Implementing a narrative-centred curriculum in an undergraduate midwifery programme: A hermeneutic study

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Andrea Gilkison Date

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Abstract

The impetus for this study was to explore the experience of using a narrative pedagogical approach in undergraduate midwifery education. A narrative-centred curriculum was implemented with the goal of facilitating midwifery students to be self-directed in their learning, to promote their thinking and improve the integration of theory and practice through interpretation of narratives.

This hermeneutic study poses the question: "what is the *experience* of midwifery teachers and students who participated in a narrative-centred curriculum?" The participants were 5 midwifery lecturers, the Head of Midwifery/Programme Leader and undergraduate midwifery students drawn from a class of 50 who were involved in the implementation of a narrative-centred curriculum in an Aotearoa, New Zealand University in 2005-2006. Data comprised teachers' research conversations, an interview with the Midwifery Programme Leader, students' focus groups and students' written reflections. The researcher has continued to be involved in this programme through the writing of this thesis.

A model based on Ricoeur's (1984) framework emerged, which shows how narrative pedagogy can be preserved within the taken-for-granted, *prefigured* world of university education. Narratives are not normally seen as integral to learning processes in the *prefigured* world of university education which has been underpinned by behavioural pedagogy, assessment processes and economic imperatives of education. This thesis argues that when the curriculum was *refigured* and a narrative-centred curriculum was implemented that students learned about the art, or *phronesis* of practice, and the tact of teaching became evident.

In the *prefigured* world of university education, student pass rates (student outcomes) are the measurement for the success of the programme, not the curricular processes (how students got there). This research is significant because it has shown how the art of practice can emerge when narratives are central to teaching and learning. This study has also shown how narrative pedagogy can be preserved within a *prefigured* world which privileges the outcomes of education over the process of education.

Chapter One: Introduction

The research question, purpose and aims of the study

This thesis tells the story of how a narrative pedagogical approach was implemented in an undergraduate midwifery programme in Aotearoa[1] /New Zealand. In 2005, a new narrative-centred curriculum was introduced into an undergraduate midwifery programme. This study focuses on the experience of the group of midwifery teachers and students who were involved in implementing the new curriculum. The question of this participatory hermeneutic study is "what is the *experience* of midwifery teachers and students who are participating in a narrative-centred curriculum?" The purpose of this study was to add to the understanding of the use of a narrative pedagogical approach within tertiary[2] education.

Through interpretation of the experiences of midwifery teachers and students who were using a narrative-centred approach, this study illuminates educational practices which occur when narrative pedagogy is used. Questions are raised and tensions are explored regarding the educational aspects and the implications of using a narrative-centred curriculum for midwifery education. The insights will assist others who would be interested in using this approach in midwifery or other educational settings.

Defining pedagogy

In this thesis the term pedagogy is used to mean the way teaching and learning is conceptualised including what is taught, how it is taught and how it is learned. The term pedagogy comes from the Greek *Paidagogos* which was the name for a slave who escorted boys to school (Sheehan, 1988). The dictionary definition of pedagogy is “the art, science or profession of teaching” (Merriam-Webster, 2009). The term has come

[1] Until the 20th century, Aotearoa was used by Māori to refer to the North Island of New Zealand. In post colonial times, it is more commonly used by both Māori and non-Māori to refer to the whole of New Zealand.

[2] Tertiary education in New Zealand refers to post secondary school education programmes. It includes Universities and Polytechnics. Tertiary institutions may offer undergraduate and postgraduate degree and diploma courses.

to broadly mean a way of thinking about education or as Diekelmann and Diekelmann (2009) note: pedagogies are "specific approaches to schooling, learning and teaching [which] help describe the philosophical and epistemological presuppositions that ground both research and practice in education" (p. 333).

Narrative pedagogy is one pedagogical approach which evolves when students, teachers and clinicians communally share and interpret narratives of their experiences in education and clinical practice (Diekelmann & Diekelmann, 2009). Narrative pedagogy can underpin any teaching strategy; it is not a particular teaching method. A narrative-centred curriculum is one interpretation of narrative pedagogy whereby the educational focus is on the interpretation of narratives, and these narratives are central to the learning of course content.

This thesis explores the experiences of midwifery teachers and students, when teaching and learning is based on narratives, and portrays these experiences over the first year as the narrative-centred curriculum was introduced. This study is committed to understanding participants' experiences, to facilitating an open dialogue between the participants in the research (midwifery teachers and students) and the researcher, and to present an authentic and compelling narrative describing this experience. The aim is to create a text which will show *where we have been, where we are and where we are going* with a narrative-centred curriculum in midwifery education.

The research methodology of this thesis is participatory hermeneutic inquiry underpinned by the philosophy of Paul Ricoeur. The basis of participatory research is that the researcher and research participants create a text which reflects their shared understandings and experiences (Herda, 1999). As I am both researcher and midwifery teacher, and a part of the research group, when writing about the group of midwifery teachers who were involved in this research, the terms ‘we’ and ‘our’ are used as this study aims to reflect the shared experiences of us as a research group.

This chapter sets the scene for this research, explaining my philosophy of midwifery and education, my pre-understandings, how the midwifery school came to be using a narrative-centred curriculum and the aims and approach of this research project.

The context of midwifery in Aotearoa, New Zealand

In Aotearoa, New Zealand today, primary maternity care is provided by Lead Maternity Carers (LMCs) who work under the Health Practitioners Competence Assurance Act (2003a). Women may select the LMC they wish to provide their maternity care. This may be a midwife or a general practitioner with a diploma in obstetrics or an obstetrician. Over 75% of women choose a midwife as their LMC (New Zealand College of Midwives, 2010). A woman's LMC takes responsibility for the care provided to her throughout pregnancy and the postpartum period including the management of labour and birth. Midwives who are self employed LMCs claim payment from the government for their services, so that maternity care is free for all eligible women in Aotearoa, New Zealand. Women may give birth at home, in primary maternity facilities or birthing centres, or in secondary maternity hospitals (New Zealand College of Midwives, 2010).

Fundamental to the way midwives work with women in Aotearoa, New Zealand, is the model of partnership (Guilliland & Pairman, 1995). The scope of practice of a New Zealand midwife is defined thus:

> *A midwife works in partnership with women on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.*
>
> *A midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance and implements emergency measures as necessary. When women require referral, a midwife provides midwifery care in collaboration with other health professionals.*
>
> *A midwife has an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.*
>
> *A midwife may practice in any setting, including the home, the community, hospitals or in any other maternity service. In all settings a midwife remains responsible and accountable for the care she provides.* (Midwifery Council of New Zealand, 2007, p. 2)

To register as a midwife, in Aotearoa, New Zealand, students complete a three-year bachelor's degree through one of five accredited universities or Polytechnics in New Zealand. At the end of the degree, students sit a national examination, which if they are successful, leads to registration with the Midwifery Council of New Zealand (New Zealand College of Midwives, 2010).

My journey towards this research

The idea for this research was seeded in my personal experience of becoming a mother. The midwifery care I received when my first daughter was born at home in 1978 prompted me to consider midwifery as a very worthwhile career and something which I would like to do. In 1978 it was necessary to be a registered nurse before one could study midwifery. My nursing and midwifery education was through a 'new' Polytechnic[3] system. Prior to this time, nurses and midwives had been educated through hospital based education programmes where students were part of the workforce, attending lectures on study days. Polytechnic students were full time students and when we went to our clinical placements we were there as students, not as employees. Our nursing training at that time was controversial because it was based in an educational setting rather than in a hospital. Some people questioned whether we would have enough practical experience to function competently. Being a student in a new curriculum was one of the triggers for my ongoing interest in questioning the best way to educate people for the health professions.

Once I qualified as a midwife I worked in different midwifery environments including a base hospital postnatal ward, provincial hospital delivery unit, and as an 'in-service educator', providing ongoing education for registered midwives. For nearly ten years I practiced as an independent (self employed LMC) midwife[4] attending mainly home births and small maternity unit births. I would often have student midwives working alongside me and clinical teaching was something which I really enjoyed.

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[3] A Polytechnic in New Zealand is a non-university tertiary education provider. During the time that I studied a Polytechnic could confer diplomas and certificates (not degrees).

[4] In New Zealand an independent midwife is self employed and contracted to the Ministry of Health to provide maternity services to women and their babies throughout pregnancy, labour, birth and the postpartum period (Ministry of Health, 2007).

When my family and I went to live in the United Kingdom in 1997 I was unable to gain registration as a midwife. I had the opportunity to work as a tutor, facilitating tutorials in the medical school at the University of Liverpool. This medical school based its curriculum on Problem Based Learning (PBL). There were about 10 out of 30 PBL tutors who were not medical doctors but were employed solely to facilitate PBL tutorials. This involved working with groups of about 10 students at a time. Thus, from day one, rather than the traditional lecture and laboratory format, medical students worked in groups with a tutor. Students used a PBL process to analyse a written case scenario, and determine for themselves the knowledge they would need in order to understand the case. At the end of the first tutorial each group would determine their set of learning objectives and then spend the rest of that week researching their answers. We would meet again twice over the next two weeks to discuss the learning that was emerging. This way of learning really fitted with my philosophy of education. I was inspired by being involved in students' discussions and sharing in their learning in this way.

The PBL curriculum that Liverpool used was not new, it had been used in medical education since the mid 1960s. Employing tutors who were not medical doctors to facilitate tutorials however, was quite novel. I discovered there was a lot of debate in the literature regarding the background of tutors who facilitated PBL groups, particularly whether it made a difference if the tutor had a medical background or not. This inspired my Masters research (Gilkison, 2000) which explored the effective facilitation of PBL tutorials.

In 2001, my family and I were at the point of returning to Aotearoa, New Zealand and I knew that I wanted to teach midwifery. Hence, I contacted Auckland University of Technology (AUT) from the UK and later that year, came back to teach midwifery. I was really excited to be able to combine midwifery and education; it felt as if a lifelong ambition had been realised. But I was in for a shock!

My first teaching session

The educational environment at AUT seemed so different from what I had experienced in Liverpool. At first I sat in with the other teachers to 'see how it was done'. The way it worked was that each teacher was assigned certain sessions to teach. It was up to the individual teacher to decide what was important for students to learn and how they

would teach that topic. I felt it was best to base my teaching on what had been taught to the students the year before and what was in the text book.

I recall with clarity my first teaching session on post partum haemorrhage (PPH); I looked at what had been done the year before and prepared my lecture with overhead transparencies. One of my colleagues sat in on my lecture as support. My first overhead was the 'definition of a PPH', which I had copied from the textbook "PPH is defined as bleeding from the genital tract in the first 24 hours after childbirth which results in the woman having symptoms of excessive blood loss" (Sweet, 1997). My colleague put up her hand and said: "Ah excuse me, but actually that's not what we teach, we teach that PPH is blood loss of 500mls after childbirth. That's the definition which is required in the State (final midwifery) examination." I wished the floor could have opened and swallowed me up. Not only had I, the expert midwife teacher, given the students wrong information, I had told them something which they might have got wrong in their examinations. I felt that the students must have thought I was really stupid and would now not trust anything I said.

As I reflect on that first lecture, I realise that what was being challenged was not whether I had given the students incorrect information, but my philosophy of teaching and learning. When students were studying in a PBL curriculum, they would often come back to the group having found variable definitions from different sources. One of the purposes of the PBL tutorial was to discuss why this might be and what the implication of this was for practice. I became aware that students seemed to only want to learn to pass the examination. A common question from students was "will this be in the exam?" In other words, "is this important information for me to know?"

It appeared to me that midwifery team curriculum meetings were dominated by discussions about 'where to fit in new topics' or 'in what order to teach things.' New topics such as family violence prevention, HIV/AIDS and smokechange education seemed to be constantly added onto, and fitted in around, an already crowded curriculum. Teachers would debate whether students should study research (for example) in the first year when they know little, or in their final year when they know a lot.

My previous experience of working in a PBL curriculum (Gilkison, 2000, 2003, 2004) had shown me how the tutorial groups stimulated thinking and discussion and given the right environment, students are capable of being self-directed in their

learning. I began to think about how PBL could be applied to a midwifery programme. I considered that PBL's focus on client problems was not precisely suited to midwifery's focus on well women.

An introduction to narrative pedagogy

A colleague from AUT, Dr Liz Smythe, had met some nursing educators from the United States of America (U.S.A) when she had attended the Heideggerian Hermeneutic Institute in 2000. She had heard about some of the work they were doing using narrative pedagogy. Dr Smythe arranged for Professors Sherry Simms and Melinda Swenson to visit AUT in 2003. They shared their experiences of their Family Nurse Practitioner programme in which learning was based on narratives. A person or a family would come to talk to their students about their experience of say, diabetes or whatever the topic was the students were studying. The students then used this story (or narrative) as the stimulus for a PBL approach to learning. They called this a narrative-centred curriculum. Hearing about this curricular approach was a real "ahha" moment for me. It made so much sense to incorporate a PBL approach in a way that would fit well with midwifery culture.

I began reading Swenson and Simms work (2000, 2003) and others who were using narratives in their curricula. In my reading I kept coming back to the work of Professor Nancy Diekelmann (2001). Professor Diekelmann also came to visit AUT in the summer of 2003/4, and presented to lecturers from the faculties of health and education. Professor Diekelmann talked about the 'additive curriculum' which was a term she used to describe the proliferation of content knowledge that was being added to nursing curricula (Diekelmann & Smythe, 2004). To me this resounded with my experience in the midwifery curriculum.

After visits to AUT by Melinda Swenson and Sharon Simms in 2003, and John and Nancy Diekelmann in 2004, I began to think about some of my assumptions about education. I came to realise, through the stimulating and challenging discussions which I had with Professor Diekelmann and with Professors Swenson and Simms, that although the midwifery teachers often discussed *what* we would teach and *when* it should be taught, we rarely discussed *how* we would teach.

These visitors from the U.S.A spoke about *narrative pedagogy* and *narrative-centred curricula* approaches that they were using in nursing education programmes in

their country. Their way of thinking about teaching and learning challenged me to think about our approach to midwifery education at AUT. When these nursing educators spoke about conventional pedagogy and additive curricula, it resonated with me. I wanted to find out more about narrative pedagogy, to explore its foundations and how it had been used in other programmes.

After these visits, the midwifery teachers at AUT began to discuss ideas for improving our curriculum. We thought about the increasing amount of information we felt students needed, and the way that students tended to be more focused on learning to 'pass examinations' rather than 'learning to think.' It was within this context, of being shown other possibilities for the way that education could be, that prompted the idea for basing the midwifery curriculum on narratives.

The midwifery teaching team agreed that the best time to introduce this approach would be in the second year of the degree programme. In the first year, midwifery students are enrolled in several shared papers with all the other health faculty students. These papers are taught by lecturers from other disciplines, so we considered it would not be possible to use narrative pedagogy with those large classes. It was decided that the second year midwifery papers would be most conducive to using this approach, and the most appropriate given I worked in this year and my colleagues were also excited about trying a narrative-centred curriculum. The aim was to integrate this new curriculum throughout the three years beginning in 2005, to be fully integrated by 2008.

The midwifery teachers developed a second year paper entitled 'Art and Science of Midwifery.' Each of the five main themes of the paper were introduced with a narrative session. The narrative to introduce each topic was provided by a woman, a midwife, the students themselves, or in one case a digital narrative[5] provided a story to begin each topic. The narratives included: 'getting pregnant', 'being pregnant', 'in labour and giving birth', 'after the birth and the newborn baby', and 'breastfeeding a new baby'. After listening to the narrative as a whole class, students then divided into groups of 10-15, each with a teacher to interpret and discuss the story and what it meant for midwifery practice.

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[5] A digital narrative uses a combination of images, music, narration and text to create a multidimensional narrative (Gazarian, 2010).

Tutorial groups used an adapted PBL process to interpret each narrative and to identify their learning needs. The specific process is detailed in the preface to the findings chapters (p. 104). To summarise, students 'brainstormed' the issues which emerged from the narrative, grouped the issues into areas which were similar, and discussed what they would need to learn in relation to that narrative. Each group developed their own set of learning objectives which guided their learning for the next one or two weeks.

Each topic was supported with on-line material (content which would previously have been either taught or delivered in workbooks); classroom time to discuss the role of the midwife related to the topic, lectures and clinical skills laboratories.

At the end of the learning period, the group met again to discuss what they had learned. The purpose of the follow up tutorial was for students to explain things to each other, to share resources, to debate differences in information, and to discuss the relevance of their learning for midwifery practice.

Justification for the study

It seemed crucial to reflectively consider and critique the new curriculum as we implemented it. This is what forms the basis for this PhD study. To my knowledge, this is the first trial of a narrative-centred curriculum in midwifery education anywhere in the world. Also, I believe that this is the first time that experiences of teachers and students have been collected as the curriculum was being introduced. Other studies collected data retrospectively, once the course using narrative pedagogy had finished. Since the aim of this study is to document and interpret the experiences of teachers and students as we journeyed through the implementation of this new way of learning and teaching, the research has been designed to capture the experiences *as they occurred.* It is hoped that insights from our experience will assist others who wish to implement narrative pedagogy into their curricula processes.

Consultation and preparation for the study

The team of midwifery teachers at the University met throughout 2004 to plan and deliberate the changes to the curriculum. This curriculum change required many discussions and debates about the fundamental philosophy, along with structural changes to papers across the whole three years of the curriculum. The proposed curricula change was discussed at midwifery programme advisory committee meetings. This advisory committee meets twice yearly and consists of internal midwifery staff and external members, including representatives from consumer groups, women's health groups, practicing midwives, a New Zealand College of Midwives representative and District Health Board[6] representatives. This advisory committee was supportive of the fundamental idea for the introduction of the new curriculum.

Consultation and dialogue occurred with another committee which oversees academic quality for the midwifery programme; the midwifery programme committee. Every change to individual papers and the curriculum is discussed at this committee which consists of internal midwifery lecturers and university academics and external members including representation from consumer groups, practicing midwives and District Health Boards.

A 'Resources to Enhance Learning and Teaching' (RELT) grant was received in 2004 which allowed me time to set up the online component of the paper 'Art and Science of Midwifery I', and time to prepare for the research.

Pre-understandings

Pre-understandings are described as the researcher's prior understandings and assumptions about the topic being studied (van Manen, 1990). A researcher's pre-understandings shape the perspective, or assumptions which they bring to the study. These in turn shape everything about the research from the question asked to the way data is analysed. Pre-understandings cannot simply be put aside; hence, it was important to identify and address the pre-understandings which I brought to the study, prior to the commencement of this research. Rather than ignoring or setting aside the

[6] District Health Boards (DHBs) are elected bodies responsible for providing, or funding the provision of, health and disability services in their district (Ministry of Health, 2010)

prior knowledge and assumptions of how we come to research, van Manen (1990) suggests making pre-understandings explicit to prevent any hasty conclusions or expose superficiality. For me, I brought the traditions of my past educational experiences as a student, midwife and teacher to the interpretive process. Rather than putting my pre-understandings aside (Husserlian bracketing), throughout the research process I have made visible my pre-understandings and shown how they have affected my interpretations. Explicating a researcher's pre-understandings and showing how interpretive decisions have been made is a key step in establishing trustworthiness in qualitative research (Koch, 2006). Koch refers to this as 'reflexivity', or the reciprocal relationship between the researcher and the subject of the research.

One of the ways which I uncovered my pre-understandings was through being interviewed by one of my supervisors. This was a very helpful process as it revealed some assumptions of which I had not been overtly aware. As I engaged in this study I became increasingly aware of a range of assumptions that I had been holding about learning and teaching.

One assumption which I bring to this research is that students should be self-motivated to engage in their own learning. Given the right learning environment I assume that students will demonstrate a naturally enquiring mind and the motivation to search for answers for themselves. It disappoints me when students want to learn passively by expecting their teachers to give them all the answers.

I see my role as a teacher to work alongside students to facilitate their learning. I have always felt that teacher-student relationship is functioning well when there is mutual learning and teaching. It is this position which has led me to be disappointed at times when students do not trust their own ability to learn for themselves. It is also this position which underpinned my enthusiasm to lead the introduction of narrative pedagogy into the midwifery programme, and to concurrently begin this research. My position has held firm alongside some ongoing disappointments.

Overview of methodology and methods

The philosophy of Paul Ricoeur [1913 - 2005] underpins this hermeneutic study which is oriented to the interpretation of the experiences of midwifery teachers and students participating in a narrative-centred curriculum. Ricoeur's (1984, 1985, 1988) trilogy

'Time and Narrative' explored the concept of how we understand the world through narrative. Ricoeur (1984) described the way understanding is reached through a three step mimetic process. The first mimetic process, $mimesis_1$, is the world upon which preconceived understandings are based. Ricoeur names this the *prefigured world.* The *prefigured world* is based on history, culture, traditions, and assumptions. In this study the *prefigured world* refers to the preconceived understanding of midwifery education.

The second mimetic process, $mimesis_2$ which Ricoeur (1984) called *configuration* mediates the *prefigured world* with a future imagined world. *Configuration* shows the potential for new curricular possibilities. Ricoeur (1984) writes that the third mimetic process, $mimesis_3$, corresponds to 'application'. $Mimesis_3$ marks the organisation we want to become; a *refigured* action (i.e. the new midwifery curriculum is embedded).

Herda (1999) has drawn on the work of Ricoeur to develop a method of participatory inquiry with a critical hermeneutic orientation. Using Ricoeur's three domains of $mimesis_{1,2\ and\ 3}$, Herda proposes that the research group (researcher and teacher participants) look at the *prefigured*, taken for granted world of $mimesis_1$ (the existing midwifery curriculum) and *configure* the potential for new curricular possibilities ($mimesis_2$). In *refiguring* the curriculum ($mimesis_3$), the research group of teachers sees itself in different capacities and overcomes [the] distance that separates the *prefigured* curriculum from the *refigured* curriculum.

Ricoeur (1991) gave hermeneutics a critical turn when he drew together philosophical hermeneutics and critical theory. For this study this means that as a researcher I shared a commitment with the teacher participants to make curricular change. This shared commitment provided a critical means for moving beyond the *prefigured,* established way of teaching and learning, towards a *refigured* narrative-centred curriculum.

Participatory inquiry with a hermeneutic lens has been used to reflect on the data which has been recorded in the research conversations with the midwifery lecturers. The interpretation of the written reflections, and the transcribed focus groups and research conversations, leads to the emergence of new understandings. This process helps to build a "community of memory among various participants setting the ground for continuation of work after the project is completed" (Herda,

1999, p. 120). “The transformatory potential of participatory research is present within language and actions of researcher and participants” (Herda, 1999, p. 83).

The new midwifery curriculum is based on narrative pedagogy, which as an educational approach is reflective, reflexive and circular in nature. So it is befitting that the research method is also reflective, reflexive and circular in nature. The experiences of midwifery teachers and students who were taking part in a narrative-centred curriculum were recorded in 2005, as the new curriculum was being implemented. The midwifery teachers’ experiences (which included me as researcher) were recorded during research conversations throughout the first eighteen months of the new curriculum. Midwifery students’ experiences were recorded in two ways; students were invited to write a reflection after each narrative session, and to participate in focus groups. A research conversation with the Head of Midwifery/Programme Leader recorded her experience of managing the implementation of a narrative-centred curriculum.

Hermeneutic interpretation of the transcribed texts from the focus groups, research conversations, written reflections and interviews has been guided by the work of Ricoeur (1984), but also those of Heidegger (1962) and Gadamer (1975/2004). Ricoeur’s (1984) concepts of *prefiguration*, *configuration* and *refiguration* have been used for the interpretation of the experience of midwifery teachers and students in using narrative pedagogy, and in the way the thesis unfolds as a story.

Organisation of the thesis

This thesis consists of ten chapters, broadly organised into three parts which relate to Ricoeur’s (1984, 1985, 1988) concepts of *prefiguration*, *configuration* and *refiguration*.

Chapter One outlines the impetus for this study, the pre-understandings which I bring and gives an overview of the research. This chapter also outlines the purpose of the research and my decision to use participatory inquiry. Part One of this thesis (Chapters Two-Five) relate to the *prefigured* world of midwifery education.

Chapter Two traces the pedagogical approach to learning midwifery in New Zealand, and shows how midwifery registration, midwifery practice, educational theory and the environment where midwives have been educated, have contributed to the context of midwifery education in Aotearoa, New Zealand.

Chapter Three contextualises this study by reviewing the literature pertaining to the development and application of narrative pedagogy. Literature which explored the use of narrative and story in education is also reviewed.

Chapter Four describes the methodology which guided this research. Central to this study are the philosophical ideas of Paul Ricoeur, Hans-Georg Gadamer and Martin Heidegger. The methodology provides the basis for Chapter Five which details the methods used to explore the experience of midwifery teachers and students using narrative pedagogy.

Part two of this thesis "midwifery education *configured*" is prefaced with a chapter which explains the actual structure of the narrative-centred curriculum. The four findings chapters (Chapters Six-Nine) show the interpretation of the experience of midwifery teachers and students involved in implementing a narrative centred curriculum. Chapter Six explores midwifery teachers' and students' experiences of *configuring* the curriculum. Their experience revealed the *prefigured* pedagogical approach.

Chapter Seven entitled 'the art of midwifery emerges' interprets the joys and highlights for teachers and students of using a narrative-centred curriculum. Chapter Eight 'Assessment enframes pedagogy' highlights the tensions between learning from narratives and the need to pass assessment points in order to qualify as a midwife. The final Chapter (Nine) in this section entitled 'configuring the curriculum,' is all about making curricular change.

The third and final part of this thesis "midwifery education *refigured*" draws the previous chapters together, with Chapter Ten 'Preserving narrative pedagogy within the prefigured world of education' reflecting on, and discussing the findings of, this study. A conclusion with implications and recommendations for educators who may be considering implementing a narrative-centred curriculum, and recommendations for further research in the use of narrative pedagogy in midwifery education is provided.

Chapter Two: Overview of pedagogical approaches to teaching and learning midwifery in Aotearoa, New Zealand 1904-2010

> *How is it that schooling, learning and teaching have become sundered such that teaching is appropriated by concerns of the teacher rather than co-occurring dialogical experiences that belong to learning and schooling?* (Diekelmann & Diekelmann, 2009, p. xxiii)

Introduction

This chapter explores the various pedagogical approaches that have underpinned midwifery education in Aotearoa, New Zealand from pre-registration to the present day. Kavanagh (1998) has noted that "the histories of nursing and nursing pedagogies… mirror the social and cultural ethos of varied times and circumstances" (p. 59). Kavanagh's observation can also be applied to midwifery and midwifery education. The interconnected histories of midwifery practice and registration, nursing, obstetrics, politics, education and maternity care, have underpinned the pedagogical approach to the education of midwives. It is these interconnected histories which this chapter explores.

Ricoeur's (1984) philosophy provides a framework for recounting and interpreting historical events. His approach will be used in this thesis to illuminate 'agents', 'motives' and 'circumstances' that have influenced the various pedagogical approaches to midwifery education in Aotearoa, New Zealand. 'Agents', 'motives' and 'circumstances' are described by Ricoeur as the elements which create a plot and frame the story of how one historical event led to another. An 'agent' is defined as the person, or organisation, which takes on a cause, takes action and does things which they take on as their own endeavour. The actions which an agent makes are described as 'motives', which explain why an agent does or did something. Ricoeur says that to identify an agent and to recognise an agent's motives are complementary processes. An agent acts within particular circumstances which determine what actions can be made within a physical, social, historical, cultural and political context.

It is important to acknowledge the specific Aotearoa, New Zealand context for the development of midwifery education and practice. New Zealand's situation with midwifery autonomy and Direct Entry midwifery education based in a tertiary

environment (university or polytechnic) is not by and large found in other parts of the world. The unique history and development is as a result of the particular agents, motives and circumstances which have come into play. This chapter traces the historical development of midwifery education in Aotearoa, New Zealand from the pre 1900s to the present. I review the literature, historical documents, textbooks, syllabi and curricula documents, and use Ricoeur's (1984) framework of agents, motives and circumstances to illuminate the implicit curriculum, or pedagogical approach, which has underpinned midwifery education in Aotearoa, New Zealand. Through uncovering the agents, motives and circumstances which have shaped pedagogy, an understanding of the *prefigured* world of midwifery education and the milieu from which narrative pedagogy surfaced is facilitated. In the first section of this chapter I discuss how a pedagogical approach may be revealed in an 'explicit' curriculum or hidden in an 'implicit' curriculum. I then go on to consider the background to the way that midwifery knowledge was learned prior to there being any formal midwifery education.

Revealing a pedagogical approach

Pedagogy has been defined as the philosophical underpinning of educational research and practice (Diekelmann & Diekelmann, 2009). The pedagogical approach is often taken for granted and embedded in education. The visible, structural aspects of curriculum have been termed the 'explicit curriculum' (Eisner, 1996). Curricular documents, such as syllabi, textbooks and assessment processes announce the 'explicit curriculum' which includes aspects of an educational programme such as the course content, length, the number of hours in theoretical and practice settings, and assessment processes.

Eisner (1996) refers to the less obvious, but assumed aspects of curriculum as the 'implicit curriculum'. The 'implicit curriculum' reveals the pedagogical approach taken, that is, *how* teaching actually happens, what is and is *not* taught, the relationship between teachers and students, and classroom norms. Exploring how teaching and learning actually occurred, that is the implicit curriculum, is important for this study as this exploration is fundamental to an understanding of the *prefigured* world of midwifery education.

Pre 1900s: No formal midwifery education

The European situation pre 1900s

Prior to the late 19th century there was no government legislated midwifery training in Western society. Women would typically learn about helping during childbirth in an apprenticeship model; through helping friends and family during childbirth, or observing and assisting an experienced midwife (Kalisch, Scobey, & Kalisch, 1981).

An early example of how a French midwife, Louyse Bourgeois (1563-1636), learned her skills revealed an apprenticeship model of learning through experience (Kalisch et al., 1981). Bourgeois' midwifery training consisted of five years hands on experience of delivering babies. Bourgeois said that her knowledge was superior to the four doctors who attended the birth of the Queen of France's fourth baby because "my art lay more in experience than in science, and that I had seen more than hundreds whereas they had seen only a few [births]" (cited in Kalisch et al., 1981, p. 9). Bourgeois held that knowledge gained through experience was superior to knowledge gained through reading textbooks. Despite this, Bourgeois is thought to be the first midwife to publish books on obstetrics and midwifery, which demonstrates that she did value midwives having theoretical knowledge to support their practice. Her books on midwifery instructions were based on her own experiences and drew upon all sources of knowledge available to her from folk traditions to the medical textbooks which she had read (Kalisch et al., 1981).

Records of formal midwifery education in ordinances from 1522 in Nuremburg, Germany showed that trainee midwives served a period of apprenticeship of four years (Wiesner, 2004). In Paris, the Hotel Dieu (the first modern hospital in Paris) has operated a training school for midwives since the mid 1500s. The Hotel Dieu apprenticed four trainee midwives at a time to assist the chief midwife for a three month period (Kalisch et al., 1981). Although formal training was neither the norm nor was it compulsory, a midwife who had received training at one of these institutions was seen by women who engaged her services as a superior midwife; and therefore, was able to command a higher fee than a midwife who did not have a certificate of formal training.

It appears that until the late 19th century, in Europe, the majority of midwives continued to learn their craft from their own experiences and as apprentices to

experienced midwives (Rongy, 1937). Some midwives also availed themselves of formal training at a hospital or learned about midwifery practice through textbooks. The pedagogical approach emphasised practical experience over having theoretical knowledge; because theoretical knowledge was not critical to practice midwifery whereas experiential knowledge was.

The Aotearoa, New Zealand situation

This section focuses on post-colonisation midwifery education and practice in Aotearoa, New Zealand. Although it is not within the scope of this thesis to examine childbirth practices or the way that they were learned by Māori prior to colonisation by European settlers in the early 1800s, it is acknowledged that, Māori, the indigenous people of Aotearoa, New Zealand, had well established birthing practices which included the passing on of knowledge and skills to help in childbirth (Makereti, 1986; Rimene, Hassan, & Broughton, 1998). The particular focus of this section is on midwifery education from a Western/European perspective.

In the early 1800s, the majority of New Zealand women settlers emigrated from Great Britain. Hence, midwifery was influenced by European midwifery practices. In the early days of European colonisation, most European women gave birth in their own homes as they had done in Great Britain. Women called upon a local 'handywoman' or 'monthly nurse' (so-called because she helped for a month after the birth of the baby) to assist them during and after the birth. A handywoman was often a relative or a neighbour who had learned their skills of midwifery through experience, from other women, or from trained nurses or doctors (Donley, 1986). These women became known within each district. Stories of these handywomen have been gathered from letters and diaries and show how midwifery skills were often learned though the handywoman's own experience of childbirth and motherhood. One story (Macgregor, 1973) refers to Sarah Herbert (1814-76) of Wainui who "became an experienced midwife, and with so many children of her own, knew what to do in times of sickness" (p. 90). Herbert was famous for having walked 15 miles through the dark bush when Mrs White, the wife of the head shepherd at Oakbourne station was confined (Macgregor, 1973).

Although not formally trained as midwives, handywomen became experienced and skilful and were trusted by women and doctors. A letter written in 1868 from a mother to relatives in England shows the trust she had in the handywoman who came to help when her daughter was having her first baby and was very ill (with what sounds like eclampsia).

> Mrs Dickey is such a nice Scotch woman… she has been similarly situated [caring for birthing women]… She is the mother of a large family… And so we got on first rate without either doctor or nurse. (Porter & MacDonald, 1996, p. 363)

Doctors were not usually involved with midwifery at this time, although in the late 1800s, a Maria Tucker of Havelock North "was often called upon by Dr McDonnell of Hastings to assist him with confinements. She was not a trained nurse but midwives were necessary in those days and she loved this work" (Macgregor, 1973, p. 204). Another woman, Jessie Stewart in Waikokopu "had no doctor for any of her confinements but was usually assisted by a midwife who rode about the countryside, possibly coming from Wairoa" (Macgregor, 1973, p. 185). One baby was coming so quickly before the midwife could get there that her husband went to the local pā[7] to get help and Jessie was ably assisted by "Old Sarah" (Macgregor, 1973, p. 185).

Up until the end of 19th century New Zealand, the pedagogy which underpinned the way that midwifery was learned was based on learning through observation and experience. With no formal midwifery education or registration, it was the experience of a handywoman which built the trust and regard which women and medical doctors held for her midwifery skills.

Late 1800s-early 1900s: Introducing professionalism

Agents: Grace Neill, Richard Seddon
Motives: High perinatal mortality rate and no formal training for midwives
Circumstances: Fitted with Liberal Government's political agenda [1891-1912]

Toward the end of the 19th century, the trust in the knowledge and skills of the handywoman came into question by some (Neill, 1961). One of the agents who lobbied for formal training for midwives was Grace Neill. Neill was a Scot who had trained as a

[7] A pā is the place where a Māori community lived.

nurse and midwife in England. She came to New Zealand in 1892 and felt sympathetic towards women who could "only afford the help of unskilled neighbours or, worse, of ignorant and often unscrupulous women practicing as professional midwives" (Neill, 1961, pp. 49-50). Neill wanted to establish 'proper' training and registration for nurses and midwives. She promoted the idea that if a midwife had no formal training (her knowledge was based purely on experience), she was ignorant and superstitious. If a midwife had attended a formal training program she was seen as knowledgeable and skilled. At the time other motives, agents, and circumstances were in accord with Neill's ideas.

One motive for the commencement of midwifery registration and training was a political one. When Neill arrived in New Zealand, Prime Minister Richard Seddon's liberal government was embarking on a programme of social legislation (Hill, 1982). The perinatal mortality rate was high at the time and Seddon stated in his 1904 manifesto that "humanity for the mother and infant" was a priority for the liberal government. "The silent martyrs are the low-waged workers' wives who keep the cradle full and bear the double burden of poverty and maternity" (cited in Donahoe, 1981, p. 24). Seddon's government wanted to provide a maternity service for the wives of 'ordinary men' (low-waged working men) who were unable to afford the services of a qualified nurse or doctor to attend them.

Neill lobbied Seddon and others, aghast that the only qualification required to be a handywoman was that the woman had borne a child herself (Neill, 1961). Neill's mission was accomplished when Seddon introduced the Midwives Act (1904) which established the legal requirement for registration and training of midwives in Aotearoa, New Zealand. As well as the first register of New Zealand midwives, the Midwives Act (1904) provided for the establishment of state funded maternity hospitals, named St. Helens hospitals after Richard Seddon's English birthplace; St. Helens. St. Helens hospitals offered a place (other than at home or private maternity hospital) for women to give birth and for midwives to be educated (Papps & Olssen, 1997).

When Seddon gave his speech introducing the 1904 Midwives Act, he made a point of discrediting untrained midwives' sources of knowledge. He stated that "midwives are usually of advanced years and when asked how they obtained their knowledge would say 'Oh, I just picked it up!'"(cited in Neill, 1961, p. 54). The

knowledge that was 'just picked up' through experience was now seen as inferior to the kind of knowledge a student midwife would gain from a formal lecture or textbook. Midwifery registration, legally required under the Midwives Act, marked the end of the apprentice-style way of learning through experience and the emergence of a pedagogy founded on learning midwifery through a period of lectures, practical work and examinations.

Consequences for midwifery education

Formal midwifery education commenced with the opening of the first St. Helens hospital in Wellington in 1905, followed soon after by hospitals in three other Aotearoa, New Zealand cities. St. Helens hospitals continued as the principal place for midwifery teaching in Aotearoa, New Zealand from this time through until 1980. Midwifery students paid fees and supplied their own uniforms and equipment for their course of training at St. Helens hospitals. Student midwives worked shifts on the wards and then attended lectures which were given by medical doctors and senior nurses or midwives (Neill, 1961). The Midwives Act (1904) specified practical and theoretical requirements for student midwives, and also set the midwifery examination, which was established as a legal requirement to practice as a midwife.

From the beginning of midwifery training, there have been connections with nursing practice and education. Under the Midwives Act (1904), a lay person could study for 12 months to become a midwife; whereas a nurse registered under the Nurses Registration Act 1901, could train in half the time; six months. Stojanovic (2002) contended that this was the beginning of the 'nursification' of midwifery and indeed midwifery's connection with nursing in practice and in education has continued.

