioners only in the event of complications. The Midwives Registration

Act of 1904 resulted in formalising the training of midwives and sought to eliminate lay midwifery (Abel, 1997). This enabled the establishment of the "St Helen's Hospitals, which provided state-subsidised maternity care to women whose husbands had low incomes" (Abel, 1997, p.62). This was the beginning of the move from birthing at home to birthing in hospitals and this provided the venue for midwifery training (Donley, 1998). The introduction of analgesia was popular with women however this was only available in hospitals and under medical supervision. This saw the growing power of the medical practitioners as women sought relief from the pain of childbirth thereby excluding the midwife from autonomous practice. Whereas in 1900 most births occurred at home, "by 1951, 95 percent of births occurred in hospital under medical care" (Abel, 1977, p. 68). During this time the role of the midwife was reduced to that of an obstetric nurse and the introduction of the Nurses Act in 1971 made it illegal to provide maternity care unless you were a medical practitioner (Abel, 1977). This resulted in all New Zealand women birthing under medical supervision with midwives relegated to a support role.

At this time midwifery was considered to be a branch of nursing with midwifery education being undertaken as a postgraduate nursing qualification (Abel, 1997) and direct entry midwifery training had ceased. While nurses have traditionally worked under medical supervision, midwives come from a long history of autonomy. This clash of ideologies meant that the Nurses Association, as the professional body, offered little support for the midwives' battle for autonomy. Midwives were legally prevented from attending a homebirth unless they could "get medical cover and few doctors were prepared to encounter the disapproval of their profession by taking responsibility for births out of the hospital setting" (Abel, 1997, p.74). This was further impacted by the presence of only a few domiciliary (homebirth) midwives who were poorly paid compared with midwives employed in hospitals. Within hospital settings today, nurses occupy senior manager roles

and continue to have “final approval over policies and procedures that influence midwifery practice” (Hendry, 2003, p.28).

Concerns from the medical profession about safety led to the closure of some rural maternity hospitals and medical opposition was expressed regarding home birth (Abel, 1997). Further erosion of the midwife’s role and women’s birthing choices led to “organised resistance” and “political lobbying by consumer advocates” and midwives (Abel, 1997, p.73). The establishment of the Home Birth Association in 1978, and Save the Midwives in 1983 resulted from this movement. The Cartwright Enquiry in 1988 furthered the case for midwifery by undermining the credibility of the medical profession (Hendry, 2003). The Home Birth Association and Save the Midwives groups had strong ties to domiciliary midwives and were instrumental in working with midwives to gain autonomy (Nurses Amendment Act, 1990) and a Direct Entry Midwifery qualification (Donley, 1986). The partnership between midwives and women consumers provided a turning point for midwifery as a profession. The Nurses Amendment Act brought significant changes to midwives’ working conditions, rates of pay and status (Abel, 1997). However the changes in conditions were less favourable to the General Practitioner (GP) practice of obstetric care and this gradually saw a significant reduction in GP care options available to women. This is the situation at the present day.

The public gaze

Throughout the preceding centuries childbirth was undertaken at home with midwives providing the care and support required. It was considered a private affair of the household and was therefore not open to public scrutiny. Through the early 1900’s childbirth underwent a radical transformation with the move of birthing into hospital settings. This public sphere is described by Danaher, Schirato & Webb (2000) as generally more “institutionalised and regulated than the private” sphere with the use of protocols and more formal ways of communicating (p. 37). While most antenatal and postnatal care is

provided within the private sphere in the midwife's clinic or the woman's home, labour care in the New Zealand setting is usually undertaken within the public sphere with over 83% of all births occurring in a secondary or tertiary hospital (Ministry of Health, 2005). Midwives are therefore required to provide care across a range of settings and need to ensure their communication and behaviour is appropriate to each setting.

Midwifery is a profession that is constantly under scrutiny. Television dramas regularly show birth in a dramatic and often unrealistic manner leading to inaccurate perceptions by women and their families about the normal progression of labour and birth. Media reporting regarding poor outcomes during childbirth are often sensationalised and lacking in correct information and show a bias by normalising the use of technology around birth (Squire, 2003). This critical gaze heightens the anxiety of women and their families about their safety during the birth process and increases their dependence on technology and medicine for reassurance (Henley-Einion, 2003). It also impacts on the midwifery profession by undermining confidence in midwifery and influences discussion both within and outside the profession about what is appropriate care for women and their babies. The decreased birth rate per woman also means women have less personal experience and knowledge regarding childbirth (Squire, 2003). The increased use of technology means that what knowledge women have is less generalisable due to the complexity of care required which results in women having a greater dependence on the experts (Henley-Einion, 2003).

Midwifery has a complex relationship with the medical profession (Abel, 1997). This is mainly due to the interdependence of the two professions while there is also ongoing competition for "control of normal childbirth" (Abel, 1997, p.265). Since obstetric technology dominates the midwife's sphere of work she must learn to work between the divide of obstetrics and midwifery (Henley-Einion, 2003). The medical profession have regularly expressed

concerns about safety for mothers and babies and the need for midwives and doctors to work as a team during the child bearing process *(*Abel, 1977; Exton, 2008; Muir, 2006*).* The emphasis by medicine on the physical has seen safety develop as "the dominant rationality in childbirth" (Wickham, 2004, p.160). This medical concept of all pregnancies being "inherently problematic and potentially dangerous" (Henley-Einion, 2003, p.179) strongly influences what is regarded as appropriate practice within midwifery. The medical model implies that birth is controllable and that untoward events are preventable by using means that are not harmful to the mother or baby (Muir, 2006). The use of technology seeks to provide reassurance and certainty from the disciplines of science and medicine that the care provided minimises or eliminates risk and thereby ensures a positive outcome (Skinner, 2005). The concept of risk and its subsequent management foregrounds risk as the primary focus of professional involvement in birthing, and thus supports the medical profession's status over midwives who claim to manage low risk birthing. This contrasts with the midwifery model which views pregnancy and childbirth as normal life events (Pairman & McAra-Couper, 2006). This expertise in low risk birthing is less valued by a society that gives primacy to technology as the path to progress.

Midwifery as a Profession

Cruess, Johnston and Cruess (2004) describe a profession as "an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills" (p.74). They further describe an implicit contract with society whereby "professions are granted status, privileges, and financial rewards on the understanding that they will be devoted to service, will guarantee competence, be moral in their endeavors, and address society's concerns" (Cruess et al, 2004, p.75). Also implicit are expectations of specific behaviours that are regarded as professional but these are not well defined. Professionals work with complex situations and these require specialist

knowledge, ways of behaving and experience to solve and their learning must be built around this (Murphy & Calway, 2008).

Midwives have earned professional status by forming a professional body to represent and develop their professional identity, by undertaking learning of midwifery within a direct entry degree programme that is separate from nursing, and by undertaking research to make midwifery knowledge and care transparent. This rise in scholarship supports the profession's development by providing evidence of what the essence and daily work of midwifery is (Smythe, 2007). However this still leaves midwifery as an emerging profession against the historically patriarchal powerbase established by medicine and working within a zone of "conflict between the needs of the woman and the authority of the facility" (Stapleton, 1997, p.49). Not surprisingly then, since its emergence as a profession midwifery has "struggled to position itself so as to support both traditional and scientific medical practices" (Parker & Gibbs, 1998, p. 150).

Wickham (2004) believes this "patriarchal domination in the fields of learning, knowledge and knowing" means "women are now having to discover and establish ways of knowing which are more appropriate to the feminine and feminist" (p.161). She further states that while midwifery knowledge has its roots in story telling and apprenticeship as ways of learning, the profession now appears to prefer scientific research over other forms of evidence (Wickham, 2004). However Jowitt (2001) argues that randomised controlled trials (the mainstay of medical research) have no place in midwifery practice since this ignores the complexity, and I would add, the personal ethics of childbirth. It is uncertain whether science can provide us with the certainty society and medicine seek when "doubt and inconsistency remain at the very heart of birth and life" (Wickham, 2004, p.163).

In acknowledgment of this tension between scientific and midwifery ways of knowing (Squire, 2003), the midwifery curriculum seeks to weave research, story telling and reflection on practice throughout the programme. The use of stories places the emphasis on the individual and her uniqueness as opposed to the focus of science on the average. Story telling promotes reflection and questioning of practice (Kinnane, 2009) which are hallmarks of a professional. It is the blending of these concepts, science and story telling that provides midwifery with evidence-based practice. This enables the midwife to provide care using the findings from research to tailor the care required by each woman as an individual who is engaged in carrying and birthing her child. Expert practitioner status is achieved due to "a wealth of personal experience of practice in combination with the processing of prior learning" (Gamble, Chan & Davey, 2001, p.122).

Educating midwives

Following the Nurses Amendment Act (1990) a pilot diploma programme at Otago Polytechnic and Auckland Institute of Technology was set up and eventually government approval was given for the Bachelor of Midwifery programme to commence in 1995. This enabled other midwifery schools (Waikato Institute of Technology, Christchurch Polytechnic Institute of Technology and Massey University) to offer the Bachelor of Midwifery from 1996. From 2010 all midwifery schools (exclusive of Massey University) offer a three year undergraduate direct entry degree programme comprising a total of 4800 hours, being 2400 hours of theory and 2400 hours of clinical practice. These clinical practice hours are undertaken in placement with practicing midwives in both community and DHB settings. Students have a maximum of four years within which to complete the programme, as determined by MCNZ.

Clinical learning has been described as more than the "application of theoretical knowledge in a clinical setting" (Best & Edwards, 2001, p. 165). It

is not just the skills as such, but the complexity of the 'mix and match' that is a feature of practice that makes up midwifery. These are described by Schon (1987) as "indeterminate zones of practice" and are part of working as a professional (p.11). This occurs when knowledge is complex and shifting and is not always well defined or explicit. Students are therefore required to learn this by observing experienced practitioners and modelling their ways of thinking and working. This requires a close working relationship between the student and the midwife, with the midwife articulating her thoughts, feelings and beliefs to support the student's learning. This ongoing dialogue and interaction supports students to make sense of the reality of midwifery (Brown, 2003).

Clinical placement immerses the student in the culture of the profession. How students experience their clinical placement has implications for their socialisation to the profession since this is the time when they learn "what the attitudes and beliefs of the profession are and how to modify practice to meet the needs of the specific situation" (Best & Edwards, 2001, p.167). Students who have positive clinical placements learn to be confident, assertive and autonomous practitioners (Miles, 2008). Midwives who model shortcuts or poor practice risk this behaviour being continued by the students who work alongside them. Therefore each midwife has a professional responsibility to practice thoughtfully in a way that perpetuates good practice and safeguards the emerging practitioners. The preparation of midwives who wish to work with students is critical since this influences the student's placement and whether the student progresses or is held back in their development toward becoming an autonomous practitioner (Myrick & Yonge, 2004).

Students who experience putdowns and bullying within their clinical placement are more likely to perpetuate this behaviour or to leave the profession. Past research has described the presence of bullying and dysfunction within the health professions and anecdotal evidence suggests

this is ongoing (Calvert, 2001; Curtis, Ball & Kirkham, 2006; Geraghty & Bayes, 2009; Hastie, 1995: Wilkins & Hawkins, 2005). Lynch (2002) describes a "wounded workplace" where "relationships are dysfunctional and people are hurting from overwork and under appreciation" (p. 183). Pulsford et al (2002) suggest there is a "correlation between morale in the clinical area, and the quality of mentorship" (p 440). Midwives have worked in an environment of change and short staffing for many years now in part due to the low numbers of New Zealand educated midwives during the 1980's, but also due to the political and sometimes controversial nature of midwifery. Repeated attacks by the media have further impacted on morale within the profession. However it is uncertain how this has affected the quality of mentorship amongst midwives.

Enablers and barriers to working with students

Little is written in the literature about midwives' motivations for working with midwifery students. However a Canadian study of preceptor's motivations for working with student doctors found passing on knowledge, the student's enthusiasm and teaching communication skills were important motivators (Scott & Sazegar, 2006). Anecdotally and within this study midwives regularly comment on the enthusiasm of midwifery students as one of the most enjoyable aspects of working with students. Scott and Sazegar include remuneration as amongst the least important reasons for working with students. This is fortunate as in New Zealand the payment for working with students is not substantial.

Midwives need particular life skills to function successfully within what is often a turbulent profession. These life skills include being robust, decisive, bold and positive (Pelvin, 2006). Fisher (2009) described the challenges midwifery mentors experienced in the UK where social skills amongst midwifery students were found to be lacking. Her study also identified that "the student's inability to cope with the stresses and social complexities of

midwifery practice and the time needed to support these students also caused anxiety" amongst midwives working with them (p. 321). Further research amongst health workers describes poor student skills as one of the least enjoyable aspects of working with a student (Shannon et al, 2006). It is important then that clinical assessments are comprehensive and consider the student's professionalism, communication, knowledge and skill levels.

Midwifery mentors in the UK valued taking a break from working with students and this was particularly applicable if there had been any problems during the placement (Fisher, 2009). Mamchur & Myricks' (2003) Canadian study found conflict between the practitioner and the student was more widespread than they expected and they recommended that it needed to be managed well since "students may experience long-lasting and deleterious effects as a result of their involvement in a conflictual relationship" (p.195).

The role of the clinical midwife

In New Zealand midwifery clinical learning is undertaken by students working alongside experienced midwives to practice their skills and to gain experience of the implicit knowledge that makes up midwifery. The act of working with students requires midwives to reflect on their practice and find ways to articulate their practice knowledge to students. This is described by Best and Edwards (2001) as beneficial for clinicians since they "gain a deeper understanding of their own practice" (p.170). It is by discussing their practice that midwives become aware of the "knowledge, feeling, expectations, assumptions, attitudes, beliefs and values" (Best & Edwards, 2001, p.170) that contribute to their decision making. Midwives work as practice partners with the midwifery school since they provide 50 percent of the students' learning opportunities. It is important then that this partnership is valued and supported by the school to ensure students undertake the learning that is required to ensure they are 'fit for practice'.

While LMC midwives are regarded as self employed they receive payment for their services to women through government funding. The care they provide informs the midwife's reputation within her community and may influence the numbers of women who seek her services. This can directly impact on the midwife's income since this is determined by the number of women she cares for. By working with a student the LMC midwife brings an unknown factor into her relationship with the woman. If the student provides care that is very different to that of the midwife this can create tension in the relationship and may impact on the willingness of the woman to seek the midwife for subsequent care or to promote her services. Hence midwives work hard to safeguard their reputation and ensure women are happy with the care they receive. The matching of students to LMC by the midwifery school is therefore viewed as a very important aspect when arranging clinical placement.

Assessment

Assessment is regarded as necessary to support student progression and development (Knowles, 1984). While assessment seeks to provide feedback on the work undertaken by the student and not about them as a person, this distinction is not always apparent for both the student and the assessor (Jarvis, 2004). Instead feedback is often regarded as a personal comment and this influences how it is given and how it is received. Since feedback provides the cues for students to focus their learning it is important that this is both timely and accurate. The use of clear expectations and assessment criteria support the students' development since their progression is both explicit and transparent.

Students progress through the programme with different levels of confidence and competence but must attain a benchmarked standard at the completion of each semester. Their assessments seek to identify areas of strength and weaknesses to enable the student to work toward continuous improvement

and self development as a life long learner. By the year three placements the student is expected to be able to provide care to women using their own initiative and requiring minimal direction from the supervising midwife. Third year midwifery students are expected to demonstrate strong communication skills and professional behaviour, and to have the knowledge and skills required to progress to an autonomous practitioner upon successful completion of both the Bachelor of Midwifery and the National Examination.

Students learn best in an environment that is "collaborative, respectful, mutual and informal" (Fogarty & Pete, 2004, p.15). Best and Edwards (2001) describe the process for developing professional knowledge in clinical situations as being "heavily dependent on interpersonal interactions" (p.165). Each student has individual learning needs and this requires the midwife to learn about these. To do this requires the midwife and student to develop a relationship to facilitate the learning however this requires an investment of time by both parties. The success of this relationship will influence what learning, both formal and informal, the student will gain from her clinical placement.

The current study

In this chapter I have sought to provide an overview of the historical and current influences which shape midwifery in New Zealand today. I have described some of the tensions which permeate the everyday work of the midwife. My position as a midwife, a midwifery educator and the researcher is described. Within this context the study sought to learn about the experiences of midwives working with third year midwifery students, including barriers that deter them and aspects that enable a satisfying and successful working relationship. As an emerging profession midwifery is working toward articulating the ways of knowing that provide the art and science that makes up expert midwifery practice.

A strong theory-practice relationship between the midwifery school and the clinical midwife supports student learning and provides greater consistency for the student during their education. By working in partnership with our midwifery clinical colleagues we can then provide students with a strong foundation. Since these students represent our future midwifery profession we need to nurture and support them as the precious taonga they are.

Chapter Two - Methodology

Method

Research within midwifery practice seeks to increase the understanding of what midwives do, as well as the safety and effectiveness of midwifery care. This in turn, informs midwifery practice. Both quantitative and qualitative research methods contribute evidence regarding the nature of midwifery by providing information respectively at a population level and from individual perspectives (Tracy, 2006). The interpretation and application of this evidence enables midwives to be explicit about their practice and to provide care that is evidence based, which is a tenet of the professionalisation of midwifery. While quantitative data can provide the numbers of midwives in practice who may work with students it does not provide any detail about their motivations or experiences when doing so. It is by gathering this information about midwives' experiences that the teaching schools can gain a better understanding of how midwives work with midwifery students. In turn this information can then support a strong working relationship that is in the interests of both the students, midwives and the profession of midwifery.

Qualitative research "collects data in the form of words and aims to describe and attribute meaning to events and the relationship between them" (Cluett & Bluff, 2006, p.284). It aims to find the "issue of concern in its everyday context" by listening intently to what and how participants share their experiences (Smythe & Giddings, 2007, p.37). The relationship between the researcher and the participants influences qualitative research throughout the process, from identifying participants, to the data that is subsequently collected and how it is interpreted. Before participants will share their experiences they must trust the researcher to respect the knowledge and experiences they describe (Smythe & Giddings, 2007).

Phenomenology supports this research as I seek to understand the nature of the experiences of the midwives in their work alongside midwifery students. This research seeks to gain a better understanding of the pressures and influences on midwives in New Zealand in their daily work. However Strauss (1987) states that social phenomena are complex and this suggests they are subject to misinterpretation since the meanings will be multi layered and subject to assumptions. This requires the researcher to be thoughtful of the participant's intent and to use their voice to portray their experiences.

The use of focus groups was regarded as an appropriate forum to gather the information required since it would elicit a wider range of meanings of experiences than individual interviews and these would be mediated by the group dynamics. The use of focus groups utilises the social networks of midwifery to explore the concepts and meanings assumed within the team approach. It would also allow the researcher to consider the ways of communicating between midwives that make up the culture of midwifery.

About focus groups

Focus groups are described as an "interview design that uses a small group of individuals to talk about their experiences, feelings or views" (Rees, 2003, p.241). The group is described as a collection of "similar individuals who are prompted by the researcher to discuss certain topics and experiences" (Rees, 2003, p.126). Participants are able to interact with each other regarding their experiences and so provide a richness of data that may not emerge if using individual interviews (Kamberelis & Dimitriadis, 2005: Morgan, 1988). While the group may elaborate on their ideas and provide justification for their stance, they may not be able to pursue issues in detail due to the number of participants and time restrictions (Cluett & Bluff, 2006). However it is the social interaction that may reveal the "group values and beliefs" (Cluett & Bluff, 2006, p.229) and this provides valuable insights for the researcher

since the research aims to capture the meaning of their work within midwifery practice.

Group dynamics play an important role in the success of focus groups and influence the information that is shared. The participants had varying levels of experience with students and it was expected this would enable a range of experiences to emerge for discussion. It is this diversity that provides the richness of data for the focus group since the range of information is greater than that of an individual interview. The interactions between the participants also provide information about how the midwives support and promote professional behaviour. How the participants position themselves in relation to each other as they process the questions becomes evident throughout the process (Kamberelis & Dimitriadis, 2005). This positioning may influence the information that is shared and hence the consensus that the group reaches.

The role of a facilitator

The facilitator has an important role to ensure all participants contribute to the process and that each participant's thoughts and feelings are acknowledged and understood within the process. My position as the researcher and the facilitator can influence the information that is shared. As a researcher who works within the midwifery profession, I was known and trusted by the participants. This was articulated by several of the participants who agreed to participate since I was the researcher. This confidence that I will treat the information the participants have shared with respect, is a huge responsibility that I have been aware of as I have interpreted the meanings within the group interactions.

I commenced the focus group sessions with a heightened awareness of the assumptions I might make from the information provided. I sought to minimise this by formulating trigger questions to initiate and maintain the focus of the discussion. Before each group I described my role as a facilitator

and not as a contributor to the group. This proved challenging at times as I struggled to maintain the role of researcher and facilitator, rather than midwifery educator. To manage this I wrote notes during the course of the group session. This enabled me to feedback to the participants after the session any information from the discussion that would have been shared otherwise within a conversation. An example of this was information regarding student availability for clinical during the summer break.

Narrative inquiry

This qualitative research is influenced by narrative inquiry. Narrative inquiry seeks to identify the meaning within the conversation by using naïve questioning. "The basis of this approach is respectful inquiry on the presumption of difference rather than commonality" (Drewery, 2005, p.310). It seeks to hear the stories of the midwives when they are working with third year midwifery students and identify assumed meanings. These stories include both good and bad experiences which provide learning opportunities for the midwives, the midwifery students and the teaching school. The analysis of the data is undertaken by interpreting the stories that are told within the group setting and seeking their meaning.

Within qualitative research the researcher's own bias and interpretation will influence the data collection and analysis. However the reader will determine the validity of the research as the findings should "resonate" with their own experience (Smythe & Giddings, 2007, p.56). My background and identification as a midwife influences how I hear and interpret the data. Within the group setting I sought to clarify information that was not stated explicitly and I felt what was described at the time was clear to me. However when listening to the data over the following weeks I found myself wanting to ask more questions since close examination made the meaning less clear. Therefore I have used the transcribed participant responses and group interactions to support my findings and interpretations and I hope this

minimises my interpretation overriding what the original intention of the participants were.