Student midwives used textbooks written by the doctors who lectured them. For example, Jellet's (1903) 'A short practice of midwifery' included topics which are still basic to midwifery education today such as female anatomy and physiology, normal and complicated pregnancy, labour, puerperium and care of the infant. Since the beginning of formal midwifery education, fundamental midwifery knowledge has been modified and supplemented in response to the agents, motives and circumstances of the day, such as the midwifery practice environment, the political and social climate of the time and trends in medicine and nursing. It is not possible to

document every change, but I have identified times where there have been significant motives or circumstances which have influenced a shift in the pedagogical approach underpinning midwifery education. While the agents, motives and circumstances are organised in a sequential manner, they did not occur in this way, and each section overlaps and is connected.

1920s: Promoting safe birth

Agents: Dr Henry Jellet, Dr Tom Paget and Dr Elaine Gurr
Motives: High maternal mortality rate
Circumstances: Puerperal sepsis

After the First World War (1914-18) the maternal mortality rate in New Zealand rose from 3.58: 1000 live births in 1913 to 6.48:1000 in 1920. The maternal mortality rate was mostly due to puerperal sepsis[8] and was one of the highest in the developed world (Mein Smith, 1986). Wives of wealthy men who could afford the services of doctors and private maternity homes had significantly higher rates than women who birthed at home cared for by midwives (Mein Smith, 1986). The mortality rate was an international embarrassment for the New Zealand government, and was the motive for an enquiry into puerperal sepsis and the maternal mortality rate. The enquiry was led by Drs Paget, Jellett and Gurr (Mein Smith, 1986) and resulted in recommendations for procedures for asepsis and sterilisation in maternity care. These procedures were published in two pamphlets 'The general principles of maternity nursing' and 'The management and aseptic technique of labour and the puerperium' together known as H.- Mt.20 regulations (Mein Smith, 1986). The H.-Mt. 20 regulations were first issued in 1926 and resulted in the adoption of strict routines and teaching relating to asepsis and sterilisation in maternity hospitals. The H.-Mt. 20 regulations dominated midwifery practice and education from the 1920s to the 1960s, with the emphasis being on learning procedures and routines.

[8] Puerperal sepsis is defined as "any bacterial infection of the genital tract which occurs after the birth of a baby" (World Health Organisation, 2008, p. 24).

Consequences for midwifery education

Midwifery teachers were charged with training students to the standards laid down in the H.-Mt.20 regulations, which emphasised that if students had plenty of practical experience then they would learn to be midwives. “It is essential that trainees should be given the opportunity of examining the greatest number of patients possible, as without ample experience they cannot learn” (Health Department of New Zealand, 1945, p. 37). Student midwives provided the workforce to care for mothers and babies at St. Helens hospitals and worked long hours in the antenatal clinic, labour ward, postnatal ward and in the community. On one day of the week lectures for student midwives were delivered by medical doctors and senior midwives on topics prescribed under the Nurses and Midwives Registration Act (1925).

Mary Lambie (1956) writes of her experience as a student midwife in the 1920s. She recalls working ten hour days in the wards at St Helens, and in ten months having only one day off. Lambie remembers lectures by Dr Agnes Bennett, but particularly notes the excellent experience she gained when attending home births with a midwifery sister. The 1920s was an era of learning through repeating protocols and procedures, for example, preparing a woman for the birth of her baby involved learning to shave and swabbing a woman’s perineal area using aseptic technique. Although the formal teaching occurred in lectures, experienced midwives would have passed on their experience to student midwives when they were working alongside them in practice, and when sharing practice stories over a cup of tea.

1930s: Pain relief

Agent: Dr Doris Gordon
Motive: Women called for freedom from the pain of labour
Circumstance: Availability of pain relief medication for labour and increased medicalisation

In the 1930s, although asepsis was still very much emphasised in midwifery curricula, relieving pain became a new responsibility of those attending women in labour. In New Zealand, Dr Doris Gordon was a key agent who lobbied women’s groups and government, advocating that pain relief in childbirth should be available for all women. Relief from the pain of labour was seen as modern and superior by middle class women and women’s organisations of the time lobbied for the right to have painless

childbirth (Mein Smith, 1986). The drugs used for pain relief in labour were a mix of an opiate and a muscle relaxant (morphine and scopolamine) known as 'twilight sleep' (Gordon, 1955). 'Twilight sleep' could only be administered by a doctor, and because of its sedating side effects women needed to be monitored in hospital by a nurse or a midwife. Assisted births such as forceps deliveries became very common because women lost the ability to actively push out their baby unaided (Donley, 1986).

Up until the late 1930s, St. Helens hospitals had been the domain of midwives. However, demand for pain relief provided one of the motives for the introduction of the 1939 Social Security Act which provided payment so that women could choose to have free maternity care in a public hospital attended by a doctor (Mein Smith, 1986). Increasingly women were choosing to have their babies in hospital under the care of a doctor so that they could avail themselves of pain relief. Doctors lobbied to be given access to St. Helens hospitals to care for their patients (Mein Smith, 1986). The provision of pain relief for labouring women was significant for midwifery education and practice because it firmly established links with medicine and nursing. Midwives were not initially authorised to administer pain relieving drugs, so provision of pain relief gave doctors an area of expertise in maternity care. Besides this, when women were sedated in labour, they could equally be monitored by a nurse who operated under a doctor's instruction as a midwife (Donley, 1986). Pain relief, therefore, provided one of the motives which led to the circumstances of increased medical procedures used in maternity.

Consequences for midwifery education

Throughout the 1930s and 1940s the student was seen as someone to be trained, and that midwifery could be learned if a set number of lectures and practical tasks were completed. An example of the syllabus from 1945 (see Appendix A) included a list of practical work to be completed. Practical tasks to be learned included administering obstetrical anaesthesia, since by 1945 some methods of pain relief could be administered by a nurse or a midwife. Special training was required to learn about safe administration of pain relief and this was one of the first delegated medical tasks which influenced the content of midwifery curricula.

The curriculum for midwifery education by the 1940s was called the 'Instructional Course for Maternity Nurses and Midwives.' The Nurses and Midwives Registration Board specified that one lecture per week was to be given by a medical practitioner on prescribed topics such as anatomy, physiology, normal and abnormal obstetrics and two lectures were to be given by a nurse-midwife on topics such as breastfeeding and infant care.

Textbooks for midwives continued to be written by obstetricians who also lectured and examined trainee midwives. For example, Corkill's textbook published in 1946 contained the lectures which he gave to student midwives at the Alexandra Maternity Hospital in Wellington. Corkill's book on midwifery and infant care provided practical instruction on the management of pregnancy and labour and the care of the infant, conforming to the syllabus prescribed by the Nurses and Midwives Registration Board. Topics included normal pregnancy and labour, infant care and abnormal pregnancy and labour. Great detail was given on procedures for asepsis and pain relieving methods. Textbooks written by midwives followed a similar pattern. For example, an English midwifery textbook (Mayes, 1941) commonly used by midwifery schools in Aotearoa, New Zealand, advised students to study pregnancy, labour and puerperium under the headings: Definition, causes, symptoms, treatment and complications. There was scarce mention of the woman's, or the family's, experience.

The H.-Mt.20 regulations which had been implemented to reduce puerperal sepsis in the 1920s were the motive for hospital routines which continued until the 1970s. Routines and procedures such as aseptic procedures for the birth, separation of mothers from babies and strict visiting restrictions drove midwifery practice and education. By the 1950s and 60s the majority of women in Aotearoa, New Zealand went to hospital to have their babies where they stayed for up to 14 days postpartum (Donley, 1986). Babies were separated from their mothers in nurseries and brought to mothers for feeding four hourly during the day. One of the consequences of the rules about separating mothers and babies was that breastfeeding rates became very low (Ryan & Grace, 2001). The motive of promoting safe birth which had commenced in the 1920s with puerperal sepsis led to midwifery practices and education being

structured around learning routines and procedures such as perineal toilets[9] and care of a baby in the nursery. Puerperal sepsis and the demand for relief from the pain of labour provided the motives for increased medical input into maternity care and the motive for midwifery practice and education to be focused on learning aseptic procedures.

1950s: The rise of the consumer movement

Agents: Parents Centre
Motive: Dissatisfied parents
Circumstances: Strict maternity hospital routines/Beginning of consumer activism

During the 1950s, social circumstances were beginning to change. Parents were demanding more say in their care, a more satisfying birth experience, more cognisance of the mother and child relationship and a more family-centred approach (Parents Centre New Zealand, 2009). In June 1952, a natural childbirth group commenced childbirth classes for expectant mothers and in 1953 this group evolved into New Zealand's first Parents Centre (an organisation which still exists today). Parents Centre childbirth classes included relaxation exercises, and for the first time fathers were encouraged to attend (Parents Centre New Zealand, 2009). Grantly Dick Reid's (1958) book on natural childbirth, which promoted relaxation breathing for labour, also became popular. Consumer groups such as La Leche league were formed to promote breastfeeding (Ryan, 1990).

In 1963, the newly formed Maternity Services of the Board of Health recommended more patient input in decision making and increased training to meet the emotional needs of patients (Hill, 1982). By 1963 the midwifery curriculum looked quite different to the syllabus of the previous 60 years which had consisted of a list of practical and theoretical requirements. The 1962 midwifery curriculum for example included topics such as psychology, social conditions and cultural differences (Nurses and Midwives Board, 1962). The social circumstances of the time again influenced pedagogical practices.

[9] 'Perineal toilet' was an aseptic procedure used to clean a woman's perineal area after childbirth. This procedure was undertaken at regular times by midwives for women who remained on bed rest for up to 14 days after the birth of her baby.

1950 and 1960s: The rise of educational theory

Agent: Ralph Tyler, educational theorist
Motive: Objective measurement of learning
Circumstances: Increasing academic influence on education of health professionals

Along with social change, during the 1950s and 1960s, behavioural psychology and educational theories were a motive which gradually re-oriented the pedagogical approach to midwifery education. Psychological research of the 1950s and 60s was founded on the idea that mental processes could be understood and human responses explained because human beings were information processing systems and human behaviour was the result of mental processes (Earl, 1961). This assumption influenced educational theorists to suppose that human beings processed new knowledge cognitively in a predictable way, and that learning could, therefore, be measured and evaluated in an objective manner.

In 1949, Ralph Tyler had published his influential book 'Basic principles of curriculum and instruction.' Tyler held that it was the role of the curriculum to define educational objectives which should be stated in terms of measurable outcomes. For Tyler it was the role of the teacher to choose the most effective learning experiences for the student, in order to meet the curricular objectives. Tyler's (1942, 1949) ideas were based on theory which came from behavioural psychology; that if the curriculum is stated in terms of predetermined measurable objectives, then the outcomes of learning can be controlled by the educational experiences in which the learner is required to participate. Curricular approaches and learning theories based on behavioural psychology reveal a view of learning that is ordered, controllable and measurable. For example, Bloom's (1956) taxonomy was based on a six step process which ranged from a basic level of remembering knowledge to the highest order cognitive process which is creating knowledge. The assumption that learning is a rational, linear, orderly and sequential process, underpins the thinking around curricula based on pre-determined measurable learning outcomes.

Consequences for midwifery education

By 1963, the midwifery syllabus document included aims and objectives for the first time (New Zealand Nurses and Midwives Board, 1963, p. 13), and 50 years on, the midwifery curriculum is stated in terms of learning objectives or learning outcomes (Auckland University of Technology, 2010). The motive of learning outcomes was to provide an objective tool which was assumed to ensure consistency of course content, teaching methods and objectively measure students' learning through assessment processes.

Diekelmann (1993) referred to a pedagogical approach which focuses teaching and learning on pre-determined, measurable learning outcomes as 'behavioural pedagogy' because of its links with behavioural psychology. Behavioural pedagogy will be further discussed in Chapter Three, but is introduced here to make the links to pedagogy.

1970s: Increasing technology available in obstetrics

Agent: New Zealand Government/Dr Helen Carpenter
Motive: Adequacy of midwifery knowledge questioned
Circumstances: New obstetric and neonatal technology available

The period between 1970 and 1990 was marked by the convergence of some major motives for change to the way midwives were educated. Maternity care was changing during the 1970s and 1980s with a marked increase in knowledge and availability of obstetric technologies such as ultrasound scanning, electronic fetal monitoring, obstetric anaesthesia, and neonatal paediatric care. There was debate as to whether the six month midwifery course at St. Helens hospitals was producing midwives able to practice effectively in an increasingly technological maternity environment (New Zealand Board of Health, 1976).

In 1970 the New Zealand Government invited Dr Helen Carpenter, a Canadian Nurse and World Health Organisation consultant, to undertake a review of nursing and midwifery education in Aotearoa, New Zealand (Papps & Olssen, 1997). In her report, Carpenter made the observation that nursing and midwifery education programmes had remained relatively unchanged since their inception, and that education remained outdated and unsuited to the needs of both students and health services. She stated

that students were "trained to undertake activities in a certain manner rather than taught to think through the application of principles to different situations and to apply these in an appropriate manner" (Carpenter, 1971, cited in Allen, 1992, p.31). To address this problem, one of the recommendations that Carpenter made was that nursing and midwifery education shift from being based in a hospital setting to a Polytechnic (tertiary) institution, and that midwifery become a postgraduate nursing specialty in maternal infant nursing (Allen, 1992).

The Obstetric society of New Zealand also expressed concerns about the adequacy of midwifery training. In a report to the Wellington[10] Hospital Board, Corkill (1977) (an obstetrician) stated that in the previous 20 years the nature of obstetric practice had changed and there was a need for medical specialties such as anaesthetics and paediatrics that would need 'highly trained midwifery staff' to assist specialists. Corkill's report proposed closing St. Helens hospitals in preference for a large women's hospital which would provide the latest technology available and training in obstetrics for medical registrars. Medical students did not have access to women at St Helens hospitals for their training, whereas a large women's hospital would provide medical students with training in obstetrics.

Consequences for midwifery education

Coinciding with the Carpenter report, other motives contributed to the decision to move nursing and midwifery education from hospitals to tertiary education facilities (Polytechnics) in the late 1970s. The Nursing Council of New Zealand and the New Zealand Board of Health expressed concern that midwives from the six month hospital programme were not functioning as required at the time of registration and a longer and more extensive training was needed to effectively prepare midwives (New Zealand Board of Health, 1976).

At the same time, in the late 1970s, there was a rise of nursing research and academic study for nurses and midwives was for the first time considered desirable (Smythe, 2007). The concerns that the six month programme was not adequately

[10] In 1865, Wellington became the capital city of New Zealand, replacing Auckland, where William Hobson had placed the capital in 1841

preparing new graduate midwives to cope with the increased technologies being offered in maternity care, along with the rise of academia ultimately resulted in midwifery education's move to Polytechnics. The period of midwifery training in the Polytechnics was increased from six to 12 months, and the course was only available to registered nurses.

With the move to Polytechnics, St. Helens hospitals were no longer needed to provide midwifery education, and St. Helens hospitals were faced with closure. Their potential closure galvanized women's groups and midwives in an attempt to keep St. Helens hospitals open. One of the concerns of women and midwives was that student midwives would not get enough practical experience if education moved from St. Helens to the Polytechnics. In a letter dated April 18th 1977 to the Wellington Hospital Board, a working party spoke of one of the main functions of St. Helens hospitals as being the preparation of midwives through experience (Fieldhouse, 1977): "It is only in a situation where student midwives can observe skilled and experienced practitioners of their profession operating in a supportive way that they are likely to emulate such behaviour." The letter goes on to say that if midwives were trained in an obstetrical unit they would end up as "half baked doctors."

Despite protests from women's groups and midwives, the final class of midwives graduated from St Helens in November 1979, and from 1980 midwifery education was exclusively based in five Polytechnics (tertiary institutions) offering a one year diploma course in midwifery for registered nurses (Pairman, 2005). Midwifery students attended classes alongside registered nurses and midwives who were studying for an Advanced Diploma in maternal-infant nursing. Some classes were specifically for student midwives to prepare them for midwifery practice and the final state midwifery examination. In the Polytechnics, although the course was longer (8 months), student midwives had less practical experience with only 10– 12 weeks being spent gaining practical experience.

My own experience as a student midwife in this system helps to illustrate some of what it was like for midwifery students at the time:

> In 1984 I studied midwifery at Wellington Polytechnic through the Advanced Diploma in Nursing (maternal-infant option). The only way to become a midwife was by doing nursing first, so I'd done that and worked as a general nurse for two years. I was one of

> five student midwives in a class of registered nurses and midwives. We had one midwife lecturer for all our midwifery classes which were held on one day of the week. Because there were just five of us it was easier to have discussions rather than straight lecture style teaching. The midwifery was on top of doing all the work such as learning about research and nursing theories.
>
> We did 10 "follow throughs" where we went to antenatal visits, the labour and birth and postnatal visits of 10 women. One was a home birth. I will never forget any of those women. As far as gaining practical skills, it was VERY hard to get the experience; some of the midwives refused to take students because they thought our education was second rate. We also had to compete with medical students who needed to get 5 deliveries. We had to do 20 births, and 10 vaginal examinations. I must have managed the numbers but when I started work in Delivery Unit I felt hopeless and that was when the real learning started (personal account).

At the same time that midwifery education was moving into the tertiary setting, social changes of the 1970s were affecting the way that childbirth was perceived. Authors such as Suzanne Arms (1975), Danaë Brook (1976), Frederick Leboyer (1975) and Ina May Gaskin (1978) challenged the 'medicalisation' (increasing use of technology) of childbirth and promoted natural birth. Research in areas such as behavioural and developmental psychology, for example, Klaus and Kennell's (1976) research into maternal-infant bonding, also affected midwifery practice and education. Questions about the importance of the time around birth resulted in women demanding a more emotionally satisfying and family-centred birth experience (Parents Centre New Zealand, 2009). Not only did midwives need knowledge about technology used in obstetrics, they needed the knowledge to attend to the woman's emotional experience as well. Textbooks in use at this time (Moore, 1978; Neeson & May, 1986) focused on planning care for the individual needs of the woman and her family, rather than simply the physiological process of pregnancy, labour, the puerperium and midwifery procedures.

With midwifery education's move from the practice setting of St. Helens hospitals to the academic setting, knowledge acquired through research findings, journal articles and textbooks became more valued than knowledge gained through experience and practice. The position was also established that theoretical knowledge was required prior to students going to the practice setting. This was different to the

St. Helens training which was composed primarily of practical experience, supplemented with one day of lectures each week.

Another difference between St. Helens training and the Polytechnic system was that teaching was not limited to a lecture format. The student was thought of as an active participant in the learning process rather than a passive recipient. Process curricula such as problem based and enquiry based learning were being used in some health education settings (Barrows & Tamblyn, 1980). At one of the Polytechnics, Auckland Technical Institute (ATI) for example, a problem based learning (PBL) curriculum was introduced into the nursing curriculum in 1984 (Horsburgh, Lynes, & Oliver, 1984). Nursing and midwifery were in the same departments in Polytechnics, so some of the ideas engendered in a process curriculum were also applied to midwifery students (personal account J. Gunn).

Midwifery education via the Advanced Diploma in Nursing (A.D.N.) course lasted for less than 10 years. One motive for the short time span was a shortage of midwives. With the closure of the St. Helens hospitals, reduced numbers of midwives were being trained. The six month St. Helens courses had trained between 157 and 185 midwives per year, whereas in seven years the A.D.N. had produced only 179 midwives (Guilliland & Pairman, 2010). There were also concerns that midwifery education had become too theoretical and was being subjugated by medicine and nursing. Midwives and women's groups became increasingly motivated to re-establish midwifery as a separate, autonomous profession with an education programme distinct from nursing (Donley, 1986).

1980s: Politicisation of midwives

Agents: Judi Strid, Joan Donley
Motive: To regain autonomy for midwives
Circumstances: The rise of feminist and consumer movement

Judi Strid who was a consumer[11] advocate and Joan Donley a domiciliary midwife were two notable agents who worked throughout the 1970s-90s to highlight the concerns about the shortage of midwives and that the midwifery programme had become too theoretical. Strid, Donley and others motivated women's groups and midwives to

[11] Consumer is a term used to describe a woman who is a user of maternity services

unite, forming a lobby group called ‘Save the Midwives.’ ‘Save the Midwives’ proposed that one of the reasons for the demise of midwifery as an autonomous profession was that education had been taken over by nursing (Strid, 1987). According to ‘Save the Midwives’, nursing should not be a prerequisite for midwifery and the group was committed to seeing a three year ‘direct entry’ midwifery programme being established in New Zealand. With this aim in mind, an offshoot of ‘Save the Midwives’, the ‘Direct Entry Midwifery Education Task Force’, which included midwives and consumers, was established in 1988 (Strid, 1987). Concerns about the inadequacy of midwifery education were also raised by groups such as the Midwives Special Interest Section of the New Zealand Nurses Association (1978), the Direct Entry Midwifery Task Force (Save the midwives direct entry midwifery task force, 1990), Parents Centres, Home Birth Associations, and midwifery educators (Guilliland & Pairman, 1991). The consumer and midwives groups were agents who argued that midwifery had been downgraded to obstetric nursing, and that was in part, due to the education provided through the A.D.N.

Consequences for midwifery education

As a result of agents such as Joan Donley, Judi Strid and Parents Centres, who lobbied government, a parliamentary committee was set up in 1986 to report on midwifery in New Zealand (Women's Health Committee, 1986). A considerable number of submissions raised the question of midwifery training; in particular that direct entry to midwifery was desirable, that there should be more practical experience, and that the course be extended. The report of the Women’s Health Committee was a motive which added to the impetus for the major reforms which occurred in midwifery practice and education between 1989 and 1992. In this short space of time, midwifery was separated from the A.D.N. in 1989, and for three years a one year diploma in midwifery for registered nurses was offered at the Polytechnics (Auckland Technical Institute, 1989) before a change to the Nurses Act in 1990 provided for a three year Direct Entry midwifery programme to commence in 1992.

1990: Midwives win autonomy and Direct Entry midwifery education

Agents: New Zealand College of Midwives, Helen Clark (Minister of Health)
Motives: Midwifery autonomy, Direct Entry, degree level education
Circumstances: Labour Government policy promoting primary health care

Since the Nurses Act 1977, which made it an offence for a midwife to provide a service unless a medical practitioner has taken responsibility for a client, only medical practitioners could legally take full responsibility for a woman's maternity care (Clark, 1990). Women went to either a General Practitioner (GP) who had completed a Diploma in Obstetrics or to an obstetrician for their pregnancy care. When a woman went into labour, she would go to the hospital where she was booked and cared for by the midwives (employed by the hospital) on duty. The midwives worked under the standing orders of the woman's GP or obstetrician, calling him or her for advice during labour and when the birth was imminent. It was usually the doctor who delivered the baby.

During the 1980s, there were moves by midwives and women's groups to increase the midwifery scope of practice so that midwives could regain the legal right to take full responsibility for maternity care. The desire for autonomous midwifery practice was the motive for the founding of the New Zealand College of Midwives (NZCOM) (New Zealand College of Midwives, 2005). The NZCOM was founded in 1989, and now a separate professional body from nursing, was able to focus on representing midwifery's interests in the political arena. Karen Guilliland, Sally Pairman and Mina Timu Timu were leading agents who lobbied tirelessly for the founding of the NZCOM and then for legislative changes which would provide for autonomy for midwives (Guilliland & Pairman, 2010; Ogonowska-Coates, 2004). Karen Guilliland became the first president of the NZCOM in 1989.

The health minister of the labour government, Helen Clark, was very sympathetic towards midwifery autonomy. She supported the legislative processes which culminated in 1990 with an amendment to Section 42 of the 1977 Nurses Act. The amendment to the Nurses Act allowed midwives to take full responsibility for maternity care. Part II of the Social Security Act was also amended to allow midwives to claim the same payment which GPs had previously been able to claim for provisions of maternity services (Donley, 1990). An amendment to section 39 of the Nurses Act allowed for the introduction of three year midwifery programmes, known as Direct

Entry midwifery because nursing registration was no longer a pre-requisite to study midwifery.

One of the motives for increasing the scope of midwifery practice was that women wanted to know their own midwife. The only way a woman could know her own midwife was if she had a home birth under the care of a GP, and find a midwife willing to attend her at home (Ogonowska-Coates, 2004). Home Birth Associations had formed around New Zealand to support women who chose the home birth option and to support the few domiciliary midwives who often practiced in an isolated environment (Ogonowska-Coates). One of the benefits of home birth, which women appreciated, was that they knew in advance the midwife who would care for them throughout labour, birth and the postnatal period. Women who chose to birth in hospitals or birthing centres also wanted to get to know their midwife through their pregnancy and have the same midwife care for them in labour and after the birth. Some 'know your own midwife' models had emerged in the United Kingdom (Flint, 1986), and New Zealand women and midwives sought to have this option for all women, not just those who were planning a home birth.

From the midwifery profession's point of view, the motive for autonomy was to restore the midwifery scope of practice so that midwives could practice under their own responsibility, and in a more satisfying way by caring for women they had developed a relationship with during their pregnancies. Joan Donley (1986) and Judi Strid (1987) continued to be noteworthy agents for change during this period. One of the ways that midwives perceived that autonomy could be achieved was through having a separate professional organisation for midwives. Up until 1990, midwives' professional interests had been represented through the Midwives Special Interest Section of the New Zealand Nurses Association (Donahoe, 1981). Midwives at the time felt that the Nurses Association did not always support their desire for autonomy from medicine and nursing.

The agents, motives and circumstances of the previous decade (the 1980s) had completely changed the face of both midwifery practice and education. Midwifery had become a post graduate nursing qualification which could only be gained in a tertiary education setting. That was now being challenged

Consequences for midwifery education

In 1992, a three year Diploma in Midwifery was offered at Auckland Institute of Technology (AIT, previously known as Auckland Technical Institute), and a three year Bachelor of Midwifery at Otago Polytechnic (Pairman, 2006). In 1996 three more institutions were approved. By 1997, midwives could study for a standalone Bachelor's degree at five Polytechnics. Between 1977 and 2003, midwives continued to be registered by the Nursing Council of New Zealand (Nurses Act, 1977). The Nursing Council (1999) specified standards of competency for entry to the register of midwives, reviewed and approved midwifery curricula and set the final external 'state' examination.

As well as meeting the Nursing Council's requirements for registration, midwifery programmes were also obliged to meet another set of requirements which were set by tertiary institutions. For example, to fit in with the diploma and degree system, midwifery curricula separated knowledge into discrete modules (later called papers). Each module had an aim, learning outcomes, specified content and assessment requirements. Each was worth a certain number of credits and had to be passed before moving on to the next module (Auckland Institute of Technology, 1994, 1997). Modules were either theoretical or clinical. The pedagogy that now dominated midwifery education suggested that to learn midwifery, students needed to study a series of individual subjects, each with predetermined learning outcomes. Learning experiences were designed by the teacher around the learning outcomes and at the end of the module learning was assessed by the teacher. If the student passed the assessment, she was deemed to be able progress on to study the next subject.

The explicit curriculum was documented in a module format, revealing a behavioural pedagogical approach; however, in the early 1990s, teaching and learning did not adhere strictly to this modular framework. Smaller class sizes meant that teaching and learning processes could be held in a smaller physical space and be more flexible and personal, allowing for more sharing of stories and experiences. Smythe (1993) who taught midwifery in this era, wrote about the value of working with a small group of students in the clinical area and the constructive relationship that was built between teacher and student when there was time to dialogue.

The NZCOM had long held that a separate regulatory body for registering midwives would ensure the final separation from nursing and define midwifery as a profession separate from nursing. In 2003, changes to the registering body for midwifery came with the Health Practitioners Competence Assurance Act (HPCAA) (2003a). For midwifery, this allowed for the formation of a separate Midwifery Council responsible for approving education programmes and registration requirements for midwives (Midwifery Council of New Zealand, 2004a). In 2006, the Midwifery Council undertook a review of midwifery education (Midwifery Council of New Zealand, 2006) consulting with midwives, midwifery teachers and the midwifery schools. Many of the submissions to this review suggested that students needed more clinical experience. The recommendations from this review resulted in revised standards for approval of pre-registration midwifery education programmes (Midwifery Council of New Zealand, 2007).

The standards prescribed the theoretical content to be taught and the practice requirements to be completed. This included a longer programme (equivalent to four years) with increased clinical practice hours (2400 hours). The Midwifery Council also set down the pedagogical approach which schools of midwifery should take:

> Theoretical content may be delivered through a variety of learning and teaching processes including online and face to face. These learning and teaching processes should promote self-responsibility, critical enquiry, autonomy, accountability, collaboration, integration, quality care, contextual understanding and life-long learning (Midwifery Council of New Zealand, 2007, p. 15).

The Midwifery Council standards emphasised the need to demonstrate competency to practice. The notion that 'a competent practitioner is a safe practitioner' was introduced under the HPCAA (2003b), and has since become a dominant discourse in midwifery practice and education. It has been argued that competence is not a simple concept. Rather than safe practice being based on a pre-determined set of competencies, Worth-Butler, Murphy and Fraser (1994) argued that a capable professional is one who is able to draw on a repertoire of skills and knowledge in different ways in different contexts to perform in a way which is recognised as competent.

Late 1990s: Education as an economic industry

Agents: Ministry of Education, Universities
Motives: Economic imperatives
Circumstances: Funding restraints on education sectors

Along with the changes to the midwifery scope of practice in 1990, and the commencement of the direct entry midwifery programme in 1992, in the late 1980s and 1990s New Zealand's tertiary education sector followed an international trend whereby education became increasingly viewed as an economic industry (Malcolm & Tarling, 2007). In 1997, a Ministry of Education review of tertiary education set goals for the future directions of tertiary education. The review stated that "growth [of tertiary education] must meet the changing needs of the labour market, economy and society" (Ministry of Education, 1997, p. 8). New Zealand tertiary education institutions were asked to compete with each other and increase productivity and accountability (Olssen, Codd, & O'Neill, 2004). The government talked about *investing* in education, and compelled tertiary educators to focus on economies of scale, performance measures, quality, and technological advances (Ministry of Education, 1997). There was a proliferation of terms such as 'information revolution', 'knowledge society' and 'knowledge economy' (Malcolm & Tarling, 2007; Simons & Masschelein, 2008).

The Ministry of Education's recently released tertiary education strategy stated that its vision for tertiary education is that "the Government wants relevant and efficient tertiary education provision that meets the needs of students, the labour market and the economy" (Ministry of Education, 2010, p. 6) and has one of its main aims as being "improving the educational and financial performance of providers" (Ministry of Education, 2010, p. 10). The ministry states that it expects its "investment [in education] to be used efficiently and effectively by tertiary education organisations and students" (p.3).

Simons and Masschelein (2008) suggest that when education is viewed as an economic industry, knowledge may function as the capital of industry, teachers as knowledge workers who impart that knowledge and students function as consumers of a commodity which they purchase. When an economic view of education prevails, the main focus of education is to sell a commodity which will provide employment for the consumer. Educational success is measured by results and degree completion. Simons and Masschelein discuss how the "concept of learning has become disconnected from

education and teaching and has instead come to refer to a kind of *capital* to something for which the learner is personally *responsible*, to something that can and should be *managed*" (p.391). Pedagogy, or how students learn, is irrelevant to an economic approach. One of the implications of a market-led university is that the university may be pedagogically constrained as it concentrates on efficient ways of providing education for increasing numbers of successful students rather than having a discussion about what makes good pedagogy (Molesworth, Nixon, & Scullion, 2009).

Along with the call for efficiencies there has been a growth of technologies within education, and a tendency to reduce teaching to broadcasting or provision of on-line content. Heidegger (1977) warned of the risks that were taken when education was instrumentalised, professionalised, vocationalised, corporatized and ultimately *technologised.* Diekelmann and Diekelmann (2009) concur when they assert that "when education is reduced to a utility or usefulness this means that there is a concomitant practice of assigning values to the types, kinds, conditions, and ways in which schooling, learning and teaching are measurable, effective and efficient"(p. xix) .

When teachers and students view learning as merely the acquisition of knowledge, skills and competencies, education may be seen as a possession. A market driven approach to education may lead students to seek to "*have* a degree rather than *be* learners" (Molesworth et al., 2009, p. 277). When knowledge is seen as a commodity, students may seek to *get* a degree rather than to *become* a midwife (Simons & Masschelein, 2008), and there is little place for the spontaneous, unpredictable, serendipitous nature of stories.

Consequences for midwifery education

In 2000, ATI received university status and was then known as the Auckland University of Technology (AUT). In response to Ministry of Education (2005) policy, AUT set its strategic targets (Auckland University of Technology, 2007). One target was to increase student numbers and improve access to education. Throughout the 1990s midwifery class sizes slowly increased. In 1992 the first year Direct Entry midwifery class at ATI took 20 students, by 2000 this had increased to an intake of 30, by 2005 to 50, then to 80 in 2008 and 120 in 2010. To improve the access to midwifery education for students outside the main centres, midwifery programmes in New Zealand have set about

implementing distance learning methods. For AUT this has involved the use of videoconferencing technology into the classroom for distance students.

From the small personal classes where discussion and sharing of story and experience could occur easily, now classes are held in tiered lecture theatres and teachers often revert to a lecture format. An increase in the technology available for education also meant that where once the teacher may have had some posters and models as audiovisual aids to her teaching, teachers and students became increasingly reliant on technology to convey messages. Firstly, overhead transparencies (which students copied down), and then as classrooms became computerised, electronic media presentations and online learning became dominant modes of teaching. Economic drivers have led to less time to share stories and experiences because of the drive to cover content and provide information to as many students as possible in as short a space of time as possible. These changes have emerged through the writing of this thesis.

Conclusion

This chapter has explored the many motives, agents and circumstances that have influenced the pedagogical approach which has underpinned midwifery education in Aotearoa, New Zealand, from the inception of formal education and registration to the present day. The intention of this exploration has been to examine the background to the existing pedagogical approach so as to provide a platform for understanding the rise of narrative pedagogy.

The exploration has revealed that curricular processes are shaped by the play between agents, motives and circumstances. Midwifery curricula in Aotearoa, New Zealand have been shaped by agents (for example, politicians), motives (for example, economic imperatives), and circumstances (for example, increasing puerperal sepsis). Curricula content, the number of practice hours required and the place where formal midwifery education occurred (hospital or university) have been influenced by the various agents, motives and circumstances which have prevailed across the last century. The pedagogical approach is rarely overt; it is implicit in the curriculum. Yet, pedagogy is fundamental to how teaching and learning happen, and therefore, is essential to drive curricular processes. The historical analysis presented in this chapter

supports the argument that it is rarely pedagogy which has driven educational change in midwifery education; it has been the interweaving of agents, motives and circumstances of the time.

Students' learning from childbirth stories has occurred informally in midwifery. When formal education commenced in Aotearoa, New Zealand at the turn of the 20th century, experience and sharing of story was regarded as an inferior way to learn. Superior learning was seen as happening in a lecture situation, with midwifery students being taught by expert doctors and nurse-midwives. The learner was seen as a passive recipient, someone to be trained through learning by repetition of routines and procedures. While story telling was not a part of the explicit curriculum, no doubt stories were told in nurse's homes[12], over a cup of tea, and in the classroom.

The 1960s and 70s marked a change to the pedagogical approach to midwifery education. Learning was defined in terms of meeting pre-determined behavioural objectives. Narrative and story could not be defined in these terms, so were perceived as being neither here nor there in education. In the 1980s, research based knowledge gained precedence over experience, and as story was not seen as research based, it was not valued.

Midwifery autonomy in 1990 and the commencement of the three year direct-entry midwifery training in 1992, coincided with increasing demands from the government to take an economic approach to education. Curricula development has been characterised by the addition of increasing amounts of content, predetermined behavioural learning outcomes and competencies, increasing student numbers, and learning through technologies such as electronic visual and networked media. With larger class sizes, efficient teaching approaches such as lectures, multi-media presentations, and online learning, tend to predominate. Stories are likely to be used as examples and classified as being 'nice to know' and seen as less rigorous and professional**.** In an environment where the content knowledge required exceeds the time available to teach, telling of stories may feel like a waste of time.

To refer back to Diekelmann and Diekelmann's (2009) question at the beginning of this chapter;

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[12] Places of accommodation where nurses and midwives could live adjacent to the hospital

> *How is it that schooling, learning and teaching have become sundered such that teaching is appropriated by concerns of the teacher rather than co-occurring dialogical experiences that belong to learning and schooling? (p. xxii)*

Schooling, learning and teaching became appropriated by the concerns of the teacher because it is the explicit curriculum which held sway over teacher-student dialogue and sharing of stories. Dialogue about learning experiences and sharing of stories has occurred, but is implicit and therefore, concealed in curricula processes. The play of agents, motives and circumstances; that is the influence of nursing, obstetrics, politics, midwifery practice and registration, education and maternity care, have underpinned the explicit midwifery curriculum in Aotearoa, New Zealand.

The exploration of the pedagogical underpinnings of midwifery curricula using Ricoeur's (1984) framework is valuable because it provides the platform for the succeeding chapter which explores the research and literature which describes narrative pedagogy, the use of narrative and story in education, and a narrative-centred curriculum.

Chapter Three: Narrative pedagogy emerges

Introduction

In this chapter, Ricoeur's (1984) framework of agents, motives and circumstances is extended to explore the international research and literature from which narrative pedagogy has emerged. Throughout the 20th century, as midwifery education was being shaped in Aotearoa, New Zealand (as described in Chapter Two), in the international arena, questions were raised about the pedagogical approach to nursing education in the United States of America (U.S.A). Through a series of serendipitous meetings and opportunities, some of the same agents, motives and circumstances which had led to the critique of nursing education in the U.S.A, extended to influence the pedagogical approach to midwifery education in the programme where this study took place.

This chapter begins by exploring the motives behind the call for the development of new pedagogies for nursing education. Next, the work of agents such as Nancy Diekelmann and other American nurse educators whose research culminated in the development of narrative pedagogy is considered. The research and literature which has evolved since Diekelmann's (2001) initial uncovering of narrative pedagogy is then explored. This exploration includes the experience of teachers and students in contexts and settings where narrative pedagogy has been adopted.

One of the motives which have influenced the narrative-centred curriculum in the midwifery programme, where this study was undertaken, has been the value of narrative and story in education. Hence, in the last part of this chapter, the literature around narrative and story is reviewed, as is the literature pertaining to narrative-centred curricula.

Motive: A 'curriculum revolution'

In the late 1980s, the National League for Nursing in the U.S.A had challenged nurse educators to ascertain how student learning was being facilitated and develop new pedagogical approaches to nursing education which would prepare nurses for a changing health care environment (Moccia, 1990). The motive behind the call for new pedagogies for nurse education in the U.S.A was that existing pedagogies did not

appear to be preparing thinking health professionals for the increasingly complex health environment. This motive created the circumstances which became known as a 'curriculum revolution' in nursing education (de Tornyay, 1990; Diekelmann, 1990; Moccia, 1990; National League for Nursing, 2003; Tanner, 1990).

Agent: Emeritus Professor Nancy Diekelmann

Nancy Diekelmann, emeritus professor from the University of Wisconsin, was a significant agent whose research highlighted disquiet; and responded to the National League for Nursing's challenge over existing pedagogical practices. She suggested a new approach, narrative pedagogy.

Behind Diekelmann's research into the experience of nursing education in the U.S.A were the milieu of the writings of educationalists such as Michael Apple (1979, 2001) and Paulo Friere (1985) who had critiqued the dominant pedagogical position. Friere criticised education for being like a 'banking system' where students were seen as unknowing learners (empty vaults) to be filled by an all-knowing teacher with information and knowledge which students stored in their banks for future use. Apple (2001) was concerned about political pressure for a return to more traditional content, methods of teaching and increased testing in education, and alleged that a business approach was being applied to education.

Nancy Diekelmann's advancement of narrative pedagogy began with her investigation of the experiences of students, teachers, and clinicians in nursing education. Diekelmann (1990) felt it was ironic that nurses created caring environments for patients, but did not place the same emphasis on caring for themselves. She interviewed students, teachers and clinicians, over a 12 year period, asking them about their experiences of teaching and learning (Diekelmann, 2001). Diekelmann used interpretive phenomenology, based on the philosophy of Heidegger, to collect data and analyse the interview transcripts. Her analysis revealed that teachers and students seemed alienated from one another; yet, they actually shared many of the same concerns about their educational experiences.

Motive: Dominant pedagogical approach

Shor and Friere (1987) coined the term 'official pedagogy' to describe the dominant pedagogical approach. Others have described the dominant approach to education as 'behavioural pedagogy' (Diekelmann, 1993), 'instructional paradigm' (Barr & Tagg, 1995) and 'conventional pedagogy' (Ironside, 2001). This thesis adopts Diekelmann's use of the term 'behavioural pedagogy' to describe curricula where "learning experiences are prespecified in terms of objectives, and evaluation of learning is linked to outcomes" (Diekelmann, 2001, p. 54).

Diekelmann suggested that the possibilities for curricular reform *within* behavioural education were minimal and that future reform would require entirely new ways of thinking about teaching and learning. Narrative pedagogy attaches importance to dialogue about beliefs, prejudices, pre-understandings and history in education; whereas behavioural pedagogy supports the idea that learning only happens through cognitive processes (Diekelmann & Diekelmann, 2009).

Motive: Behavioural pedagogy not preparing health professionals well

During the 1970s, Marton and Saljo (1976a, 1976b) defined learning approaches as 'deep' or 'surface'. Surface approaches to learning such as memorisation and rote learning were thought to be motivated by meeting minimal requirements to pass assessments. Deep learning approaches were associated with a motivation to read widely, relating new learning with previous relevant knowledge in order to discover new meanings for the enquirer. Behavioural pedagogical approaches were considered to encourage surface approaches to learning, and there had been moves in some educational forums to redress the perceived problems of a pedagogical approach which relied on surface learning. Diekelmann (1992) for example, found that although nursing students were skilled at passing examinations, they were less skilled at critically interpreting actual clinical practice situations.

As discussed in the previous chapter (p. 28), during the late 1970s in Aotearoa, New Zealand, a Canadian Nurse, Dr Helen Carpenter had made recommendations for changes to nursing and midwifery education, stating that nursing and midwifery education remained outdated and unsuited to the needs of both students and health

services. Carpenter's concerns were very similar to those being raised by Diekelmann and the National League for Nursing in the U.S.A.

Motive: Increasing content knowledge needed for health professionals

Nurse educators in the U.S.A critiqued behavioural pedagogical approaches, saying that it privileged amassing of content knowledge over thinking (Diekelmann, 1993, 1995, 2002b; Ironside, 1999a, 1999b, 2004, 2005). They asserted that thinking in health practice was much more than learning knowledge and applying that knowledge in clinical situations. Diekelmann (2002b) observed that as concern rose over students' abilities to practice competently within an increasingly complex health system, that more and more content knowledge and skills were being added to curricula. She coined the term 'additive curricula' to describe curricula which had become laden with ever-increasing amounts of content knowledge which teachers and professional bodies deemed necessary for students to practice effectively in the health care setting. The increasing amount of knowledge and skills to be taught, served to further reinforce the dominance of efficient teaching methods for imparting large amounts of content.

There were parallels in Aotearoa, New Zealand. When midwives won the right to practice autonomously in 1990, the imperative to ensure students were taught 'everything' they needed to know to practice safely became even stronger. For example, whereas once the midwife and the doctor would do an initial assessment of the newborn baby, now that task fell solely to the midwife. Alongside this were additional skills, such as prescribing, perineal suturing, family violence screening, and new assessments made possible by advances in technology. While the direct entry three year degree programme opened the way for a longer period of midwifery specific learning, still there was too much content for the time frame. Within this arose tensions of what sort of learning was most important. In contemporary midwifery education the approach to learning is defined as achieving 'competencies' (Midwifery Council of New Zealand, 2004b).

A further criticism of a behavioural pedagogical approach was that students were led to believe that for safe practice they only needed to know what the teacher told them they needed to know (Ironside, 2003a). When students learned only what their teachers told them was important a 'teacher-centred' learning environment was

created which some educators have said was contradictory to self motivated learning, deep learning approaches and thinking (Barr & Tagg, 1995; Barrows & Tamblyn, 1980; Diekelmann & Lampe, 2004; Ironside, 2003a). Palmer (1998) wrote that teacher-centred pedagogy assumes that "the teacher has all the knowledge and the students have little or none, that the teacher must give and the students must take, that the teacher sets all the standards and the students must measure up" (p. 116).

Others critiqued the dominance of teaching and assessment methods such as lectures and examinations which had become inherent in behavioural pedagogical approaches (Diekelmann & Diekelmann, 2000; Diekelmann & Smythe, 2004; Hazel, 2008; Smythe, 2004). Tanner (2004) claimed that behavioural pedagogy encouraged students to learn only what they needed in order to pass examinations and once passed, students moved on to the next course, forgetting that section of information.

Dahlberg, Ekebergh, and Ironside (2003) alleged that a behavioural pedagogical approach viewed learning as linear and sequential, leading to the assumption that theoretical knowledge was necessary before students could move on to more 'advanced' learning in clinical practice. In other words, students needed to learn a level of knowledge (*what* to think), before they could learn how to apply knowledge (*how* to think) (Ironside, 2004; Smythe, 2004). This led to the long held assumption that it is best to introduce theory in the classroom and then apply it in the clinical setting (Diekelmann & Diekelmann, 2009). Benner (1991), like many others mentioned, recognised the constraints of behavioural pedagogy, and wondered whether that way of learning provided the best preparation for students going into practice.

Consequences: Narrative pedagogy emerges

The agents, motives and circumstances outlined above led to the call for a 'curriculum revolution' by nurse educators, the critique of education by other educationalists (Apple, 1979; Friere, 1985; hooks, 1994), and the result of Diekelmann's (2001) research, culminated in the proposition that narrative pedagogy could address some of the concerns with behavioural pedagogical approaches. Narrative pedagogy has been defined by Diekelmann and Diekelmann (2009) as enacting "hermeneutic phenomenology as it gathers students, teachers and clinicians in communally interpreting the narrative telling of their experiences in nursing education and

participation in nursing practice" (p. xii). In other words, narrative pedagogy is an approach to teaching and learning which is committed to the interpretation of teachers', students' and clinicians' narratives about their experiences in education and practice.

Narrative pedagogy claims to incorporate "conventional, critical, feminist and post modern discourses" (Diekelmann, 2001, p. 253). According to Diekelmann, narrative pedagogy engages teachers, students and clinicians in thinking about education and practice from several theoretical perspectives to analyse how power and the construction of knowledge impact on teaching, learning and practice. Diekelmann (2001) emphasised that the important aspect of narrative pedagogy is that "students, teachers and clinicians gather and attend to community practices in ways that hold everything open and problematic"(p. 55). When learning materials are held open and problematic, teachers and students may reflect on whether a textbook (for example) contains objective facts (Brown, Kirkpatrick, Mangum, & Avery, 2008).

Narrative pedagogy can underpin any teaching strategy; it is not a particular teaching method (Diekelmann, 2001). The process of how narrative pedagogy may be realised is through creating an educational environment that invites dialogue between teachers, students and clinicians. Diekelmann saw narrative pedagogy as 'curriculum-as-dialogue', which is in contrast to 'curriculum-as-road-map' associated with behavioural pedagogy (Scheckel, 2005).

Literature emerging from Narrative Pedagogy

As Diekelmann (2001) interpreted teacher and student stories from transcribed interviews, she used phenomenology to analyse the teaching and learning experiences of teachers, students and clinicians. Diekelmann drew on Heidegger's (1962) notion of *Besorgen*, translated into English as *concern*, meaning the practices with which people concern themselves. From her research, Diekelmann named the practices with which teachers and students concerned themselves, the 'concernful practices of schooling, learning and teaching.' The following table (p. 49) summarises Diekelmann's (2001), and Diekelmann and Diekelmann's (2009) 'concernful practices of schooling, learning and teaching' which articulate the activities that underpin narrative pedagogy.

Table 1: Summary of the 'concernful practices of schooling, learning and teaching'

Concernful Practice	***Definition***
Presencing: Attending and Being Open	Presencing enables the open clearing such that the play of being-with as the with-world of engaged openness shows itself
Assembling: Constructing and Cultivating	Assembling students and teachers; the how of bringing them together in the curriculum
Gathering: Welcoming and calling forth	Gathering is the dialogical experiences that result when students and teacher are in attendance as situations that call forth thinking-saying and learning Includes a welcoming, safe, fair and respectful learning environment.
Caring: Engendering Community	Learning communities engendered as supportive and fair, students feel safe and respected. Engendering is a reciprocal call – has no control of what is called out (may be rage and fear as much as solicitous self-transcendence)
Listening: Knowing and connecting	Learning to know and connect with students
Interpreting: Unlearning and Becoming	The experience of learning is dialogical. For learning to disclose and beckon as itself there must be a possibility for unlearning to occur
Inviting: Waiting and Letting Be	The letting-be of silence is its own teacher and teaching
Questionings: Sense and Making visible	A co-occurring concernful practice. Making visible is claimed by thrownness. Transforms asking questions into a questioning that calls students to sense and the associated letting of meaning-making become visible
Retrieving Places: Keeping open a future of possibilities	Creating the space for thinking and dialogue
Preserving: Reading, writing, thinking-saying and dialogue	How teachers and students experience coming together in reading, writing, thinking-saying and dialogue

(Diekelmann & Diekelmann, 2009)

Many studies which have researched narrative pedagogy have used the language of Diekelmann's (2001) 'concernful practices.' For example, a number of studies have explored the concernful practices of *knowing* and *connecting* (Dahlberg et al., 2003; Diekelmann & Mendias, 2005; Diekelmann & Mikol, 2003; Ironside, Diekelmann, & Hirschmann, 2005). Dahlberg et al. (2003) found that nursing students had more positive learning experiences when they felt that their teacher knew them personally

and Ironside et al. (2005) ascertained that students were able to know and connect with patients if they themselves knew and connected with a clinical teacher. These are features of the concernful practices of *knowing and connecting*.

Ironside (2005) and Scheckel and Ironside (2006) found that when a nursing school cultivated interpretive thinking, students were helped to think through and interpret their practice experiences. In this manner, the 'concernful practices' of *questioning* and *interpreting* were fostered. *Questioning* and *interpreting* were found to be just as important to students as learning content from lectures. For students, *how* they learned something was equally as important as *what* they learned (Ironside, 2003a).

This current study further expands and adds to the work of others who have researched the 'concernful practices of schooling, learning and teaching' by exploring and interpreting the experiences of midwifery teachers and students as a narrative pedagogical approach is being implemented.

How has narrative pedagogy been adopted?

During the 2000s, as educational programmes adopted narrative pedagogy, each programme has developed its own way of implementing this approach. For example, some nursing schools have a 'Voices Day', an all school storytelling day in which students, teachers and clinicians share their stories of their experiences of teaching and learning (Diekelmann, 2003). On 'Voices Day' teaching and learning experiences are shared publicly, and through their interpretation uncover new understandings. In narrative pedagogy the emphasis is not merely on sharing stories but on "collectively interpreting the common meanings and significances of the story" (Dahlberg et al., 2003, pp. 32-33).

Diekelmann and Diekelmann (2000) applied a narrative pedagogical approach in a course on ethics in genetics. Instead of debating the 'right' ethical answer based on ethical frameworks, principles or rules, students dialogued and raised questions. McGibbon and McPherson (2006) used narrative pedagogy in a violence and health workshop. They found that when content was no longer central to the course, space was created for nursing students to explore their own feelings about the issues.

At the University of the Sunshine Coast in Queensland Australia, McAllister et al. (2009) have used narrative pedagogy in a post graduate midwifery course to engage

students and foster a learning community. Students read a novel with layers of complexity called 'The Birth House.' The dialogue about the novel between students and teachers was found to awaken students' political consciousness through showing the perspective of a dominant or a marginalized position. Students talked about being 'enlightened' in regards to aboriginal culture. In another narrative activity, intergenerational exchange of stories was used to develop an appreciation of the development of nursing profession and build professional identity. Vandermause and Townsend (2010) used a narrative pedagogical approach as a way to enliven teaching and foster thoughtful practice in a graduate course for nurses in the field of addictions.

One consistent finding, which has emerged from studies into narrative pedagogical approaches, is that when a learning environment fosters interpretation of narratives, a space is created for dialogue, reflection and thinking about subject matter in a different way from the thinking which might happen in a lecture environment.

Students' and teachers' experiences of narrative pedagogy

Relatively few studies have evaluated students' and teachers' experiences as they participate in narrative pedagogical curricula. This is an important area to research because it will reveal the immediate experience of narrative pedagogy, rather than how the experience is perceived after a time of reflection. One pilot study (Ironside, 2003b) evaluated students' experience of the implementation of narrative pedagogy in an introductory nursing course. Interpreting both quantitative and qualitative data, Ironside found that students tended to describe their experiences of narrative pedagogy by making comparisons with traditional courses. Some students preferred the lecture-test format and did not think they were being well taught because the course structure was different. Other students spoke positively about how they reflected on practice and thought about things in new ways.

Swenson and Simms (2003) studied students' experiences of a narrative-centred curriculum and how this way of learning influenced their clinical practice. Students were interviewed over the telephone after they had graduated from the narrative-centred course. It was found that some students struggled to learn in this way, expressing concern that they were not given everything they needed to know. Other students felt it served them well because they learned to listen to patients in a new way, which Swenson and Simms aptly described as "listening to learn" (p. 184).

This study aims to add to the findings of Swenson and Sims (2000, 2003) and Ironside (2003b) through a further exploration of the experience of students using a narrative pedagogical approach. Whereas Swenson and Simms researched the experiences of postgraduate nurses in the U.S.A who participated in a course based on narrative pedagogy, this study researched the experiences of undergraduate midwifery students in Aotearoa, New Zealand.

The use of narrative and story in educational contexts is also relevant to this study, as it was the interpretation of narratives which were fundamental to the educational approach. The next section explores the literature on the use of narrative and story in education.

Motive: Learning from narrative and story

Storytelling is a traditional means of sharing information, communicating ideas, and passing on cultural identity (Davidhizar & Lonser, 2003; Lave & Wenger, 1999). It has been said that women especially use story to describe their experiences (Belenky, Clinchy, Goldberger, & Tarule, 1986; Blaxter, 1983). This is significant, because fundamental to midwifery practice is the partnership between midwives (who are predominantly women) and women (Guilliland & Pairman, 1995). The midwifery partnership is built on shared understandings and it is through storytelling that women tend to share their experiences.

Diekelmann (2001) and Young (2004) have emphasised that narrative pedagogy is not simply using storytelling as a strategy for learning. Some educators, however, have found using narrative or storytelling to be an effective mode of developing a narrative pedagogical approach (Davidhizar & Lonser, 2003; Kirkpatrick & Brown, 2004; Lunt, 2000; Sandelowski, 1994). Baumann (2008) observed that stories were being used successfully in narrative pedagogical approaches in nursing education to bring complexity into the classroom and to foster student thinking.

Storytelling is also one way that nurses and midwives share practice experiences with colleagues (Firkin, 2003; McAra–Couper, 2007; Wieck, 2003). Midwives in Firkin's (2003) study used reflection and professional engagement with other midwives as a way of maintaining ongoing development of expertise and

knowledge. This was one of the benefits of belonging to collectives and practices. As one of the midwives in Firkin's study says:

> Everybody asks everybody something, you know. Even now. Someone was asking me the other day, you know I've got this woman with this, this and this what would you do? And you'd say well you know I'd do this. Oh good, I've done that. (p. 29)

Storytelling has been found to be an effective means of uncovering the knowledge embedded in practice (Sandelowski, 1994) and building practice wisdom (Heinrich, 1992). Polkinghorne (1988) talks of the way that health practitioners use narrative explanations to represent their interpretations of patients' narratives. When health professionals use narratives in this way, a diagnosis becomes more of an explanation rather than simply a categorisation.

Teachers have found that stories are a useful way of capturing students' interest and attention (Davidhizar & Lonser, 2003). McDrury and Alterio (2001) held that through "sharing stories, it is possible to create meaning, to understand what has happened and to prepare for what may happen in the future"(p. 63). Wells (1986) recognised storytelling as an activity that pervades all aspects of learning because it is through story that teachers and students can share their understandings of a topic. Creating meaning and understanding is fundamental to narrative pedagogical approaches and storytelling is a means of facilitating this. Prior to midwifery registration and formal education, experience and story sharing was the only way to learn midwifery. As behavioural pedagogy became more dominant, stories have been seen as a useful adjunct or illustration; rather than a valuable component of learning.

Defining narrative and story: Is there a difference?

There is an ongoing debate in the literature about whether there are significant differences between the terms story and narrative. Some see a clear difference, some identify degrees and types of narratives, and for others there is no difference. The question for this study is does it matter which term is used and how story and narrative are defined?

This thesis concurs with Ricouer (1984) who does not differentiate between narrative and story, but describes two different types of narratives; historical and fictional. For Ricoeur, both types of narratives comprise a plot, characters, a context

and a temporal sequence. Story has been defined similarly. Sarbin (1986) defined narrative as coterminous with story, because both are “a symbolized account of actions of human beings that has a temporal dimension”(p. 3). Bruner (2002) and Gaydos (2005) have used the terms narrative and story interchangeably in publications. However, Paley and Eva (2005) have argued that a failure to distinguish between narrative and story has led to inconsistency and assumptions about the meaning of narrative.

Paley and Eva (2005) propose that story is an interweaving of plot and character to elicit an emotional response from the reader, whereas narrative refers to a sequence of events and the causal relations between them. Like Paley and Eva, others have perceived a narrative to be more structured than a story (Benner, 1991; Dolk & den Hertog, 2008; Immerwahr, 2008). Immerwahr held that narrative is not simply a story; narrative is a structure for organising factual claims. Dolk and den Hertog agree when they defined narrative as “a framework of discourse providing an event with structure and meaning” (p. 217). Paley and Eva identified degrees of narrativity on a continuum, with story situated on the ‘high narrativity’ end of the continuum.

For this study, the terms story and narrative have the same meaning. Both narrative and story convey meaning through a framework which includes a plot, characters and a context. The follow section reviews the literature which explores the use of narrative and story in educational environments.

Narrative in learning environments

The crux of narrative pedagogy is the dialogue between teachers and students when they jointly interpret their shared experiences in practice and education (Diekelmann, 2001). There are clearly links between narrative pedagogy’s shared dialogue between teachers and students and the value of listening to and interpreting stories for learning. As Palmer (1998) says “if we want a community of truth in the classroom, we must put a third thing [teachers and students being the first and second], a great thing at the center of the pedagogical story” (p. 116). There is compelling support from the literature that this third great thing can be narrative. A curriculum where narratives are central to learning has been described as a narrative-centred curriculum (Swenson & Sims, 2000, 2003). The literature shows the wide range of education settings,

including children's, nursing, adult and medical education, where narrative has been found to be a valuable way of enriching learning experiences through creating more engaging learning experiences and increasing a deeper understanding of subject matter.

In the field of nursing education, Koenig and Zorn (2002) found that nursing students gained insight and deeper understanding of their practice when a storytelling process was employed. Kawashima (2005) found that sharing stories encouraged otherwise reticent Japanese nursing students to express their own ideas in the classroom. Online discussions based on reflective stories promoted self-understanding in a caring course for nurses (Chan, 2008). In a geriatric nursing course, Kirkpatrick and Brown (2004) drew on narratives found in film and literature for students to interpret and discern their own beliefs about death and dying.

In children's education, Mott, Callaway, Zettlemoyer, Lee, and Lester (1999) utilised the compelling nature of narratives in order to improve motivation in literacy education by co-constructing narratives with children to develop educational software. Research indicates that narratives have been employed effectively in interactive learning environments using storytelling and narrative techniques alongside computer technology (Hazel, 2008; Mott & Lester, 2006). The use of story is commonplace in children's religious education (Connolly, 2004), and narratives have been used as a means of encouraging children to interpret different kinds of knowledge when they learn about science (Barker, 2006; Stewart, 2007). Peter (2009) found that storytelling through drama helped autistic children to recognise the patterns and sequences which frame culture.

In adult education, McDrury and Alterio (2001) describe how reflective learning can be achieved using different kinds of storytelling. They found that the learning depended on the setting, the listeners and the story itself. In McDrury and Alterio's opinion "the most beneficial learning comes from valuing affective responses during reflective dialogue focused on the practice event" (p. 73). Brody and Witherell (1991) found that when adult students were given permission to share personal narratives they described the experience of having 'lost their voices' when they came back to school because of a lack of open dialogue in the classroom. Once the classoom culture changed and dialogue was encouraged, Brody and Witherall found that adult students invariably explored themes of gender and culture.

Fisher (2002), an experienced political science teacher, wrote that no-one had ever told him about the power of story as a teaching tool. He said:

> It took me years to learn the importance of creating a safe space in the classroom for stories to be told… Now, I use student stories as text in every course I teach as a means of building community in the classroom and fusing the personal and theoretical. (p. 421)

Loads (2010) explored ways of preparing graduates to deal with "unpredictable, intricately, interrelated and ever changing situations which can only be understood through frameworks that are themselves unstable and contradictory" (p. 409). She found that teachers themselves needed to deal with uncertainty through professional development workshops involving artwork and reflection.

Narratives used in education settings are not limited to oral storytelling. Some courses have used narratives drawn from films, books, literature, poetry, myths, journaling and digital media (Benmayor, 2008; Brna & Luckin, 2008; Crawley, 2009; Darbyshire, 1994; Hazel, 2008; Wall & Rosen, 2004). In response to the recognition of the importance of narrative for patients and doctors, Columbia University have offered a Masters program in narrative medicine (Columbia University School of Medicine, 2009).

Essentially, the experience of using narrative and story in education is that interpretation of narratives can contribute to an exploration of culture, values, beliefs and different ways of knowing which can be transformational for both students and teachers (Benmayor, 2008). As Immerwahr (2008) notes: "Narratives represent meaning that is situated and remembered in stories related to real situations, but it may be overlaid by theories, beliefs, attitudes, expectations, assumptions and the desire to be seen in the right" (p. 217). It is these beliefs and assumptions which are exposed when teachers and students interpret narratives together.

Narrative centred curricula

When Swenson and Sims (2000, 2003) established a postgraduate nursing course for family nurse practitioners, they based the teaching and learning approach on narrative pedagogy. Swenson and Sims (2003) drew on the capacity of narrative to foster "listening practices that promote thinking and making meaning" (p. 188), and in doing so launched what they termed a "narrative-centred curriculum".

The course was based on learning from narratives. Patients, their families, students, preceptors and faculty came to share narratives about their health issues with the class. Students used a modified PBL approach to discuss and interpret the narratives they heard and to identify the learning issues which arose from the narrative. Students chose learning issues they knew little about to prepare a summary of their selected learning issue to share with the class at the next meeting (Swenson & Sims, 2003). This is the approach which has been adopted for the undergraduate midwifery programme where this present research is undertaken and adds a new dimension to Swenson and Simms' (2003) findings regarding postgraduate nursing students' experiences of a narrative-centred curriculum.

Conclusion

Midwifery education in Aotearoa, New Zealand has increasingly grappled with the demands of teaching increasing amounts of knowledge, skills and competencies to larger and larger classes. During the 1980s class sizes were smaller, and discussion, small group work and process educational methods were easily facilitated. As previously mentioned, at ATI (where nurses and midwives were educated), a PBL curriculum was initiated in the 1980s (Horsburgh et al., 1984). Since the introduction of the three year midwifery degree programme in 1994, the midwifery programme has increasingly come under the pressures of a university system where midwifery knowledge is broken down to individual papers with learning outcomes, each of which must be assessed and achieved. Class sizes have increased from an intake of 30 in 1992, to 80 in 2005 and 120 in 2010. Student numbers onsite and at a distance have increasingly led to a reliance on behavioural pedagogical approaches.

Professor Diekelmann's visits in the early 2000s, along with her connections with midwives and nurses in Aotearoa, New Zealand have resulted in her work influencing the pedagogical approach to midwifery education in this country. This review of the literature has explored the agents, motives and circumstances that have contributed to the body of research around narrative pedagogy. The literature reviewed has placed this research within the context that prompted the implementation of a narrative-centred curriculum and initiated this research. Historical accounts of the changes to the midwifery education in Aotearoa, New Zealand have been well documented (Donley, 1986; Guilliland & Pairman, 2010; Hill, 1982; Pairman,

2005, 2006). This thesis adds a further dimension to the work of these authors through an account of midwifery students' experiences of their education.

Limited research exists about teachers' and students' experiences of teaching and learning as they are engaged in a narrative-centred curriculum. No studies to date have researched the experiences of midwifery teachers and students engaged in this way of learning *as* the curriculum is being implemented. This participatory hermeneutic research makes an important contribution to the knowledge of narrative pedagogy and narrative-centred curricula for midwifery education.

Chapter Four: Methodology

Introduction

The aim of this research is to understand and interpret the experiences of midwifery students and teachers who were using a narrative pedagogical approach in undergraduate midwifery education. When considering an appropriate methodology for this study, I felt a philosophical position was required which would facilitate the uncovering and interpretation of experience, and at the same time support an open dialogue between teachers and students, researcher and participants. I also felt it was vital that the philosophical position fitted with the underpinning philosophy of narrative pedagogy which is fundamentally interpretive of experience. Interpretive research supports critical, post-modern and humanistic perspectives on educational experience (Giles, 2008). Compared with traditional positivist research which seeks to measure teaching and learning, interpretive research delves into the meanings of such experiences for the participants as a way of understanding and possibly changing the educational experience (Herda, 1999).

The philosophy of the French philosopher, Paul Ricoeur [1913-2005], has provided a platform upon which this research is based. Ricoeur draws together phenomenology and hermeneutics, and his philosophy has underpinned the participatory inquiry research approach used in this study. Philosophers in a hermeneutic tradition (for example Paul Ricoeur, Martin Heidegger and Hans-Georg Gadamer) explore the notion of interpretation of experience. Ricoeur's (1976, 1981, 1991) philosophy explores the idea of how interpretation of language, especially written language, reveals experience. Ricoeur's theory of hermeneutic interpretation has offered a valuable foundation which has guided this research process. In this chapter, Ricoeur's philosophy is explored, as is the way in which his philosophy has underpinned the methodology and methods used in this study.

Hermeneutics: The development of Paul Ricoeur's philosophical hermeneutics

The term hermeneutics originates in the Greek word *herme* and means to bring understanding through language. Ricoeur (1981) proposed a definition of hermeneutics as "the theory of the operations of understanding in their relation to the interpretation of texts" (p. 43). In the context of research, hermeneutic processes aim

to understand and interpret meanings through the medium of language, and to create a text which shows this interpretation in a way that can show possibilities for the future (Allen, 1995; Danner 1997). A narrative-centred curriculum aims to facilitate students' interpretation and understanding of women's narratives, so that they in turn can see possibilities for ways they can provide effective midwifery care for women. The philosophy of the educational processes and the research processes are, therefore, consistent with one another.

Koch (1999) wrote that interpretation is a process that permeates our every activity, and that hermeneutics is the mode through which human beings share understandings through language. Koch gives the example of a nurse asking a client to tell their history. As the client tells her story the nurse observes and listens, and as she or he does so, begins to interpret to reach an understanding through uncovering what the client is really trying to say. This interpretive process is what we are encouraging when midwifery students listen to women's narratives; we ask them to ask themselves, "what is this woman *really* trying to say?" and through interpretation the student says "this is what I believe the woman is *really* trying to say". Ricoeur (1981) has also explored ideas about the way human beings interpret and understand language through devices such as searching for hidden meanings and reading between the lines.

Development of Ricoeur's philosophy

Ricoeur's prolific philosophical writings span a 60 year career and includes 30 books and 500 articles exploring a range of philosophical ideas (Kaplan, 2008b). His career as a philosopher began as a prisoner of war during the Second World War, where he smuggled a copy of the book *Ideen I* into the camp. *Ideen I* is the work of the German phenomenologist Edmund Husserl (1980), and introduces ideas pertaining to a pure phenomenology and to a phenomenological philosophy. *Ideen I* had been banned because Husserl was Jewish. Ricoeur proceeded to translate *Ideen I* into French by writing in the margins in pencil. This translation was published after the war, launching Ricoeur's philosophy in the direction of phenomenology (Reagan, 1996). Husserlian phenomenology was extremely influential at this time, in both Germany, where Husserl taught Martin Heidegger (among others) and in France, where Husserl

influenced Ricoeur, and other French philosophers such as Jean-Paul Sartre, and Maurice Merleau-Ponty (Philosophy Department Marquette University, 2009).

After the war, Ricoeur (1966) published his first work *Freedom and Natur*e, which was his doctoral thesis on the philosophy of the will. Then, in the late 1960s, he turned to hermeneutics as he started to explore the question of interpretation of language and action in the context of an interpretive philosophy. Ricoeur (1970) contrasted Husserlian phenomenology to Freudian psychoanalysis in his book *Freud and Philosophy*. Husserl's hermeneutics were based on intuitive understanding, whereas Ricoeur (1981) came to think that simply describing phenomena was not enough; in order to interpret and understand meanings, analysis was also needed.

During the 1970s the work of previous hermeneutic scholars, in particular Schleiermacher and Dilthey, were also influential on Ricoeur's developing philosophy (Ricoeur, 1981). Schleiermacher's work focused on philology (linguistic analysis) of classical texts and exegesis (interpretation) of Old and New Testaments. Dilthey's work, on the other hand, explored "the opposition between the *explanation* of nature and the *understanding* of history" (Ricoeur, 1981, p. 49). Ricoeur (1981) thought that the consequences of Dilthey's separation of explanation and understanding placed explanation and understanding in opposition. Ricoeur endeavoured to resolve this opposition through finding an epistemological method (as Schleiermacher had done) which would integrate explanation and understanding, thus expressing "on the epistemological plane the hermeneutical reorientation demanded by the notion of the text" (p. 43).

Ricoeur (1981) sought to design a method of interpretation which would uncover meaning and lead to understanding. He was mindful that interpretation was influenced by the genre of the text, the context in which it was written, and the reader and the context in which it was read. Ricoeur contended that "hermeneutics was born with the attempt to raise exegesis and philology to the level of *Kunstlehre,* that is, a 'technology' which is not restricted to a mere collection of unconnected operations" (p. 45).

Hermeneutic philosophers

Other hermeneutic philosophers have also informed this research. Heidegger (1962) suggested that it is through language that the meaning of *Dasein* can be uncovered.

Heidegger used the term *Dasein* to describe human existence. *Dasein* literally means Being-there, and is used in everyday German to refer to the existence of anything at all. Heidegger restricted the term *Dasein* for human beings alone, since he believed that it is only human beings that truly exist and interpret the world (Harman, 2007). Language is not just used to express what we see, but also when we speak, others see what we mean. For Heidegger it is language that makes humans what they are since humans are always interpreting and articulating the world, even when no words are used (Harman, 2007). Gadamer (1975/2004) builds upon Heidegger's notion of language. For Gadamer, language is interplay between speaker and interpreter, understanding being reached through dialogue within a background of prior understandings of what language means.

As for Heidegger and Gadamer, interpretation of experience through spoken and written communication is central to Ricoeur's hermeneutics. For Ricoeur (1974b) "interpretation is the hinge between linguistics and non-linguistics, between language and lived experience" (p. 66). Ricoeur's (D. Pellauer/1973) theory of hermeneutics seeks to explicate an epistemology of interpretation, as he explained; "it is in the linguistics of speech that event and meaning articulate themselves" (p. 132).

Meaning found in text

For Ricoeur (1981), the hermeneutical task is to interpret the text itself, rather than a search for participants' unique meanings, as one would do in a phenomenological study (van Manen, 1997). As Ricoeur stated "interpretation is to follow the path of thought opened up by the text, to place oneself en route towards the orient of the text" (p. 162).

Phenomenology asks the ontological question of 'being', which Ricoeur (1981) says becomes " a hermeneutical problem insofar as the meaning may be concealed, not by itself, but by everything which forbids access to it" (p. 114). Ricoeur (1974a) speaks of "the graft of the *hermeneutic problem* onto the *phenomenological method"* (p. 3). Moving beyond seeing hermeneutics and phenomenology in opposition, Ricoeur (1981) sees the two as mutually dependent, stating that "on one hand hermeneutics is erected on the basis of phenomenology; *phenomenology remains the unsurpassable presupposition of hermeneutics*. On the other hand, phenomenology cannot constitute itself without a *hermeneutical presupposition"* (p. 101).

Ricoeur's theory of interpretation includes two stages; first, explanation or what the text says; and second, understanding or what the text talks about. Explanation is directed towards analysing the structures of the text, while understanding is directed toward grasping the meanings the text discloses. "To understand a text is to follow its movement from sense to reference: from what it says to what it talks about" (Ricoeur, 1976, pp. 87-88).

A text may have several different meanings for each reader. As Ricoeur (1974a) said, "every reading of a text always takes place within a community, a tradition, or a living current of thought, all of which display presuppositions and exigencies" (p. 3). Ricoeur's (1981) perspective is that interpretation is affected by the history, traditions, culture, and pre-understandings which the reader brings to the interpretative process; although Ricoeur does emphasise that even though we are affected by the past, we do not have to be wholly determined by it. The point of view that critical reflection on history and tradition enable an appreciation of other ways of acting indicates a critical position to Ricoeur's philosophy.

Pre-understandings and interpretation

According to Ricoeur (1981), the basic hermeneutic position is that we must already have a prior understanding before we can begin to interpret our world, and that interpretation consists of explicating experience in terms of our prior understanding. My own pre-understandings have been discussed in Chapter One of this thesis. This section shows how Ricoeur's notion of pre-understandings has been applied to the interpretive process in this research.

Ricoeur (1981) has drawn on Heidegger's (1962) notions of *fore-having, fore-sight,* and *fore-conception (Vorhabe, vorsicht, vorgrifft)*, in appreciating the link between pre-understandings and interpretation. Heidegger (1962) says that:

> in every case … interpretation is grounded in something we have in advance – in a fore-having" (p. 191). Understanding therefore happens under the guidance of fore-having and from the interpreter's point of view, which is "grounded in something we see in advance – in a fore-sight… (p. 191)

So as I interpret, I bring my *fore-having*, the pre-understanding which I already have to the interpretive process, and then with *fore-conception,* based on *fore-having* I begin to grasp the meaning in advance, and with *fore-sight*, see other interpretive possibilities within that text.

For Ricoeur (1991), the interpreter can never be completely distanced from their own *fore-having* or prejudices. Ricoeur (1981) puts it thus; "history precedes me and my reflection; I belong to history before I belong to myself" (p. 68), and further that "the concept of distanciation is the dialectical counterpart of the notion of belonging, in the sense that we belong to an historical tradition through a relation of distance which oscillates between remoteness and proximity" (pp. 110-111). We belong to a history, to a society, to a nation, to a culture, to a tradition, and as we read a text (or research transcript) we bring these traditions forward with us. Two of the signifying features of Ricoeur's philosophy of hermeneutic interpretation are the notions of *distanciation* and *appropriation*. The next section explores these notions in detail.

Distanciation and appropriation

Ricoeur (D. Pellauer/1973, 1974b, 1976, 1981, 1991) held that when dialogue is written down as a text and leaves its original author, a distance is created between the author and the reader, the context in which it occurred, and from the original audience. A text may be reread and reinterpreted many times by new readers in new contexts. According to Ricoeur (1981), written text therefore, has a life of its own; or what Ricoeur refers to as *distanciation*. Thus, rather than the meaning of a text residing with its author, for Ricoeur meaning is found within the text. Ricoeur (1981) asserts that through *distanciation*, we stand back and imagine how we could respond to what is imagined through reading that text, and through a process of interpretation, or *appropriation* we come to understand ourselves. As Ricoeur (1981) claimed "to understand *oneself* is to understand oneself *in front of the text"* (p. 113).