Ethical considerations

Ethical approval was gained from the University of Waikato Faculty of Education and the Waikato Institute of Technology ethics committees prior to commencing any contact with participants. An information sheet (Appendix 1) and an invitation to participate (Appendix 2) were posted within the education provider's local geographical area to 60 midwives who have contracts with the School of Midwifery and who work with midwifery students. This same information was also sent to the local District Health Board (DHB) tertiary facility for distribution amongst the midwifery workforce. The information sheet and invitations were also placed on the notice board in the ward meeting room. I also reminded midwives of the research by personally inviting their involvement when I visited the DHB. This seemed to be the most effective way to recruit DHB midwives as prior to this none had contacted me despite stating that they had seen the posters. Midwives were encouraged to contact me as the researcher, directly to volunteer their participation. When the midwives contacted the researcher any questions they had were answered and those consenting to participate were sent the demographic profile (Appendix 3) and the consent form (Appendix 4) to read prior to the focus group session.

As the midwifery community in New Zealand is small this meant that ensuring participants' confidentiality was very important. I sought to ensure this by inviting participants to contact me directly at home, and then arranging for the sessions to be held in a community venue away from midwifery practices. However using focus groups raises a problem regarding confidentiality and anonymity since the identity of participants and the discussion that occurs is known to all participants. As a result of this participants may monitor their own participation to ensure they feel safe within this setting. This may result

in the information shared being filtered to meet the perceived group think. Even a skilled facilitator may struggle to keep a balanced conversation in the presence of an articulate participant with a skewed perspective. While I am not an experienced facilitator the participants contributed enthusiastically and experiences raised were usually shared by others.

A focus group is not a problem solving or decision making session, rather it enables participants to be heard and information to be gathered (Patton, 2002). It is also representative of the interactions that may be found within the professional community. Since the number of participants is small the findings cannot be generalised but this in no way detracts from the information gained. It can be more accurately described as a snapshot of the group's perceptions at this time and provides information about their experiences.

A tenet of informed consent is that the participant has the right to withdraw from the research. Any participant who declines to continue is entitled to do so however once the group has commenced, the input from each participant within the focus group influences the course of the group process and this cannot be reversed. When undertaking data analysis it is also difficult to determine each individual contribution. This was explained to the group before commencing the focus group. It was also explained that should a participant leave during the process the rest of the group would continue, however this did not occur.

My position as an educator and as the researcher creates a potential conflict of interest. Due to my many years working as an LMC in the community most of the midwives are known to me, as am I to them. Since I am new to the education role any criticism made by the participants regarding problems with the teaching school may not be regarded as a direct criticism of my work. Conversely there may be an expectation by the participants that I can now

correct any issues that may be identified within the group. While some changes are within the scope of the midwifery school others are situated within the wider culture of midwifery. Therefore I come to this research setting aside my role as a midwifery educator and instead focus on my research to gain a perspective on the experiences midwives have when working with midwifery students.

Participants

Twelve midwives volunteered to participate in the focus groups. The midwives were divided into two groups of six for each group and this was allocated in the order of when they first contacted me. The first group met in September and the second group met in October.

I wanted to include perspectives from both LMC and DHB midwives in the research, as I felt this was both inclusive of all midwives and representative of the midwives working with third year midwifery students. Since third year midwifery placements are predominantly within the community this split of ten LMC (community) and two DHB midwives reflects the students' placement allocations of community and DHB during their third year.

Of the twelve participants, nine had worked with students during the year of the research and three had not. Eight of the participants had been working with student midwives for 7 or more years while four had worked with students for between 1 and 3 years. None of the participants had worked with students in the range of 3 to 7 years. Four of the midwives had been practicing for between 3 – 8 years, three had been practising between 9 – 14 years and five had been practising for over 15 years. None of the participants fell into the 4 – 6 years of practise range.

Ten midwives stated they worked in community settings and three identified the hospital as their place of work (one midwife worked across both

community and hospital settings). Ten midwives identified their own practice as having few or some homebirths. Seven midwives provided care in a primary setting mainly, three did sometimes and one provided care only a few times in a primary setting. While three midwives worked mainly in a secondary setting, five said some of their practice occurred in a secondary setting and four said only a few of their births used this setting.

Nine of the midwives had a New Zealand midwifery qualification and three had an overseas midwifery qualification as their first qualification in midwifery.

Focus Group process

The two groups met at a local community centre for a two hour session each. This enabled a settling in time and the discussion time was approximately 1 hour and 50 minutes. The sessions were video and audio recorded to ensure capture of the data. As the researcher and facilitator I also took notes during the sessions. I used a brief set of questions to prompt the discussion (Appendix 5). These questions included those factors the midwives felt contributed to the relationship with the student, and the midwives' understanding of the roles of the student, the school and the midwives in the placement. Further trigger questions included questions about professional behaviours and the perceived effects of the presence of the student on the relationship between the woman and the midwife.

Tea, coffee or juice and food were provided to support the informal atmosphere and to promote sharing of information. Before commencing participants were invited to ask any questions to clarify the process but none were forthcoming. Completed consent forms and demographic profiles were completed and collected at the beginning of the session if this had not already occurred. Following the session each participant was sent a thank you card to acknowledge their contribution to the research.

Analysis of data

The tapes were listened to within a week after each focus group session. Detailed notes were taken from these to capture the content discussed. The group interview was then replayed to see if there was any further reaction from myself as the researcher and any further detail was inserted into the notes. Once the tapes for each group were transcribed into note form this information was also sent to the participants of the specific group. Participants were encouraged to contact the researcher should they identify any errors, feel concerned about disclosure, or wish to elaborate further on the discussion, however none responded. I then revisited the research questions to ensure there was a focus on the research question in the analysis of the data. The notes were then read looking for key themes. Once these were identified the data was again reviewed to ensure accuracy with the information and that the focus of the research was consistent.

At this stage I identified limitations in the notes I had transcribed from the focus groups as I felt I was lacking sufficient detail of the participants' dialogue. I therefore transcribed the sessions in full. This identified further dialogue for inclusion and enabled me to refine the themes. While two main areas were identified, these were broken down further into three themes within each area. The data was found to share some common characteristics enabling a progression through the themes and showing interconnectedness between the themes. This interpretation of the data follows the central ideas that are found within the interaction between the participants. It seeks to capture the discussions and shared understandings of how the midwives interact with the students they work alongside.

Throughout the group process there was engagement by the participants and acknowledgement of their shared experiences when working with students. Those experiences which were not shared by the group elicited no response from the group when they were described and in one instance received a

response stating that the other participant had never experienced this. This occurred twice and has not been included in the data since I believe it represents an individual view rather than the moderated group view. In both situations I believe it was related to how the individual midwife interacted with others and the consequences she had experienced with this.

The interpretation of data carries a responsibility by the researcher to determine the understanding and meanings that lie within the conversation. When interpreting some of the data I found myself wanting more information about what exactly the participant was meaning, since this was not always as clear upon re-listening to the data. It is these assumed and implied meanings that are shared in the group setting that are sometimes difficult to articulate in writing with any great certainty, that this is what the speaker intended.

Summary

In this chapter I have described the methodology I have used, my role as a facilitator and the ethical considerations of the project. I have described how the participants were recruited and how their confidentiality was protected. The participant's profile is illustrated by using their demographic data. The analysis of the data is described including the challenges I experienced of ensuring accuracy in my interpretation.

Chapter Three - Findings

Introduction

Both focus groups commenced with an introduction to the research topic and an outline of the research aims. The participants were first asked to describe a positive experience they had when working with third year midwifery students. They were then asked to discuss how they perceived the role of the student, the role of the school and the role of the midwife within this relationship.

The data was thematically analysed and two broad groupings were identified. The first describes the midwives' work with the student and the second describes the implications for the midwives when working with students. Within both of these a further three themes were identified. Themes describing the midwives' work with the students are: *that confidence thing*, *it's not just about clinical skills* and *learning to be professional*. The second theme describes the implications for the midwives when working with students and includes: *we are responsible*, *what is expected of me* and *wanting a break*.

Midwives' work with students - that confidence thing

The midwives described times when they saw students gain confidence during their clinical placements. They described their pleasure in watching the students grow in confidence and competence during the placement. A sense of pride and ownership of the student's achievement was evident amongst the group as they discussed times when their student had taken a *real part* and the *buzz* this gave them.

> *-I really like it when they…it's that confidence thing…when they do a palpation and realise this baby is breech and they recognise it. I don't think they realise they recognise the normal until they realise they recognise the abnormal. It reinforces the fact that I do actually know*

what I am doing because I know this is not right, and when it all starts clicking into place and seeing their confidence jump with it – it's good.

While confidence and competence are linked it was the student's lack of confidence in their knowledge that the participants described experiencing most often.

Amongst the participants there was considerable discussion around the ability of the student to *step up* when required. These stepping up requirements appeared to vary between the different participant midwives, as each described varying levels of expectation and participation for the student. This was dependent on the student's perceived ability and the midwife's judgement of what was appropriate. There was an expectation that students would *get in there and do it* when providing clinical care and this was seen as part of the *stepping up.* Students who actively sought out learning opportunities were regarded as taking the initiative and this was viewed by the midwives as appropriate. However the midwives were aware that students were often careful to not appear *uppity (*which was described as - *I can do this, this and this)* and so consequently the student may hold back which could result in the student appearing to be reluctant to *step up*. This is a fine line that students and midwives tread in providing and accessing opportunities for learning. Overall there was an expectation amongst participants that third year students would have sufficient knowledge and experience to be able to provide appropriate care while direct supervision by the midwife was reduced. This was seen as part of the students' progression toward meeting the competencies for entry to the register of midwives.

The participants identified times when they felt that the student was clinically able but lacked confidence to step up to the level that was expected. When this occurred the midwives described how they would create opportunities for the student to increase their learning.

- I left a third year student on her own and then she realised that yes…. I had always believed that she could do it and she was competent enough to do it. I know you can do it – that's why I left you.

Another participant described how she arranged for students to undertake an antenatal visit by positioning the student in the seat the midwife usually occupied. This was to signal to the woman that the student was providing her care for this visit. It also conveys a message that the midwife trusts the student to provide the appropriate care. However at times the midwife felt she needed to leave the room to promote the students involvement when a student seemed reluctant to take on the role of the midwife for that visit. This requires midwives to make a judgement on the capability of the student and to then provide the opportunities that are appropriate to her learning needs.

The participants described how a negative influence during the student's previous placement could subsequently affect the student's confidence and competence. They felt this could be due to a personality conflict between the student and the midwife where differences in expectations were not identified or managed.

- I have had a third year student where the first month was spent undoing the putdowns she had from previous placements and rebuilding her confidence - couldn't start anything else because she had had such negative experiences in the past and it wasn't her midwifery skills that were a problem – it was her confidence in her abilities.

The participants were aware of the different levels of confidence amongst the students and felt this often related to the student's experiences prior to entering the programme. They felt that those students who had previously worked with a range of people had better communication skills. However they agreed this was not necessarily an age related attribute as they described experiences of working with younger students who they described

as *brilliant* while sometimes the older students may not be. Rather it was described as the student's ability to relate well to a variety of people.

> *-They vary a lot in their levels of confidence, how comfortable they are with taking the initiative and thinking ahead. I think that is the thing we encourage them to do – thinking ahead all the time. What is coming up? And some of them are really good at that and some not so much. It depends on what they do – but hopefully by third year they have that sorted.*

Midwifery students come from a variety of experiences, ages and stages of life and this influences their learning and confidence when working in clinical placements. The group identified that they enjoyed the *enthusiasm* and *fresh knowledge* the students brought to clinical. This passion for midwifery was identified several times by the midwives within both groups as important within the profession and they expected students to demonstrate this. Midwifery is a profession that demands a high level of commitment and the students' enthusiasm would reflect this passion.

Midwives' work with students – it's not just about clinical skills

The midwives described the skills and attributes they expected the students to have to become a midwife. They first described concrete tasks such as *research based knowledge*, competence in a variety of *practical skills* and being *computer literate*. Students were expected to know why specific laboratory and screening tests were required and to be competent within the skill range that was required for student midwives. This skill range includes practical skills such as palpation, taking observations and management of emergency situations. The participants discussed the anticipatory thinking they expected students to demonstrate when working with women. This was described by the midwives as the ability to plan care which is appropriate to each woman thinking ahead to situations that may occur and anticipating what may be required. A participant described an occasion when the student

demonstrated this by being one step ahead of her as she anticipated what resources she would need and had these already available.

> *-It helped her as a student to see it's not just all about clinical skills. It's about thinking and putting the whole picture together.*
> *-It helps them to recognise its so much more (during a midwifery emergency) than putting a leur in*

The participants described years one and two of the degree programme as focusing on skill based learning while year three involved the more complex knowing that occurs when the student began to think like a midwife. By year three the students were expected to be clinically competent in specific tasks but working toward *pulling/bringing it all together*. This ability to provide all aspects of midwifery care was seen as challenging for some students as they juggled the different components required to provide holistic midwifery care.

> *- I find first and second year is spent on trying to get them good at specific things. You might pick one or two things at each birth; whereas the third year is much more about trying to get them to bring it all together, which as we know is not easy. By the time you listen to the baby and do all the things you are meant to do and document – you know - all at once, and that's quite a big thing for them to learn how to do it. I always find at the start of the third year that's something they find hard and I work on that.*

Bringing it all together requires the integration of theory and practice. This was described by the midwives as exciting to experience as the students were able to gain a new perspective on their clinical placement and a deeper understanding of theory. An example was given by a participant whereby she had asked a student to explain the physiology of the symptoms a woman had presented with. The student was able to relate her observations to her science lessons which showed her understanding of the woman's condition.

The midwife was thrilled that the student had recognised the learning opportunity and could relate her theoretical learning into practice.

While the midwifery school teaches the theory of practice and provides simulation, the clinical placements enable the students to practice the skills they must master within a real time setting and amidst the chaos that makes up professional practice. However it is this real time setting and the unpredictability of clinical placement that created some problems when students did not gain the experiences they expected during their clinical placement. This created frustrations when the midwives felt the student failed to understand the alternate learning that presented and thereby gain the most of each opportunity.

> *-Students need to be encouraged to understand that every experience offers learning opportunities and is positive in that sense….she might have a crap day but (there are) still skills that the midwife has.*

By third year the participants expected the students to show a *leadership role* and be able to take the initiative when they were providing care. This *leadership role* was described as meaning that the midwife was able to stay in the background providing supervision of the student while the student provided midwifery care that was appropriate and timely. However it was agreed that this requires the student to be able to demonstrate strong clinical skills, maturity and self confidence, and the participants stated that this was something they felt that some students did not demonstrate in their third year. The participants felt that those who did not demonstrate it often needed extra support and clinical time to reach the standard that was expected. One participant described an experience when she had worked with a student who required this extra support and clinical time to meet the expected standard. It was agreed within the group that students all had different learning styles and levels of knowledge. The participants expected that placement with different midwives would consider the learning styles and requirements of the student

and that this would be matched to what the placement could offer. An example provided was that a student who required a lot of repetition to assist her learning would be best placed with a busy midwife who could offer repeated hands-on learning opportunities.

The participants described how they modelled thinking like a midwife and encouraged the students to think for themselves and develop an understanding of the complexity of midwifery. The midwives sought evidence of maturity in the student and not just competence in tasks when assessing the students' development. An example of this was described as the student's ability to undertake an appropriate discussion with the woman about aspects of her birth plan. The students were expected to have developed patterns to enable them to think and work in a logical manner, using checklists (in their head) and planning their actions before routine visits. By third year students were expected to have mastered the entirety of this however at times students were more disjointed as they learnt to *pull it all together.*

The midwives described how they would verbalise to students what they were doing during the course of their everyday work to ensure students gained the learning that was embedded within each midwifery action.

> *- it's not like rote learning or this is the information that you give always the same way but that they are actually thinking in a logical way and starting to develop some check lists in their head – what do we do … all that stuff you do automatically. I find it quite challenging 'cause it becomes second nature for us but you have to remember it's not for them and so you've got to…your role is working them into that so it's becoming second – you're not just having a conversation in the car*

Modelling the desired behaviour and being explicit about what was expected was regarded by the participants as the usual way to communicate this knowledge. However it was described as difficult to articulate to students at

times as the midwives felt it was second nature to them and therefore hard to put into words.

The participants had experienced situations when students became anxious about the amount of learning and expertise they felt they needed to achieve prior to commencing practice as a graduate midwife. Despite her extensive experience as a midwife one participant was clear that she did not regard herself as an expert. Instead she described how she accesses the knowledge she requires to maintain a safe practice and in doing so demonstrated her commitment to lifelong learning. This was affirmed within the group setting to be the normal practice amongst the participants.

- I would hate it if my student saw me as an expert and I try to communicate that to them

- It's the same with students we don't expect them to know everything….it's okay to say get back to me about that tomorrow.

- Absolutely and that's all part of our ongoing taking responsibility for our own updating and so on.

- and to acknowledge to a student that I'm going to ring up and talk to the obstetric staff because I had this scenario and I hadn't had it happen before and it's good for them to see that

- Then they're always more likely to seek further advice.

- That's exactly it – they're not scared to ring

- It's about role modelling and recognising your scope of practice

By modelling and articulating their ways to practice the midwives are supporting the student's learning about the complexity of care which makes up midwifery practice. Within this context the midwives described how they demonstrated problem solving, working within a multi disciplinary team, communication and working within the midwifery scope of practice. The participants were in agreement that students needed to understand when and how to access other expertise to ensure their safe practice as a midwife and believed they modelled this.

A participant described how she knows that a student is making the connections and learning from their clinical experiences. She felt this occurred when the student could see the bigger picture. This she felt, was related to the student progressing toward being a reflective practitioner.

> *-the other positive thing would be when the student has come away and looked at the whole episode and whether the student has debriefed or is really truly thinking the whole thing – like how did I do and what could I have done better – looking for that feedback and looking for where they are in the whole picture and that for me is showing almost passion – they're not just there for a skill.*

The participants had experienced some students who they felt were not well prepared for the demands of clinical placement within their final year and they suggested that the midwifery school should provide more direction to the students to ensure they understood the requirements and expectations (within third year the majority of the student's placement is with LMC midwives doing on call work in the community). However they agreed that midwifery is a demanding profession and that they themselves did not truly understand the commitment that was required prior to entering the profession. The participants described situations where the chaotic lifestyle of a student had impacted on their own workload as they sought to provide support for a student with limited family support. The midwives felt that the student/midwife needed to have a strong support network to be able to undertake midwifery education and practice. When evidence of the student's poor organisation flowed into the midwife/woman relationship the midwives felt this was unprofessional.

When undertaking clinical placement the midwives wanted the students to be ready to *live the life of the midwife*. While the midwives felt sympathy for the students' unpaid situation, they were also frustrated by what they described

as a perceived lack of commitment should a student not perform at the expected level or struggle with family demands that intruded into their clinical time. The participants described their own experiences of juggling family commitments during their education and work and regarded family support as critical to be able to work successfully as a midwife.

> **-***I've had a couple of students where I've had absolutely no issues with their skills, documentation and what else but because of their family commitments, childcare commitments – they haven't done the births – they may have done the hours so they get the hours in and I've sat them down and I had one of them in tears and I said look I think you'll be an awesome midwife, you've got wonderful skills but what you've done with me is not independent midwifery - you can say to me your child has got the flu so therefore I can't come. You as an independent midwife have to make an alternate arrangement. You've got to walk out on your child and say I can't, and it's a hideous thing you have to do*
>
> *-Yes but it's reality*

The DHB midwives were also able to relate with this demand on a midwife to attend to her work despite other family commitments. The expectation amongst the group was that the student or midwife should have other family members who would share the load of childcare and that work commitments were paramount.

While students were expected to have their own learning outcomes for the placement it was acknowledged within the group that they *may not know what they don't know*. The midwives did not expect the student to know everything and worked with the students to identify and close any knowledge gaps the student may have. Several participants described asking the student to find information about practice issues that they were not knowledgeable about to feedback to the midwife the next day. Undertaking this homework was thought to assist the student's learning. The participants felt the students had

access to the most up to date information via their education at the midwifery school and it was expected they would pass this knowledge on to the midwives. This reciprocal learning was regarded as important by the participants within the student/midwife relationship and it was described by the midwives as part of why they worked with students.

The midwives described times when the students needed to be able to make connections with women and their families quickly, particularly in a tertiary setting. Students who demonstrated this and were appropriately responsive to the woman's mood and need were regarded as having the *maturity* that was required to be a midwife. Within the group it was felt that the students contributed something of value to the situation, despite the student not always being aware of this. Several participants described times when they had debriefed with a student about their role in an episode of care and fed back about what the student did well. Students had expressed surprise as they had not always recognised their contribution. While skills were regarded as important it was these communication and professional behaviour skills that were seen as critical to the development of the student.

One participant identified that within long placements, as the placement progressed she would be *in sync* with the student and so their working relationship would become more efficient. This resulted in the development of a close professional relationship between the student and the midwife. This created a sense of belonging to a team when working together and would support the student's sense of belonging to the profession.

> *-I quite like it when you work with third years for a length of time, how you get very in sync towards the end and it's almost like you can give them a look and they know what you mean – you start to do something and they are already onto it – it feels like you have become a team. You don't have to tell them because they have already pre-thought it.*

Midwives' work with students - learning to be professional

Notions of loyalty, professionalism and understanding what is right can be complex concepts to teach to midwifery students. Breaches of these standards by students frustrated the participants since it was expected students would understand these clearly within the first one to two years of their education. Examples of unprofessional behaviour included: being late to placement, lack of communication skills, lack of confidentiality and the inability of the student to reflect on their own professional behaviour. Both groups described unprofessional behaviour they had experienced when working with students. Amongst the participants it appeared this created issues within the placement as some participants felt uncomfortable at times to feedback to students about behaviour they felt was unprofessional. There was a sense within the group that providing written feedback which contained negative information was not supportive of the student's development, and the midwives instead preferred to offer this verbally.

The participants described the attributes of being a professional which included adhering to the principles of confidentiality and having strong clinical practice and knowledge that was research based. Instances of students breaching professional boundaries and behaviours were described and these caused concern to the participants. Participants described times when students would share their own birth experiences within the midwife/woman partnership in ways the midwife felt was not appropriate. When this occurred the midwives saw the student as a participant who encroached on the woman's time and they did not feel this was fitting. The midwives agreed it was appropriate to share a little of yourself with the woman to establish a rapport and that this could vary between different women. However they felt there were boundaries reflecting the professional relationship and students often breached these. The participants agreed that finding the balance between personal and professional was difficult and that these boundaries

were not always clear to students as they interacted with women. The midwives felt at times that this was a source of irritation for both the woman and the midwife.