Appropriation is Ricoeur's (1981) translation of the German term *Aneignung* "to make one's own what was initially alien" (p. 185). Drawing on Gadamer's (1975/2004) notion of 'play' Ricoeur says that we interpret or *appropriate* meaning from language by moving between near and far, the familiar and unfamiliar, between foreign and known, and this 'play' has a potential to transform us which leads to

understanding ourselves and others. The link between *appropriation* and transformation is what Gadamer (1975/2004) means when he talks of a 'fusion of horizons', where the interpreted meaning of the writer and the reader converge. In Ricoeur's view, *appropriation* is the "cornerstone of hermeneutics" (p. 191), and is the counterpart to *distanciation*. *Appropriation* does not attempt to determine the subjectivity of the original author, rather it *responds* to the text itself, and hence the meaning which the text unfolds. For this study, meanings are *appropriated* by a process of to and fro discussions with the other midwifery teachers and in the light of my own pre-understandings which I bring to the research process.

The notions of *distanciation* and *appropriation* are significant for participatory hermeneutic inquiry (Herda, 1999). *Distanciation* allows for a person to distance themselves from the text temporally and contextually. *Distanciation* was important for this study. I was involved in day to day teaching and assessment of the students who were participating in the research; I worked alongside the teacher participants and at the same time led the introduction of a new curricular process. It took time, for example, for me to read the transcripts from the student focus groups as I felt personally affected by some of the conversations. I also felt responsible for the other teachers' interests. These things would understandably influence my interpretation and analysis of the research conversations and focus groups. I was able to distance myself temporally and contextually once the students who were involved in the first year of the new curriculum had graduated at the end of the following year and I was no longer involved in their teaching or assessment. The process of *distanciation* made it possible for me to put aside some of these feelings and recognise some of my own biases and pre-understandings.

Ricoeur's theory of time and narrative

Data from the teachers' research conversations, student focus groups and written reflections was interpreted with the guidance of Ricoeur's theory of narrative interpretation. Ricoeur's (1984, 1985, 1988) theory of interpretation is explicated in the three volumes *Time and Narrative*. Within these works, Ricoeur illuminates a philosophy of historical and fictional narratives, and their relationship to time, narrative structure and narrative identity. This has provided a basis for the way that data is interpreted in this study.

History and fiction

Ricoeur (1984) compares different kinds of narratives; historical and fictional, and how their narrative structures relate to time. He differentiates between a historical chronicle, which simply lists events, and a narrative, which implies a connection between them. Fictional narratives may also be about events, but tend to focus on deepening characterisation of the players within the structure of a plot. Fiction presents us with a narrative in which characters unfold and in doing so the reader can imagine a different way of seeing the world, through the characters' eyes. Ricoeur (1988) integrates the two classes of narratives, pointing out that historical narratives are made more intelligible when they are modelled on plots borrowed from fiction. As Ricoeur (1992) says "do we not consider human lives to be more readable when they have been interpreted in terms of the stories that people tell about them?" (p. 114).

When a woman tells her childbirth history to a midwife, or comes to class to tell her story of her childbirth experience, she relates this history as a narrative, not just as a chronicle of events. Equally when teachers and students talked about their experience of using narrative pedagogy, they told them as narratives about "what happened in their tutorial groups" or "what they heard in class". As Aranda and Street (2001) point out, the process of narrating experience is always set within a historical and temporal frame that the teller brings to the story. Ricoeur (1984) shows how the features of fiction are used when people describe events and experiences, and how these help us in interpretation.

Emplotment and mimesis

The distinguishing feature of narratives, whether they are historical or fictional, is that they have a plot. Ricoeur (1984) refers to a model of *emplotment* to show how a plot combines episodes of a story into a meaningful whole. The function of *emplotment* is to configure language into a conceptual network that allows us to speak meaningfully about human action. The conceptual network which helps us to understand the meaning that is being conveyed through the narrative includes factors such as time, cause, motive, action, passion, work, agent and goal (Ricoeur, 1984).

Ricoeur uses the Aristotelian term mimesis (meaning imitation of life in art and literature) to explain how we come to understand meanings within narratives. As outlined in Chapter One, Ricoeur (1984, 1985, 1988) presents mimesis$_{1,\ 2\ \text{and}\ 3}$ as an

activity consisting of three stages that he calls *prefiguration*, *configuration* and *refiguration* (as previously outlined in Chapter One, p. 11).

Mimesis$_{1,}$ also known as narrative *prefiguration*, is the expression of our pre-understandings of the world of action. The plot of a story is prefigured by way of being "grounded in a pre-understanding of the world of action, its meaningful structures, its symbolic resources, and its temporal character" (Ricoeur, 1984, p. 54). Mimesis$_1$ (a past) is the world of everyday action already characterised by a conceptual network that makes narrative possible. In other words, in order to represent (or interpret) human action we first need to pre-understand what human acting is in its various forms. Something has to exist before it is configured. Mimesis$_1$ creates the pre-figured life, our traditions, assumptions, goals and motives, it is a world already *figured* (Ricoeur, 1984).

Mimesis$_{2,}$ known as narrative *configuration*; is the actual telling of the story through the pre-understanding of mimesis$_1$. In the telling of the story, *emplotment* acts as a mediation between the events of the story as a whole, its "agents, goals, means, interactions, circumstances, unexpected results" (Ricoeur, 1984, p. 65), bringing the story together in one temporal whole. Ricoeur (1984) speaks of mimesis$_2$ with reference to fiction. He says that mimesis $_2$ "opens up the kingdom of the *as if"* (p. 64), showing the reader/listener a potential world, or way of being; whereas mimesis$_{1,}$ shows the reader/listener the world *as it was*.

The third mimetic process or *refiguration* refers to the impact that narratives and stories, historical or fictitious, have on the reader/listener. Mimesis$_3$ is where the world of the text and the world of the reader meet. Mimesis$_3$ is close to Gadamer's (1975/2004) notion of 'fusion of horizons.' For Gadamer, one person's interpretations and understandings merges with another's, to form a 'fusion of horizons'. At the level of mimesis$_3$, Ricoeur (1984) says that the interpreting of narratives shows the reader/listener a new world or way of being to the extent that "what is interpreted in a text is the proposing of a world that I might inhabit and into which I might project my ownmost powers" (p. 81).

Narrative at the stage of mimesis$_3$ has its full meaning when placed in its time [or context]. Ricoeur (1984) writes that:

> mimesis$_3$ marks the intersection of the world of the text and the world of the hearer or reader; the intersection therefore, of the world configured by the poem and the world wherein real action occurs and unfolds its specific temporality. (p. 71)

This is the world *refigured* through narrative understanding, so that "'what is' is no longer what we call everyday reality; or rather, reality truly becomes reality, that is something which comprises a future horizon of undecided possibilities, something to fear or to hope for, something unsettled" (Ricoeur, 1981, p. 187).

As a result of the interplay of narrative in the *refiguration* of time, the reader/listener's world is changed through seeing other possible worlds opened up by the text. Through reading or listening to a narrative, the narrative transforms the *prefigured* world of the reader, and this makes possible a *refiguration* of the world of the reader. Completing the hermeneutic circle, mimesis$_3$ returns mimesis$_2$ to the world of action and life (mimesis$_1$). Ricoeur speaks of this as "an endless spiral that would carry the mediation past the same point a number of times, but at different altitudes" (Ricoeur, 1984, p. 72).

For this study, the features of *emplotment* and mimesis have been fundamental. The interpretive process at all stages has been based on identifying the *prefigured* world of midwifery education, and how through a to and fro process of *configuration*, sharing and analysing experiences, we adapted our teaching and learning processes to come to a new way of seeing midwifery education, a *refigured* world.

Time

A constant thesis of Ricoeur's (1984) work is that we only understand time in relation to the sharing of narratives. In the first part of Volume One of *Time and Narrative*, Ricoeur (1984) puts Augustine's theory of time side by side with Aristotle's theory of plot. His analysis is that Augustine looked at the nature of time without concern for narrative structure, and that Aristotle constructed his theory of plot without paying attention to the temporal dimension. Ricoeur's philosophy reconciles narrative

structure with the temporal character of human experience. Ricoeur (1984) emphasises throughout his work that "time becomes human time to the extent that it is organised after the manner of a narrative; narrative in turn, is meaningful to the extent that it portrays the features of temporal experience" (p. 3). Through narrative understanding we can think about time and be critical of what we do know of it, as well as what happens in it, as Ricoeur (1988) expresses "there can be no thought about time without narrated time" (p. 341).

The implication of seeing the relationship between time and narrative in this way is that narrative contributes to a new understanding of time. Ricoeur (1984) states "making a narrative [*le faire narrative*] re-signifies the world in its temporal dimension, to the extent that narrating, telling, reciting is to remake action following the poem's invitation" (p. 81); meaning, that time itself is never directly observed, time only becomes meaningful when it is articulated through narratives, and conversely narratives become meaningful in the context of time.

Time became significant in this study when interpreting students' and teachers' experiences of a narrative-centred curriculum. Both teachers and students spoke about time as a commodity, or time being 'used up' when they were listening to the narratives or having a discussion, when it could have been 'used' for something more important.

For this study, time also offered a different perspective on interpretation. Interpretation of teachers' and students' experiences changed from the initial interpretation when narrative pedagogy was first introduced to later when the curriculum had been running for longer. Initially the curricular change elicited strong responses as teachers and students adapted to a new way of doing things, but over time, as everyone got used to narrative pedagogy, it became the way we did things. My interpretations reflected this change.

Narrative identity

Ricoeur (1984) bases his philosophy of narrative interpretation on the *prefigured* world which contains a world of history, traditions, symbols and rules through which we interpret the world. According to Ricoeur narrative takes language, which signifies or figures action, and through *emplotment* adds new features to it that give it a new meaning by turning it into the story of 'doing something'. Narrative provides a way to

extend discourse beyond the level of individual action; a narrative conveys things over time, in the past and in the future. A narrative tells a story about human action and its meaning. When this story is heard or read, and then understood, it contributes to our *refiguring* our understanding of human action and future possibilities.

In hermeneutic participatory research, discussion about future possibilities is made possible by what the text points to. Ricoeur (1981) describes hermeneutic interpretation as "the explication of the being-in-the world displayed by the text. What is to be interpreted in the text is a proposed world which I could inhabit and in which I could project my own-most possibilities" (p. 112). In other words, as we interpret narratives, we come to understand something about ourselves

Historical and fictional narratives conveyed by a culture clarify an individual or a community's self-knowledge, leading to what Ricoeur (1988) calls "narrative identity" whereby "the story of a life continues to be refigured by all the truthful or fictive stories a subject tells about himself or herself. This refiguration makes the life itself a cloth woven of stories told" (p. 246). Narratives, in fact, constitute the identity of individuals and community, as their actual history is founded on the taking up of narratives (Ricoeur, 1988).

As we teachers shared our stories of using a narrative-centred curriculum through research conversations, we interpreted what was happening in our teaching and learning processes, we looked at the *prefigured* world of midwifery education, the way we had done things in the past, and in doing so came to understand our own philosophies of education. Through research conversations, *configuration,* we reflected on what had worked well, and what could be done differently and we *refigured* the way we see midwifery education. Through a participatory research process, we created a unique cultural identity for our midwifery programme.

Participatory inquiry

Along with the interpretive process, underpinned with hermeneutics, it was the aim of this study to maintain dialogue between researcher and participants in order to work together collaboratively to make curricular changes as we went along. Whilst this dialogue was not totally possible with the student participants, for ethical reasons, dialogue was the foundation of the research conversations we had as a group of midwifery teachers.

Participatory inquiry emphasises doing research 'with' rather than 'on' people (Heron & Reason, 2006). Through dialogue and participation, a participatory research approach is committed to making changes based on the research process (Fadem et al., 2003). The philosophy on which participatory inquiry is based is generally acknowledged as coming from the work of the critical theorists Paulo Friere and Jurgen Habermas (Koch, Selim, & Kralik, 2002). There is an emphasis on building equitable partnerships throughout the research process and achieving a balance between research and action for the mutual benefits of all partners (Israel et al., 2003).

Participatory inquiry is not a method as such, rather it is an orientation to research (Minkler & Wallerstein, 2003); there is no one single set of instructions for "doing" participatory research. The underlying principles of a participatory orientation have been defined as being community centred, facilitating collaborative, equitable partnerships, promoting co-learning and capacity building among participants, building a body of shared knowledge, emphasising local relevance, and being a cyclical and iterative process (Israel et al., 2003). These fundamental principles need to be adapted to each unique research situation (Herda, 1999).

Participatory inquiry is an umbrella term for different methods which emerged out of dissatisfaction with a positivist research paradigm, and a critique of the role of the researcher in the developing world (van der Riet, 2008). Participatory inquiry has been variously named community based participatory research (Minkler & Wallerstein, 2003), field-based participatory inquiry (Herda, 1999), participatory action research (Fals Borda, 2006; Koch, Mann, Kralik, & van Loon, 2005), community-based participatory action research (Koch et al., 2002) and co-operative inquiry (Heron & Reason, 2006, 2008).

Participatory inquiry approaches have tended to be used in social science research where issues of cooperative action and democracy are significant; for example, a model for prevention of community violence (Koch et al., 2002), aboriginal people living with diabetes (Koch et al., 2005) and a healthy neighbourhood community project in Texas (Williams, Bray, Shapiro-Medoza, Reisz, & Peranteau, 2009). The emphasis with participatory research in these situations is that it is undertaken by the participants who are involved in collectively researching their own situations with a commitment to social change. When participatory research has this aim, it also holds elements of critical theory (Kemmis, 2008). Research based on a

participatory approach is also said to have a transformative potential based on the principle that participants are actively involved in the research process, and that there is co-ownership of the research process and outcome (van der Riet, 2008).

In this study, the midwifery teachers collectively were committed to collaborating in making educational change based on our experiences, and within the context of an established educational system. This creates an element of critical positioning. The relationship I had with participants was complicated by the three roles I held as a curriculum leader, a teacher and researcher. When a participatory research approach is used, the relationship between researcher and participants potentially facilitates a more 'real' understanding of experience through the researcher being an 'insider'. The tension can be that issues of power relations between researcher and participants are raised (Wallerstein & Duran, 2003). For example, in the context of this research, issues of potential power imbalances between teachers and students were raised so it was ethically not possible for students to be involved as equal participants.

Participation in all phases of the research does not mean that everyone is involved in the same way with all activities (Israel et al., 2003). Data analysis was predominantly done by me, as researcher, with feedback to the teachers to see if it met with their experiences. It would not have been possible for teachers to have spent the time needed to analyse the data with me, due to their busy teaching schedules.

For this research, the participative process between me, as the researcher, and the teacher participants involved in the research process, paved the way for a new way of looking at teaching and learning in midwifery education. We each brought our knowledge of midwifery and midwifery education to the research group and through research conversations were able to express, share and analyse what was happening with the narrative curriculum, and make adjustments as we went along in response to our experiences and student communication. This worked for the group of teachers and even though the students were not participating in the same way, when they had issues to discuss they came to us or to the Head of Midwifery/Programme Leader because they felt listened to and knew that their experiences were important to us.

The principles of participatory inquiry guided this research and facilitated a creative method which both interpreted the experiences of the teachers and students and also constituted the process by which teachers and students dialogued and

adapted the curriculum to meet our needs and to develop a shared memory which would enable the ongoing use of a narrative-centred curriculum.

A critical positioning to Ricoeur's hermeneutics

Critical theory is defined as "a social philosophy, a social science, a theory of knowledge, and a rationally grounded practical philosophy geared toward overcoming one-sidedness and injustice" (Kaplan, 2003, p. 4). Kaplan (2008a) points out that as a rule hermeneutic philosophers are not considered to be cultural critics; and as a result Ricoeur is generally overlooked when it comes to critical theory. Yet much of Ricoeur's work seeks to establish a connection between hermeneutic phenomenology and a critique of ideology (Ricoeur, 1974b, 1981, 1991). Ricoeur (1991) contended that hermeneutics had come to an impasse because it lacked a "critique of ideology" (p. 270), and that the moment hermeneutics and critique become radically separated they will "be no more than …ideologies" (p. 307).

Whether hermeneutics could be critical, or not, was a point of debate between Gadamer (on the side of hermeneutics) and Habermas (on the side of critique). For Gadamer (1975/2004), understanding is always affected by history, prejudice, authority and tradition, and 'fusions of horizons' may be attained by reaching a consensus of understanding through dialogue. Habermas thought that tradition not only transmitted understanding but could also transmit violence and domination, and that consensus achieved in dialogue may be systematically distorted, and violence and domination perpetuated through false consciousness (Kaplan, 2003). Habermas is a central figure in one branch of critical theory, another branch being the Institute of Social Research known as the 'Frankfurt School' which includes the theorists Horkheimer, Adorno and Marcuse who sought to synthesise the works of (amongst others) Freud, Marx, Hegel and Kant (Held, 1990). While there are differences between the branches of critical theorists, all believe that "through an examination of contemporary social and political issues they could contribute to a critique of ideology and to the development of a non-authoritarian and non-bureaucratic politics" (Held, 1990, p. 16).

Ricoeur (1981) proposed a reconciliation which accounts for both hermeneutics and the critique of ideology, arguing that Gadamer's philosophical aim of interpretation through tradition does not necessarily contradict Habermas' aim of

evaluating and criticising false consciousness and communication. Ricoeur's mediation of the Habermas-Gadamer debate forms a unique version of critical theory, as his hermeneutic philosophy interprets texts and actions as well as evaluating issues of power and authority (Kaplan, 2003). For Ricoeur, hermeneutics and critique of ideology are part of a process of interpretation geared toward improving interpretation by identifying processes that may distort or prevent understanding.

Ricoeur's (1981) hermeneutics offers a critical position in several ways. First the notion of *distanciation* creates a critical distance between the author of a text and the pre-understandings of the person who is doing the interpreting. Second, a critical position is offered through examination of the role which culture, history and tradition have in interpretation. Third, culture, history and tradition may be reinterpreted so that new ways of acting and being in the world can be explored. Ricoeur claims that "the task of the hermeneutics of tradition is to remind the critique of ideology that man can project his emancipation and anticipate an unlimited and unconstrained communication only on the basis of the creative reinterpretation of cultural heritage" (p. 97).

For Ricoeur (1981) narrative interpretation is based on a historical connection mediated by diverse social institutions, such as groups, classes, nations, and cultural traditions. Narratives are never ethically neutral; they either implicitly or explicitly induce a new evaluation of the world and of the reader as well. According to Ricoeur (1988), it is up to the reader to choose among the multiple proposals of ethical justice brought about by the reading. This involves a critique of the past and a reinterpretation of tradition, a view which points toward a critical hermeneutics. Ricoeur (1981) makes this link when he says that "he who is unable to reinterpret his past may also be incapable of projecting concretely his interest in emancipation" (p. 97).

The idea that interpretation is based on history, tradition, culture and society offers a critical position for this study. *Distanciation* provides an opportunity for me to critique my own biases and pre-understandings which I bring to the interpretive process. A critique of the pedagogical underpinnings of midwifery education and New Zealand's university system offer a way to understand the experience of midwifery teachers and students when we attempt to implement a different pedagogy. Finally,

interpretation of experience within the context of the past has enabled us to see a way forward for a new way of providing midwifery education.

Conclusion

Ricoeur's theory is permeated with themes of interpretation of language, self and narratives which have proven fundamental to the interpretation of the experience of midwifery teachers and students in using a narrative pedagogical approach in midwifery education. The methodology used in this study is based on the philosophical insights provided by Ricoeur's philosophy of hermeneutic interpretation.

For this study, Ricoeur's philosophy provided a foundation for narrative interpretation in two ways; through informing the curricular process which is based on interpretation of women's narratives, and for the research process which is based on interpreting the experience of midwifery teachers and students. For midwifery students as they listen to and interpret women's narratives, they consider the *prefigured* world of midwifery, what they already know and understand about it. As women shared their narratives with the class, students were able to *configure* what they already knew about midwifery and in the light of women's experience, understand their own values and beliefs and then look forward to planning the provision of effective midwifery care though *refiguration.*

In terms of the research process, Ricoeur's three domains of mimesis$_{1,\ 2\ \text{and}\ 3,}$ provided a foundation for data analysis. As the researcher, when I read the transcripts I thought about the already figured, taken for granted world of mimesis$_1$ (both my own pre-understandings, and the world of the existing midwifery curriculum) and through a process of *configuration* (rereading the stories, and returning the transcripts to research participants) the midwifery teachers and I began to see ourselves in different capacities, the world *refigured*.

Ricoeur's theory of narrative interpretation, occurring through *prefiguration*, *configuration and refiguration* of narratives, provides a framework for the way that data is analysed and the text of this thesis is created. The following chapter will explicate the particular methods used in all stages of this study.

Chapter Five: Methods

Introduction

The previous chapter presented the philosophical underpinnings and methodological stance which has guided this hermeneutic study. This chapter brings together the philosophical underpinnings with the specific methods that have been employed in this research. The consultation and preparatory process is explained, along with the study design, the way participants were invited to participate in the study, ethical considerations, how data was collected and interpreted, and the way that rigour has been substantiated.

Consultation and preparation

Prior to the commencement of the new narrative-centred curriculum at AUT in 2005, extensive preparation and consultation occurred with advisors, both within and external to the University.

External Consultation

External advice was received regarding the proposed new curriculum from other educators who had used narrative pedagogy and narrative- centred curricula in nursing education in the U.S.A. A telephone discussion was held in the initial stages of planning this research with Professors Swenson and Simms (July, 2004). Given their experience with using a narrative-centred approach, I was interested in their thoughts on the focus of the research, methodology and methods. During this preliminary discussion, Professors Swenson and Simms agreed that it would be useful to record the experiences of teachers and students as the curriculum was being implemented rather than in retrospect.

Advisory committee consultation

AUT's midwifery programme advisory committee was also consulted throughout 2004. The Midwifery Advisory Committee meets twice yearly and consists of internal and external members. External members include representatives from consumer groups, women's health groups, practicing midwives, a Māori representative, a New Zealand College of Midwives representative, district health board representatives and midwifery lecturers. This advisory committee was supportive of the fundamental idea

for the narrative-centred curriculum, and for the research that would run alongside it. I consulted the committee regarding the research protocol which was developed to address confidentiality issues for student and teacher participants. They were assured that the protocol would ensure participants' protection.

Planning and design

Extensive dialogue was held with my research supervisors regarding possible methods and processes. We discussed the ethical considerations of research when the researcher, as in my case, is involved with participants on a day to day basis.

I met with the students who were going to be the first group to participate in the narrative-centred curriculum to explain the way it would work. I discussed with them the value of recording their experiences of participating in the curriculum and asked what, for them, might be an acceptable method of data collection. Keeping a structured reflective journal to hand in at the end of the semester was one proposition, but students voiced concern that it might be just "one more thing to write up". We came to an agreement that meeting as a focus group or writing something in class time would be more suitable for them.

Consulting with Māori

An important consideration for this research was consultation with Māori. The Treaty of Waitangi[13] is the founding document for New Zealand, and as such has relevance for New Zealand researchers where Māori are involved as participants, or where the project is relevant to Māori (Health Research Council, 2009). The Treaty of Waitangi has three basic principles: protection, participation and partnership. Each principle has significance for researchers in New Zealand. The concept of partnership requires that researchers work together with Māori communities to ensure Māori individual and collective rights are respected and protected; the concept of participation requires

[13] In 1840, the Treaty of Waitangi was signed by William Hobson on behalf of the British Crown, and over 500 Māori chiefs representing their iwi (Māori tribes). The Treaty of Waitangi established British law in New Zealand, while at the same time guaranteeing Māori full rights of authority over their land, forests, fisheries and culture (Orange, 1987).

that Māori are consulted with regard to the research design, implementation and analysis of research, especially where the research involves Māori; and the concept of protection requires that researchers actively uphold Māori individual and collective rights in the research process (Massey University, 2006).

For this study there were Māori students in the class who could potentially be participants. The idea of a narrative-centred curriculum is relevant for Māori people who have a strong oral tradition as a means of passing on knowledge between generations (Makereti, 1986). With this in mind, a dialogue was instigated with the Māori advisory committee for the Schools of Nursing and Midwifery at the University, known as Kawa Whakaruruhau Komiti (see letter Appendix B). This dialogue with Kawa Whakaruruhau resulted in developing a special research protocol for students who identified as Māori. The research protocol for students who identified as Māori is discussed further on page 82 in this chapter.

Study design overview

The consultation and preparation which occurred throughout 2004 with internal and external advisors, midwifery students, my research supervisors and Kawa Whakaruruhau Komiti resulted in the development of the research methods used in this study. Four methods were developed; two to record and interpret the experiences of midwifery students through focus groups and written reflections. The third method recounts the experience of midwifery teachers through research conversations, and a fourth method conveyed the experience of the Head of Midwifery/ Programme Leader. Ethical considerations were fundamental to addressing the specific design of this study, and will be discussed first, followed by an explication of the specific methods employed within this study.

Ethical considerations: Protection of participants

There are particular ethical challenges when the researcher is also a co-participant, and research participants are students or colleagues of the researcher. Boundaries may blur between researcher and participants (Fadem et al., 2003). I was concerned that teachers and students might feel coerced into participating in the research or reluctant to voice their honest point of view, for fear of affecting relationships. I did not want this to happen, at any cost, so it was crucial to develop a research process

which would ensure that student and teacher participants were protected. It was especially important that students' progress through the programme would not be affected by their choice to participate or not to participate in the research.

Ethics in research involves "trustfulness, openness, honesty, respectfulness, carefulness and constant attentiveness" (Davies & Dodd, 2002, p. 281); in other words, ethics is about being open, visible and accountable at all stages of the research process. In this study, ethical considerations have been paramount at all stages; throughout the consultation and preparation of the study, the way participants were invited into the study, the questions asked, and the way that data was recorded, transcribed, and analysed.

Formally, ethical approval for the research methods (focus groups and written reflections) involving midwifery students was granted through the AUT Ethical Committee (AUTEC) Dec. 2004 04/222. Midwifery students' experiences of participating in a narrative-centred curriculum (Appendix C). Ethical approval for the research involving the midwifery teachers (research conversations) was granted through the AUTEC Oct. 2004 04/184 'The experience of midwifery lecturers in implementing a narrative-centred curriculum into an undergraduate midwifery programme' (see Appendix C).

In June 2005 an amendment to 04/184 allowed for ethical approval to interview the Head of Midwifery/Programme Leader in order to gain her perspective of the implementation of the new curriculum (see Appendix C).

The specific strategies employed to maintain the safety of participants in this study were:

- My primary supervisor met with both the student group and the teachers group to inform them of the study, to explain the research process to potential participants, how their safety would be ensured throughout the study and to make it very clear that they were under no obligation to participate;
- The method of obtaining consent was that students and teachers who were willing to be a part of this study returned their consent forms to my primary supervisor. If they did not wish to be involved, doing 'nothing' meant they were not part of the study and no further approaches were made;

- Consent forms have been retained in a locked cabinet at AUT under the care of my primary supervisor to preserve their anonymity. As researcher, I never knew which students had participated in the study;
- The soft copies of the transcripts from the focus groups, research conversations and the interview are kept in a computer file which had a password only known to me. The audio tapes and hard copies of the transcripts are kept in a locked filing cabinet, to which only I have access. At the completion of the study the tapes from the teachers' research conversations will be destroyed. All of the data will be destroyed after six years. This is in accordance with the requirements of AUTEC (2004).

Protection of the student participants: Anonymity and informed consent

As I was one of the teachers involved in the teaching and assessment of students enrolled in the paper, it was essential that students who agreed to participate in the study remained anonymous. This was to make sure that assessment processes and students' progress throughout the programme would not be affected. To ensure anonymity, it was important that I did not directly set up or run the focus groups. Therefore the research was explained to potential participants by my primary research supervisor who was not involved with teaching in the undergraduate midwifery programme. She gave out the participant information sheet and consent forms (see Appendices D and E). Those who agreed to participate in the focus groups then returned the completed consent form by mail to her. If they did not return the consent form, it was assumed that they had chosen not to participate in the research and no further communication regarding this decision was made.

Protection of the teacher participants: Confidentiality and informed consent

There was potential for the teachers I worked with to feel pressured by me or by the rest of the group to participate in the research. I realised that it would be difficult for any one teacher not to participate if the others all agreed, so special care was taken to ensure that no-one would feel coerced into participating in the research group. With

this in mind, my primary research supervisor met with the midwifery teachers (without my presence) in February 2005 to explain the research process and to discuss and answer questions about the research. This was an opportunity for them to consider all the permutations of being a part of the teachers' research group while at the same time being a colleague of the researcher. A participant information sheet (see Appendix F) was prepared which outlined the involvement of potential teacher participants.

Potential teacher participants were given time to consider whether they would consent to be a part of the research group. If the teachers agreed to participate in the study, they signed the consent form (see Appendix G) and gave it to my primary research supervisor. If they did not sign the consent then it would be assumed that they did not wish to participate and no further approaches were made. All potential participants (three midwifery teachers) consented to participate.

Data collection methods: Midwifery students

Potential midwifery student participants were the group of 50 who were enrolled in the midwifery paper 'Art and Science of Midwifery' in Semester One (February-July) 2005. They were the first cohort of midwifery students at AUT to participate in a narrative-centred curriculum. Two methods were developed to collect the experiences of the midwifery students; focus groups and written reflections. It was anticipated that these methods would provide rich data in recording students' experiences of participating in a narrative-centred curriculum. The precise methods and participant recruitment for each method will be described separately.

Data collection 1: Midwifery students' focus groups

Timing

I recognised that midwifery students' experiences with the new curriculum could potentially change over time. Therefore I felt that it would be valuable to record students' experiences through focus group discussions around the middle of Semester One, once the narrative curriculum was well underway, and then to meet again at the end of the semester to see if they felt differently looking back over time.

Protocol for students who identified as Māori

The research protocol which was developed for students who identified as Māori consisted of offering those students a separate student focus group with a Māori facilitator. Of the 14 students who consented to participate in the focus groups, two identified as Māori and wished to be part of a separate group facilitated by a Māori interviewer. A Māori woman from AUT's health faculty who was not involved with teaching midwifery students agreed to facilitate a focus group for students who identified as Māori.

Organisation

Fourteen students (out of the group of 50) consented to participate in the focus groups. The list of students (with their contact details) was given to an independent research officer. The research officer was an AUT employee of the Centre for Midwifery and Women's Health Research who was experienced with facilitating focus groups. Her role was to organise students into groups of 5-8, and then telephone or email participants to arrange a suitable time and place for the groups to meet. The students were divided into three groups by the research officer, one group of two Māori students, with the remaining twelve students divided into two groups, one with seven participants and one with five. Two of the groups met with the research officer and the Māori students met with the Māori interviewer.

Focus group interviews

The student focus group meetings lasted for approximately one hour and were audio taped. The tapes were sent by the research officer to be transcribed by an experienced transcriptionist who had signed a confidentiality agreement (see Appendix H). I provided a list of questions for each facilitator to ask the focus groups. It was anticipated that different issues would come to the fore for students at different points in the semester. Assessments, for example, tend to be due at the end of the semester so questions about assessment were asked later rather than earlier. The list of questions is shown in Appendix I.

The transcripts

Once transcribed, transcriptions of the focus groups were read by the research officer who removed all identifying data from the transcripts. If students mentioned for example, their children, or where they lived, or if they mentioned teachers by name,

this information was removed. Each participant was labelled as A, B, C and so on by the research officer before passing on these transcriptions to me. This was so I would not know who participated. Once transcribed, the audio-tapes were destroyed, thereby eliminating any possible identification of individual students through voice recognition.

Drop off in participation

Unfortunately, there was a big drop off in student participation between the first focus groups and the second meeting scheduled later in the semester. The group which had seven participants midway through the semester fell away to two attending the focus group at the end of the semester, despite four having confirmed their attendance. The group which had five participants in the earlier meeting had three in the later group, although seven had confirmed they would come. This could be attributed to busyness of student life, priorities of clinical placements and study, or else a feeling that the curriculum was embedded and "the way things were done" therefore their input was not required. The Māori group consisted of two students who did meet twice with a Māori interviewer to discuss their experiences. This part of the study took six hours and produced ninety-two pages of transcribed conversations for interpretation.

Analysis of student data

When I received the first transcripts from the student focus groups and read through them, I was disturbed by some of the student discontent with the curriculum. I was not surprised however, as we had already had feedback from the students through their student representatives and through the tutorial groups that some were anxious about their ability to learn in this new way. I found that I had to put the transcripts to one side for a while as I felt a sense of being personally responsible for the students' dissatisfaction and found I could not reflect on what they were saying without feeling discouraged. The transcripts from the second focus groups held three months later, revealed that students were more positive than they had been initially about this way of learning, which was reassuring for me. Once I felt less concerned, I was able to return to the earlier transcripts and found I was able to see through some of the worries which the students had and, over time, consider some of the reasons why they had initially struggled with the new way of learning.

Data collection 2: Midwifery students' written reflections

Along with collecting data via focus groups, I felt it would be significant to record students' thoughts, experiences and reflections immediately after each narrative session. Hence, a second method was developed which would provide students with an opportunity to give immediate written feedback on what they had learned from the narrative session.

For each narrative session I provided blank A4 sheets of paper with a prompt printed on them. The prompt for this reflection was based on the literature from narrative pedagogy (Ironside, 1999b) and simply stated at the top of an A4 page (see Appendix J): "When I heard the stories about [getting pregnant] today I was thinking…" At the bottom of the page was a space where students could choose a pseudonym. The pseudonyms students chose were quite creative. Some chose a phrase as their pseudonym, for example one student chose 'A woman centred approach with an attitude of mutual honour and respect'. The pseudonyms were used to ensure students' anonymity, and to enable the tracking of individual student comments to see if there were any differences in responses between narrative sessions.

The sheets of paper for written reflections were made available at the end of each narrative session. The students who consented to hand their reflection in could either complete them there and then, or take with them to hand in later. They were asked to write a short statement which reflected what they had thought about as they participated in that narrative session. There was no compulsion to complete this task, or to hand in the piece of paper.

A box was provided at the front of the classroom for students to post their reflections so as to further protect their anonymity. A sign was taped to the box (see Appendix K) reiterating that it was voluntary for students to participate in this exercise. By choosing to hand in the written reflection, students' consent was implied for the use of their reflections as data for analysis and possible future publication. After the session the box sat outside one of the midwifery teacher's offices (not the researcher's) for students to hand in later.

A total of 79 reflections were written by students after five narrative sessions. Some students filled the whole A4 page while others wrote one sentence.

Data collection 3: Midwifery teachers

There were four midwifery teachers, including myself, who taught the paper 'Art and Science of Midwifery I' at the beginning of 2005. I realised the value of recording teachers' experiences, challenges and insights gained before, during and after the narrative-centred curriculum was implemented.

These discussions would show our collaboration and reflection on our experience of teaching in a narrative-centred curriculum. Our conversations would also record the changes made over time. I expected there would be some key times where it would be significant to record our conversations, such as prior to the commencement of the paper and after the first tutorial groups. Apart from these key times, I anticipated that we would meet approximately two-three weekly throughout the first semester.

Teachers' research conversations: The first meeting

With everything in place for the new curriculum and the parallel study, we met for the first time in the week before the commencement of the new curriculum. We were excited as we had spent the previous year planning for this. We were also a little apprehensive about how it would all work. I talked to the group about where they would like to meet as I thought that they may wish to meet away from the University campus. They all felt it was more convenient to meet in a room at the University, which we did. I had a list of prepared questions for the first session which was developed in discussion with one of my research supervisors. The questions used as prompts were:

- What has brought us to the decision to introduce a new way of teaching?
- Why have we chosen narrative pedagogy?
- What excites us about this approach?
- What frightens us about this approach?
- How will our role as midwifery lecturers change in a narrative-centred curriculum?
- How do we feel about these changes?

It was useful to have these questions in front of us for the times when the conversation waned; they prompted teachers to reflect on the issues. This conversation was audio taped and lasted approximately one hour, as was the case with the subsequent six research conversations. Having the tape recorder sitting on the table was an issue for one or two of the teachers whom I noticed seemed inhibited initially. They seemed to relax as time went on. In total we met seven times over the first two years of the implementation of the new curriculum.

Transcription process

The audio taped research conversations were initially transcribed by an experienced transcriptionist who had signed a confidentiality agreement (refer to Appendix H). When I received the transcripts I would listen to them again to put the names to the voices, and to fill in any parts which the transcriptionist had been unable to hear. After the first two research conversations I started to transcribe the conversations myself as I found it was useful for me to go through and listen carefully to the conversations. It helped me to reflect on what it was we had said. The transcripts from the research conversations were then returned to the teachers who had participated in that meeting, so they could see the course of the discussion, change parts of their conversation that upon reflection they disagreed with, or did not want included, and/or provide additional insights. No teachers asked to have anything changed at this stage.

My thinking processes

I kept a research journal throughout the first two years of the implementation of the narrative-centred curriculum. As soon as possible after each research group, I reflected on the mood of the group, what had been discussed, what had gone well, and what could have been improved upon (see Appendix L for an excerpt from my journal). Journaling was a useful tool because I felt quite isolated at times throughout this process. I was involved in trying to ensure the smooth running of the new curriculum, very busy with teaching, marking and administration, as well as trying to focus on the research process itself. Sometimes I wished I had never started the new curriculum or the research because it was all such a juggling act. Writing in my journal was cathartic and enabled me to put things into perspective. My research supervisors and mentor

were also very helpful sounding boards at this time and their frequent informal conversations over a cup of coffee helped to keep me going when times were difficult.

Ongoing research conversations

One of the elements of participatory research is that transcripts from previous research conversations are read by participants prior to the next meeting, and that when the group meets again, transcripts prompt discussion based on what had been said previously. I found that most times teachers were too busy to read the transcripts before the next research group, so I would begin each of the subsequent meetings with a summary of what we had been talking about the previous time. I asked if they had had any further thoughts, or how the teaching had gone in the light of any changes we might have made at the previous meeting. During the ongoing phase of the research I also went prepared with some research questions (as shown below) which could be used to guide and stimulate open conversation if the need arose:

Is there a difference in the way students seem to be learning?

What learning is emerging for us as teachers?

What effect do the narrative sessions have on:

- Our teaching?
- Students' learning?

Is there a difference in the way we view teaching and learning?

Even though I went in with this list of questions and thoughts based on our previous conversation, I found it very difficult not to be 'the researcher'. As the other teachers spoke I often found myself thinking, "what should I ask next?" or "where is this conversation going?" Sometimes I had to restrain myself from guiding the conversation in a particular direction towards what I wanted the teachers to talk about. Sometimes, for this reason, I was distanced from the conversations and on occasion felt as if it was more of an interview rather than a conversation. Often at the forefront of the teachers' minds (and mine too) were the practicalities of the new curriculum, such as dealing with particular dynamics in the tutorial groups or how much formal teaching should be done. These practical details and the changes we made in response to our discussions and student feedback are valuable aspects of this study.