> *-trying to get the balance between personal and professional life with the woman to – like you might get on very well and have an incredible rapport and then share a little bit of yourself but not – it's all that – little bits of yourself are okay but it's knowing what is that barrier – that grey area you shouldn't step in there*
> *-there's that bit that helps build a rapport and then there's overstepping*
> *-you need to find common ground don't you – things that you both share*

As part of their professional practice the midwives described being careful about what they shared with their partner/husband as they felt this avoided the partner inadvertently sharing information, especially if they worked within the same community. Midwives often sought their midwifery colleagues to debrief with as they are bound by the same professional code of conduct. However students did not always seem to understand the importance of this or to apply the principles of confidentiality consistently.

> *-Recently I had one where (the student) saw the woman's notes and said 'oh is she pregnant?' She told her husband and this woman ended up having a termination …..the husband did work for this woman and he could have said something. I was really cross. I don't tell my husband who is pregnant as he will blab – did you know so and so is pregnant?*

It was acknowledged this could be less of an issue in a larger community where people did not always know each other. However it still remained a problem and caused the midwives concern as they regarded confidentiality is one of the basic requirements of professional behaviour.

> *-When you are talking about issues that are really important – confidentiality would be just about tops, especially in a small*

community. You can't say I know so and so or they were married to so and so because they probably know the person and you can't do that.
-Even Christian names are something that I don't find acceptable.
-Yeah like Joanne had a breast infection…..oh she went to my antenatal class.
- You just can't go there.

Students were expected to be organised and attend appointments and meetings punctually. It was regarded by the participants as unprofessional to be consistently late and disorganised. Those students who left assignment work until the last minute were seen as being disorganised. While the relationship between student and midwife is a professional one aimed at enabling the student to gain clinical experience and learning, there are times when it appears the midwives are required to provide personal support for the student. The participants described times when they were required to support students as they learnt to balance the multiple demands of study and family.

- I think if in first and second years things happen and they don't realise the impact until it catches up with them later on and things feel like they are crashing in
- Yeah, we're the ones that take the meltdowns
- Being aware from the beginning and really stressing about the workload and take responsibility and have things sorted at home
- Yeah child care sorted out
- Sometimes you feel like you're their mother and say, well I know but – this has to be done today

It was acknowledged within the group that students often had more time to spend with the woman and this could influence their relationship. At times the student and woman were felt to have a stronger relationship than the woman had with the midwife. For some midwives this was problematic as they felt

they were not meeting the needs of the woman. If the woman had a stronger relationship with the student then the student was regarded as a potential competition for the midwife's future workload. This was because there was an expectation that the woman would seek the midwife's care for her subsequent pregnancies and would recommend the midwife to her friends. One participant summed up the mixed feelings this aroused.

> *-it is great that the woman had found the student so good and is happy to trust her…… My mentor side says 'great' but my midwife side says 'ohh'.*

For one participant this was the reason why she avoided working with third year students for their long placement as she felt she was too new in self employed practice to manage the competition that the student may present.

The relationship between the midwife, the woman and the student has the potential to become complex as each member negotiates their understanding of how they are situated and what their role is.

> *-You've got to look at the reality of the relationship you're trying to balance and the confidence you're trying to give to the woman - supporting the student – so it's a three way relationship. The time you're with the woman is the woman's time and not the student's time and if the student is there as a participant in that - but it's not her time – it's the woman's time. The student's time is the gap in-between.*

This statement positions the woman at the centre of the relationship with the student placed alongside this central relationship. The midwives described the times when the woman's needs came first at the expense of the student's learning needs. They found this difficult as they balanced the conflicting demands from the woman and the student. The midwives were aware that the dynamics of this may influence the student's placement experience and they worked to mitigate this by encouraging women to enable students to care for them. Most of the participants had used the flyers supplied by the midwifery school describing the role of the student when in clinical placement.

In summary I have described how the midwives express their role to build confidence in the students and how they work to provide opportunities for the students to develop their skills. The midwives regarded themselves as role models for the students and described how they shared their ways of thinking and practicing to support the students to develop their own professional practice. In return the midwives expected the students to be ready to *live the life of a midwife* and be ready to cope with the demands that this entailed. Students were expected to show maturity, self confidence and have strong clinical skills within their third year placement.

Implications for midwives' practice - we are responsible

Working with students was seen as an added responsibility for midwives on top of their workload. The midwives described how they felt responsible for the student's practice and this impacted on their confidence regarding leaving her to work unsupervised. One participant stated there is *enough potential for me to muck it up*. It was stated that those midwives who did not want to be responsible for the student would not work with students. This may not be the case with DHB midwives who are expected by their managers to work with students undertaking DHB placements.

-We are responsible for what they do

-We are responsible all the time

-If you don't want to be, you don't have students

-If you don't want to be double checked you don't take students – if you don't want to be challenged.

Most midwifery care is undertaken by the midwife working alone. Hence working with a student opens the midwife's practice to scrutiny and this may make the midwife feel more vulnerable. Participants were aware their practice was critiqued when working with a student and welcomed this as providing transparency around their practice. The participants were

comfortable with students discussing their placement experience with the tutors at the midwifery school and stated that they expected that should any practice problems be identified this would be managed by the school contacting them directly.

> *- I was thinking about when the students feed back about their experience with us. We probably don't get much of that back to know how that went*
>
> *- We get nothing*
>
> *- For example – if there was a midwife who constantly didn't do things right and we weren't told then we would keep on doing it. So we probably don't get very much feedback from the student*
>
> *- If a student has had a bad placement – is it a midwife or student problem? You hear all sorts of stories from the students about midwives out in the community and you've got to take it.*

In opening up her practice to a student the participants were aware of the risk that the student may misinterpret the midwife's practice and subsequently discuss her interpretation with other student colleagues and midwives. While the participants appeared resigned that this occurred they expressed anxiety about being on the receiving end of such stories and in these situations sought reassurance from the midwifery school about the appropriateness of their practice. This appears to position the midwifery school as an assessor of the midwives' practice.

Each participant determined the degree of supervision regarding what skills and care they would encourage a student to do, with some maintaining direct supervision of the student all year, while others stepped back to allow the student to develop her own style. This created a discussion around what supervision was appropriate for students and at what point the student was in fact being used as a *lackey* for the midwife.

> *-I have left a third year student to do an appointment while I have been in the rooms and I feel sometimes that I need to get out of the room*

then to build their confidence up….because they're not thinking am I saying this right? And to be quite honest I sometimes have to get out 'cause I can't shut my mouth. And then I go in at the end of the visit and just say is there anything you are worried about or is there anything you haven't been able to answer. But I wouldn't ever dream of sending them off to do postnatal visits.
-I see students being really used as lackeys and given far too much responsibility and sometimes they haven't realised what they have agreed to and the risk they have put themselves at.

The participants stated that the midwifery school should advise students of the limitations of their student role when undertaking placement. However they felt that many students would be unable to decline a midwife's request to undertake care without supervision. The midwives believed this was influenced by the midwife-student relationship where they felt the student sought to please the midwife and hence would be reluctant to decline her request, and also due to some students having greater confidence in their ability.

Most participants described leaving a student to undertake some midwifery care on their own and felt their close supervision minimised any risk in doing this. This close supervision was regarded as important to ensure students developed strong clinical skills and involved discussing the care provided and monitoring the student's development. Anecdotal stories were shared within the group regarding other midwives who allowed students to work without supervision and this was not regarded by the participants as professional or safe behaviour. They felt the students affected were keen to please and were not aware of the possible implications of something going wrong. Students were also felt to be at risk of developing poor practice habits since they lacked supervision from an experienced midwife. Since midwives often work

in small groups or on their own, at risk ways of practicing may continue unchecked, simply because the midwife is not aware of her error.

> *-You work as a midwife on your own – they (the student) might think they are doing it right, and then they carry on doing it and they actually are not doing it right because they've been so unsupervised that they've developed this whole part that's not right or correct*.

The issue of appropriate supervision created considerable discussion amongst the participants. The lack of a clear definition of the stepping back role that midwives take creates confusion about how much supervision is required. To manage this midwives described interpreting supervision by using their own areas of comfort and the student's ability as guidelines.

One participant described how she encouraged women to work with students as she saw this as a way to safeguard the midwifery service for the area. Most participants had used the leaflet provided by the midwifery school to explain the role of the student and this had been useful. However not all women were happy to have a student involved in their care and when this occurred it could create tension within the relationship between the midwife and the woman. For one participant this had meant the student had to absent herself from the clinic room for the duration of the woman's visit. At other times the woman expected the student to take an observation role only and issues arose if the midwife tried to step back to enable the student to practice her skills.

> *- There are some occasions when the woman doesn't want you to sit on the chair. She wants every interaction, even if you are not doing anything, she wants you to look like you are. You might not do anything but she wants you to stand beside her. You can't step so far back that the woman feels she's not supported by her midwife.*
>
> *- Also to get women who'd come back to you*
>
> *- Its quite hard 'cause you're talking women into agreeing to take students as well*

This illustrates the fine line midwives tread as they seek to provide learning opportunities for students, while ensuring their future income is not adversely affected.

The fear of the student failing concerned the midwives as they felt this could be a reflection of the quality of the placement and the learning the student had experienced with them. The role of the midwifery school in assessing students was not discussed at this time; instead the participants appeared to regard their role of assessing the students in isolation. This puts added responsibility and pressures onto the midwives when working with students.

> *- I had a student who failed her state exam. You know it's nothing that you did but you feel absolutely gutted, you think, could you have done more? Where did she fall down? It's really hard….*

Implications for midwives' practice - what is expected of me?

Students rotate regularly through a variety of midwifery placements in different work settings to ensure they are exposed to a range of midwifery practices. Within LMC practice MCNZ require that students do not undertake a placement with the same midwife more than twice throughout their education. The participants agreed that students' working with a variety of midwives was positive and they felt that this exposure to a wide variety of models of care is good for students to see. They believed this would facilitate the students' understanding of the variety of practices that make up the profession of midwifery.

The participants were representative of the clinical midwives who undertake assessment and provide feedback about the students' clinical performance. This assessment and feedback enables the teaching school to attain an overview of the student in both theoretical and clinical contexts. However the midwives described their difficulties assessing students at times and their anxiety to make sure they got it right.

- I do sometimes find it difficult to really understand what is expected of me …. some of their things … I read them dutifully to see…yes, yes, yes. I don't want to either not sign them off for something or sign them off for something that they haven't achieved. What is realistic?

Many of the midwives in the group agreed they did not have a good understanding of what level the student should be at. This was despite the midwifery school providing information about the level of skills that are expected the participants and that most participants had worked regularly with students over a long period. The participants admitted they did not read the information sent to them by the midwifery school because they were busy and they found the information too wordy. Amongst the participants it was agreed the Preceptor workshops (a one day workshop covering the Bachelor of Midwifery curriculum, adult learning principles, and assessment of the student facilitated by the midwifery school) were useful in bridging this gap and those who had attended felt they were more confident about what was expected of them when working with midwifery students.

The time commitment to undertake debriefing sessions with students was not always recognised by the midwives when they first began working with students. While they agreed the presence of the student enabled some aspects of care to be completed faster due to the help of the student there was also a need to allocate time for debriefing and discussion about how the student was developing and to identify their learning objectives. This debriefing was described as less common at the DHB however and this was felt to be due to ongoing staff shortages and high turnover of staff which was thought to make this less of a priority. The nature of LMC placement meant the student and LMC spent time together travelling in a car or waiting at a clinic and this provided opportunities to debrief.