Number of meetings

In total the group of teachers met seven times. Initially, there were four teachers (including myself as researcher) who were involved in the new curriculum and all participated in the research group. After the first two research conversations, one of the teachers chose to withdraw temporarily as she was finding her participation too stressful on top of adapting to the new curricular processes. A new teacher who joined our team in May 2005, after having the study explained to her by one of my supervisors, consented to participate and joined in for the next five research conversations. On average four teachers participated in the group. On one occasion there were only three because one was at a birth. The teacher who temporarily withdrew from the research later rejoined the group so that there were five in the last two research conversations.

Scheduling meetings

Due to our teaching commitments and busy lives, it was often difficult to co-ordinate meeting times that suited everybody. Some meetings were rescheduled when unforeseen events took precedence. Once we did sit down to meet however, it was a very valuable time to talk about how everything was going. This was not something that we would normally do, so it was actually quite special to take a breather from our busy lives and discuss important things. Considering how busy we all were it is remarkable that the teachers continued to be motivated to come to the research groups, something for which I feel very grateful.

Team building process

Over the time of these discussions and throughout implementing the new curriculum, a bond developed between the five teachers who were involved in the first year. It was a challenging year, especially in the first semester, but we successfully worked the issues through as they arose. I think these discussions helped us to bond as a group and come through the process having learned about ourselves as a group of teachers.

Self as researcher and teacher

On reflection, even though I had hoped to participate equally in the teachers' research conversations, I found this difficult. As the researcher I was the one who set up the meetings, read the transcripts from the previous meeting, and prepared prompts for the group discussion. Taking on the role of facilitator meant that I felt unable to

participate equally in the group's discussion. With hindsight, I could have had more of a voice if someone from outside our group of teachers had facilitated. The down side of that approach may have been that our conversations may have become dominated by my opinion. I was the person who initially had the passion to introduce a narrative-centred curriculum. I was the one who hoped to gain a doctoral qualification from this research. It was in my interests that the new approach should be seen to be successful. My keeping quiet in the focus group conversations did however create space for the other teachers to speak their thoughts. I now recognise that my turn to 'speak' is in the writing of the thesis.

As a curriculum developer, a teacher, researcher and research participant I felt very responsible for the success of the curriculum and the research. I felt isolated and vulnerable at times. To that end, an experienced academic and counsellor joined my supervision team as my mentor, and was available for one on one debriefing conversations. I did take the opportunity to debrief at times when I felt the need.

Interview with the Head of Midwifery/Programme Leader

Rationale

Over the time of the research, it became evident that the Head of Midwifery/Programme Leader also had a considerable input into the development of the new curriculum. I decided it would be valuable to record her experience of this curriculum change. One of the aims of this project was to document and analyse the process of the implementation of a narrative-centred curriculum and what adaptations midwifery lecturers made as the course unfolded. As the new curriculum was implemented, the Head of Midwifery/Programme Leader (also a midwifery teacher) was involved in dealing with student and staff issues as we adapted to the new way of teaching and learning. I felt that to record her perspective would be invaluable, as it would add to and enhance the data which was already being collected.

Strategies to protect the Head of Midwifery/Programme Leader's anonymity

I initially talked to the Head of Midwifery/Programme Leader to see if she would be agreeable to be interviewed. She agreed in principle, so we discussed the ethical issue concerning her participant anonymity as she will be clearly identifiable as the only

Head of Midwifery/Programme Leader in Auckland, New Zealand. She agreed that if a pseudonym was used, and efforts made to remove identifying information from all transcripts, and that if she had the opportunity to delete any parts of the interview she considered sensitive or inappropriate then this could work for her. I designed a participant information sheet (see Appendix M) outlining her participation in the study and how her anonymity would be protected as much as was possible. She was given an opportunity to consider the information before consenting to be interviewed (see Consent form Appendix N).

Focus of the interview with the Head of Midwifery/Programme Leader

I audio taped an interview with the Head of Midwifery/Programme Leader in March 2006, as we were commencing the second year of the narrative-centred curriculum. I had devised a list of potential questions which could act as prompts, as shown below, however I found that as the conversation flowed, the questions were not really necessary.

- What were your concerns /what excited you about introducing a narrative-centred curriculum?
- What was your perspective of what was happening for staff and students as the new curriculum commenced?
- What has your role as Head of Midwifery/Programme Leader been with the introduction of a narrative-centred curriculum?
- What tensions have arisen for you with the implementation of the new curriculum?
- How do you feel the programme is going now?
- What changes do you think we need to make?
- Do you see a difference in the way teachers are thinking about teaching and learning?
- Do you see a difference in the way that students are learning?

Reflection on the interview with the Head of Midwifery/Programme Leader

I emerged from the interview with a tremendous amount of respect for the Midwifery Programme Leader. She had been very candid and had shared how much she had, at times, worried about some aspects of the changes; yet, she had always given me so

much scope as the teacher leading the curricular change. I had not realised this until she revealed so in the interview. I transcribed the interview myself and returned the transcript to her to see if there were parts of the conversation that, upon reflection, she disagreed with, or did not want included. She did choose to remove some parts of her conversation.

Summary of data collection

Data collection occurred throughout 2005 for the students, and for the teachers throughout 2005 until October 2006. Students' experiences were recorded though three focus groups (one for Māori students) who met twice each, midway through, and at the end of semester 1, 2005. All students also had the opportunity to write written reflections after each of the first five narrative sessions.

Five midwifery teachers (including myself as researcher) participated in seven research conversations to record our experience of a narrative-centred curriculum and the changes that we had made as we went along. I interviewed the Head of Midwifery/Programme Leader to ascertain her experience of managing the midwifery programme throughout the curricular change process.

Altogether data available for interpretation consisted of 92 pages from the students' focus groups, 79 written reflections from students, 77 pages of data from the teachers' research conversations, and 14 pages from the interview with the Midwifery Programme Leader. Data collected is summarised on Table 2 (p. 92):

Table 2: Summary of data

Date	Midwifery teacher research conversations	Student written reflections	Student focus groups
Feb 9th 2005	4 teachers (Andrea, Deborah, Emma, Lilly)		
Feb 14th 2005 The 1st narrative		'Getting pregnant' 31 reflections	
Feb 18th 2005	4 teachers (Andrea, Deborah, Emma, Lilly)		
Feb 21st 2005 2nd narrative		'Being pregnant' 15 reflections	
Feb 28th 2005 3rd narrative		'In labour and giving birth' 18 reflections	
Mar 7th 2005 4th narrative		'After the birth and breastfeeding a new baby' 11 reflections	
Mar 14th2005 5th narrative		'The newborn baby ' 4 reflections	
April 28th 2005	4 teachers (Andrea, Deborah, Emma, Sarah)		
May 6th 2005			Group 1: 7 participants
May 9th 2005			Group 2: 5 participants
May 16th 2005			Maori group: 2 participants
July 18th 2005			Group 1: 2 participants
July 29th 2005			Group 2: 3 participants
August 2nd 2005			Maori group: 2 participants
August 15th 2005	3 teachers (Andrea, Deborah, Sarah)		
August 22nd 2005	4 teachers (Andrea, Deborah, Emma, Sarah)		
Feb 7th 2006	5 teachers (Andrea, Deborah, Emma, Sarah, Lilly)		
March 2nd 2006	Interview with Head of Midwifery/Programme Leader		
May 17th 2006	5 teachers (Andrea, Deborah, Emma, Sarah, Lilly)		
Totals	77 pages of data	79 written reflections	92 pages of data

Data interpretation framework

To ensure methodological consistency it was important to use Ricoeur's (1984, 1985, 1988) theoretical framework of *prefiguration, configuration and refiguration* to inform my analysis of the research transcripts. Herda (1999) suggests a sequence for data analysis which is based on Ricoeur's two stages of interpretation (as explained in Chapter Four), and links this in with participatory research. First, in the words of Ricoeur (1981) 'fixing' the research conversations in transcribed audio taped conversations, then pulling out the significant statements, grouping these into themes and placing them in categories provides an explanation of what the text says. Understanding what the texts say comes through substantiating the themes or important ideas with quotes from conversations/transcripts, and then examining these themes to determine what they mean in light of the theoretical framework.

Building a community of memory

According to Herda (1999), an important element in participatory hermeneutic inquiry is the opportunity for research participants to take an active role in the data analysis process. I gave the transcripts of our research conversations back to the teachers after each research conversation so that they could either change parts of the conversation or provide additional insights. The idea being that we as a group of teachers would collaborate to build a "community of memory" (Herda, 1999, p. 120) and set the ground for a continuation of a narrative-centred curriculum. The continued discussion and conversations with teacher participants did meet the aim of building a 'community of memory'. We reflected on how we used to teach (the *prefigured* world of midwifery education), and how doing things differently (*configuring* the curriculum) changed the classroom and tutorial group dynamics. Many times we talked about how we could improve upon what we were doing (*refiguring* the curriculum) with the teaching and learning processes. We also recognised how our teaching and learning processes are constrained by university processes such as required learning outcomes and assessment processes.

Striving towards co-participation

Williams et al. (2009) found that improved interpretation of data occurred in participatory research when researchers and participants had greater input into the interpretation process. I found this was very hard to achieve as the teachers who

participated in this study were always extremely busy with teaching and their own academic and practice lives. Ultimately the best way I found to receive feedback from the teacher participants was through giving them drafts of the findings chapters to read, where they could see the development of the themes and were able to tell me whether what I had written reflected their experiences. Their feedback affirmed that my interpretations resonated with their experiences.

Wallerstein and Duran (2003) found that participatory data analysis is very difficult to achieve, and they suggest that the final interpretation of data often falls to the researcher. This is what happened in this study.

Data analysis

The first part of data analysis involved printing out each of the research transcripts onto a different coloured paper so that I could cut them up and still know which focus group, research conversation or reflection each piece of data came from. I read and reread the phrases and paragraphs, looking for similarities and differences. There were literally hundreds of small pieces of coloured paper all over my floor as I tried to group them into piles which reflected similar ideas. I did not want to force ideas, so started out by sorting data into 25 broad categories, as depicted in Table 3 (p. 95). Rather than being a step by step logical process, these categories prompted my thinking about what themes were arising from the data which explicated teachers' and students' experiences.

I created a word document for each of the 25 categories and pasted in all the quotes which illustrated that category. An example of the category 'Art versus Science' is shown in Appendix O. Next, I read and re read the data, often moving data from one category to another, or copying one piece of data into more than one category because it seemed to relate to more than one area. I started to look beneath the surface for what was really behind each category, and started to tease out what the quotes within each category were really talking about, as shown in Table 3 (p. 95).

Table 3: Showing categories teased out

Category	What is beneath the surface?
Art vs Science	What knowledge is valued?
Clinical	Does the narrative curriculum relate to the clinical area?
Curricula Change	Making change is hard
Doubt own ability to learn	How do we see 'real' learning?
Exams_Assessment	Learning to be a midwife, or learning for assessment?
Facilitating Tutorials	Facilitation is different from past ideas of teaching
Facts_Told what to know	Just tell me the facts
Grades	Learning the "Right" stuff
Group Process	Facilitation is different from teaching
Knowledge	What counts as knowledge to be a midwife?
Learning	Learning the Right stuff
	Teaching ourselves
	The way we learned in the past
	Which learning is valued?
Learning Objectives	Core or group objectives
Lecturers Role	Facilitation is different from past ideas of teaching
Maori Experience	Maori students experience different
Managing Change	Change process
Narratives	The trouble with the narratives…
	What we are learning from the narratives…
	Is learning changing from the narratives?
Narratives vs Science_Knowledge	But we're supposed to be learning about science
Online	The technology of education
Safety	Secure in the knowledge
	Teacher Student security_insecurity
	Science makes us feel safe
Stressed_Anxiety	Don't feel safe
Teacher_student relationship	Relationships are different from traditional teacher-student relationships
Teaching	Teaching is changing
	Teaching concerns
	We are not being taught the right way
Thinking	Thinking about things differently
	It takes a lot of extra work and time to think
Tutorials	Facilitation is different from past ideas of teaching , and learning through discussion is not what we are used to
Workload	The time it takes to do the work of learning

One example of categorising data is given in the following quote from Chloe, a student. I originally put this quote into the category 'teaching' because Chloe talks about not getting proper teaching:

> *I don't just don't want to be excellent, I want to be a safe midwife, I want to know my stuff, that is why I am here, I want the best possible education and I got told I can get that here. And to me part of an education is being taught. I can go home and sit down and read every book under the sun without paying four thousand dollars a year and eventually come up with the same knowledge, but the whole point about being here is to be guided and to be taught what I need to know in order to be safe, and then I can spend the rest of my career adding to that.*

On reconsideration I moved this data into a sub category of 'we are not being taught the right way'. I found myself thinking about the 'right way' to be taught. What is it about our past experience (the *prefigured* world) of learning which means that students conceive good teaching to be a certain way?

A sample of my thinking

I realised that there were many overlaps between what Chloe was saying about not being 'taught the right way', with other categories such as 'learning the right stuff', 'teaching ourselves', 'the way we learned in the past', 'what knowledge is valued?', 'how do we see 'real' learning?', 'learning to be a midwife or learning for assessment?', ' just tell me the facts', 'what counts as knowledge to be a midwife?', and ' which learning is valued?' The thinking would take me back to the original transcripts to attempt to interpret and understand the meaning that the text revealed. I thought about the *prefigured* world of midwifery education and why students would feel safer or more in control with a particular mode of teaching and learning? Why would a teacher or a student feel that one kind of knowledge was more important than another? Is it possible to measure learning? What is the role of assessment in teaching and learning?

It surprised me that some of the students did not seem to see the value in learning for learning's sake. On reflection, I realised that my own pre-understandings about education were different from those of many of the students and some of the teachers. My past educational experiences with problem-based learning and my reading about narrative –centred curricula had exposed me to seeing other ways that

education could be. I could see a future possibility for a *refigured* way of teaching and learning; whereas others had not had this exposure.

I also reflected on other data from students and teachers. For example, this following piece of data from one of the teachers' research conversations highlighted one of the *prefigured* expectations of teaching; that the teacher is responsible for student success: "*My other concern is that when they do come to exam time is it going to reflect on me?"* (Lilly, Teachers, Gp2, p.3). Bringing together Chloe's feelings about not being taught the right way with other data from teachers and students helped me to see how much assessment dominates how teaching and learning happens.

How themes began to emerge

I also started reading and writing around each of the emerging themes. For example, when I looked at the category 'narratives', one of the things I wanted to know about was whether students' learning was changing from the narratives. In this excerpt from a student focus group the interviewer is asking whether students found that they were listening differently to women in their clinical placements.

Interviewer:

> *How do you find yourself listening to women's experiences? In relation to your clinical experience have the narratives changed the way that you now listen to women?*

Agnes (Students, Sem2, Gp1, p. 17):

> *I think it might have changed, but I think for myself, and probably for you as well, you are talking to people who have been listening to every single detail, and how long have we been passionate about doing this, how long have I been picking up every detail that I could, and thinking about that, and what the impacts of that were anyway. I have wanted to do this [midwifery] since I was 18 years old; it has taken me 11 years to get to this point. I think for some of the girls it may have changed the way they listen.*

I thought about what Agnes was really trying to say when she talked about how she listens. This is what I wrote about this piece of data. It raised questions in my mind about what we really mean by listening.

My reflections:

"Agnes is talking about *how* she listens to women. She talks about how she has been listening to *every single detail* of women's stories since she was 18, when she first wanted to become a midwife. She says she has been *picking up every detail that I*

could, and thinking about that, and what the impacts of that were anyway. She sounds as if she has been like a sponge, absorbing as much as she possibly could about midwifery from women's stories for years and years. So for her, she feels that she has already been listening to women, so doesn't feel the WAY she listens has changed, but she thinks that *for some of the girls it may have changed the way they listen.* For me this raised questions such as "what is listening? What do we really mean by listening to another person? Are there *different ways* of listening? Does Agnes listen in a different way *to the other girls?* When we talk about listening, do we really mean just the act of listening?"

I looked for other data within the student focus groups where students talked about listening to the narratives. Some examples are:

- …I like to delve in, and that gives a better understanding and from that perspective the narrative learning is great…
- …I think it is really subjective to what you have done in your life, and the narrative curriculum is opening it up even more…
- …like the women who did come in to speak to us, I did keep some of the memories of what they said with me, and I do think about it…

I saw afresh the reason why I had been so committed to refiguring our pedagogical approach to draw more intently from women's stories. Data analysis was also aided though reading around the topics of teaching, learning, assessment, and philosophical concepts such as "*techne*" and "*phronesis*". The reading I did around each of the emerging themes expanded my thinking. The categories served as a mechanism to prompt and provoke thinking. They were a means of bringing questions to the data and being open to insights that emerged. I constantly related my thinking to Ricoeur's concepts of *prefiguration*, *configuration* and *refiguration* eventually concluding that indeed it was this very process which was at the heart of our experience. Further, there was a dominant 'plot' (Ricoeur, 1984) which limited the degree to which refiguration was possible. This reflection ultimately led to the structure of this thesis, and the development of the model 'a square peg in a round hole' which is based on the Ricoeur's concepts of *prefiguration*, *configuration* and *refiguration*.

Rigour

The best way to judge the trustworthiness of research, which has used qualitative methods, has been the subject of much debate in the research literature (Giddings & Grant, 2009; Heron, 1996; Koch, 1998, 1999, 2006; Lincoln & Guba, 1989; McBrien, 2008; Rolfe, 2006; Sandelowski & Barroso, 2002). Koch (2006) maintains that rigour of qualitative research can be shown through presenting a transparent audit trail. If an audit trail clearly shows the reader the influences and actions of the researcher, then the trustworthiness of that research can be established.

Instead of research rigour being based on validity or reliability, as it would in the quantitative paradigm; researchers in the qualitative paradigm have suggested that methodological rigour be based on 'trustworthiness' (Koch, 1998, 1999, 2006; Lincoln & Guba, 1989). Research rigour is a term used to refer to the trustworthiness or quality of the research methods employed (Davies & Dodd, 2002). Davies and Dodd (2002) regard ethical decision making at all stages of the research project as being fundamental to rigour. Throughout this research, ethical considerations have been an over arching principle. I have set out a clear audit trail which shows how all methodological, theoretical and interpretive decisions have been made from the outset.

I have adapted several frameworks for demonstrating research rigour which includes the concepts of trustworthiness, reflexivity, credibility, transferability and dependability.

Trustworthiness

An integral part of the trustworthiness of this study is my ongoing self critique and self appraisal or self reflexivity. I also show how I have maintained the credibility of this study; its transferability or "fittingness" and an audit trail of the decisions I made along the way demonstrates the study's dependability.

Rolfe (2006) suggests that there are three broad positions when it comes to deciding how to best judge the trustworthiness of qualitative research. One position is that qualitative research ought to be judged according to the same criteria as quantitative research, i.e. that research findings are said to be sound if they are accurate and are generalisable. The second position is that a different set of pre-

determined criteria is required to evaluate qualitative research; and the third position, questions the appropriateness of any predetermined criteria.

The second position of having a set of pre-determined criteria for qualitative methods has resulted in many different frameworks to express the rigour of a study. Examples of such frameworks include 'credibility, transferability and dependability' (Lincoln & Guba, 1989), 'trustworthiness, auditability, credibility and confirmability' (Fleming, Gaidys, & Robb, 2003) and 'member checking, audit trail, reflexivity and triangulation' (McBrien, 2008). Koch's (2006) criteria of 'credibility, transferability, dependability and confirmability' have been used by many researchers to demonstrate research trustworthiness.

Witt and Ploeg (2006) disagree with having any predetermined set of criteria for qualitative research as they argue that they are insufficient to fully express the rigour, particularly in phenomenology. Rolfe (2006) and Sandelowski and Barroso (2002) also argue that research quality cannot be assured by any set of predetermined criteria. Rolfe agrees with Sandelowski and Barroso's view that research rigour is demonstrated in the artfulness of writing up the research report. Sandelowski and Barroso go on to say that the only place for evaluating research studies is in the report itself.

In participatory research, trustworthiness is said to be achieved through establishing credible accounts of the experience of research participants (Grant, Nelson, & Mitchell, 2008), and through maintaining respectful and trusting relationships between researcher and participants (van der Riet, 2008). Bradbury and Reason (2001) suggest that the success in creating significant and enduring change is a signal of trustworthy participatory research.

Reflexivity

Koch (1998) considers that the entire research process is a reflexive exercise. Reflexivity means that as a researcher I ensure my own integrity and credibility throughout all stages of the research process (Giddings & Grant, 2009). This means being aware of and making clear my own pre-understandings and how this has impinged on the research process. Prior to the commencement of this study I was interviewed by one of my research supervisors. Listening to and transcribing the audio tape of this interview made me realise some of my beliefs and prior assumptions

which impacted on the questions I asked, the research methodology chosen and the way I have interpreted data.

One of my strongly held beliefs that came through from this interview is that students will be self motivated to be active in their own learning and that my role as a teacher is to work alongside students to facilitate their learning process. My assumption is that within the teacher-student relationship there is learning that takes place on both sides. The narrative-centred curriculum is based on this assumption of reciprocity, and it came as quite a shock to me when not all the students and teachers saw it this way! Disclosing these pre-understandings from the very beginning of explicating my pre-understandings, through to interpretive decision-making adds to the credibility of qualitative research.

Another element of self reflexivity is for the researcher to keep a journal, in which reflections on the processes of the research and the interactions between researcher and participants are recorded (Koch, 2006). A journal was kept, which held a record of not only the research processes, but also the development of my thinking and the insights gained. Reviewing this journal has reminded me of my multitude of feelings throughout the research process, which now with hindsight I can integrate as a part of the research findings. Parts of my journal have provided valuable data for this study.

Credibility

An important feature of trustworthiness is the credibility of the research. In this study my involvement in the curriculum and my presence in the teachers' research group gave me the ability to create credible and authentic interpretations of the teachers' experiences. I was a part of that group so could more easily check participants meanings than if I had not been present. My interpretations of our experiences were fed back to the teachers who confirmed that they represented a credible account of their experience. Sharing a commitment with the teachers to create a text which reflected our experience enhances the credibility of these research findings.

I have attempted to achieve familiarity with, but also maintain distance from, participants and to write about the experiences of the teachers and students in a way which communicates that I have recognised and managed the tensions, paradoxes and

contraindications encountered. Sandelowski and Barroso (2002) say that revealing these tensions demonstrates methodological flexibility; another element of credibility.

Transferability

Transferability refers to the ability of the research findings to "fit" into other contexts. The term "fittingness" has been used by Lincoln and Guba (1989). Over the last five years I have presented aspects of this research at midwifery and educational conferences in New Zealand, Australia and in the U.S.A. Whenever I have presented this research it has been met with much interest. I have had many discussions with educators from many different schools who can see the value in incorporating narratives into the way they teach. These discussions and the questions that I have been asked have provided me with valuable feedback and ideas as I went along.

One thing that inevitably happens whenever I present is that women offer to come and share their stories with our students. This reveals to me that women themselves want students to learn from their stories and see that story telling is a valuable tool for learning.

I have also presented aspects of this work to other doctoral students and postgraduate supervisors within the university and their feedback has always helped me to consider areas which I may not otherwise have thought of.

Grant et al. (2008) and Bradbury and Reason (2001) suggest that the rigour of participatory research is enhanced if the change is significant and enduring. In this study, the narrative-centred curriculum which began in 2005, is now well embedded in 2010. Narratives are now used in all three years of the midwifery programme as an integral part of the curriculum.

Dependability

The dependability of qualitative research is said to lie in its ability to be audited. Keeping an audit trail means that a clear description of all theoretical, methodological and interpretive processes and decisions would enable another person to follow those decisions (Koch, 1996).

Through keeping a trail of documentation, excerpts from the raw data, reflective journal and interpretive writing I have shown throughout this thesis how all decisions have been made from pre-understandings to theoretical, methodological and

interpretive decisions. While readers may not share the authors interpretations, they should be able to discern the means by which it was reached (McBrien, 2008).

Conclusion

Researching in my own 'backyard' has provided me with many personal and ethical challenges. The ethical considerations of a research method where participants were in such close contact with the researcher were challenging. Considerable thought and effort went into developing a reliable ethical framework for this study.

At times the research process has been extremely difficult, but also exciting and very 'real'. I have been immersed in the research and the curriculum for six years now, and have learned an enormous amount, not only about teaching and learning in a narrative centred curriculum, but also about myself.

This chapter has shown the specific methods that were employed in this research to record and interpret the experiences of midwifery teachers and students in using a narrative pedagogical approach in midwifery education. The congruence between the methods and methodological stance described in the previous chapter has been described.

The processes used to contact participants, protect their anonymity, facilitate informed consent and enable safe participation in the research have been explicated. I have also shown how the data was gathered, transcribed and interpreted from both the students and teachers who participated in the research. The final part of this chapter has addressed the question of the trustworthiness of this research.

The succeeding four findings chapters are prefaced with an outline of the actual process which we used when implementing and developing the narrative-centred curriculum. A preface provides a context for the reader to understand the experience of teachers and students.

Preface to findings chapters

Chapters One, Two and Three of this thesis have explicated the *prefigured* world of midwifery education through laying the foundation for this study. Chapter One introduced this study's research question, its justification and an overview of the methodology and methods used. Chapter Two explored the pedagogical approach to midwifery education through uncovering the agents, motives and circumstances which have shaped midwifery education in the period 1904-2010. Chapter Three reviewed the research and literature relating to the emergence of narrative pedagogy and narrative-centred curricula. In Chapter Four and Chapter Five, the methodological stance and methods used for this study were detailed.

The next part of this thesis (Chapters Six to Nine), 'midwifery education *configured*', presents the findings of this study. To place the findings in context, they are prefaced with an explanation of the actual structure of the narrative-centred curriculum, which was implemented in 2005 by the midwifery programme at AUT.

Context

The first cohort of students to be involved in the narrative-centred curriculum at AUT, were enrolled in semester one of the second year of the 3 year Midwifery degree in 2005. In 2005 each academic year consisted of two semesters; and midwifery students enrolled in four papers (or courses) each semester. In the first two years of study, some of the 16 papers, which midwifery students were required to complete, were common to all Health Faculty students (nursing, physiotherapy, occupational therapy, podiatry and paramedicine). The common subjects studied included general anatomy and physiology, research, pharmacology and interpersonal communication skills, considered fundamental to all health professionals. The other courses in the first two years were specific to midwifery. Some topics covered midwifery theory; for example, 'Art and Science of midwifery I' and 'Lactation and Breastfeeding', and some were clinical practice papers, such as Midwifery Practice I, II and III.

In order to register as a midwife in Aotearoa, New Zealand, every student needed to satisfactorily complete all twenty four papers in the three year degree, after which time she was recommended by the midwifery school to the Midwifery Council of New Zealand as a suitable candidate for registration as a midwife. The Midwifery

Council sets the final National examination which candidates must pass in order to be registered to practice in New Zealand (Midwifery Council of New Zealand, 2004a).

The narrative centred curriculum was first introduced into the midwifery theory paper, 'Art and Science of Midwifery I' (taught in semester one, year two of the programme). 'Art and Science of Midwifery I' focused on developing the knowledge base and skills for midwifery care related to normal childbirth and the normal neonate. The main learning themes were early pregnancy, pregnancy, normal labour and birth, and normal postpartum mother and baby.

Preparation of students for the narrative-centred curriculum

On the first day of semester one, 2005, the Year Two midwifery teachers met with the students to introduce the first semester midwifery papers. In this session, the rationale for the introduction of the narrative-centred curriculum was explained, and the actual process of the narrative-centred curriculum was outlined (see page 107 for the narrative-centred curriculum process). Students were then prepared for the first narrative session to be held the following day. They were given a student guide for the narrative-centred curriculum in the paper booklet for Art and Science of midwifery I (see Appendix P) outlining the proposed narrative process. In subsequent years, examples of previous students' experiences of the narrative-centred curriculum were included in the orientation to the curriculum. Hearing other students' experiences helped new students feel more confident in the curricular process. The next section of this preface outlines the specific curricular process that was used.

Narrative-centred curriculum process

Each of the main themes, of the paper 'Art and Science of Midwifery I', were introduced with a narrative session. The narrative to begin was provided by a woman, a midwife, the students themselves, or in one case a digital narrative[14]. The narratives were focused on the experience of: 'getting pregnant', 'being pregnant', 'in labour and giving birth', 'after the birth and the newborn baby' and 'breastfeeding a new baby'. After listening to the narrative, the students were divided into groups of 10-15, each

[14] A digital narrative uses a combination of images, music, narration and text to create a multidimensional narrative (Gazarian, 2010)

with a teacher, to interpret and discuss the story and what it meant for midwifery practice.

The purpose of the first tutorial, immediately after the narrative session, was for students to interpret the narrative they had just heard, before moving on to a three step process (adapted from a PBL process) to further analyse the narrative. First, students analysed the story by 'brainstorming' on a whiteboard all the issues which arose from the story. Second, they explored these issues, discussing them and deciding what they already knew about the issues raised from the narrative (activating prior knowledge). The student group then identified gaps in their knowledge and what they would need to learn about in order to further understand the issues. Each group then formulated learning objectives which involved deciding on a list of questions they were to work on for the week. For a fuller explanation of the narrative-centred process refer to the tutor guide to the narrative-centred curriculum in Appendix Q.

For the three step process to work, it was important that each group decide on their own learning objectives, with guidance from the teacher. Students' learning objectives were, therefore, based on what they had determined were the important learning issues raised by the narrative, and what they already knew about the topic. It was expected that students' learning objectives would cover biological science as well as sociological and psychological issues, ethics and midwifery practice.

A list of fundamental 'core objectives' based on specific learning outcomes had been devised prior to the narrative session by the midwifery teachers who taught in the paper. The 'core objectives' were related to the fundamental learning objectives which teachers expected every midwifery student to have a grasp of by the end of the semester. Teachers had a copy of the 'core objectives' before they went into the tutorials, and the 'core objectives' were posted online for students to see after the first tutorial. Refer to Appendix Q for examples of the lists of 'core objectives' in the tutor guide for the narrative-centred curriculum.

Each topic covered in the narrative sessions was supported with lectures, tutorials, on-line material (content which was previously delivered in workbooks), and clinical skills laboratories, when appropriate. An example two week timetable (Figure 1, p. 107), shows the placement of the narratives, the classroom teaching, tutorials and clinical skills laboratories. The narrative sessions and tutorials are highlighted.

Figure 1: Example two week timetable

Week 1

Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***
0900- 1030 Narrative 'In labour and giving birth' 1100-1230 Narrative tutorial groups – brainstorm the narrative	0900-1030 Midwife and care in labour. Working with pain	0900-1030 Midwife and care in labour. 1st stage of labour 1100-1200 Tutorial groups: 1st stage of labour scenarios	0900-1030 Midwife and care in labour.2nd stage 1100-1200 Tutorial groups: 2nd stage of labour scenarios	*Health Research*
1300-1600 Self directed study	1300-1400 Midwife and care in labour. Working with pain 1400-1600 *Self directed study*	1300-1400 Midwife and care in labour. 1st stage 1400-1600 *Self directed study*	1300-1400 Midwife and care in labour. 2nd stage 1400-1600 *Self directed study*	

Week 2

Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***
0900-1600 Clinical skills laboratory: Vaginal Examinations Birth mechanisms	0900-1030 The midwife and care in labour 3rd stage 1100-1200 *Self-directed study*	0900-1030 Management of Postpartum haemorrhage **1100-1200** Tutorials	0900-1030 Postnatal care 0-6 weeks 1100-1200 Tutorial groups narrative feedback tutorial *'In labour & giving birth'*	*Health Research*
	1300-1400 Guthrie test Vitamin K 1400-1600 *Self directed study*	1300-1400 Management of Postpartum haemorrhage 1400-1600 *Self directed study*	1300-1400 Preparation for clinical placements 1400-1600 *Self directed study*	

As shown in Figure 1 (p. 107), the narrative sessions and first tutorial took place at the beginning of each two week cycle. Tutorial groups met again to feed back on their learning around the group's learning objectives at the end of that week (or two weeks). As undergraduate students it was important that each student was involved with all of the learning; therefore, it was expected that all students study all of the learning objectives. The purpose of the narrative feedback tutorial was to review the groups' learning objectives. This was an opportunity for students to help each other to understand the topics they had been studying, to debate different sources of information (for example, why a textbook might say one thing and an article something different) and to discuss the ways in which their learning related to midwifery practice.

The role of the teacher in the narrative tutorial groups was to facilitate the discussion, interpretation and thinking process. Teachers had additional roles of ensuring a safe environment for students to share their views, to facilitate the group process, to ensure that students stayed on track with their learning, that no one student dominated the group, and that all students participated.

Preparation of teachers for the narrative-centred curriculum

Prior to the start of the new curriculum, I convened a one day workshop to prepare teachers for the actual process of the narrative-centred curriculum. My own understandings of a narrative-centred curriculum were drawn from my past experience as a PBL tutor, from the reading I had done and the discussions I had with educators who were using similar curricular processes. A teachers' guide to facilitating narrative-centred tutorials was provided to the teachers (see Appendix Q).

After the new curriculum had started, teachers identified that they needed further skills in group facilitation; hence a workshop with an experienced PBL facilitator was arranged. New teachers who joined the teaching team were subsequently orientated to the narrative-centred curriculum process by working alongside an experienced teacher for at least one narrative/tutorial group cycle.

Setting up the narrative sessions

As shown in Figure 1 (p. 107), the narrative session took place at the beginning of the week and usually lasted about an hour and a half. The sessions took place in a large classroom or tiered lecture theatre with the whole class present and were informal and involved interaction and dialogue between students, teachers and the narrator.

The narrator was sometimes a woman, a midwife or the students themselves. The women and midwives who were invited to come to class to share their narratives were known by a midwifery teacher. Midwifery teachers are also practicing midwives, so mostly the women and midwives were known to teachers through their practice. On the orientation day it was emphasised to students that the stories which were shared were to be treated with honour, respect and without judgment. The atmosphere which was created was important for both the narrator and the listeners. If students were invited to share their narratives, it was emphasised that there was no obligation to share if they did not wish, and that when a person did share a story within the class it was to be kept confidential to the students, teachers and the person sharing their narrative.

Lecture topics

The philosophy of the narrative-centred curriculum was that if students could easily read information from a textbook or from online resources, then it was not necessary to have a lecture on that topic. As shown in the example timetable (Figure 1, p. 107), the majority of classroom time was spent relating the topic to midwifery practice issues. This required the collation of comprehensive online information. The online resources were arranged around each narrative and included: readings from the required midwifery textbook (Henderson & McDonald, 2004), links to web based resources, and online tests which students could complete as many times as they wished to test their learning.

Students progress through the programme

The first cohort of students who used the narrative-centred curriculum succeeded well in the programme and registered as midwives at the end of the following year. Subsequent cohorts have also succeeded in the programme at the same rate as they had done previously.

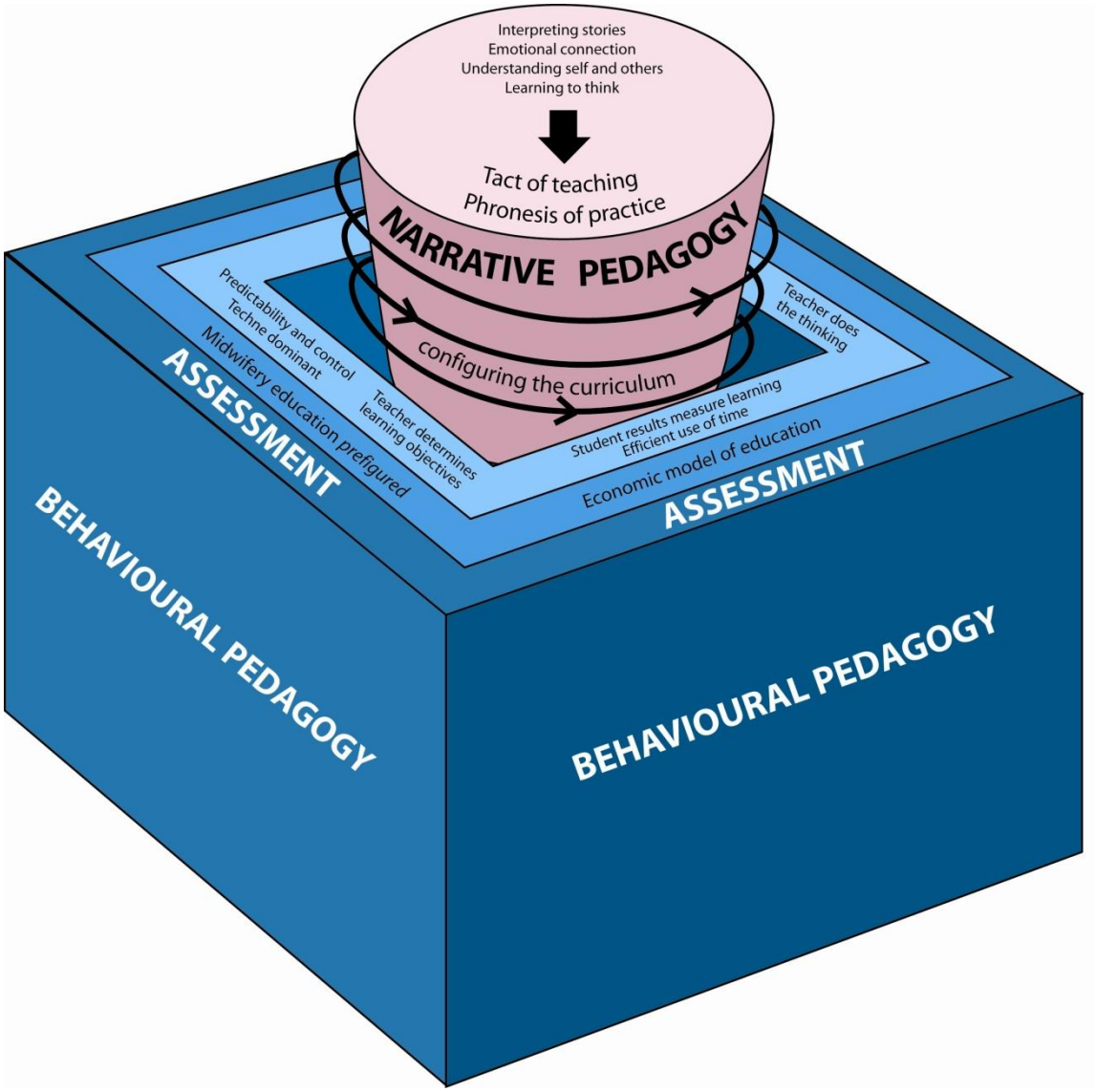
Findings chapters

The next four chapters present the findings of this research and offer an interpretation of the experience of teachers and students when using a narrative-centred curriculum for the first time. To use Ricoeur's (1984) philosophy of *prefiguration, configuration and refiguration; configuration* is the means which draws together all the elements of the *prefigured* world (the existing pedagogical approach), with the *refigured* world (the new narrative pedagogical approach). The process of *configuration*, or the experience of making curricular change, is told in the four findings chapters.