- I think I underrated when I first took a student how much input I was going to – how organised I was going to have to be and quite what their needs were and now I'm much more aware of the fact that I do

need to devote some specific time each week looking at what we've achieved, what skills they've managed to practice, what experience they need to debrief about and making an hour at least each week available specifically for that 'cause I tend to finish the day with the student and go righto, get out, see you, bye I'm off home and I needed to recognise that it's not appropriate.

The midwives were aware of different learning styles and used this information when working with the students. Their awareness of this led them to provide a range of learning opportunities to help students learning.

- I think we really need to be able to assess what level they are so you can help them accordingly - also understand students have extremely different learning styles – some are very tactile, some very visual. If something isn't getting through then if I sit down with them we can identify how they learn.

Students were expected to be aware of their learning objectives and learning styles by third year and to be an active participant in seeking the experiences and learning they required.

The midwives described seeking a strong relationship with the midwifery school and enjoyed regular and meaningful communication throughout the placement. This was regardless of how well the placement was going. The midwifery school regularly phones LMC midwives during their working day to discuss the placement. However the LMC participants found phone calls could be problematic as often they were with the student or with a woman and this made a frank and open discussion difficult. If problems arose in the relationship the midwives expected the school to support them to resolve the issues. The participants did not see this as a failure but rather an example of how not all relationships work. Several midwives described how they met the students prior to agreeing to work with them and used this time to ensure they were more likely to be compatible when working together. They used this

sharing of information to ensure expectations were explicit for both the midwife and the student.

The newly implemented three way meetings (a one hour meeting between the midwife, student and tutor to assess the student's learning) were valued by those participants who had experienced them. The participants stated they sometimes found it hard to give negative feedback directly to the student or in written form however they felt the three-way meeting enabled them to do this as it was part of a discussion. The ability to discuss their feedback made the midwives feel they were able to qualify and soften it, as opposed to providing written feedback only which they felt could be a *bit harsh*. They regarded the three way meetings as more transparent than one on one meetings of the past since both the student and the midwife could hear what each other said.

> *- The paperwork has to be done but sometimes you can say things more nicely in words than if you have to write it down. It looks a bit harsh… 'lacks knowledge' … when written down.*
> *-It can be quite subjective*
> *- And vary in different areas*
> *- Some areas are hard – like dress code*
> *- If it's written down they're going to jump on it but if it's in general conversation and it comes around…*

Some felt uncomfortable providing any negative feedback and so would gloss over the issue with the student. Possibly as a consequence of this, the midwives described experiences when students were not working at the level they would expect despite having had skills signed off within previous placements by previous midwives. They found this inconsistency frustrating and for this reason usually expected the student to work alongside them for the first week of placement to ascertain the student's actual skill level. This inconsistency of assessment is problematic both for the confidence level of the student and for ensuring students are progressing appropriately.

Implications for midwives' practice - wanting a break

The midwives discussed the efforts they put into establishing the relationship with the student by ensuring the student was aware of how they worked and what was important within their practice. At this time the student was also expected to contribute their expectations and learning objectives for the placement. When placement did not work well the midwives described adding further requirements to their *list* to ensure they would match the student's expectations.

- *Not all relationships work….after some students the list gets longer*

The laughter which followed this statement suggests most of the participants in the group could relate to this. The midwives described several of the opportunities they used to share information with students, ranging from a regular meeting for coffee to the conversations held while travelling in the car to the next appointment. It was apparent that this requires the midwives to invest time in the student to support a positive relationship.

The participants also discussed the things they did not enjoy when working with students. While it was agreed that students helped with the workload at times, this was offset by the extra time required for the midwife to explain what she is doing and to debrief with students.

-It makes the workload easier…my student has been a great help to me. When they leave you are suddenly alone in the car.

-Yeah and suddenly it seems to take ages after a birth to finish off (lots of laughing)

-They do a lot of practical stuff. No-one makes you a drink, or gets you stuff, or reminds you it's lunch time and they're hungry – so there's lots of practical stuff

-I agree – cutting down the time after a birth

-But it can take longer

-The intensity – sometimes the intensity of it – you know if you have been up at a long birth and its 3 o'clock in the morning and by the time you finish it is 5 and you have to go through things and explain things and you think…

-You'd be out the door but then you're still an hour

-You're still going – but then you're still going - it takes a lot and I could do it so much quicker

At this stage one participant stated that her experience in the DHB was that due to a lack of time she rarely was able to debrief with the student beyond superficial detail. While she acknowledged the role of the clinical supervising midwife from the teaching school in supporting the student she queried whether she was missing part of her role when working with students.

The participants discussed some of the other experiences they had when working with students. They described the way they had to consider the student on a daily basis and how this affected their planning.

-Sometimes I get tired of all the talking and all the energy that's required to go into those (students) sometimes

-It is tiring – you can't have a student all the time – you have to have a break

-It's nice to put your own hands on for a change

-And not having to think about somebody else for a ….

-You know… if they ring up with low fetal movements you just go

-The worst would be the lack of spontaneity

-You probably spend as much on them as you get paid for having them – cell phones calls

-But then you've had all that free labour too

While the group agreed with this statement they regarded it as part of the role of a midwife to support midwifery students as they saw this as a way to support the future of the profession.

- I do it for the future (of midwifery) and not for the money.

The NZCOM Code of Ethics states that “midwives participate in (the) education of midwifery students and other midwives” (NZCOM, 2008, p.13). Amongst the participants there was considerable good will to work with students and most experiences they described were positive. In allocating points to midwives who work with midwifery students, Midwifery Council recognises the role of the midwife in educating students. However the DHB midwives felt their workload was too heavy to enable them to provide the support to students they would like to be able to do. Local midwifery students were targeted by midwives for support in local placements as they were seen as the future workforce in the area. This was particularly true in rural areas that had a shortage of midwives and the midwives described their desire to support local women through their education to ensure continued services in their area. To promote student involvement to women the midwives asked women how much were they prepared to invest in our future workforce.

In summary the midwives have described the uncertainties that they experienced when working with students. They are aware of their professional responsibility to supervise the student appropriately and to provide timely and appropriate feedback that supports the student’s development and progression. Opening up their practice to scrutiny presents some risks for midwives, especially if students do not understand their practice. It may also create tension in some partnerships with women and the LMC midwives were careful to make their expectations clear to both the student and the woman. Failure to do so could impact on their income if women were unhappy and did not promote the midwife or seek her care in the future. While the added help from the student was welcomed the midwives also enjoyed the independence of working alone and providing one on one care to women.

Chapter Four - Discussion

Overview

While midwives acknowledged their professional responsibility to work with midwifery students they also expected a break as they enjoyed the opportunity to practice independently of the student. When commencing a placement the midwives sought to establish a relationship with the student to help understand the student's learning needs and to support her access to learning opportunities. The midwifery school has a responsibility to support the placements by ensuring students and midwives are adequately prepared with clear expectations. Further support with assessment processes will alleviate the midwives' anxiety regarding this.

The teaching relationship

A trusting relationship is required between the midwife and student if the student is to share her thoughts and feelings and feel supported by the midwife. In sharing their knowledge and expertise the midwives are investing in the students' development, and consequently in the future of midwifery. When a mismatch of expectations or miscommunication occurs the placement may become troubled with both the midwife and the student being disadvantaged. The student may be perceived to be lacking knowledge and the midwife may be frustrated at the student's perceived inability to provide the level of care that she is expecting. These tensions may impact on the student's confidence and this can influence the midwife's desire to work with students in the immediate future. In this situation the midwifery school has a strong role to play to identify the issues early and either mediate or terminate the relationship.

The relationship between the student and the midwife is a professional one that seeks to support the student in her learning. However the distinction between the midwife providing support as opposed to counselling for the

student is sometimes lost and this means the midwife is required to provide support and emotional care not only for the woman but for the student also. This increased workload may be draining for the midwife who finds herself in multiple and possibly conflicting roles as a teacher, counsellor and assessor of the student and this may influence the objectivity of the assessment process. It is important that students learn to work within the boundaries of professional relationships to avoid overloading the midwife and for their own future development.

Developing professional knowledge

When students enter the clinical workplace they are exposed to the shifting and often exhilarating world of midwifery practice. While students learn how to perform routine tasks and skills, it is their learning of the 'mix and match' of this that suggests they are beginning to appreciate the flexibility and complexity that makes up midwifery care. Not only is the student learning to provide evidence based care that is tailored to the woman's needs, she is also learning to continually evaluate the relevance of this care by reflecting on her practice. Just as with mastering any new skill students need time and repetition to ensure they can perform the required tasks in an effortless collaboration and develop their own pattern of caring. While each skill on its own may not represent a challenge, it is the bringing together of these that signifies movement toward working as a midwife and is part of the learning within year three.

To develop this critical thinking process within the student, the midwife must be able to articulate her thinking to the student. Behind each decision the midwife makes is a raft of knowledge, beliefs and values that influence her practice. The midwife must understand the importance of this otherwise she is unlikely to place any value on this process and this can be to the detriment of the student's learning. At times the midwives found it tiring and difficult to articulate their thinking process since they made decisions 'automatically'.

This apparently effortless decision making is evidence of expert practitioner status however by describing their practice the midwives are able to gain a greater depth of understanding about their own ways of working. This is described by Best & Edwards (2001) as a means of increasing the professional knowledge of the practitioner and hence of benefit to the midwife.

Midwives introduce students to the social and ethical context of practice and this influences the students' understanding of the culture of midwifery and their place in it. These clinical experiences are powerful learning opportunities for students and can outweigh the theoretical teaching that is provided within the midwifery school since the student learns that this is what it is 'really like' in practice. The expectation within the profession is that midwives will model midwifery practice that is of a high standard and clearly explain the rationale for any variations they may use. Failure to do this puts the student at risk of learning poor practice habits with flow on consequences for her future practice.

Since real practice presents as a blending of many situations students need to be able to improvise using their existing knowledge and experience and build on this to further develop their knowledge. This requires exposure to many different situations, both clinically and through stories, with support required at times to identify the learning that lies within each experience. Due to the unpredictable nature of midwifery practice, learning opportunities arise that cannot be planned for. A student who is not able to identify these learning opportunities risks becoming frustrated by their clinical experiences as they may not have the overview of what is happening and thus fail to access the learning available to them. Those students who are strategic learners may only see value in learning that meets their immediate perceived needs and not value learning for its own experience. For the midwives the

student is placed with, this lack of flexibility may result in mismatched expectations and frustrations within the placement relationship.

Story telling has a strong role in midwifery education however issues arise concerning the appropriate use and confidentiality of these. Early in the programme students share their own pregnancy and birth stories but these have limited use in the clinical setting where the focus is on the woman. The boundary regarding what and when it is appropriate to share their story is poorly defined and this is problematic for some students who do not understand this wavering line between establishing a rapport and the behaviours that are expected within a professional relationship. Following their clinical placement students share stories of their experiences amongst their class mates and these must be tempered with the requirements of confidentiality since it can be easy to identify individuals. Students need to respect the knowledge they gain as part of their work experience and appreciate the potential risks with the information they hold. This is part of their learning, and failure to manage this responsibility damages the professional status the student is aspiring to achieve.

Being able to communicate by *a look* when in clinical placement suggests a strong sense of shared understanding between the midwife and the student. This silent communication is important in midwifery where every word and action seeks to reassure the woman and her family that all is well. While the external veneer of the midwife may appear calm, underneath she is thinking about what may occur and is working to ensure she is prepared for this possibility. Students must learn to understand and work within this aspect of midwifery culture and this is part of their learning while in clinical placement. Initially at least, the risk for miscommunication is high given the subtle ways that information, thoughts and feelings may be communicated within such a setting.