The image of a 'round peg in a square hole' (see Figure 2, p. 111) has been developed as a metaphor which depicts the experience of midwifery teachers and students who were implementing a narrative pedagogical approach. The square hole represents the prefigured world which includes behavioural pedagogy that frames the potential for a narrative pedagogical approach. The round peg represents the *refigured* world of the new narrative pedagogical approach. A round peg does not fit snugly into a square hole. There are gaps and movement, representing the dynamic tensions we experienced. The movement of the round peg is the *configuration*. The image of a 'round peg in a square hole' is used to portray the argument which is developed from this research process and affects the way the findings are presented in the following chapters.

Chapter Six shows how the experience of a new pedagogical approach revealed the *prefigured* world of behavioural pedagogy, this defines the square hole. Chapter Seven defines the round peg and shows the exciting aspects which emerged from using narrative pedagogy. Assessment is what drives a curriculum; and therefore, surrounds both the *prefigured* (square hole) and the *refigured* (round peg) world. Assessment is explored in Chapter Eight. The final findings chapter, Chapter Nine, is about the process of *configuration*; it includes the experience of making curricula change or the experience of fitting the round peg (narrative pedagogy) into a square hole (behavioural pedagogy/prefigured world).

Figure 2: A Round Peg in a Square Hole



Chapter Six

Configuring the curriculum revealed the *prefigured* pedagogical approach

> *…there is not a future time, past time or present time, but a threefold present, a present of future things, a present of past things and a present of present things. (Ricoeur, 1984, p. 60)*

Introduction

Ricoeur's (1984) philosophy explains that the way the present is experienced is within the context of the *prefigured* world (history, society and culture) and the *refigured* world (future possibilities). The review of the pedagogical processes underpinning midwifery education in Chapter Two showed that the philosophy which underpins teaching and learning (pedagogy) is rarely made explicit in curricula. Pedagogy is *prefigured*; it is usually assumed and taken for granted. When the narrative-centred curriculum was implemented, the pedagogical approach was *configured*; it was new and different. The new pedagogical approach proved both exciting and challenging for teachers and students. This chapter explores the challenges which were revealed in midwifery teachers' and students' experiences of participating in a narrative-centred curriculum. Teachers' and students' experiences showed that when a new pedagogical approach (a *refigured* world) was adopted, the things which were revealed were the taken for granted (*prefigured* world), of midwifery education.

Prefigured world of education: Teachers prepare lessons and provide answers

Teachers were steeped in the *prefigured* world of midwifery education. They were used to preparing a lesson on a set topic, to decide how best to teach the topic and then going into class with a prepared lesson plan, ready to answer students' questions. With the change to narrative pedagogy, the teacher's role became very different. Now their role was to facilitate the group process, and to guide students' interpretation of the narrative and formulation of their questions (learning objectives). It was not possible to prepare in the same way for the narrative tutorial groups because the discussion activated by the narrative sessions was unpredictable. The new role of the teacher was not to answer students' questions, but to help students formulate questions and find their own answers. The experience of the teachers who

participated in this study showed that it was unsettling to put aside the familiar way of teaching. The move to facilitation was challenging.

Facilitating the group process was a different way of teaching. For example, Lilly talked about facilitation as being the hardest thing for her because, as a teacher, she was used to providing students with answers to their questions:

> *The hardest thing I think for me is to be able to facilitate instead of jumping in and giving them the answers. I am used to doing that, there has always been structure to our teaching. It's a different role all altogether to be a facilitator and guiding them.*
> Lilly (Teachers, Gp1, p. 8)

Lilly expressed concern about how hard it is to facilitate a group. Having a structured lesson plan and providing answers to students' questions was her norm for teaching. As Brook (2009) points out, planning and being prepared is a prevailing activity in the everyday practices of teaching. It was harder for Lilly *not* to provide answers than it was to have a structured lesson where she felt prepared to answer potential questions on that topic. The *prefigured* role of a teacher is that she should be able to answer students' questions knowledgeably. One of the underpinning philosophies of PBL, which was adopted by the narrative-centred curriculum, is that it is beneficial for students' learning if they formulate their own questions (learning objectives) and research their own answers (Barrows & Tamblyn, 1980). Teachers in PBL curricula have also struggled with the concept of acting as a facilitator of discussion compared with the traditional role of a teacher as an instructor (Hutchinson, 1991; Jackson & Prosser, 1989; Maudsley, 1999).

Being prepared makes teaching 'easy' because the teacher controls the content, can anticipate likely questions and prepare the answers to potential questions on a pre-given topic. Having planned content to teach a class gives teachers a sense of confidence. Emma describes how having a planned lesson gives her a sense of security when she is teaching;

> *...we have had time to prepare and you've got a lesson plan. It is the security. I am certainly not comfortable going up to the front and facilitating whatever may happen.*
> Emma (Teachers, Gp3, p. 11)

Even though Emma was an extremely knowledgeable and experienced midwife, in a narrative-centred tutorial, the teaching role was not to impart that knowledge but to facilitate student learning. The evidence from analysis of research conversations with teacher participants showed that teachers found it hard to say *'I don't know the answer to that question'* because in the *prefigured* world holding a lot of knowledge shows a teacher is competent and gives her a sense of security. Emma says that she feels like a 'fake teacher' when she is facilitating a group because as a teacher she feels she should know a lot. She said she did not always remember specific anatomical things (like every bone of the pelvis); but she would revise them if she was preparing a lecture.

> *I feel I should know a lot. I can't keep a lot of information in my head, I am fine with the practice issues, but when it comes to the theoretical things I remember them when I swot them up for a lecture or for an exam…. And I have still got the idea that the teacher should know those things. Like the pelvis, be able to rattle off every little bit of it. I still have got that feeling that I am a bit of a 'Clayton's' teacher when I go to the tutorials.*
> Emma (Teachers, Gp3, p. 10)

'Claytons' is a type of non-alcoholic whiskey (fake whiskey), so Emma is saying that she feels like a fake teacher if she does not appear knowledgeable in front of students. Heidegger (1962) explains that *Dasein* (being-in-the-world) finds itself in things; what matters to a person shows in remembering. A person is understood as a being for whom certain things have significance and value. What was significant for Emma was that as a teacher she should show that she knew a lot, and even if she does not always remember all of the content, in a conventional teaching situation she has the opportunity to revise the topic and be prepared. Appearing competent and knowledgeable in front of students gave teachers a sense of being a 'real' teacher. As another teacher, Sarah, said *I think that other thing is about, for me, you should not feel incompetent in front of the students* (Sarah, Teachers, Gp6, p. 5).

Traditionally for teachers, competency is demonstrated through authoritatively providing students with information and ready answers. A potential negative effect of a teacher providing ready answers for students is that it can create dependence on the teacher and promotes the idea that there is only one response for every midwifery practice question. There are many potential actions a midwife may take in midwifery practice; actions depend on each unique situation. The world of practice has been

termed an 'uncertain world' (Leibowitz et al., 2010); each situation is unique, and knowledge and practice constantly changes. One of the goals of the narrative-centred curriculum was to prepare students for future practice where they could think for themselves in an uncertain world.

Instead of providing content and answering questions, the teacher's role was to help students to learn how to learn, by stimulating their own thinking about possible answers. One of the students, Donna, felt she was not being taught the right way when the teacher asked things like "how do you think it happens?" or "what do you learn from that?"

> *In my tutorial we just sit there, and all we get is: Well how do you think it happens? What do you learn from that? People remember stories, and I think that is the whole point, what this narrative thing is about… But it is not being taught the right way.*
> Donna (Students, Sem 1, Gp1, p. 25)

The idea of the narrative-centred curriculum was to guide students in their own learning, by facilitating students thinking about what they needed to know, what they already knew about the issue, and guiding them to where they might find answers for themselves. This was interpreted by Donna as *not being taught the right way*. In the *prefigured* world, teachers provide information and answers, and students listen and take notes. In a narrative-centred curriculum, the teacher's role is to help students formulate their own learning objectives and to ask them to think of possible answers for their questions.

For students, the experience of the narrative tutorials was that they felt they were not being taught the 'right way'. For teachers, the experience of facilitating groups created a sense of 'being a fake'. What these experiences revealed was that it felt harder for teachers to facilitate learning than it was to pass on information to learners, and harder for students to pursue answers to their own questions. As Heidegger (1954/1968) so insightfully put it:

> Teaching is more difficult than learning. We know that; but we rarely think about it. And why is teaching more difficult than learning? Not because the teacher must have a large store of information and have it always ready. Teaching is more difficult than learning because what calls for this is: to let learn. The real teacher in fact, lets nothing else be learned than- learning. (p. 15)

The *prefigured* world of education gave time to prepare and structure formal teaching. The experience of teachers in this study showed that when they were prepared and felt knowledgeable – they felt real. Narrative pedagogy changed the focus of teaching from giving information, to discussion and reflection. Heidegger, however, maintains that real teaching is about letting learning happen; and for him, letting learning happen is actually more difficult than holding and presenting a large amount of knowledge.

Teachers "thrown" by the tutorial process

Teachers were also at a loss regarding how to deal with some of the group dynamics in their narrative tutorial groups. Lilly comments after the first feedback session with her tutorial group:

> *The first hour I found so hard. I went in with such optimism, I thought they're bound to have gone in and done some work on it and let's see what they've done! And my heart was gradually sinking as they went on. Mega issues for some, not a big deal for others. But my concern is now that this is having a knock on effect for the rest of the group, not ALL of them, but you can see a distancing from me and the rest of the group, you can see the heads down, no eye contact. She contributed her little bit but then I thought how do I now deal with this issue?*
> Lilly (Teachers, Gp2, p. 3)

Lilly expressed that *her heart was sinking* when she was faced with issues such as students who were distant from her and the rest of the group, or those who did not contribute to the group. Lilly was uncomfortable and at a loss with how to deal with the group dynamic. Heidegger (1962) describes a sense of not feeling comfortable as *thrownness*. Heidegger says that we experience *thrownness* when we are called to attention by a situation. *Thrownness* serves as an indicator of matters of concern which are already present or are absent. As teachers experienced *thrownness,* matters of concern about the *prefigured* world of midwifery education were revealed.

Lilly's experience in the narrative tutorial group exposed things which would not be evident to a teacher in a lecture situation. The narrative tutorial groups uncovered the students who had not done the learning, the high achieving students and the struggling students. Also uncovered were the students who did not realise what they did not know, and students who may have learned the 'wrong' things. These

are issues which teachers are not faced with in a lecture situation, as it is assumed that all students learn the same things from a lecture. The tutorial groups also exposed group dynamics, which exist, but are not always seen by the teacher in a large class setting.

Lilly was concerned that students might not be learning enough or learning the 'right things' with the narrative-centred curriculum;

> *My other concern is that when they do come to exam time is it going to reflect on me because of the teaching and the way it's all coming to a head, the gaps, if they've gone along that little track, and for the rest of the group – there were two quiet people in the group that don't contribute. It's difficult to draw them into the discussion…*
> Lilly (Teachers, Gp2, p. 3)

For Lilly, one of the indicators of her ability as a teacher is student success in assessments. Hence, she felt particularly concerned that the students in her group might not have learned the right things for the examination and then if they failed, it would *reflect on her teaching*. In a *prefigured* world, it is the teacher's role to tell the students what they need to know [to pass the examination][15] to become a midwife. Heidegger (1962) uses the notion "for-the-sake-of-which" to explain the way that human activity makes sense of itself. For example, being a teacher or being a student is a "for-the-sake-of-which" that informs our activities. "*Dasein* (being-in the-world) needs "for-the-sake-of-whichs" and the whole involvement structure in order to take a stand on itself, i.e. in order to *be* itself" (Dreyfus, 1991, p. 95). Dreyfus (1991) explains that these are not seen as roles as such, but rather something that informs all a person's activities. Heidegger (1962) explains that *Dasein* finds itself in things; what matters to a person shows what they are. We understand the person as a being for whom things have significance and value. Students' success is one of the "for-the-sake-of-which's" of teaching; teachers feel they have done a good job when students pass their examinations.

[15] I have put parentheses around to pass the examination as this is simply the tool which will allow students to reach their ultimate goal of becoming a midwife. So although students want to learn to pass the exam, the reason the teachers focus on this, is that passing the exam will ultimately allow students to practice as a midwife.

For a teacher, individual student results are a measure of teaching success. As Margaret (Head of Midwifery/Programme Leader) pointed out, it is the collective student pass rates which show the university whether a curriculum is effective or not:

> *…once the reporting starts to come in… the examination board which deals with students' results really only want to look at, collectively, apart from individual students, they're really only interested in the pass rates. Are the pass rates OK, and if they're not why aren't they? So if we had a poor pass rate that would flag that maybe they would investigate what we were up to, they'd say well this obviously isn't working.*
> Margaret (Interview, p. 6)

It is a poor pass rate which would alert the university to *investigate what we were up to* [with the curricular processes]. For the university, student pass rates (student outcomes) are the measurement of the success of the programme, not the curricular processes (how students got there). In the *prefigured* education system, the university, teachers and students view results as the measure of what students have learned and teaching effectiveness. For the *refigured* narrative-centred curriculum, it is the thinking which happens along the way which is equally as valuable as the outcome of that thinking (student results).

Prefigured world of education: The teacher determines students' learning objectives

Students' experience of the narrative-centred curriculum revealed that the challenging part of the process was taking responsibility for deciding what they needed to know (their own learning objectives), and the depth and breadth of their learning. One of the goals of a narrative-centred curriculum is that students become adept at identifying for themselves what they need to know and develop the skills of finding answers to their questions. The purpose of the first tutorial, after the narrative session, was for groups to discuss all the issues which had emerged from the narrative and what they would need to learn in order to understand these issues.

The idea that it is beneficial for learners to become self-directed by practice in identifying their own learning needs and locating their own learning resources, comes from work on the way that adults learn (Knowles, 1973, 1975). The process of analysing a problem and identifying learning objectives is fundamental to PBL curricula and is the process which was adapted for the narrative-centred curriculum. A further

reason to develop this skill was that New Zealand midwives have a professional requirement to be able to reflect on the care they have provided for women and to be able to identify their own learning needs in response to this reflection (New Zealand College of Midwives, 2007).

Students initially did not trust their own ability to formulate learning objectives and to be 'self directed' in their learning. Although each group devised their own set of learning objectives based on the narrative which they had just heard, we had also predetermined a set of 'core' objectives which we felt that each student would need to have covered to prepare for the examination at the end of the semester.

Prior to the new curriculum commencing, teachers debated whether we should make 'core' learning objectives available for students at the beginning of the course, after each narrative, or at the end of course (as a checklist). On the one hand, we wanted students to learn to be self-directed by identifying their own learning needs; on the other hand, there was a basic level of knowledge which we wanted to ensure each student had. We decided that we would post the list of 'core' objectives online after the first post-narrative tutorial groups. Our thinking was that there is a basic body of knowledge which we expected all midwifery students to have, and that by posting the 'core' objectives online students could check that their group objectives had covered these (see Appendix Q for examples of group and core objectives in the tutor guide for the narrative-centred curriculum).

Regardless of timing, the problem with providing core objectives for students was that they inevitably saw that there were two sets of objectives; their group's objectives and the 'core' objectives. Students assumed that the 'core' objectives were the ones that they were going to be examined on, which potentially defeated the purpose of students identifying their own objectives. For example, one of the teachers talked about how her group was possibly wasting time figuring out their own objectives when they were going to be posted online:

> *Last year I found my group were frustrated that they had to work out objectives and then there were going to be possibly different objectives posted on line and they saw it as a waste of time spending an hour brainstorming when what they really needed to know was what had been decided by us.*
> Emma (Teachers, Gp6, p. 5)

We had expected that students would just answer their group's learning objectives and use the 'core' objectives to check at the end of the semester to ensure they had covered everything. April, like many students, thought that she would need to do both sets because students were going to be examined on the 'core' objectives. This created pressure for students to complete what could be two different sets of objectives. As April says:

> *I find self directed really hard because you have your core objectives, but on top of that you have your tutorial objectives, and it is kind of like a war as to which you are supposed to focus on, because you know the core ones are the ones you will be examined on and the tutorial ones are the ones you have to feed back to the group about, and they are both important.*
> April (Students, Sem 1, Gp2, p. 6*)*

April sees it as a *war* between two lists of objectives, those which her group has identified and the 'core' objectives. She sees them as separate, different and in conflict. This was the first focus group in semester one when students were just getting used to this way of learning. In fact, teachers did offer guidance towards the areas which were important for students' study, and when we looked at the groups' learning objectives, compared to the core objectives, there were many overlaps. April incorrectly perceives that there would only be exam questions on the core objectives not the groups' objectives, so wants to spend time learning what she thinks she will be examined on.

Students were used to teachers making explicit what they should learn and the depth and breadth of that learning. When this *prefigured* structure was removed, students felt anxious about their own ability to make such decisions. Chloe says her phone is ringing constantly with other students ringing to ask her 'do we need to know that?'

> *My phone rings constantly with the people that I study with ringing me up and going, "do I need to know this?", and it is not because they are asking me, but because we are all doing it to each other, we are constantly ringing up and going "oh my God, I just found this in the book, do we need to know that?" What is the level that we are supposed to be at?*
> Chloe (Students, Sem1, Gp 1, p. 29)

Students feared that they were not learning what they needed to know for the examination and that teachers were not giving them the guidance which they were expecting. An example from one group's objectives in relation to the narrative 'getting

pregnant' was: 'How does the placenta develop?' In the past, a teacher would have decided what information about placental development was important for a student midwife to know, would prepare teaching materials and then set a question in the examination. When students went to study this topic for themselves they discovered that there was an enormous breadth of information on placental development which they could potentially learn about, whole books have been written on the subject. Students became anxious when they realised the scope of some of their learning objectives and sought guidance from each other, not only regarding what to learn, but also the depth of learning.

> *Do we need to know the placenta and fetal interaction, physiological changes in pregnancy, those things, and what level do we go to? Do we need to go to what they are? Do we need to go to how they happen, or do we need to go into what would stimulate that to happen, and how and when. There is a huge range there, but basically we are all crossing our fingers that we study to the right level, and when we go to the exam we will find out whether we have or not.*
> Chloe (Students, Sem1, Gp 1, p. 15)

When students set their own learning objectives, they realised for the first time the potential depth to which they could go. There was so much that could potentially be learned; it is impossible to learn it all. For students, knowing which information they could be examined on provided a sense of security. The danger, however, is that this may be a false security because if examinations set the limits of learning, then students may erroneously think that is all there is to know about the topic.

Learning objectives posed a dilemma for teachers. As one of the teachers, Deborah points out:

> *The other thing that I want to say is if you come into a meeting or a tutorial with just your set of objectives it has the possibility of putting blinkers onto other stuff that might come up, you know like we've focused on this and we've got to get to these objectives instead of letting the group decide. Some issues come up and like I say one session that I did was, the one that stands out for me last year really was about the whole thing about death and dying that had nothing really to do with the topic, but it explored a lot of people's issues and talked about, for them, you know, how they could possibly cope with that whereas if you come into a thing with a set goal and objective, you don't get that necessarily.*
> Deborah (Teachers, Gp6, pp. 8-9)

Deborah recognises the depth of discussion on death and dying which evolved in one of her groups. This was not an anticipated discussion but had come out of a narrative on antenatal screening. Deborah points out that if learning objectives are pre-determined then the possibility for this discussion to emerge may be stifled. Learning objectives point students towards what to learn, provide evidence that all students have studied the same topics and make sure that important content is not overlooked. For teachers, the dilemma lay between wanting to ensure that all students had learned the content of the 'core objectives' and at the same time recognising that if students only looked at the pre-determined objectives creativity and discussion may be stifled, and the aim of promoting self-directed learning might be lost.

Our grappling with the problem of learning objectives led us, in semester two, to adapt the tutorial process. Instead of tutorial groups specifying learning objectives, at the end of the first brainstorming tutorial students identified learning themes; general areas on which they would focus their study. Through this process, teachers came to know when it was time to provide more guidance for the students without compromising self-directed learning.

> *I think that you can come up with themes, I think you can do a sort of two step... tease out the issues and come up with some specific learning out of those themes, so like anatomy and physiology or something, then you know, "what is normal anatomy of the breast?" I think it worked better with the themes. I think one of the problems that we had was that we became a bit too entangled in our own process at the beginning of last year... trying to do it the perfect way, and maybe we relaxed as well as the students as we became more familiar with it.*
> Deborah (Teachers, Gp6, p. 1)

Adapting the way tutorials were facilitated as we went along was a process of *configuration* between the 'perfect way' and teachers becoming more experienced and more confident with knowing when to be more directive with the depth and breadth of the content which students needed to study, and when it was better to let the discussion flow in the direction students were going.

We still held to the principle that it was better for students to seek answers where possible for themselves. As Sarah says: *We are going to give them more direction around formulating the questions; not providing the answers* (Sarah, Teachers, Gp6, p. 4).

Students appreciated the guidance as well. As Belinda comments:

> *We found that if we had a little bit more guidance in key points to actually focus on, without the lot, rather than going look at this subject, well we do not want to look at the whole subject, and it is rather difficult for my learning because I like to know that I need to learn that, that and that, and if I have got time I can branch out, but if I don't I know I have covered the basics.*
> Belinda (Students, Sem2, Gp2, p. 10)

Along with refiguring the use of learning objectives, we also spaced out the period between the narrative brainstorming tutorial and the follow up tutorial from one week to two weeks, because students struggled to complete their learning in the original timeframe. As one of the students, Effie said:

> *Well we found that with our [self-study],'cause we all work together, and we just get one day to do them to get the[learning objectives] all done, and there is probably about eight or fifteen of them by Thursday, and it is too much.*
> Effie (Students Sem1, Gp1, p. 2)

Initially we gave students one day per week for their self-study, reducing the number of lectures. As students asked for more lectures, we found ourselves comparing the value of lectures over tutorials, and this opened up discussion around the purpose of the narrative tutorial groups.

> *Yeah I think we're still doing a lot of taught classes, and the students seem to love the narrative. It seems that those sessions really enrich, well they complement each other, the teaching sessions and the narrative sessions it seems to really come alive and bring things together. The students and teachers alike are still very reliant on the teaching session and I'm not quite sure if that's a problem or if we could do it differently or should do it differently but I think we do still rely heavily on that.*
> Sarah (Teachers, Gp7, p. 2)

For teachers it was finding a balance between facilitating self-directed learning and giving students too much direction. By the second semester of the new curriculum, teachers had developed skills which enabled them to know when to provide more direction and when to let the discussion flow.

English as a second language students

Students who have English as a second language found it particularly confusing to not have the direction of a teacher telling them what to learn, the depth to go to, and whether they are right or not:

> *Well for us [who have English] as a second language, we like to know where we stop, we like to be constructed, like last year we knew exactly where we go. This year we don't know where we are going to stop, we go online and there are all sites, and you go and get lost.*
> Geraldine (Student, Sem1, Gp 1, P. 6)

Geraldine expressed that for students for whom English is another language, students like to know from teachers exactly where to go, and when to stop. It wasn't only students who have English as another language who wanted teachers to tell them what to learn. Belenky et al (1986) found that when women (from any background) saw themselves as recipients of knowledge, then they saw people in authority as holding the 'truth'.

Learning from the narratives was a good way to learn about a different culture. Freida, for example looks upon the woman's narrative as a way to learn about culture.

> *For me, from another culture, it is a good thing for me to watch the woman telling her story of what is happening because I haven't had any experience to say how in this culture, how women react being with the midwife. For me it is good watching that, but sometimes I feel, think.. is all midwife doing the same thing? or is she entirely doing her own thing. I sometimes get a little bit.. um.. I cannot decide, is this for everyone, or just the single thing.*
> Freida (Student, Sem 1. Gp 1, P. 3)

Learning about another's cultural perspective is an important part of learning the art, or *phronesis* of midwifery practice. The narrative sessions provided a safe place for students to learn about cultural perspective and how culture influences the way a woman might respond to pregnancy, or to her midwife.

Different kinds of clinical reasoning: Techne and phronesis

Polkinghorne (2004) contends that there are two kinds of reasoning which health practitioners use when applying knowledge to changing practice situations. He draws on the Aristotelian notions of *techne* and *phronesis* to describe these kinds of knowledge. *Techne* refers to the knowledge and skills about practice, which have been

produced by technical-scientific reasoning; and *phronesis*, refers to the reasoning used to deliberate about the best action.

As I interpreted data from the students' focus groups, it emerged that students considered there were different *kinds* of knowledge. In Danielle's case she talked about one kind of knowledge that she gains from listening to the woman versus science knowledge, which she cannot gain from the narratives.

> *…I do think that we need to be listening to women, it is all about women and voices and that, but I certainly think that we cannot learn science [from the narratives], because the science does need to be safe, it needs to be safe for us, so we need to know the science.*
> Danielle (Students, Sem1, Gp2, p. 5)

Danielle referred to science in terms of specific knowledge and skills for practice, and associates science with safe practice. Although she recognises that 'we need to be listening to women', knowing how to listen, in Danielle's view, will not make her a safe midwife. From our experience as midwifery teachers, we knew that listening and responding appropriately to each woman's unique situation was the very thing which would make safe midwifery practice. As one of the teachers, Emma put it:

> *It's taking the level of thinking to a higher academic level isn't it? It is not just recall and description it's the critical thinking and a deeper analysis… but then the effort required is quite huge.*
> Emma (Teachers, Gp6, p. 12)

For a midwife's clinical decisions to be appropriate and safe, her decisions cannot simply be deduced from technical-scientific knowledge *(techne)*; the reality of practice is that each woman is unique and unexpected happenings occur. Dall'Alba (2009) points out that "while knowledge and skills are necessary, they are insufficient for skilful practice and for transformation of the self that is integral to achieving such practice" (p. 34). Polkinghorne (2004) says that insights and perceptive understanding are produced from 'phronetic reasoning'; a different kind of clinical knowledge from *techne,* which refers to cognitive knowledge and practical skills. Phronetic reasoning is said to produce a "perceptive understanding or insight about what is called for in a particular situation" (p. 106).

It was hoped that a narrative-centred curriculum would foster a deeper kind of thinking to that which can be induced in a lecture situation. As midwifery teachers, we wanted students to gain specific knowledge and skills *(techne)*; but a midwife also

needs to know when and how to apply that knowledge, and to think critically and reflectively about practice situations *(phronesis)*. It was anticipated that if students learned to think critically and reflectively during their education, then in the future they would be able to respond appropriately to the many unpredictable and complex situations in which they would find themselves in practice.

Effie talked about knowledge as if it was a *techne*, which she would 'rather have first', before hearing the woman's experience.

> *I find that is back to front for me, I would rather have the knowledge first, and then have the experience of the woman coming in so I can relate to what she is saying to what I have learned, rather than starting with the experience and trying to put that into knowledge.*
> Effie (Students, Sem1, Gp2, p. 2)

Effie is referring to the *prefigured* education system which has been primarily based on first knowing about the *techne*, because that is seen as easy to learn and to teach; it is tangible, measurable, and visible. It can be broken down into its parts. Polkinghorne (2004) suggests that the technological view of what counts as knowledge has permeated our culture, "It is what our schools and universities teach and what informs the practices of our institutions" (p. 26).

In this next passage, April gives an example of the tension between *techne* and *phronesis* for her as a student. The stories showed things which April had not considered and made midwifery more real (*phronesis*); yet, she worried about what was in the textbook (*techne*):

> *The first narrative session that we had, we kind of all got up and told our stories, and by the end of it most of us were in tears, because it was just so amazing to hear the stories of other people, they were things that I never ever considered that people go through. It was like getting pregnant, and things I had just never ever considered, and it was really amazing and it was a quite special day, to be able to share with everyone. Listening to the stories that women have to share is fantastic, and <u>it makes midwifery be more real, not just in the textbooks, but at the same time you really worry about what is in the textbooks because you know you need to know it.</u>*
> April (Students, Sem1, Gp2, p. 2)

In this example, the textbook can be considered to be a metaphor for *techne*. No textbook can ever contain everything a student needs to know for midwifery practice; yet, the *prefigured* world gives *techne* (the textbook) primacy. The complexity of

midwifery practice means that midwifery actions cannot be deduced simply from *techne* learned from a textbook. The *prefigured* education system privileges *techne* because *techne* is tangible, measurable and examinable. *Phronetic* understanding is much harder to define and measure.

Deborah, an experienced midwife and teacher, explains that she did learn about a *techne* (the in-depth physiology of labour) in the past, but has now forgotten that exact knowledge. However, she now has an embedded understanding (*phronetic* understanding) of the physiology of labour and uses this in practice without even thinking about it.

> *Well it is that sort of thing, there is a certain body of knowledge there that you retain in your brain as a midwife, but some of the stuff becomes absorbed somehow, and I cannot say exactly the in-depth physiology of labour, but if I am looking after somebody I can talk them through.*
> Deborah (Teachers, Gp5, p. 9)

Phronetic reasoning is less tangible than technical-rational reasoning; it has a quality of lateral thinking and varies from situation to situation (Polkinghorne, 2004). The *phronetic* understanding about the physiology of labour, which Deborah says she has *absorbed*, has come with time and experience. Belenky et al. (1986) explore the concepts of *understanding* and *knowledge*, coming to the view that *understanding* involves "intimacy and equality between self and object" whilst "*knowledge* implies separation from the object and mastery over it" (p. 101). Using Belenky et al.'s analysis of separate and connected knowing would indicate that Deborah has an *understanding* of the process of labour, she is intimate with the process and works with it; rather than having *knowledge* of the process of labour as a separate object.

Interpretation of midwifery students' experience of a narrative-centred curriculum revealed that learning about the *phronesis* of practice involved more time than learning from lecture notes.

Learning takes time

The time it took for students to find the information for themselves frustrated some who were used to studying in a structured way. In this excerpt, Chloe feels as if she is "wasting" time when she says:

> *…I am not saying that the work is too hard, or too close together, that is not at all what I am saying because what my point is that I am normally someone who has a really strict timetable, this is my essay time, this is my exam time, I need to learn these parts ra-ra-ra. I don't know what to learn, when every time I open a text book I don't know where am I and where am I going. How deep do I go? It just doesn't work. I am wasting valuable time, but I might not be wasting it. I don't know if I am going too far in. But it is taking you two or three times longer to get.*
> Chloe (Students, Sem1, Gp1, p. 31)

With the narrative-centred curriculum the usual 'boundaries' are not put in place by the teachers, meaning that students have to make some of their own decisions about where their learning will take them. Because a teacher has not directed Chloe to the important pages of the textbook to read, she does not know to what depth to go. She wonders if she is *wasting valuable time* reading sections which may or may not be important. Learning does take longer when students do their own research.

As discussed in the methodology chapter, Ricoeur (1984) recognises the philosophical enigma in thinking about time. Time can be thought of as objective, measured and chronological, or can be thought of as 'the present moment' in which past, present and future time are grasped together (non-chronological or psychological time). Ricoeur maintains that both chronological and non-chronological dimensions come into play through narrative telling, and that this leads to an understanding of the perspective of the narrator. For example, expressions such as "to have the time to" "to lose time" or "to take the time to" reveal much about a person's relationship with time and their perception of what is important in the world.

Betty for example says she "does not have enough time" to research the topic herself, and that a teacher should provide that material: *Well we do but we do not have enough time for it and that is really where their support should come in and provide a little bit more ready material* (Betty, Students, Sem1, Gp2, p. 7). If the teacher has prepared material to give students, then it is the teacher who has taken the time to think about the subject and produced teaching materials which convey what the teacher thought was most important about that subject. In other words, the teacher presents students with the product of that thinking time. This is what is expected of a teacher in a traditional curriculum. The time and effort it took to go and find information created stress for students.

Here Danielle conveys the struggle which she had with the time it took to do the learning:

> *I just think time is a huge factor for students, it is such an immense factor because we do all have other things going on in our lives, and I know for me I learned my lesson really early on, that I need to have something, I cannot just have one thing, you know, like I have to have a life outside school or I would go crazy and I won't be able to cope. So you know, it is really a time factor for me anyway, so when you feel you are doing something that is not productive, the full productive use of your time, it can be frustrating, it makes me feel frustrated, you know. Like if I am not getting the most out of this that I can possibly get, then I start to get a little bit "oh no".*
> Danielle (Students, Sem1, Gp2, p. 20)

Danielle wants to feel that she is being productive with her study time so that she can have time for other things in her life. Talking about learning as if it ought to be productive relates to the view of education as an economy. An economic view of education (as discussed in Chapter Two) is that knowledge is a commodity, which teachers purvey and students purchase. When Danielle talks of wanting to spend her study time productively, she is seeking an efficient way of gaining knowledge. This points to *prefigured* efficiencies of education, when evidence of having learned something is having produced something tangible.

Danielle goes on to say that she felt as if she was writing in the library all the time. In a traditional lecture situation students write down notes from the teacher's lecture (often copied from a multi-media presentation) and then study these in their own time. With the narrative-centred curriculum, students needed to write their own notes on the subject and for Danielle she feels she is writing all the time:

> *I feel I am just writing notes all the time and then I haven't got the time to study and discuss things because I am in the library writing. I just seem to be writing all the time.*
> Danielle (Students, Sem1, Gp2, p. 8)

Danielle is talking about the pressure of writing her own notes in the initial semester one focus group when students were getting used to the new curriculum. At the end of the following year, 2006, I presented some initial findings from this study to the cohort of students who were now at the end of their third year of the midwifery degree. In the ensuing discussion, one of the students said that her notes from second year were

much better to revise from because she had written them herself, rather than copied from a teachers' lecture. So even though in the moment it seems hard and is more time-consuming, if a student does their own research and writes their own notes, this may be better for their long term learning. Although it was more time-consuming for students to write their own notes, to spend time discussing the narratives and doing their own study, some students did recognise a broadening of their thinking. One student talks about the broadening in her thinking which is happening from learning from the narrative:

> *I think also, as far as to give something positive to the narrative for just a minute, I have noticed in my conversation with other class mates, none of whom are here, we have started to use certain buzz words like, look at the whole picture, and what about this aspect – so there is a lot of that sort of forcing ourselves to go outside of well this baby has not gained weight and so we should put it on formula. There is a lot of broadening happening in terms of that sort of stuff.*
> Chloe (Students, Sem1, Gp1, p. 14)

There are some kinds of learning which do not appear to be tangible or measurable, but are equally as important. Chloe has learnt something more than a *techne*, she is talking about phronetic understanding. The kind of knowledge needed for *techne* is easy to learn, but also easy to forget. As Gadamer (1975/2004, p. 315) points out, "we learn a *techne* and can also forget it. But we do not learn moral knowledge, nor can we forget it" (p. 315).

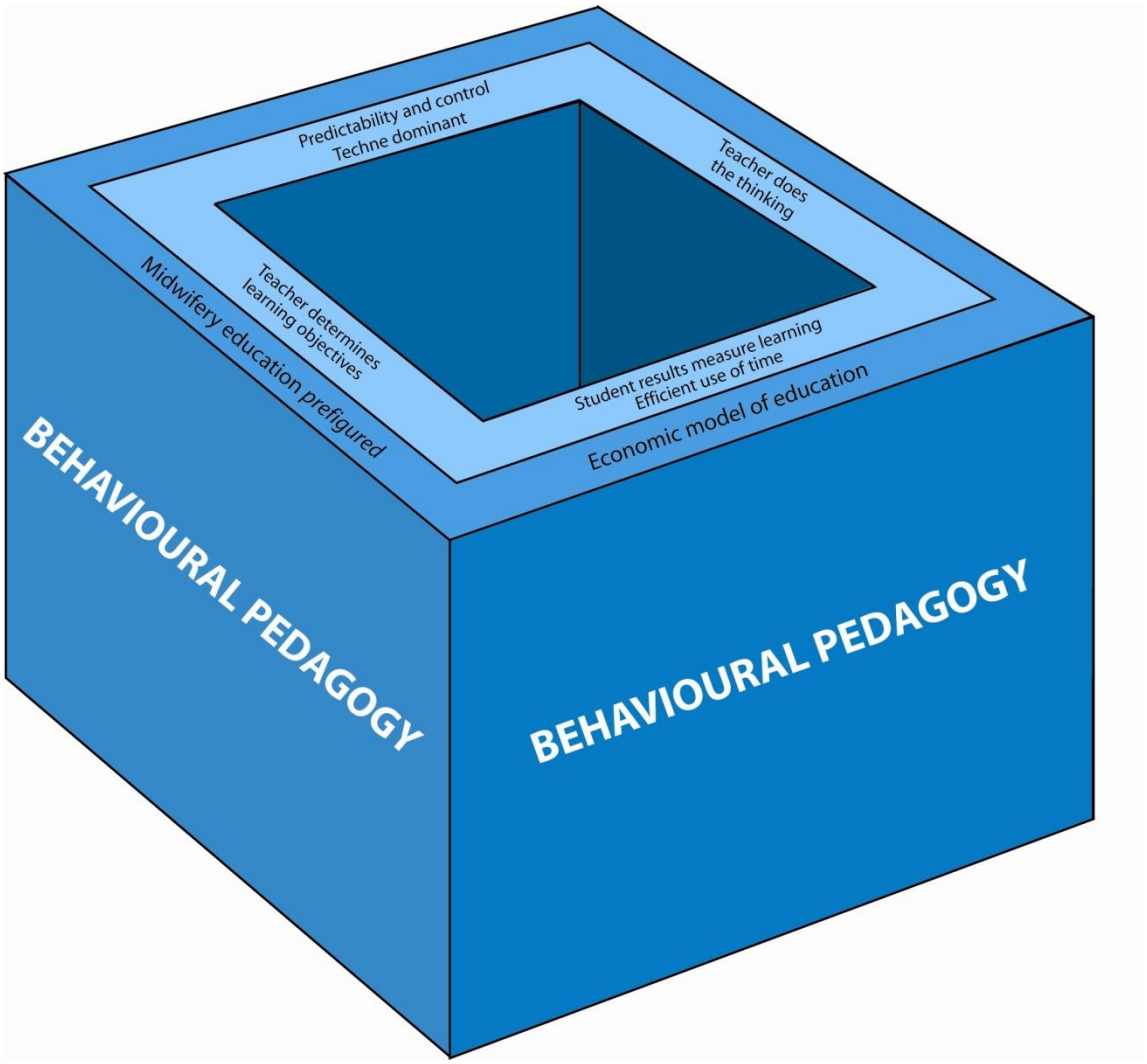
Interpretation of students' and teachers' experiences of a narrative-centred curriculum, revealed that time was significant. Time in education is seen as a commodity, which may be used productively and efficiently, or it may be wasted. In the *prefigured* world of education listening to stories, discussing and writing are seen as potentially a waste of time because they are not productive activities.

Time also had another effect on the experience, because over time, as teachers and students got used to the *refigured* curriculum, we lost the feeling that this was an experiment and it became the accustomed way of learning, and benefits were appearing. This will be explored in the following chapter.

Conclusion

When the curriculum was *configured* and a new pedagogical approach was implemented, the teachers' and students' experiences revealed the *prefigured,* taken for granted, world of university education. Students and teachers initially felt unsure of their ability to teach and learn in such a different way, because in the *prefigured* world of education the teacher is in control of learning, deciding what is to be taught and how it is to be taught. Education is predictable. The teacher is the one who does the thinking, and presents students with the results of that thinking. Education happens efficiently, *techne* is dominant, and student results measure learning. These elements create a frame which provide a sense of security for teachers and students, but also enclose the potential for curricular change. The following diagram, Figure 3, gives a visual representation of the frame.

Figure 3: Prefigured world frames the possibilities for pedagogical change



The next chapter explores further the experience which emerged for midwifery teachers and students when we *configured* the curriculum and used narratives as a foundation for teaching and learning.

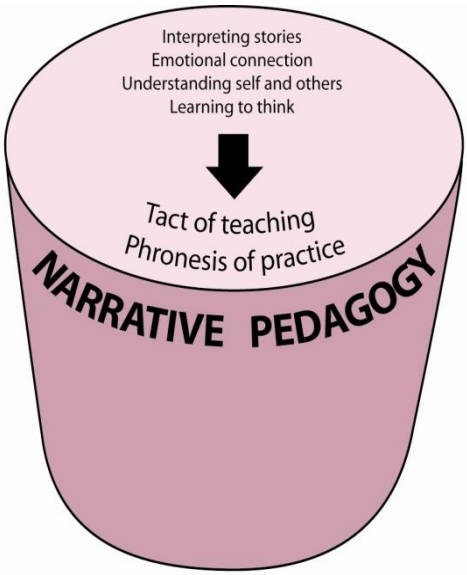
Chapter Seven

Configuring the curriculum: the art of midwifery emerged

Introduction

When narratives became central to the curricular processes, some exciting consequences for teaching and learning in midwifery education were revealed. This chapter explores the experience of *configuring* the curriculum. Data showed how a narrative-centred curriculum facilitated students' learning about the art, or phronesis, of midwifery practice. For teachers, the experience of facilitation in a narrative-centred curriculum was a balancing act between knowing when to step in, and when to let a discussion flow. The tact of teaching became apparent. The findings explored in this chapter, are shown as a round peg as illustrated in Figure 4.

Figure 4: Configuring the pedagogical approach



To set the scene I start by describing the first day of the new curriculum in 2005.

The first day of the narrative-centred curriculum

The first day of the new curriculum was February 15th 2005. 'Getting pregnant' was the topic of the first narrative session. Students and teachers were invited to share narratives about the experience of becoming pregnant. Students were very open and generous with the stories they shared, and the session felt like a great success. The following is an extract from my research journal after that first narrative session.

> *The next day students came back and we asked if some of them would like to share their stories of early pregnancy with the class. We had story after story, which was filled with emotion; students who had become pregnant by accident and didn't want to be; students who had tried for years and been through all sorts of infertility treatment to get pregnant; one had been an egg donor. Teachers also shared stories alongside students. There wasn't a dry eye in the place. The tissues were being passed up and down the rows. This first session was mind blowing. The emotions which were revealed and the discussion which ensued in the tutorial groups were poles apart from anything which teachers or students had experienced in the classroom before.*
> (Researcher's journal 15.2.05)

Immediately after the first narrative session, students were offered the opportunity to reflect on the session by completing the prompt:

"When I heard the stories about [getting pregnant] today I was thinking…"

One of the students reflected:

> *For me, I was honoured to be part of the class, hearing the person's own story, told in her own way. I feel my body opening up a conversation in its own language. Every story has its unique meaning. It seems that each story's unravelling evidence of past experience which leads to vital connections with our world and also the art of midwifery. It demonstrates the powerful love of being a mother*
> (Student written reflection: Getting Pregnant: Pseudonym: A woman centred approach with an attitude of mutual honour & respect)

The students' responses were an exciting start to the narrative-centred curriculum; I had never previously experienced this kind of shared feeling happening in a lecture situation. As I read the transcripts from students' written reflections after each narrative, and later those from the students' focus groups, I pondered on the words they used to describe what they learned from the narrative. Some of the words used to express their reaction to the narrative sessions were:

- ≈ Revelation
- ≈ Opened my eyes
- ≈ I can empathise with the woman
- ≈ A huge amount of emotion
- ≈ Gobsmacked
- ≈ Realisation that wow
- ≈ I didn't realise that I would feel that way
- ≈ Those sorts of things have stuck with me because it was so different from what I have seen in practice
- ≈ It was a real learning thing for me
- ≈ It never occurred to me
- ≈ There is a lot of broadening happening
- ≈ I never thought of it from that angle because it makes you think outside the square

The words and phrases which students used to describe their experience revealed an emotional response when they listened to, and interpreted, the narratives. A traditional lecture aims to provide information to students in as interesting a way as possible. Each student may experience emotions during a lecture, whether the emotions are raised by the material presented, or what happened to them on the way to the lecture, or to what is going on in their lives outside university. Yet, an educational approach based on behavioural pedagogy, does not value the emotions of teachers or students for learning. Education is viewed as outside a person's emotional sphere and would not normally aim to encourage or document the expression of emotions.

The narrative sessions and the tutorials facilitated the expression and interpretation of the emotion of the narrator and the listener. Students' reflections showed that they learned about themselves, others and midwifery practice, through experiencing emotional responses which were aroused by the narratives.

Learning through emotions expressed in the narratives

The emotions which students told of experiencing while they listened to the narratives appeared to help them to think about each woman's unique history. One of the student participants, Floss, wrote that she was 'amazed' by the emotions aroused by the narrative session where students shared their experiences of getting pregnant:

> *How amazing it is to be pregnant and it is a life changing event! There is a huge amount of emotion involved which may be positive or negative. Until hearing the women's stories, you cannot know or appreciate the women's history and you certainly cannot make judgments.*
> (Student written reflection: Getting Pregnant: Pseudonym: Floss)

The positive and negative emotions which Floss experienced, through listening to the narratives, led her to appreciate the individuality of each woman's experience. Floss learned not to make assumptions and judgments about a woman through hearing the emotions about pregnancy which were expressed in the narratives.

Another student, Tessa, wrote that her 'eyes had been opened' by the diversity of experience which had been revealed in the narratives:

> *How every woman's experience was totally different – pregnancy is such an emotional thing to go through. As a midwife I will try to remember this session in antenatal clinics so that I can empathise with and be connected to the woman. We also come with our own journey (emotional baggage) and it must be treated with respect and love. Whether it is a positive or a negative experience at first getting pregnant the babies we have are much wanted. Women get pregnant and use different methods to get pregnant that I had never even heard of – so it opened my eyes.*
> (Student written reflection: Getting pregnant: Pseudonym: Tessa)

In this passage, Tessa reflected on the emotional experience of becoming pregnant. Tessa's emotional response to the narratives led her to recognise that her own pre-conceived ideas (emotional baggage) needed to be put aside so that she could attend to each woman's unique experience of pregnancy. Gadamer (1975/2004) says that people learn when "something is not what we supposed it to be" (p. 349), and that when we experience something not as we supposed it to be, we gain self-knowledge. Tessa's *eyes had been opened* when she saw that the experience of pregnancy was not as she supposed it to be. The insight which Tessa gained, from reflecting on the narratives, led her to make a connection between each woman's unique experience and how this might relate to her midwifery practice in the future; *I will remember this when I am in antenatal clinics*.

In the next excerpt, Tyrin also makes the link between the narratives and her future midwifery practice:

> *There are a wide range of emotions involved in getting pregnant. Shock, celebration, fear, waiting, ecstasy, grief, decisions about whether to keep baby, worry about telling parents, guilt, past miscarriages, infertility.*
> *As midwives we need to be sensitive to all the different situations involved and the journey that our client has had before she comes to see us.*
> (Student written reflection: Getting Pregnant: Pseudonym: Tyrin)

The narratives exposed Tyrin to the diverse feelings which surround pregnancy and she recognised the importance of a midwife being sensitive to the wide range of emotions which women may experience. For midwifery practice, it is crucial that a midwife is sensitive and responsive to each woman's emotions in relation to her pregnancy. Sensitivity and responsiveness to women's emotions is a part of the phronesis, or the art, of midwifery. Although sensitivity to a woman's emotions is a vital part of midwifery practice, it is not something which can be taught in a lecture, or read about in a textbook. Lectures and textbooks tend to avoid the individuality of women, and concentrate on physiology and midwifery management for specific conditions. The emotion of women's experience, which became apparent in the narrative sessions, provided an opportunity for students to learn about being sensitive to women's individual experiences.

Gaining self knowledge and insight from the narratives

When students reflected on their learning from the narratives, they often compared the narrator's experience or attitudes to their own beliefs. Hughie, for example, talked about how some of the women were like her and some so different:

> *Some women made me think how incredibly like me they were, other stories made me think I was poles apart, not just in life experience but attitudes to life and pregnancy, in particular the issue of motherhood… These statements led me to the revelation that these conversations women have around pregnancy and birth are often windows to their values and beliefs.*
> (Student written reflection: Getting Pregnant: Pseudonym: Hughie)

Hughie compared herself with the narrators; some she felt very alike to, and some very different from. Ricoeur (1992) has said that narratives are the medium through which humans interpret and understand themselves "…self-understanding is an interpretation; interpretation of the self, in turn, finds in the narrative, among other signs and symbols…a life story" (p. 114). Learning about oneself is important, because

having self-knowledge is one of the elements of insight (Gadamer, 1975/2004). As Gadamer explains, "insight is more than the knowledge of this or that situation… it always involves an element of self-knowledge and constitutes a necessary side of what we call experience in the proper sense" (p. 350).

In the next reflection, Crystal wrote about gaining insight from the emotional charge of the narratives:

> *How big an event it was in their lives, how much it affected them even many years later it is so emotionally charged. I will definitely keep this in mind when working with pregnant women, I have learned so much. So precious and totally valuable insight.*
> (Student written reflection: Getting Pregnant: Pseudonym: Crystal)

Crystal told how she had *valuable insight* from listening to the narratives, and that she would remember what she had learned in midwifery practice. Gadamer (1975/2004) says that ultimately all humans aspire to be discerning and insightful, but insight is not something which can be learned; it is something which human beings *come* to. Some of the student participants in this study *became* insightful through listening to the narratives.

The understandings about themselves, and others, which students drew from listening to the narratives, revealed the group of concernful practices which Diekelmann and Diekelmann (2009) named 'learning as listening'. To learn from listening to a narrative is about coming to understand; rather than achieving measurable cognitive gain. As Diekelmann and Diekelmann say, "Listening can tell the human being that it must give ear to (listen to) the listenable, not as cognitive gain or other such quantifiable magnitude, but as immediate, practical, and prudent understanding" (p. 224). Students in this study demonstrated that narratives helped them to gain insight through recognising their own assumptions, and being sensitive to each woman's individual emotional response to pregnancy.

Understanding the 'otherness of the other' from the narratives

Coming to understand another's point of view through narratives was an important element of learning in the narrative centred curriculum. In one of the narrative sessions a woman shared her experience of antenatal screening tests. She spoke about her decision-making around the result of those tests which might involve terminating

her pregnancy for fetal abnormality. In one of the student focus group discussions, Agnes talked about coming to a *realisation* that her beliefs were different to those of the woman's:

> *One of the things that came out yesterday was the realisation that 'wow' I never realised that people, I had heard, but I never realised that people would actually abort a baby just because they had doubts. Like, to me, I just would not do that, and my experience is that it is not something my friends or family have done, if that came up they would have had the baby and loved it, and so it was quite a realisation for me, not that I felt that way, but that I didn't realise that I would feel that way.*
> Agnes (Students, Sem2, Gp1, p. 17)

Through interpretation of the narrative, and comparing her own world view with that of the narrator, Agnes came to a *realisation*, recognising that another person's world view was very different to her own. The narrative provoked Agnes' thinking about her own values, and those of her friends' and family. Agnes was surprised by her own reaction to the narrative, and this surprise alerted her to her own beliefs. She learned about herself through engaging with the woman's world view which she expressed in the narrative, and became aware that others may have a different attitude from her own.

Gadamer (1975/2004) maintains that when people are able to put themselves in someone else's position, and see another person's world view, that they become aware of what he calls, the "*otherness of the other".* Gadamer also contends that to recognise the *otherness of the other*, a person must already have a horizon of their own in order to be able to transpose themselves into [another's] situation. When Gadamer uses the term horizon, he means "that one learns to look beyond what is close at hand – not in order to look away from it but to see it better, within a larger whole and in truer proportion" (p. 304).

Agnes was surprised by her own feelings, because she did not *realise that she would feel that way*. Heidegger (1962) says that when another way of being is seen, a horizon of 'having been' is disclosed. When a horizon of having been is disclosed, a person can discover where they stand in the horizon of the present. Through hearing the narrative, Agnes has learned something about herself; she thought about her own values and was surprised by her own reaction. Agnes saw the *otherness of the other* in the narrative about antenatal screening. She came to a realisation that the view of a

woman who might abort her baby if she doubted its normality, differed from Agnes' *prefigured* understanding from her past experience with family and friends. Acknowledging her own pre-understanding, Agnes was able to see the *otherness of the other*; and although the horizon of the other was different from her own, she understood it.

It is by means of recognising the *otherness of the other* that practitioners can provide individualised and genuine guidance (Gadamer, 1996). Therefore, an ability to see and accept another's horizon of understanding will be useful for midwifery practice. If a midwife were to rely on self-evident understanding, without recognising her own preconceived ideas and beliefs, then she might miss an important aspect of what a woman is really trying to convey and may standardise her midwifery response. The narrative-centred curriculum facilitated students' recognition of the *otherness of the other* which would potentially lead them to think about providing individualised midwifery care. A behavioural pedagogical approach, in contrast, may assume that there are standardised ways of practicing; and teaching and learning may, therefore, be based on that assumption.

Learning to think through discussion

When students shared their learning in the narrative tutorial groups, opportunities arose to have a deeper level of discussion than would be had when just course content was discussed. For example, in one of my groups, a discussion about the menstrual cycle led to discussion about technologies of ultrasound scanning and the ethics of termination:

> *And when we were talking about the menstrual cycle and ovulation, she said well what happens if a woman gets pregnant on the pill, one of them said that. What happens if she gets pregnant on the pill, how can she get pregnant when she is on the pill, and we ended up talking about how the oestrogen stops the ovarian cycle and so on, and she said I have been on the pill for years and I never knew how it worked, and she kept coming back to it, so that is how it works. And what does the progesterone do, you know, how does that work, and so on…. Well they did say that they found it really hard and things, but they went with it and we had this discussion about all sorts of things, because we ended up having this big thing about scanning, should scanning be free and women do it for fun and have pictures in their baby books, and things like that, and what were the real*

> *implications of nuchal translucency[16], and what happened if you had a Downs baby, and some students would never terminate, they thought it was just terrible, and we ended up having, what I thought, was a very worthwhile discussion.*
> Andrea (Teachers, Gp2, p.5)

A conventional class on the menstrual cycle would typically consider the hormones and menstrual cycle from a physiological perspective. The narrative tutorial groups provided an opportunity for a much deeper level of discussion around the topic. As a teacher, I could see the value of this discussion. The ethics of ultrasound scanning, and implications of finding out information about a baby in advance, are issues which are not normally explored in a lecture situation. Yet, discussion and sharing of different perspectives which arose from thinking about the menstrual cycle in a different way facilitated a deeper exploration of issues. The narrative-centred curriculum involved more than simply knowledge acquisition; students were encouraged to think about a topic from different perspectives. As Diekelmann and Diekelmann (2009) point out, "For hermeneutic phenomenology, schooling is more than the processes inherent in knowledge acquisition and skills training" (p. 193).

The tutorials became a time where students felt that they could share their own experiences more freely, and discussions led to thinking and reflection. Agnes talked about one of the tutorial groups which met straight after the narrative session:

> *That was a tutorial to get people to come up with brainstorms and stuff, and I don't know about your tutorial group, but mine did come up with a lot of more, in a sense we were more reflective. We were thinking more, not just honing in on the issues, but recognising our own limitations and beliefs. So it was more kind of "arty". So then I have also got this bunch of things to think about in terms of in my practice, I am going to be thinking about this.*
> Agnes (Students, Sem1, Gp2, p.2)

For Agnes, the tutorial group's discussion encouraged reflection and helped her to recognise her *own limitations and beliefs*. Further to this, Agnes said she had a *bunch of things to think about* in her practice and she was going to continue her thinking. The opportunity for students to reflect on their values and beliefs was an important aspect

[16] A nuchal translucency scan is an ultrasound scan which measures the thickness of the fetus' nuchal fold which when combined with the woman's age, can calculate the risk of that fetus having Down syndrome.

of learning in the narrative-centred curriculum. As Palmer (1998) points out, “Learning does not happen when students are unable to express their ideas, emotions, confusions, ignorance and prejudices. In fact, only when people can speak their minds, does education have a chance to happen” (p. 75). Agnes was able to reflect on her own values, which she recognised as learning about the art of midwifery, and her future practice as a midwife.

Unless a student is very confident, the opportunity to express her values does not usually happen in a large class. As the following student said, in a smaller group she felt more comfortable to express herself, and had more opportunities to talk than she would in the larger class:

> *I think for me it was when we had the small groups, because I wasn't very good, and my heart would start to race if the whole class was there – but in a small group I feel safer to talk, so yes, the tutorials are very good for me.*
> Betty (Students, Sem1, Gp2, p.17)

The size of the group did matter for discussion and reflection. Ideally the tutorial groups had a maximum of 15 students and a teacher. The groups exposed students to multiple points of view; rather than just the teacher's, as would be the case in most lecture situations. In the following passage, Aroha talked about hearing other people's points of view as being something that she could learn from:

> *I think I quite liked that sort of informal way of having a classroom discussion, and hearing different points of view that people talk about, because with the other way you really only have the lecturer's viewpoint and yours, but I think this other style of learning sort of gives you a lot more ideas about different people's ideas, and also you learn a lot of stuff that you cannot really know about listening to other people, I think. So I think it gives you a wider range of ways of learning, or enhancing the information that you already have.*
> Aroha (Māori students, Sem2, p.3)

Aroha spoke of the advantage of hearing many points of view in the narrative tutorials, compared with hearing only the lecturer's point of view in a lecture situation. Listening to other people's ideas, Aroha felt that her learning was enhanced, as it added to the knowledge which she already had. In a lecture, a teacher provides information, but students' understanding of that information is invisible. As Smythe, MacCulloch, and Charmley (2009) point out, “understanding lies in the art of listening” (p.22). The narrative sessions and tutorial groups were a means of students coming to *understand*

about practice, rather than learn information about practice. Students in Smythe's (2004) study on 'thinking' said that when they met over a cup of coffee, they could spontaneously "discuss and have a good old debate" (p. 329). The narrative tutorials provided a venue for discussion and debate which was important for thinking and understanding.

Gadamer (1975/2004) stresses the importance of discussion and conversation, as it is through language that understanding emerges. It is through situations where we do not understand that we become conscious of the "conditions of all understanding" (p. 386). Heidegger (1954/1968) tells us that "we come to know what it means to think when we ourselves try to think" (p. 5). In other words, we express our *thinking* through conversation.

One of the aims of the narrative tutorials was to facilitate understanding and thinking though discussion and debate. One of the teachers spoke about the way that she helped students to think about taking a woman's blood pressure in labour:

> *That is right, and it is not only about thinking, and I never really understood about this thinking outside the square really, it seems a strange thing, but critical thinking is thinking about your thinking. Okay I am going to look after this woman in labour and I think I will take the blood pressure hourly. So why are you thinking that you will take the blood pressure hourly, you know, and I think that is an easier way of saying it you know. What is your rationale, thinking about your thinking.*
> Deborah (Teachers, Gp5, p.7)

Rather than the teacher, Deborah, asking students how often to take a woman's blood pressure, she asks the question: *Why are you thinking you will take the blood pressure hourly?* This question provokes a different way of thinking about taking blood pressure. It stimulates thinking about the individual situation and why in a particular instance the blood pressure should be checked at certain intervals. In the tutorial group, Deborah encouraged students to *think* about midwifery practice, rather than to *inform* students about midwifery practice as she might in a lecture situation.

For teachers, encouraging students to move their thinking from recall and description took more time and effort than providing information in a lecture. Emma spoke about what was required to take thinking to a higher level:

> *It's taking the level of thinking to a higher academic level isn't it? It is not just recall and description it's the critical thinking and a deeper analysis, and maybe it's lovely to get the story and think an hour later that they'll do all this work, but then the effort required is quite huge. And it is human nature to baulk at that amount of work.*
> Emma (Teachers, Gp3, p.6)

Teachers made efforts to help students to think about practice. Lilly, for example, gave her group an article to help them to learn about thinking:

> *I said "well how do midwives learn to critically think in practice?" I said I'd photocopy an article for them if it would help. I said you have to <u>understand</u> practice, you can reel off those pages, but you might not understand. When we went back in for the second tutorial, for the objectives, I couldn't believe how good that was. And they did get there, and they did the brainstorming on the board, and a lot of sharing of information. Some of them had gone off into fantastic explanations.*
> Lilly (Teachers, Gp2, p.3)

The question which Lilly asked was: *How do midwives learn to critically think in practice?* This question would be unlikely to arise in a typical classroom. The assumption of behavioural pedagogy is that students must first learn a body of knowledge, before they can learn to think (Ironside, 1999a). Lilly helped her group to think about thinking by giving them an article on critical thinking and when the students came back to the group, she could not believe how good their sharing of information and explanations were. Thinking is central to learning and understanding (Peters, 2009), and the narrative-centred curriculum provided a vehicle for learning to think.

The tact of teaching

This study found that when the pedagogical approach was *configured,* the tact of teaching showed itself. van Manen (1991a) defines tact as consisting of a complex array of qualities. A tactful person is able to interpret another's inner thoughts and feelings from clues such as their demeanour and body language. van Manen says that:

> In teaching it is often the unsteady, unstable, inconsistent, variable moment that requires tactful action of a sort that is essentially unplannable. And these unstable moments are not accidents in teaching but rather are essentially an integral part of teaching (p. 530).

In the following extract, Deborah shows her use of tact in an unplannable moment which occurred during a tutorial group:

> *There was one woman in the group, she had a very chequered obstetric history, and she was one of the women that told the story the other day, and she said in her second pregnancy she had weekly scanning, weekly vaginal scans for eight weeks, or something, and one of the other students said oh I cannot stand all those early scans. So we had this discussion about what was appropriate for this woman in terms of reassurance…*
> Deborah (Teachers, Gp2, p.6)

Deborah knew the value in being flexible and letting the discussion flow. Facilitating the narrative tutorial group discussions was unpredictable. Whilst this created a challenge for teachers, it also provided exciting moments for teaching and learning. Teachers learned to trust the process, became more comfortable, and 'knew' when to let the discussion go off on its own and when to intervene (the tact of teaching). Facilitating discussion can require some quick thinking, as Lilly shows in the next example:

> *There was an amazing discussion, really, about a woman and sexual health in pregnancy, and it came out as smear taking in pregnancy …pregnancy changes, they said "what if she's sexually active?" … so we went down that track so I thought OK let's give them a scenario like what are you going to do now? So I was just thinking quickly off the top of my head.*
> Lilly (Teachers, Gp2, p.5)

Lilly said the group was having an *amazing discussion*, and she recognised the value of this. In a narrative tutorial group, many issues could potentially arise, and Lilly had to *think off the top of her head*. Lilly knew that it was a really useful discussion and let the conversation flow. When teaching happens in lectures, the questions and topic can be planned and learning is controlled; a teacher does not necessarily have to think off the top of her head. The narrative-centred curriculum facilitated the tact of teaching to become more visible, and teachers found a balance between letting a discussion flow, and providing students with content knowledge.

It was evident from the teachers' conversations, that they learned to trust their instincts and developed a sense of when a conversation was or was not important. In

this passage, Deborah talked about a group discussing coffee and the effects of caffeine on pregnancy:

> *Yeah, how you run your tutorial group will depend on how you're feeling, how the group's feeling, what's happening, what the major issues of the day are. I mean I remember one session I had last year I didn't cut off or anything but they were all sort of coffee addicts and so they started having a conversation the effects of caffeine on a pregnant woman? That sort of thing.* Deborah (Teachers, Gp6, p.10)

In this mode of teaching and learning, the group needs an openness and willingness to pick up the unexpected questions that are deemed relevant. It is such everyday concerns as 'coffee' that are likely questions of pregnant women. Deborah knew that it was a relevant discussion, even though it was unexpected.

Despite the initial struggles with facilitation versus lecturing, over time teachers became more comfortable with facilitating the narrative tutorials and began to be more trusting of their own abilities to facilitate the tutorial groups, although they wanted to develop facilitation skills further:

> *There are still skills that I'd like to hone up; like in my group I had two students who'd suffered postnatal depression and at one session their experience just took over and they were upset and we had to let them talk until they felt they'd said enough. So most of the session was about postnatal depression, and I thought there were some in the group who were starting to look as if they wanted to move on, and yet given what those two were talking about we needed to stay with it*
> Emma (Teachers, Gp7, p.7)

Emma recognised that it was important for these students to share their experiences with the group. She worried about the other students who 'looked as if they wanted to move on' but she knew it was important to let the discussion continue. Emma shows the tact of teaching when she knew it was important to let the discussion about postnatal depression continue without it crossing the boundary of becoming personal therapy. The narrative tutorial groups created an opportunity for the tact of teaching to be visible. When teaching happens in a lecture theatre, the tact of teaching is less visible. Tact happens as a student approaches a teacher after class or seeks out a teacher in her office to talk. I argue that behavioural pedagogy is more liable to conceal the tact of teaching because it assumes that every student sitting the class is the same and will receive the information given by the teacher in the same way.

Narrative pedagogy reveals the tact of teaching through valuing dialogue, discussion and expression of emotions, all of which require pedagogical tact.

Finding the balance

For the teachers in this study, it was at times challenging to find a balance between letting the discussion flow and directing student learning. In the next passage Lilly spoke about keeping a balance between ensuring that students are *on the right track* and students' self-directed learning:

> *But I also think though that it's important that we check, oh I hate that word it's not checking, that they are on the right track 'cos there is a safety element involved here and maybe some of them have gone off on the completely wrong tangent. So it's keeping that balance as well, you know? So some of them do this fantastic work, so what happens if you've got that person that doesn't contribute or there's that one person who says oh I didn't realise how to do this or I haven't had time to do this?*
> Lilly (Teachers, Gp7, p.2)

Facilitating the narrative tutorial groups was a balancing act for teachers in group dynamics, between students who were not contributing and students with different abilities. A teacher needs to be confident to know when to let the discussion flow and when to intervene and put the group back on a track. It was a matter of finding the balance between the majority of the group and the one who had gone off track, or had not done the learning, and knowing when to intervene and how much direction to give. While the workshops and courses on group facilitation could teach the *techne* of group facilitation, it was with time and experiences that teachers learned when and how far to guide students; teachers learned pedagogical tactfulness.

When students direct their own learning there is the possibility that they may not proceed as the teacher imagines they should. In this excerpt, Emma said that she found herself sometimes taking over to fill in the silences when the students had not done the work themselves:

> *One of the things I found hard is that sometimes when I have had a busy week, they would have done very little by the final tutorial, and I find myself leading them rather than trying to bring out what they have done. Sometimes it might be nothing. There might be one or two who have done quite a bit of work, so I go away thinking I haven't done this properly, because it is really about their learning rather than about my teaching, but to fill in the silences, I very often just take over, and I think they are not playing the game properly.*
> Emma (Teachers, Gp3, p.4)

Emma says that students were *not playing the game* properly. Gadamer (1975/2004) refers to play as in a "to and fro movement" suggesting that the play "represents an order in which the to-and-fro motion of play follows of itself" (p. 105). As such, the play does not depend upon those who play it, but on the movement of the play itself. Balancing is a to and fro movement of play (Gadamer, 1996). Play can be both frightening and exciting. As Lilly said, it takes *courage* to let a discussion go:

> *I think for me it's a combination and I'm really comfortable now with facilitating the group and doing the Masters paper on facilitation and PBL has helped me a lot. I have learned a lot from that process. And I still believe that you've got to give them some direction, but sometimes it takes a bit of courage to just let it go wherever it wants to go 'cos it's important for them to explore those sort of concepts as well. And I know sometimes you're looking at your watch and you're thinking oh the time's going on, but that's important for them. But then you go down the path, as Deborah was saying that there is some stuff that they really must know. It's having the balance without giving them all the directive learning from lectures as well.*
> Lilly (Teachers, Gp7, p.2)

It takes courage to let a discussion play out and let a group of students control their own direction. Lilly, in the excerpt above, was speaking in a research conversation after 15 months experience of the narrative-centred curriculum. Time and experience developed teachers' skills at knowing when to intervene. Diekelmann and Diekelmann (2009) say that what is at play in teaching, in its richest sense, is when teachers and students are engaged together in co-responding. When teachers and students respond freely with each other, the teacher-student hierarchy may be broken down. As Diekelmann and Diekelmann contend, "when teaching is read as co-responding, the division between teacher and student becomes open, serving to lead into uncharted territory" (p. 263). The uncharted territory of teaching as co-responding can be both exciting and frightening; it takes courage to go there because it is uncharted. To co-respond with students can also be exhausting, as it requires a teacher to think and respond on the spot.

In the next passage, one of the teachers, Sarah, talked about some of the discussions potentially being *dangerous and dicey:*

> *They all have these stories that they need to get out, and I remember we had that conversation a long time ago, not long after I started, it was in a team meeting and there was this concern raised that we shouldn't be getting into stuff like that with students and it was really sort of dangerous and dicey, it's like well yeah but that's what happens.*
> Sarah (Teachers, Gp7, p.7)

Sarah talked about the possibility of the discussion becoming *dangerous and dicey* and that concern had been expressed that *we shouldn't be getting into stuff like that.* Sarah was referring to students expressing their emotions in a tutorial group. The team of midwifery teachers had discussed how sensitive topics could be raised in the tutorial groups. Generally the teachers felt ill-equipped to deal with this and suggested that the tutorial groups were not an appropriate forum for students to show their emotions.

Talking about sensitive topics being raised in a tutorial group, another teacher Deborah said, you cannot ignore the emotion and personal experience which sometimes arose:

> *You can't not, it comes up and hits you in the face. You have to deal with it because it seems so rude to completely ignore it, I mean in my group there was a student and we were talking… I don't know it was about finding out about community support services for women, and the discussion came to the family violence stuff, and we were sitting around in the group and she was sitting opposite me, and she was the person I least expected in many ways and never had said terribly much anyway and she just started crying but you know very silently and she was sitting across from me so it was like in my direct line of vision. You could see she was distressed but she was pretending not to be, and it was a really hard one – it's like how to deal with a situation like that because everyone else could see she was distressed too, she didn't necessarily want to talk about it, she didn't want to talk about it, I think what I did was get up and sat next to her and put my hand on her arm or something like that and carried on.*
> Deborah (Teachers, Gp7, p.7)

In this tutorial group, it was likely that Deborah discerned it would be unsafe for the student to open the conversation with her in such a public setting. Such a conversation needs to wait until privacy can be achieved, so Deborah tactfully acknowledged the emotions by putting her hand on the student's arm. She intuitively knew what to do in the particular situation. Even though emotions may arise for a student in a lecture

situation, it is unlikely that the teacher would recognise them. The tension of relationship emerged in the narrative tutorials. For the teachers, the tensions of relationship could be a problem between creating an authentic relationship, open to sharing ideas and emotions, and then potentially dealing with dicey situations. The relationship between a teacher and a student has been described as being "always in play" (Giles, 2008, p. 142). Deborah's experience of knowing how to be with a distressed student is an example of the play of relationship.

The impact of different narratives

Our version of the narrative-centred curriculum included inviting narratives from the students themselves, women, midwives and one digital narrative. This is a point of difference between PBL and a narrative-centred curriculum. PBL learning scenarios are usually designed by teachers to focus students' learning on a particular problem or case (Barrows & Tamblyn, 1980). With a narrative-centred curriculum the learning which students gain from listening to and interpreting a person's narrative is much less predictable. Although guided to a particular topic (e.g. breastfeeding, getting pregnant, becoming a new mother), in this study, the way a narrator shared her experience was always unique and could not be predicted. Some data in this study revealed that there was a difference in the way that students learned according to whom the narrator was.

As an example, Effie said that although she loved listening to the narratives, if it was a visiting woman, she soon forgot that narrative. She found the narratives which students from the class shared were more valuable because you could go back to them and ask the narrator questions afterwards:

> *To be totally honest I actually do not think, I love listening to the story, and it is great, but I could not tell you a lot about many of the stories apart from those first ones <u>when it was us</u>, because I found that <u>when it was us</u> you can also go back and ask people questions later, or if it was people that you know you can get them to elaborate if the question comes up a week later, while you are studying it again, or you can ask that person again whereas you get one story and they are gone, and if you do not ask the questions then there is no other opportunity to ask your questions.*
> Effie (Students, Sem1, Gp2, p.4)

Effie described how she can continue the conversation about a narrator's experience when she knows them personally (such as a class mate). She is saying that she remembers the class's own stories, but forgets the narratives from the women who

she sees only once. The narrative sessions where students and teachers shared their own stories were often very powerful and led to a sense of genuineness, or authenticity between teachers and students.

The teacher's own story

For one of the narrative sessions about the experience of breastfeeding a new baby, the woman and her midwife (who was also one of the teachers) were present together. The woman had experienced a lot of difficulty with establishing breastfeeding, and she spoke at length about her problems and the advice she had received from her midwife in resolving them. One of the students, Carmel, spoke about the benefits of having both the woman's and the midwife's narratives together:

> *Yes, I didn't think it would make that much of a difference at first, until it happened and then I could see how significant that was for my learning, having the midwife's decisions and what was going through her head at the same time as what was going on for the woman.*
> Carmel (Students, Sem1, Gp2, p.3)

Students rarely see what is going on in a midwife's or a teacher's head in terms of thinking. When a midwife acts, or a lecture is prepared, the action or lecture is the result of the teacher's thinking. Reflecting on what it was like to be a teacher and a midwife, and hear a woman talking about her experience to students however, left Emma feeling that her practice was exposed in front of the students:

> *In an ideal world women do not get [these breastfeeding problems] – with ideal preparation and midwifery, that shouldn't happen and yet here is a woman who had every problem under the sun, and I feel negative in my practice about that and to reveal that to students.*
> Emma (Teachers, Gp3, p.8)

Emma felt exposed by showing students that she could not prevent, or immediately have a solution, for the woman's problems, and would have liked a separate opportunity to explain her decisions to the students. Whilst students felt it was really good learning to hear the midwife's narrative alongside the woman's, Emma, the midwife, felt that her practice was exposed and potentially open to critique by students. When teachers and students co-respond, the openness potentially exposes a teacher as being less than perfect, therefore making her vulnerable to critique. In a lecture situation, a midwifery teacher might discuss practice in terms of best practice

for a particular situation; her own practice is not exposed. Herein lies the tension, a midwife exposing her practice is excellent learning for students, but potentially exposes the teacher's imperfection as a practitioner. While there is the potential for rich learning in such revealing, the less discerning student may be more critical or judgmental and cause the teacher to feel that she could lose credibility.

Creating an authentic learning environment

The narrative-centred curriculum created an opportunity for an authentic learning environment to surface. An authentic learning environment relates to the concernful practice of 'schooling as attending' (Diekelmann & Diekelmann, 2009). An authentic learning environment is one in which the teacher creates an environment that inspires the formation of students as authentic human beings (Ream & Ream, 2005). Creating a safe setting for students and teachers to share narratives helped to facilitate an authentic learning environment. One of the students, Mandi, was struck by how students and teachers felt safe enough to share personal stories with the class:

> *What struck me the most was the fact that everybody in the room felt safe enough to share such personal, emotional stories without fear of judgment. I felt so privileged to be invited to share this experience and be able to live the story with the women sharing their lives and emotions. I also felt it was a sign of how wonderful this experience will be with the lecturers joining in and sharing such beautifully personal stories. I came away feeling really honoured to have been part of this day.*
> (Student written reflection: Getting Pregnant: Pseudonym: Mandi)

Creating an authentic learning environment includes creating a welcoming, safe, fair and respectful learning environment that values individual students' experiences and cares about where they have come from. An authentic learning environment is one of the important aspects of narrative pedagogy (Diekelmann & Mikol, 2003). As well as creating a safe place for narratives to occur, the tutorial groups created a safe place for students to share their own personal experiences. One advantage of gathering students to share personal experiences was that the teacher-student relationship was enhanced.