A demanding profession

The midwives expected the midwifery students to demonstrate their enthusiasm for midwifery. This enthusiasm could be considered mandatory when working in a profession that is so demanding of individuals and is often in the media spotlight since this would be expected to sustain the midwife/student through the difficult times of their working life. However it may be challenging for some students to uphold this enthusiasm when they are facing multiple demands from study, clinical placement and family and they are tired and feeling overloaded. For students who have been full time mothers becoming a midwife is a big change in lifestyle for both themselves and their family. Learning to work as a midwife requires the student to manage these demands and to learn to negotiate their needs both with their family and with future colleagues and peers in order to succeed.

The midwives expected a high level of commitment for themselves and the students and this calling to public service is described as a hallmark of a profession (Cruess et al, 2004; Hampton & Hampton, 2000). However the expectation that the midwife/ student should leave their sick child for another family member to care for suggests an underlying culture whereby the midwife prioritises her work over her family demands. This suggests the midwife is indispensable in her work setting but replaceable in the home setting. Other writers have described the "notions of hero, martyr (and) workaholic" which permeate the workplace culture of midwifery (Lynch, 2002, p.183). These notions flow through the midwives' accounts of managing the conflicting demands of family and work which were described as difficult but unavoidable. As women we have sought to have it all – the career, the family and a life for ourselves. In fact this suggests that something has to give and in this situation it is the family that must support the midwife in her practice. As health professionals midwives are expected to model behaviours that support their own well being and failure to do this may result in burnout. However the dialogue suggests some midwives have yet to master the

balance of family and work demands and this has implications for students' perceptions of the demands of midwifery practice.

Tensions in the relationship

Midwifery practice is intimate and the misalignment of the student and midwife has the potential to create tension within the work environment. Midwives often work in isolation from each other, coming together when issues arise or at regular intervals to debrief and discuss their practice. To support the student's learning requires ongoing debriefing and explanation by the midwife describing her thinking and practice however this talking and critiquing is in contrast to the normally quiet and insular workplace of the midwife. This contrast could create tensions particularly if the student and midwife do not share similar ways of working and interacting.

The time that LMC midwives and students experienced together in the car and at clinic seemed to benefit both by ensuring they had the time to debrief with a focus on the student's learning needs. This was not the same for DHB midwives who cited busy-ness as the reason they did not debrief beyond a superficial level with the students they are working with. Unlike LMC midwives, DHB midwives have little control over their workload and chronic short staffing means that in many DHB placements students work with a different midwife each day due to roster demands. Hence the DHB midwives are less likely to develop strong relationships with the students they are working with and this will influence their experience and own learning. While recognition of the time required to work with a student should be factored into the workload of DHB midwives this is unlikely to occur in a culture of short staffing.

As a self employed practitioner the LMC midwife's workload is influenced by the reputation she has in her community. The relationship the midwife has with the woman and the care she provides will help determine how sought

after the midwife's services are. Invested in this relationship is the implicit expectation by the midwife that the woman will seek her services for subsequent pregnancies and will promote the midwife's services amongst her community. Bringing a student into this relationship carries risk for the midwife that this relationship will be interrupted by the presence of the student. For a midwife who is well established in her practice this offers little in the way of a threat however to a newly established practitioner this could adversely affect her caseload and subsequently her income. For these midwives a third year student may represent a possible threat to her livelihood, rather than a future colleague to be encouraged and nurtured. Fisher (2009) describes similar findings where midwife mentors "sought to meet students' learning needs but also felt protective of their own relationships with their clients" (p.322).

Throughout their midwifery education students are working toward meeting the competencies for entry to the register as a midwife. This requires students to take what was described as a *leadership role* when working with women. To enable this, the student must first be confident in her relationship with the midwife and the woman. Since the student often comes to the placement once a relationship between the woman and the midwife is established this requires the student to negotiate an understanding of the expectations held by the midwife and the woman. If these are not explicit this may impact on their relationships and thus can affect the learning opportunities for the student when working with the midwife. In effect the midwife is the gatekeeper to the relationship since how much she invites the student to participate will determine the experience the student gains.

When accepting a student for placement the midwife needs to ensure the student has access to the appropriate learning opportunities. To enable this, women in the midwife's care must agree to allow the student to be present and for the student to provide aspects of her care. This may represent a

conflict of interest for the midwife should the woman decline to allow the student access or limits the students' involvement. If this occurs the midwife is not then able to provide the learning opportunities to the student that she had expected to. This may create tension within these relationships as the student is excluded from her expected place alongside the midwife while the midwife continues with her relationship with the woman.

Who is supervising?

The quality of midwifery supervision is important to the student's progression and will influence their development. While the midwife needs to use her judgement to assess the supervision the student requires, there are legal requirements for care to be supervised by a registered midwife. Historically midwifery has been taught in an apprenticeship style with the student providing increasing care independently as she progresses in her learning. In this era of litigation and complexity of care strong clinical supervision and debriefing supports the student's learning and development toward professional and autonomous practitioner status. When a midwife does not provide appropriate supervision she risks undermining the professional and self regulatory status that midwifery has attained since she breaches the trust placed in the profession by society. Without appropriate supervision midwives will have difficulty assessing the student's level of knowledge and performance. This limited feedback does not provide the same opportunity for students to refine their practice and they will assume they are functioning at the appropriate level.

The midwives perceived students were *double checking* their practice. While students may ask questions about the midwife's practice and share the learning that they have gained to date, as a beginning practitioner the student is not well placed to understand the many influences on the midwife's decision making. Therefore the midwife, as the health professional carries the responsibility to debrief with the student and ensure the student

understands her decision making, since this is part of the student's learning. If this does not occur the students' discussion may be misinformed and this carries a risk for the midwife's practice to be misunderstood. Students can be challenging and judgemental of a midwife's practice and midwives require resilience to manage this critique of their practice. While it is in the interests of the profession for midwifery practice to be transparent the influence of the media and societal expectations creates a risk in this for the midwife and the profession if this is not understood.

Assessment concerns

Midwives are required to apply their judgement regarding the student's ability and what her learning requirements are in order to provide opportunities for her to further her learning. While students have learning objectives for each placement, they often 'do not know what they do not know' and this requires the expertise of the midwife to identify these gaps. When midwives encourage students to *step up* by putting the student forward to provide care they have assessed the student as capable. However students tread a fine line between appearing *uppity* or *taking the initiative* and this may make it difficult for the midwife to correctly identify the student's true level of ability or knowing. This also requires the student to determine and then negotiate the level of interaction with the midwife that will enable her to gain appropriate experiences during the placement. If the student is too hesitant she may be perceived as not interested, however if she is too forward she may be seen as over confident. In effect she needs to learn how to be a 'good student'.

The inconsistency of student skill levels described by the participants is of concern to me since this undermines the assessment process. The midwives expressed concern regarding their role in failing a student, yet equally they were unhappy with students who failed to meet the expected standards. Sharples et al (2007) describe the difficulties midwives had with failing students and the support they required once a student failed. As health

professionals midwives are accountable for their assessments of students but their anxiety about the process and accuracy of their assessments suggests midwives need more direction and support with this. The midwifery school has moved to support midwives in the assessment processes by undertaking assessment with the midwives using three way conversations and midwife feedback forms.

When seeking feedback from midwives working with students a conversation elicits more information than written feedback since nuances in conversation enable potential issues to be explored in a timely manner. Many of these potential issues related to the assessment of professional behaviours and the midwives found this feedback more subjective and difficult to articulate. The ongoing dialogue increases the flow of information between the student, the midwife and the midwifery school and provides support for the midwife and promotes appropriate feedback for all parties involved. This also recognises the midwife's place within the team that is supporting the student's development.

Learning the dance of knowing

The midwife and student participate in an intricate dance throughout their relationship as they learn to work with each other and learn the skills and ways of knowing that are midwifery. While the success of this relationship is dependent on many variables being recognised, the nature of these suggests they may not be self evident since these include the assumptions and expectations held by each partner, and the influences of the multiple roles they may take. Immersion within clinical practice exposes the student to the many intricacies that make up midwifery and the student must be vigilant to identify the subtleties that are around her and learn to respond appropriately. As the professional guide the midwife must make these 'rules' clear to the student. However as a beginning practitioner the student may be awkward and require direction from the midwife to support her development and

understanding. These may be her first steps toward learning to manage professional relationships.

By working with students midwives share their knowledge and expertise and this contributes to the growth and development of the profession. When midwives are reluctant to share their knowledge, or feel uncomfortable correcting students this creates a situation of risk whereby the student fails to gain the expected learning, and at worst perpetuates ways of practice that may be harmful. As a new comer to the dance the students do not know all the steps or the different ways these may be forged to make up a new dance. It is the need to understand and learn to work with this complexity that is so important in the student's learning if they are to develop professional behaviours.

Midwives work with risk on a daily basis and they learn to manage this. They practice within a framework which may include ways of working and support networks, and this enables them to feel confident within their practice. Introducing the student into this delicate balance may upset the equilibrium since the daily rhythm is altered. Clinical experiences may trigger unexpected responses within students and while most midwives can accommodate this there are times when this may be tipped too far. Hence midwives need to be prepared and supported when working with a student to facilitate the student's learning from the clinical situation. Clinical placement experiences leave some students feeling as if they have two left feet and are always in the wrong place while others will discover they are natural dancers.

What can the school do?

The midwifery school has a role to prepare midwives for the reality of working with students in clinical placement. However it turns out that information sent to the midwives prior to the student commencing placement was not read as the midwives regarded it as too wordy. This suggests the midwives did not

value the information provided even though they appeared to recognise a professional obligation to prepare for the student they are to work with. In response the midwifery school has sought to make this information more succinct and will assess this within the feedback from midwives. The introduction of preceptor workshops for midwives and three way meetings between the midwife, student and midwifery school has increased the knowledge the participant midwives have of their role when working with students and about the work of the midwifery school. Feedback from the midwives has been positive regarding this increased support and this was also evident in UK studies of midwifery mentors (Finnerty, Graham, Magnusson & Pope, 2006; Nettleton & Bray, 2008). By supporting the midwives when assessing students in clinical placement it is anticipated the assessment process will be strengthened and be more consistent while also increasing the midwives' understanding of the students' level of skill and the assessments undertaken.

The preparation of students for clinical placement is equally important. Students need to have the expected skills and an understanding and sensitivity of the culture they are entering. While they are learning to function in a new environment they need ongoing and consistent feedback on all aspects of their work and behaviour to support their development. Learning professional behaviours requires clear standards and expectations that are modelled by midwives both in the midwifery school and in clinical placement. Since professional behaviour is not self evident to all students midwives need to provide consistent and timely feedback to those students who do not behave in a professional manner.

Considering the context of midwifery practice within a demanding profession and the ongoing public scrutiny and tensions within society, I acknowledge the conflict that midwives can experience as they seek to meet the needs of women and students. While for most placements these would be in

alignment, for those occasions when they are not this may create considerable tension for the midwife as she seeks a solution. It is understandable that midwives are anxious when placements are not harmonious since the flow on effects within their practice may be unpredictable. The midwifery school has a responsibility to place students thoughtfully with awareness of the need to minimise potential tensions while continuing to expose students to a variety of practices. Should issues arise the school needs to mediate or terminate the relationship while supporting the student and the midwife.

The participants welcomed a close relationship with the midwifery school to support their work with the students. This is also described by Fisher & Webb (2009) who found that mentors wanted more recognition and support in their role. The midwives requested clear information about what was expected of them during the placement and what the assessment criteria is. They preferred phone or face to face contact on a regular basis throughout the placement. The midwifery school can provide reassurance to midwives that the student's placement and experience was appropriate by providing feedback from the student. However this does not seek to assess the midwife's practice rather it describes the learning opportunities that the student experienced and the actions that supported her learning. While this does not occur currently this would support midwives to gain a deeper understanding of the student's learning experience and requirements and will be included in future practice by the midwifery school.

The sharing of midwifery practice is an important part of understanding the positioning of midwifery in New Zealand. Anecdotally I suggest that many midwives underestimate how important their every day practice is and the learning that takes place when this is discussed. The NZCOM Journal seeks to publish contributions from midwives in practice to promote the sharing of such knowledge and this exploration of the everyday practice of midwifery

gives voice to a rich dialogue about the nature of midwifery and the beliefs and values that inform midwifery practice. By sharing these aspects of daily practice within exemplars of midwifery care midwives share the knowledge that students are seeking and can model ways of maintaining confidentiality within story telling. This is evidence of midwifery's unique ways of knowing and failure to value this relegates midwifery knowledge as less important than other ways of knowing.

The participants expressed a desire for the focus groups to become a regular event to enable them to feedback their experiences to the school on an annual basis. Facilitating an annual focus group would enable the midwives to feedback directly to the school about their experiences when working with students. This open dialogue would support the position of the midwives as practice partners and acknowledge the importance of their role when working with midwifery students. The effect of the group setting enables midwives to give voice to events that may appear trivial, but have the ability to upset the balance of the relationship between the midwife, woman and the student and impact on the placement experience. It is these midwives who provide the clinical learning opportunities to the students and our strong relationship is critical to ensure students access timely and appropriate learning throughout their midwifery education.

Limitations of this research

As with much qualitative research this thesis gives voice to a small number of participants who work with student midwives regularly. While some of these findings may be transferable to other groups of midwives they are not generalisable. However I hope the findings may find resonance amongst other midwifery educators and midwives who work with students since it is recognition of this voice that validates these findings. I have struggled at times to keep the midwife voice separate from that of the researcher and I have revisited my writing and thinking with the aim of maintaining some

separation. However my world view will always be shaped by my life experiences and within this midwifery is a strong influence.

The midwifery school has undergone a transition during the time this research was undertaken. We have many new staff and we are incorporating new systems within our teaching delivery. The new curriculum introduced in 2010 has enabled the teaching staff to review every aspect of delivery and this has challenged our assumptions about teaching and learning. This study has influenced our decision making regarding how we undertake clinical supervision and clinical assessment processes have been modified in response to the midwives' feedback.

Indications for further study

The focus of this study has been on the experiences of midwives who work with students however there are other voices, such as midwives who do not work with students, students themselves and the families who support midwives, which are not documented in the literature.

While the majority of midwives do work with midwifery students the views of those midwives who do not may provide an understanding of the beliefs and experiences that have influenced their decision. This could also consider how the midwives position themselves in regard to their professional responsibilities to work with midwifery students.

As this study progressed the absence of the voice of New Zealand midwifery students within formal research became more evident. While I have anecdotal evidence from midwifery students regarding their experiences in clinical placements formalising this voice would be of benefit to the decision making that occurs around students' learning. Research considering the students' experiences and what constitutes a good learning opportunity for students would add to our knowledge.

I had not expected the experiences and views of the DHB and LMC midwives to be very different. However it became apparent that despite some core similarities there were differences between the experiences of these two groups when working with students. Much of this seemed to hinge around the fact that DHB midwives worked with many different students whereas LMC midwives focused on one relationship at a time. This resulted in LMC midwives knowing their students more intimately due to the longer time they spent together. Extended periods of time travelling together to provide midwifery care provided further opportunity for discussion which does not occur in a DHB setting. The nature of the work undertaken by LMC also ensured the women they cared for met and knew the student. However in the DHB setting students were exposed to different relationships due to the rostered nature of the midwives' work and the high turnover of women who require tertiary services. Further work with DHB midwives would increase knowledge about their experiences when working with students.

The midwives demonstrated a high level of commitment to the profession and it was apparent that the support of their families was a requirement to work successfully as a midwife. Research that explores the experiences of families who support midwives in their practice would be of value to the families who support midwives, and to prospective students and their families.

Communication is a cornerstone of midwifery practice. A breakdown in communication may impact on the care the woman receives and her satisfaction with her experience. Research into midwifery ways of communicating including the story telling that occurs and the subtle ways of sharing information that occurs in the birth room, would allow an exploration of this important aspect of midwifery culture in New Zealand.

Conclusion

By the third year the midwives expected the students to have mastered the required midwifery skills and have a strong knowledge base to build from. They expected students to be aware of the bigger picture and to be responsive to the demands of their work and not just focused on completing tasks. Midwives were frustrated when students could not manage this and did not appear to understand appropriate professional behaviours and boundaries. The midwives described the difficulties they had in providing feedback to students, particularly negative feedback and predominantly this was related to breaches of professional behaviour. Since much of the student's learning comes from what they observe in clinical the midwives have an important role and included in this is feedback to the student. Failure to provide appropriate feedback may result in students perpetuating behaviours they believe are correct and this carries risk both for the student and for those she works with.

The midwives enjoyed regular contact with the midwifery school to support them when working with students. They expressed anxiety around assessment processes and getting this right and expressed their frustration with inconsistency in previous assessment they experienced when working with students. Work by the midwifery school seeks to increase the midwives' knowledge of assessment requirements using Preceptor Workshops and midwifery tutors to work alongside midwives for assessments. The midwives enjoyed the learning they gained from working alongside students and found this beneficial to their practice knowledge. While tensions arose at times between some women and students, most placements were a positive experience and the midwives took pleasure in the student's progression through the programme.

Midwives have a professional responsibility to work with students to enable their knowledge and experiences to be passed on. In doing so midwives also

gain valuable learning opportunities for themselves as they experience greater insight and understanding of their own practice. This building on current knowledge is one of the hallmarks of a profession and is important for its ongoing development. However midwives also face multiple tensions and these must be acknowledged and mitigated, if possible by both the school and the profession. It is by nurturing our emerging midwives that we strengthen the midwifery profession as today's students are the practitioners of tomorrow and their knowledge and confidence in women and birthing will be testament to the support and nurturing they have received from the midwives of today.

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Appendix 1

Factors that encourage midwives to work with third year midwifery students

Information Sheet

I am embarking on a research project as part of the requirements for my Master of Education degree at the University of Waikato. Within the course of my work as a midwifery lecturer I became interested in students' experiences when working with midwives. There is a considerable amount of literature describing this but very little describing how midwives experience this relationship. Since midwives provide a very important component of the students' learning experience I believe the midwives experience needs to be better understood. Topics for discussion will include the role of the midwife, the student and the midwifery school in facilitating this relationship for learning. It is hoped that the research will assist midwifery educators to provide quality clinical experience and learning opportunities for students, and to identify what supports are required by midwives. Your experiences are very important in helping us as education providers to grow high quality midwifery graduates and I welcome your contribution to midwifery knowledge in New Zealand.

I invite you and your colleagues to participate in this research if you are a midwife who works with third year midwifery students in a community or hospital setting. Participation would involve completing a short demographic profile and then participating in a focus group session lasting a maximum of 2 hours. The group would consist of no more than seven midwives representing both core and lead maternity carer settings. This will be held in the community at a time and place that is suitable for all participants.

Your information will be anonymous and participation is voluntary. The completed research will be submitted for publication in the New Zealand College of Midwives journal and the information will be used for presentations to interested parties.

If you are interested in participating I would be pleased to hear from you to discuss the possibility further. You can contact me either by email: liz.james@wintec.ac.nz
Or by telephone: home (xxxx) or work (834 8800 ext 8620) for further details.
Please feel free to ask me any questions about the research before indicating your willingness to consider the possibility of involvement.
My supervisor is Dr Wendy Drewery (address in letterhead).
Thank you
Liz James

Appendix 2

Coffee? Midwives love to talk and share food. Come and join a group of midwives for a discussion about working with midwifery students

In my work as a midwifery lecturer I hear many of the students' stories from their clinical practice. Students' experiences are well documented in literature; however there is very little information about how midwives experience this relationship. Since clinical placement plays a very important role in the students' education I believe it is important that midwifery schools work alongside midwives.

I am currently completing my Master of Education at the University of Waikato and this research is toward my three paper thesis titled ***Factors that encourage midwives to work with third year midwifery students***. I invite you to participate in a two hour focus group of about seven practising midwives, at a time and place to be arranged.

Topics for discussion include:

What are midwives thoughts and feelings about their work with student midwives?

What makes the placement work for you?

How can midwifery schools work with midwives to support the development of student midwives?

Please contact me if you are interested to help me in this project, or if you would like further information before deciding. I will return every call and would love to talk with you. The project has ethical approval from the University of Waikato School of Education and also from the Wintec Ethics Committee. Please be assured of your confidentiality.

Liz James
Wintec, Tristram Street, Hamilton
Telephone:
Email: liz.james@wintec.ac.nz

Appendix 3

Demographic profile for focus group participants

Have you worked with third year student midwives this year? Yes No

Where is your practice based? Hospital Community

How long have you been working as a registered midwife?

3 – 8 years 9 – 14 years 15 years plus

Is your midwifery qualification obtained in New Zealand? Yes No

How many years have you been working with student midwives?

1 – 3 years 4 – 6 years 7 years plus

What does your midwifery practice mainly comprise of?

Secondary/tertiary hospital	mainly	some few
Primary birth centre	mainly	some few
Homebirth	mainly	some few

Appendix 4

Factors that encourage midwives to work with third year midwifery students
Participant Consent Form

I …….. consent to being a participant in the above named research project and I attest to the following:

1. I have been fully informed of the purpose and aims of this project and the nature of my participation
2. I understand the benefits that may be derived from this project and I have been informed of any potential harmful consequences to me by taking part in this project
3. I understand that I will be treated respectfully, fairly and honestly by the researcher and I agree to treat the other participants in the same way
4. I understand I will be offered the opportunity to debrief during or at the conclusion of the project
5. I understand I may withdraw from this project before commencement of the group process
6. I understand that my anonymity and privacy are guaranteed, except where I consent to waive them
7. I understand that information gathered from me will be treated with confidentiality, except where I consent to waive that confidentiality
8. I agree to maintain the anonymity and privacy of other participants and the confidentiality of the information they contribute

□ Please mark the box if you would like a copy of the completed research. Please include your preferred contact address

_____

Participant……..Date…….

Researcher……..Date……

If you have any further questions please contact me or my supervisor.

Researcher: Liz James
Waikato Institute of Technology
Private Bag 3036
Hamilton

Supervisor: Associate Professor Wendy Drewery
Department of Human Development and Counselling
School of Education
University of Waikato
Private Bag 3105
Hamilton

Appendix 5

Themes for focus group

Tell me about those factors that contribute to a successful relationship you had with a student midwife.

How do you create a relationship with the student?

What do you see as the role of the student?

How would you describe the midwives role?

What do you see as the role of the midwifery school?

Midwives identify themselves as a profession. What would describe as attributes of a profession?

Can you describe how you would manage conflict in the relationship you may have with a student?

What would you like midwifery schools to do to support you to provide clinical experience for a midwifery student?