An important aspect of creating an authentic relationship between teachers and students introducing a new curriculum was being open to the play of relationship

by being flexible, and listening to students. Throughout the process teachers responded to student feedback as we went along. As Effie said:

> *I do feel very supported by them [the teachers], a lot of the time as well, I do, I have always felt that they were on my side and are here to help me and are willing to help with anything, any problem that I have.*
> Effie (Students, Sem1, Gp2, p.5)

For students, a sense that they were being listened to mattered. As Giles (2008) points out, "relationships matter and the influence of the teacher-student relationship does not end" (p. 120).

Learning from narratives: Phronesis can emerge

The narratives created an opportunity for midwifery teachers to talk about *phronesis* of midwifery practice related to an individual woman, rather than a generalised prescription for management based around a problem. When teaching happens in a lecture format, midwifery management of practice situations is most likely to be talked about in terms of best practice or evidence-based practice. Midwifery teachers knew that as well as incorporating research into practice, students needed to understand the art, or *phronesis*, of practice. Sarah talked about the value of explaining midwifery decisions based on a particular woman's needs:

> *I think the peculiarities of looking after a particular individual woman, and with different sorts of things you might have to deal with as a midwife, the impact on the practice… it would be good to be able to explain that as an explanation of what decisions you have made.*
> Sarah (Teachers, Gp3, p.8)

When narratives are the trigger for student learning, then the person's individual experience comes to the fore; and when teachers and students discuss midwifery care for an individual woman, the opportunity arises for the teacher to share how she might think about midwifery care in an individual case.

An example of a student's learning about midwifery practice from a narrative is evident in the following passage:

> *And the session about a breast feeding Mum. Like in my practice I saw such a difference in relation to breast feeding, and then we had in that session a lady and she was a client of one of our teachers, and all of the time there was this kind of conversation around her point of view, and then there was the lecturer's input into it, and that was really beneficial for me because it*

> *was so different to what I have seen in practice. It was a real learning thing for me.*
> Betty (Students, Sem1, Gp2, p.13)

Betty talked about *really learning* when she listened to the midwife's view, along with the woman's, in a narrative session on the topic of breastfeeding. For Betty, real learning about midwifery practice happened because she listened to the midwife talking about her decision-making in practice alongside the woman's narrative. According to Polkinghorne (1988), health practitioners learn from hearing others' practice experiences by linking those experiences with similar experiences of one's own.

Linking practice experiences with one's own is demonstrated in the following extract from one of the teachers:

> *You see for me, too, as a midwife, I was sitting there listening to the story gobsmacked at both her story, and your perseverance too, as a midwife, like sitting there as an experienced midwife I was thinking to myself I would have given that up you know, a long time ago.*
> Deborah (Teachers, Gp3, p.6)

Even though Deborah is already an experienced midwife, she has seen another way of practicing when she listened to the narrative. Deborah compares her past experience of helping women with breastfeeding problems and thinks that she *would have given that up.* Listening to a narrative, and comparing her past experience with similar clinical problems, adds to Deborah's repertoire of potential clinical actions. Gadamer (1975/2004) tells us that "a person who is called experienced has become so not only *through* experiences but is also open to new experiences" (p. 350). An experienced person is equipped to have new experiences and to learn from them. According to Benner (1984), practice wisdom develops from the turning around of previously held beliefs. Thus, learning through experience actually occurs when what they thought would happen is disconfirmed. As Polkinghorne (2004) maintains;

> A person's practical knowledge develops and changes as he or she engages in problem solving through intelligent inquiry. By trying different approaches and learning which ones work and which do not, one accrues a fund of knowledge about what might be useful in future situations. Those who engage in phronetic deliberation informed by inquiry eventually become more efficient and successful practitioners. (p. 123)

Polkinghorne (2004) suggests that a person can become more accomplished in phronetic deliberation through reflection on practice, and ones practical perception can be sharpened by discussing particular situations. Ricoeur (1992) considers that practice wisdom is formed through public debate, discussion and shared convictions. This study found that phronesis of practice can be learned through listening to narratives and the interpretation and reflection which followed. As Swenson and Sims (2003) asserted "experience, and reflection on experience is the best teacher" (p. 164).

Conclusion

This research found that when the pedagogical approach to midwifery education was *configured*, the tact of practice and the tact of teaching emerged. The tact of practice was seen to emerge when students understood themselves and the 'otherness of the other' when they reflected on the narratives. The tact of midwifery practice is at the heart of phronesis. For students, learning in the context of real life stories provoked an emotional connection with the narrator, which led to self understanding and seeing another's horizon of understanding. The discussion which occurred in the narrative tutorial groups helped students to think about the art, or phronesis of midwifery practice. The group of concernful practices, Diekelmann and Diekelmann (2009) named 'learning as listening', was revealed.

The new *configuration* of the pedagogical approach facilitated the tact of teaching to emerge and revealed the play of relationship between teachers and students. The play between teachers and students on one hand facilitated authentic teacher-student relationships, and on the other may expose students' emotions and teachers' vulnerability. This study has raised the question of how a teacher learns to be tactful. Whilst there is no given formula for learning the tact of teaching, van Manen (1991b) says that tact may constitute the essence and excellence of teaching pedagogy.

The next chapter explores the influence which assessment processes had on the experience of teachers and students in a narrative-centred curriculum.

Chapter Eight: Assessment enframes pedagogy

> *The exam is our whole focus, we literally live from one exam and essay to the next, and I know that at the end of everything it is all going to fall into place and I will get to where I want to be, but until then the exam is my whole focus.*
> Effie (Students, Sem1, Gp2, p. 5)

This study found that assessment drives every part of the curriculum; from what and how teachers teach, to what and how students learn. Assessment holds all the elements of a curriculum together, similar to the way that Ricoeur (1984) described emplotment as holding all the elements of a story together. Emplotment is a dynamic mediation between events, bringing together "factors as heterogonous as agents, goals, means, interactions, circumstances, unexpected results" (Ricoeur, p. 65). With regard to a curriculum, emplotment brings together factors such as the university organisation, the physical learning environment, course content, and the way in which teachers and students act. Emplotment organises a story, or in this case the curriculum, into an intelligible whole. This study found that it was the assessment processes which determined the limits of where emplotment could go, in other words, assessment *enframed* the curriculum.

Teachers' and students' experiences of a narrative-centred curriculum revealed the tremendous influence which assessment has on the pedagogical approach. Assessment pointed students to the parts of the course content which were considered most important, and drove what, and how they studied. For students, passing assessments was the key to moving on to the next level of the programme, and to ultimately pass the national examination and gain midwifery registration. For teachers, assessment processes encouraged teaching in ways which would lead students toward achieving assessments, and provided a tool to measure whether students had reached a particular level of cognitive gain. Perhaps most significantly assessment offered a way of identifying students who were not meeting the expected standards.

While assessment processes have been developed in education to measure students' attainment of learning outcomes, this study found that assessment may have inadvertently *enframed* pedagogy. Heidegger (1977) used the term *enframing* to mean

the way that humans have attempted to reduce things to their utility, and attempted to control, order and arrange them. *Enframing* is the phenomenon that drives humans to order, command and measure things (such as learning). Heidegger (1977) proposes that humans become *standing-reserve* when they are reduced to their utility and ruled by the idea of scientific representation. For instance, if learning is considered as an object which can be utilised and measured, then the assessment outcome determines the 'use' of the unit (i.e. the student) to the profession of midwifery.

Heidegger alleges that *enframing* becomes a danger *(entrapment)* when humans are oblivious to the effects of the *enframing*. For example, the danger of assessment *enframing* pedagogy is that teachers and students may be *entrapped* by the limiting effect which assessment has on the potential to *refigure* a curriculum's pedagogical approach. This chapter explores the way that assessment processes were found to *enframe* pedagogy, the idea of which is depicted in Figure 5 (p. 158).

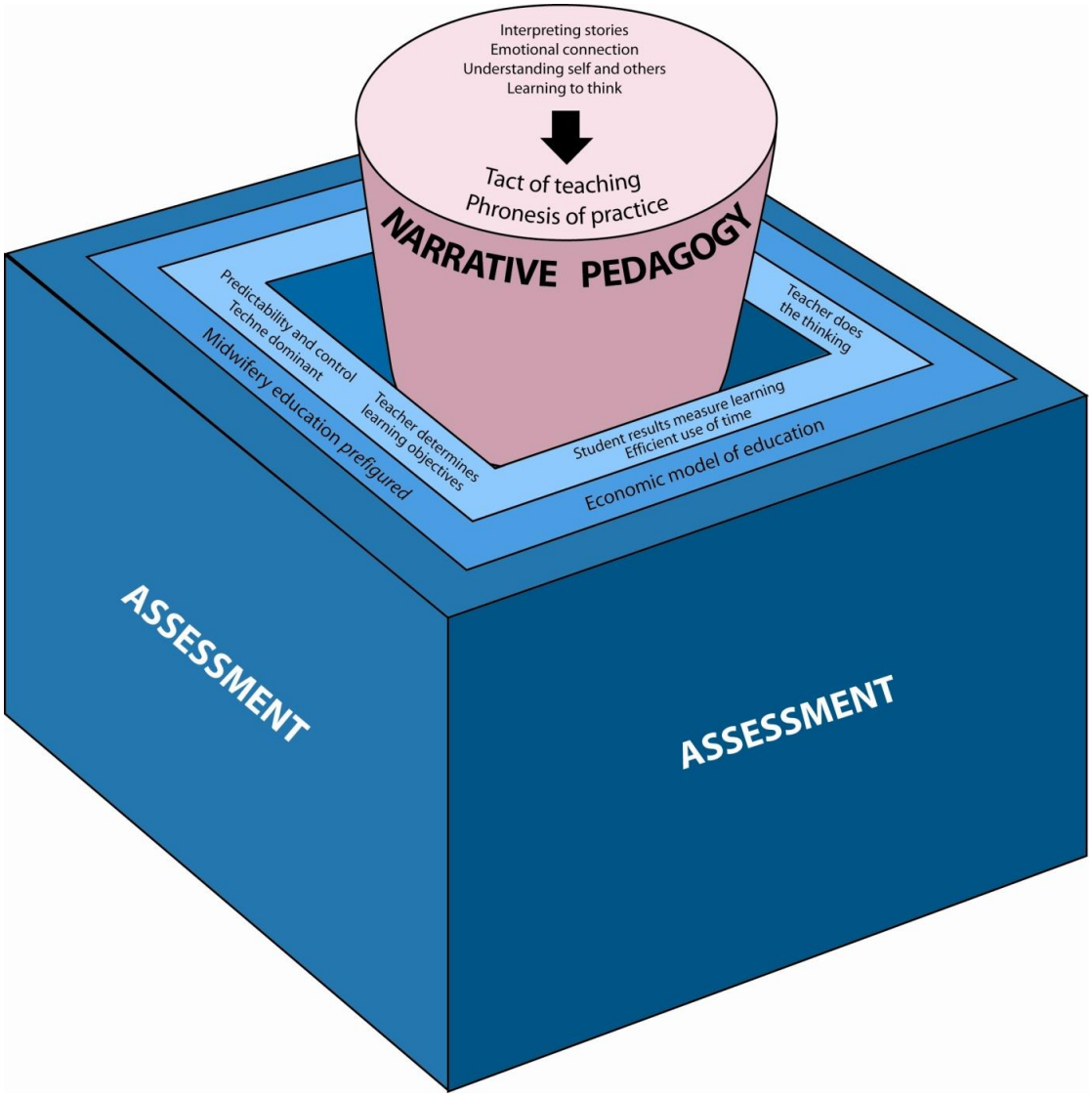
Assessment and emplotment

As previously outlined in the preface to the findings chapters, the undergraduate midwifery programme consisted of a mix of theory and practice papers. Most papers were either solely theoretical or solely practical. The narrative-centred curriculum was first introduced in the theory paper 'Art and Science of Midwifery I'. The assessment processes for this paper were an essay on normal birth and a three hour examination which included multiple choice and long answer, scenario based questions (see examples in Appendix R).

Even though the teaching and learning processes had been *configured*, the assessment processes were retained. The rationale for retaining the existing assessment processes was threefold. First, it was essential that there was some measure of whether each and every student had achieved the minimum safe level expected for students at that point of the midwifery degree. Second, the university required that each learning outcome be assessed so that students could be shown where they had or had not achieved in a paper. The third reason was to prepare students to sit the Midwifery Council of New Zealand's national examination prior to registration. The national examination was entirely based on multiple choice questions. Underpinning all of the assessment processes is the knowledge that one day a student could become a registered midwife. In New Zealand this means s/he has full

responsibility for the safety of mother and baby. Assessment carries the mandate of public safety.

Figure 5: Assessment enframes pedagogy



While the new teaching and learning processes were focussed on interpreting narratives, for student participants, in this study, achieving a passing grade in examinations was their most important focus. One of the student participants, Carmel, said that *it is all about the exam*:

> *It is distracting, and it really annoys me how everyone says, it is not about the exam, because we have lecturers who say that, and what a load of crap. It <u>is</u> all about the exam, because if you do not pass that, well okay, "see you". We have an exam at the end of this paper, and you actually have to pass the exams to get the degree to become a midwife.*
> Carmel (Students, Sem1, Gp2, p.5)

For Carmel, learning to be a midwife was *all about the exam* because she had to pass an examination to move onto the next semester in the degree, and to reach her ultimate goal of registering as a midwife. Teachers tried to tell students that there was more to learning midwifery than passing exams but, from Carmel's perspective, that was totally untrue.

Teachers believed that there was a lot more to learning to be a midwife than passing exams. In the excerpt below, one of the teachers, Andrea, held students responsible for their emphasis on learning only what they were to be examined on:

> *I have really hated the way students got so anxious about assessment and they used to say just tell me what I need to know for the exam. And I think really it started to get me down because I felt that they weren't going out and learning and they were not motivated to go and find things out for themselves, they just wanted to be told what to learn, and it was my job to know it all and tell them.*
> Andrea (Teachers, Gp1, p.1)

Andrea had an expectation that students ought to be motivated to learn for themselves, rather than dependent on her to tell them what to learn. Teachers and students had become oblivious to the way that assessment had *enframed* teaching and learning, holding each other responsible for the dominance of assessment.

Assessment signals what is most important to know

Student participants in this study placed different values on the learning which they gained from the narrative and the kind of learning they felt was needed to pass the examination. April, for example, talked about different kinds of learning; one of which she gained from listening to women, and other more valued, important knowledge which she needed to pass the paper. April said that she usually saw learning as *the things that I am going to be examined on:*

> *I do not know how much learning I can get from the stories, and from the way I usually see learning, like the things that I am going to be examined on, but it makes me think about what the experience was like, I think about it a lot, and it makes me think what it is like for your client, and so I guess it builds on your empathy there. Which is a type of learning I guess, but I feel at the moment I am more focused on trying to learn all the important stuff that I am supposed to know just to pass this paper, and it is great to learn all of that, and always at the back of my mind is am I missing out on some of the science that I really need to know.*
> April (Students, Sem1, Gp2, p. 4)

April said that she learned to empathise with the women through hearing their narratives, and she recognised that this was one kind of learning. Learning about empathy, April saw as secondary, perhaps 'nice to know' but peripheral to becoming a midwife; rather than the *important stuff that I am supposed to know just to pass this paper*. Assessment, for the students in this study, signalled the most *important stuff* to learn in order to progress onto the next part of the course and eventually qualify as a midwife.

Assessment cannot measure phronesis

Examinations do not easily show a student's thinking about practice, or the way she might apply thinking to practice. An examination can only contain the types of questions which can be answered with a correct or incorrect answer. In the following excerpt, a student, Chloe said that examination questions are based on *concrete information* and so she needs to learn *concrete information* for an examination:

> *I need concrete information, if the questions are based on concrete information, and you need to have the concrete learning to back it up. So the narrative curriculum and concrete learning do not work.*
> Chloe (Students, Sem2, Gp1, p.7)

Chloe expected that her midwifery education would consist of being taught *concrete information* (techne) which she would learn from teachers, and then demonstrate her learning when she reiterated that information in an examination. Chloe said *the narrative curriculum and concrete learning do not work,* meaning that the art (phronesis) of midwifery was not needed to pass an examination. Although a student could pass an examination based on *concrete information,* she may not have a grasp of the phronesis necessary for midwifery practice. Midwives need the art *and* the science, techne *and* phronesis, to be skilled practitioners. The only road a student can take to becoming a midwife is through passing examinations which primarily examine cognitive gain of the subject.

The paradox is that it is only possible to assess certain kinds of knowledge in an examination. Heidegger (2001) says that measuring something is only possible when it is thought of as an object. Making learning into something objective that can be measured modifies and reduces the very nature of learning itself to that which *can* be

measured. An example of learning being reduced to what is examinable is evident in the next excerpt:

> *And so I feel like I am a broken record here, but again it comes back to the science, the majority of the exam is going to be around the science, and okay the critical thinking and applying it and everything like that, but before you are able to apply it and critically think, you have to know the science. So I feel it is a vicious circle.*
> Erica (Students, Sem1, Gp1, p. 27)

Erica describes her learning as a *vicious circle* of learning the science for the examination, as a basis for application to practice. Assessment is at the root of Erica's *vicious circle* because her learning is focused on learning what is measurable in an examination, the science. Techne (factual knowledge) is measurable in an examination, but application of that knowledge, or phronetic understanding (the art of practice), is not something which is so easily measured. Teachers knew that the things which were harder to teach, the phronesis of practice for example, were equally as important as techne; but phronesis is not teachable or measurable using the traditional teaching and assessment tools available under the university system.

Another student, Agnes, said that while the narratives opened up an alternative way of thinking, she still studied the way she had always learned in the past when it came to preparing for examinations:

> *I found… I mean for me, I find, I do find the narrative, from the perspective of making me think with the stories and that sort of thing, really has opened that side of it up for me, but as far as the knowledge, as far as the sitting of the exams, that hasn't changed for me, I still do what I always did, I still learn the same way, and I still get the same marks.*
> Agnes (Students, Sem2, Gp1, p. 3)

For Agnes, the narratives *opened up a side of her; a new way of thinking* that a traditional lecture would not have exposed. She described that although the way of teaching had changed, her personal way of studying remained the same. One imagines that she goes back to textbooks and seeks to absorb knowledge and find answers to questions which have 'right' answers.

Agnes talked about two different ways of learning, one which she uses to learn for examinations and one which makes her think about the narratives. This is a conundrum because the art of practice is equally as important as the science, yet the phronesis of practice is not something which can be ordered and measured therefore

does not fit with an assessment process such as an examination. Some aspects of the art of practice, such as partnership and communication, were assessed by midwifery lecturers in midwifery practice, but the tools available do not readily assess *phronesis*. Assessment processes may inadvertently indicate to students that *phronesis* of practice is less important than the *techne*.

Learning for assessment limits the time for thinking

The narrative-centred curriculum provided opportunities for students to have the freedom to learn where their thinking took them. In a behavioural pedagogical approach, the limits of learning are defined by the teacher, and students have lecture notes to revise for an exam. When the pedagogical approach was *configured*, and a narrative pedagogical approach was applied, students became anxious about missing relevant points for their learning, which might be in the examination.

In the next passage, Effie talked about the pressure of assessments which meant that she spent her time studying for examinations rather than exploring other aspects of learning which would be valuable for practice:

> *I think everything that you learn is valuable for your knowledge anyway whether you are examined on it or not, you are always adding to your knowledge which makes you a better midwife, but the reality is that there are so many assignments, and so many exams to do, and so much pressure on you to accomplish that, that time restraints mean that the knowledge becomes de-valued, because it is actually important. There is no point in me knowing all this amazing stuff about this, and not anything about what I am going to be asked about, does that make sense? Like I can see the big picture, but right now the focus is getting through these three years to then become part of the big picture.*
> Effie (Students, Sem1, Gp2, p.2)

Although Effie saw the value in everything she learned, time constraints meant that she concentrated on learning what she needed to know to pass assessment points. Effie said *there is no point in knowing things unless she is going to be asked about them*. If Effie only studied what she believed she would be examined on, her learning could be limited, she could miss exploring topics which might have led her to new insights and thinking. Diekelmann (1992) asserted that “testing has come to take so much of teachers and students time that there is little time left for anything else” (p. 76). Students needed to know about many aspects of practice on which they were not

necessarily examined, but time pressures meant that they learned first and foremost for assessments.

Chloe also talked about having a *really strict timetable* for her study:

> *I am normally someone who has a really strict timetable, this is my essay time, this is my exam time, I need to learn these parts ra-ra-ra. I don't know what to learn, when every time I open a text book I don't know where am I and where am I going. How deep do I go… It just doesn't work. I am wasting valuable time, but I might not be wasting it. I don't know if I am going too far in*.
> Chloe (Students, Sem1, Gp1, p.31)

Chloe felt that she might be *wasting valuable time* by reading about things which may not be in the examination. She wanted to spend the time she had available for study, to learn what would likely be examined, rather than reading and thinking around the topic. Ironside (2004) has questioned the relationship between learning content and thinking, concluding that although content knowledge was necessary, the emphasis on covering content had overtaken the time needed to think. Leathwood (2005) agrees that the amount of work required and the number of assessment points in a university course, mean that there is often little time left for thinking. The academic structures of the university, such as papers having to be completed within a semester, mean that students have to pass assessment points within a time frame, not at their own pace (Smythe, 1993).

Assessment reduces students' confidence in ability to learn

The nature of an examination is to expect students to give the correct answer (predetermined by the examiner) to a question. If a student answers a question which is marked as incorrect according to the examiner's criteria, then the student is deemed to have inadequate knowledge. In other words, it is not the student who is being assessed, but the written answers in the examination which serve as evidence of learning. Danielle expresses doubts about her ability to give the answer which a teacher might be looking for:

> *I think the narrative, for me, has just made me doubt myself, not given me confidence. It completely makes me doubt whether or not I can do it, that I am learning enough, that I have got the right knowledge. I know I will be a great midwife, and I can communicate and really benefit women, but I doubt myself whether I have the academic capability because I do not know*

> *what I should be learning, and I feel like maybe I am putting the wrong stuff in, to what I actually need to be putting in.*
> Danielle (Students, Sem1, Gp2, p.8)

For Danielle, the assessment processes have diminished her confidence in her ability to learn the 'right' knowledge to pass the examination. Danielle was confident that she could communicate well with women (more akin to the *phronesis* of practice), yet doubts her academic capability. The assessment processes, in this case, have inadvertently undermined Danielle's confidence in her own ability to know what to learn. One of the aims of the narrative-centred curriculum was to motivate students to be independent learners. An element of being an independent learner is the ability to assess the quality of one's own work (Gibbs, 2006).

Another student, Chloe, spoke of the examination as having right or wrong answers, and the need to come to the same answer as the lecturers:

> *An examination, you have a right answer and a wrong answer, there is no story involved. It is a scenario based situation, and if you do not get exactly how the lecturers feel that you need to have, it doesn't work. I mean that is the science part of it. I mean, it just does not gel; you cannot have a narrative curriculum with an examination based assessment.*
> Chloe (Students, Sem2, Gp1, p.5)

Chloe gave the sense that she needed to provide the same answer as that of the lecturers to pass the examination; yet, suggests such a feat would require perceiving what is in lecturers' minds. Midwifery students are educated in a world which has right answers, as in an examination, but they need to practice in a world of uncertainty. We want graduates who can assess the quality of their own work once out in practice. However, assessment processes possibly have the detrimental effect of making students dependent on a teacher to make decisions about the quality of their work.

When teacher participants spoke about assessment, the dilemma of having predetermined criteria diverged from the pedagogical approach. In the next passage Sarah says that having set marking criteria does not sit well with the learning processes:

> *I do think, and I know someone has raised it before, that whole thing of the exam and the way that we have set criteria, I mean theoretically, and it does kind of seem to work as I was just saying before, but theoretically it does not seem to sit well together, that whole idea of trying to get students*

> *to investigate and explore and decide what they need to know in terms of the learning process, and the assessment process says well that is all well and good but actually you have to come up with the things that we have already set in our criteria and check these off, otherwise you won't pass. But I am not quite sure how to get around that.*
> Sarah (Teachers, Gp5, p.6)

The research conversations between teachers provided an opportunity to identify how assessment was *enframing* pedagogy. When teachers decide what the examination questions and answers are, then the teacher is set up as an authority on the content. Gadamer's (1975/2004) view of the authority of a person, such as a teacher, is that it is based on a person having superior judgment and insight over another. Gadamer maintains that "the essence of authority claimed by the teacher, the superior, the expert… are legitimised by the person who presents them… in this way they become prejudices not just in favour of a person but of a content" (p. 281). As Leathwood (2005) points out, "assessment, rather than developing lifelong learning, may in fact undermine this by creating a dependence on the teacher as arbitrator of whether something is learned or not" (p. 318). Diekelmann (1992) also found that testing practices in nursing education were counterproductive to its intent, making students dependent on the teacher for the right answer.

When teachers set examinations, pre-determined marking criteria were written. On one hand, a predetermined, right way to do things in midwifery practice was important because of the issue of public safety; yet on the other hand, placed the teacher who set the examination as the authority over whether a student has answered that question correctly or not. Teachers wanted students to think for themselves, to come up with rationale for what they were doing, but assessment does not normally allow for different ways of thinking about a problem. At times, teacher participants in this study grappled with this duplicity:

> *I heard myself saying to bunches of the students more than once that when they ask you these questions, well what about that? What happens then? What was the right answer there? Or what if I said this because I thought da-de-da-de-da? And I have said to them well I think if you can come up with a good rationale, you can make a good argument and have a good reason for believing that you can explain to people, and it stands up, then that is okay, that is good enough. But it is not quite like that in the exams.*
> Sarah (Teachers, Gp5, p.7)

Sarah said to students, that if they can come up with a good rationale for their answers, then that is enough. However, an examination does not make room for students to come up with good rationale. An examination may be at odds with *phronesis*.

Refiguring pedagogy shows the enframing

When the teachers' research group met, the students' anxiety about learning the right things for the examination was one of the things which they discussed. The conversation centred around what students were expected to learn for examinations and what a midwife really needed to know for practice. Sarah points out that even though she learned things (like the bones of the pelvis) as a student, now she has forgotten them:

> *I have been thinking about that quite a bit, from my own perspective coming here, I cannot believe I have forgotten all of that stuff, and now actually, let's say the bones of the pelvis, the detail of that stuff, or the pelvic floor, and it is quite complex and it is quite a bit to learn and remember, and I think well I had actually forgotten a great deal of that stuff, and I have worked all of these years, and I am telling them now that they actually have to learn that and know that stuff and be assessed on it, and I just hope and pray that they do not actually say to me "well what do you know?"... And if you don't know it and you have done alright all of this time, then why do I need to learn it now, do you know what I mean?*
> Sarah (Teachers, Gp5, p.10)

Sarah recognises that although she had forgotten much of the information, which she learned as a student, she has practiced very competently for years. She realises that some things which she learned as a student she did not use regularly in practice, so she feels hypocritical asking students to learn something that she can no longer remember herself. The research conversations between teacher participants opened up a discussion about what students really needed to learn for practice. Sarah highlights a dilemma; teachers set examinations for students based on knowledge which teachers once knew but cannot now remember, and yet examinations show students what the most important knowledge is for a midwife to have. The knowledge required for midwifery has been built on what has been taught in the past, and by the Midwifery Council of New Zealand (2007) who set the standards for undergraduate midwifery education and the final national examination. The dilemma is that knowledge which

has been determined as fundamental for midwifery may not necessarily be purposeful for practice.

Sarah is stuck in the middle between gearing her teaching towards adherence to pre-specified outcomes on the one hand, and optimising the opportunities for the development and support of independent, autonomous and lifelong learners, on the other. As Molesworth et al. (2009) assert, a tension is created for students and teachers between learning for own "self-development and the external requirement for the students to *have* the right amount and type of knowledge to operate in the market" (p. 281).

Assessment measures the quality of education

For the university, it is only a poor pass rate that would alert them to investigate what 'we were doing'. Student pass rates are seen as the measurement of the success of the programme, not the curricular processes. As Margaret (Head of Midwifery/Programme Leader) says, the university examination board only wants to collectively look at student results:

> *…once the reporting starts to come in… the examination board which deals with students' results really only want to look at, collectively, apart from individual students, they're really only interested in the pass rates. Are the pass rates OK, and if they're not why aren't they? So if we had a poor pass rate that would flag that maybe they would investigate what we were up to, they'd say well this obviously isn't working.*
> Margaret (Interview p.6)

The paradox arises that the university monitors the quality of education through measuring student outcomes from its courses, while at the same time the university is promoting learner autonomy, independence and lifelong learning (Auckland University of Technology, 2007). With the rise of the 'knowledge economy' (Williams, 2007), measuring student achievement is thought to be an objective and reliable way of measuring the outcomes of education (Bryan & Clegg, 2006) and an indicator of a quality education system.

Assessment determines safety to practice

Through assessment, teachers could sometimes identify students who were a concern and perhaps not suitable candidates for midwifery. Sarah said that those students caused her concern:

> *...I find that a bit of a concern. There are some wonderful students, but some of them you just think "arrgh". Would you want that person to look after your sister or personal friend or yourself? So there are lots of different things that we are trying to do with the assessment tool, it is public safety.*
> Sarah (Teachers, Gp5, p.13)

There were some students who Sarah would not want to see in practice and based this on a measure of whether she would want that student to look after someone close to her. Sarah knew what mattered in practice, but *phronesis*, insight and authenticity do not necessarily matter in an examination. However, assessment served the very necessary purpose of setting a minimum standard for midwifery practice which would ultimately protect the public. Teachers would be negligent if they let an unsafe student into practice. Safety to practice can mean many things; as Smythe (2010) pointed out, safety itself is an interpretive act. For example, an examination can test a level for safe practice, such as a normal fetal heart rate, but the measures available do not always show when practice has become unsafe. For example, the way a student might communicate information about a concerning fetal heart rate to a woman cannot be adequately assessed in a written examination. They can write down words which they might use, but not the tone or manner of how they communicate.

Another teacher, Deborah, spoke about the purpose of assessment being to identify students who were unsuitable for midwifery:

> *And that is the people that I have a concern about, those assessments, and I do not want them to be a midwife. It is nothing to do with they are not nice people, but some people are not cut out to be a midwife. And that is about where assessment leads.*
> Deborah (Teachers, Gp5, p.12)

The experience of the teacher helps Deborah to know whether a student is cut out to be a midwife; but a teacher's experience alone is not verified as an objective measure of a student's capabilities. Assessment may serve a useful purpose in corroborating a teacher's judgment about a student or identifying students who are not suitable for midwifery. Assessment is regarded as offering an objective value-free measure of a

student's progress; yet at the same time, a teacher's experience and insight told them when a student was not reaching the expected standard. On the one hand we had moved to a pedagogical approach which valued the *phronesis* of practice, but on the other hand, as assessors, *phronesis* could only offer a subjective judgment. It was still the measurement of the examination which counted.

Conclusion

Midwifery teachers knew that understanding the art, or *phronesis*, of practice was crucial for a student to become a competent midwife. Yet the thing which signals whether a student has reached the standard necessary to pass on to the next part of the midwifery degree, is passing assessments. Data revealed that assessment practices, particularly examinations, determines for students and teachers what counts as valid knowledge, and had a profound effect on the way that students learn. Assessment determines whether students can progress through the programme and serves as an indicator of the midwifery programme and the university's success.

Assessment processes used in the midwifery programme were based around behavioural pedagogical approaches which are assumed to be fair, objective and measurable, *techne* being easier to measure than *phronesis*. Yet assessment may actually undermine students' capacity to judge their own work through a reliance on the authority of teachers, or the opinions of others in making those judgments. Exams can only test one kind of knowledge and that students have that piece of knowledge at the time of the examination. Exams do not test how long students retain that knowledge or whether they are able to apply it to practice.

Teachers' experience often showed them which students should or should not pass, but, teachers' experience was seen as merely subjective. The measurement of the examination counted as an objective measure of a student's ability. The pedagogical approach may be *configured* but it is much harder to *configure* accepted assessment practices because of the need to ensure that graduates practice at a safe level for public safety. The university and the registration body also have a powerful impact on assessment. If education and assessment are viewed as a machine, teachers could be seen as *standing reserve* who operate the machine of assessment, and students as *standing reserve* who become useful if they are deemed to have passed assessments.

Discussion and reflection on the narratives in the tutorial groups created opportunities to think about practice issues in a different way, but this study found that summative assessments frame what counts as real knowledge and learning. So strong is this link between assessment and the way that students learn, that Bryan and Clegg (2006) conclude that different approaches to learning may more accurately be described as approaches to *assessment*. When a student studies, passing the assessment is her target. For Ricoeur (1998), learning should be seen as a change, rather than a target. If a learning environment has the capacity to challenge a student's way of thinking, then according to Ricouer, *refiguration* has occurred. This presents a paradox, because assessment processes are a target, reinforcing and rewarding what a student already knows, perhaps meaning that they have learned only what they have been told to learn. They may not have learned to 'think'.

Thomson (2001) asks if an ontological conception of education may help overturn the *enframing* of education. Data from the teachers' research conversations and student focus groups in this study suggested that while assessment *enframes* pedagogy, a narrative pedagogical approach opened up a discussion between teachers and students about assessment processes. It is anticipated that assessment formats, such as those in use in clinical papers where teachers make judgments based on their discernment of how a student is progressing will be developed further. The challenge is to find ways which may better assess students' *phronetic* reasoning, and help students to develop their own skills of self-assessment.

Chapter Nine: *Configuring* the curriculum

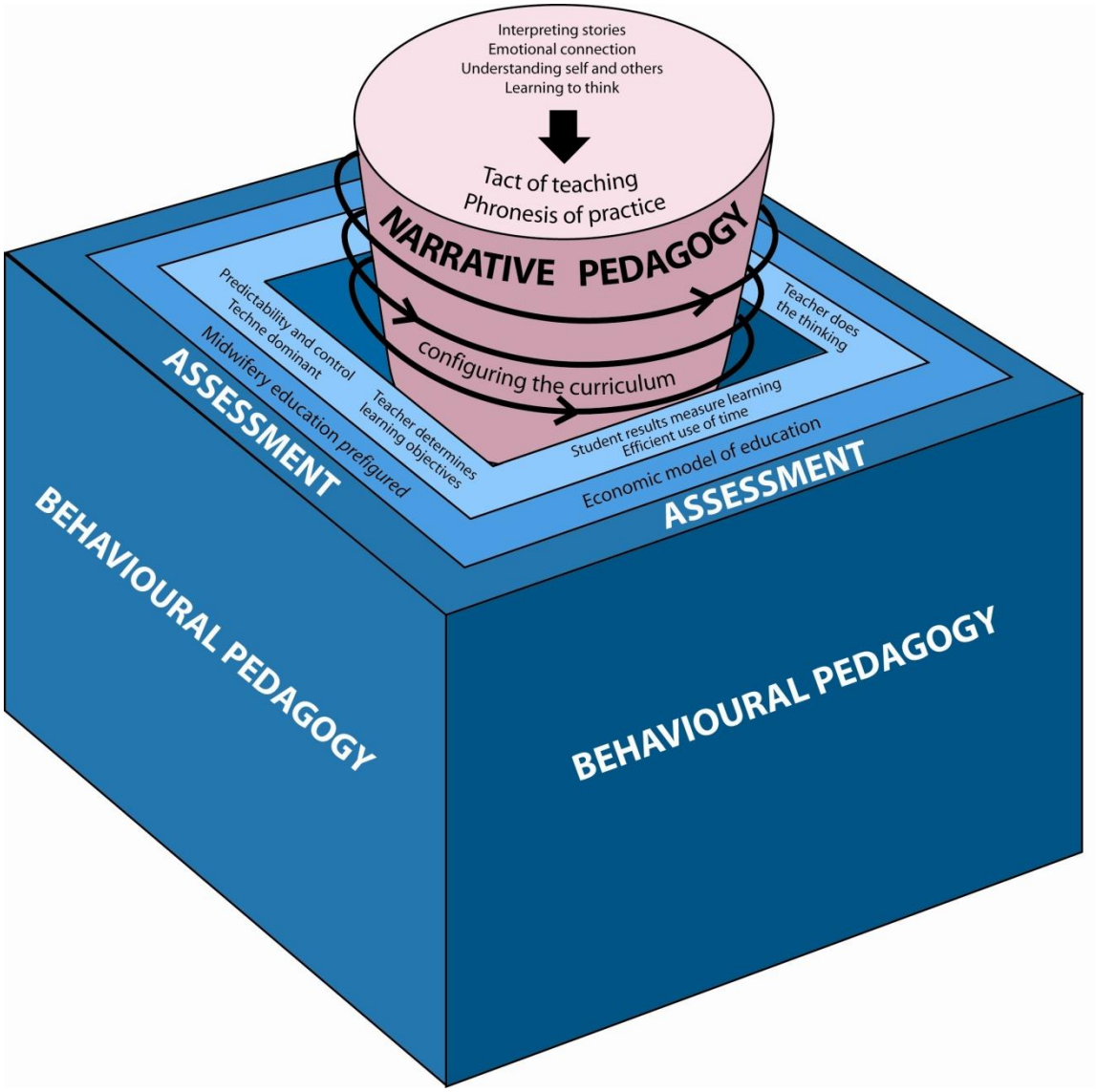
> *Innovation remains a form of behaviour governed by rules. The labor of imagination is not born from nothing. It is bound in one way or another to the tradition's paradigms. But the range of solutions is vast*
> (Ricoeur, 1984, p. 69).

This chapter explores midwifery teachers' and students' experiences of making curricular change. Ricoeur (1984) talked about the way that people move to new ways of being or acting, describing the change process in terms of three mimetic processes; *prefiguration*, *configuration* and *refiguration*. *Configuration* (or the change process) is the mediating function between *prefiguration* (pre-understandings), and *refiguration* (a vision of how the future could be). Ricoeur's philosophy shows that the possibilities for *configuring* a curriculum lie between the *prefigured* world of education, and the imagined new future of education *refigured*. He points out that any innovation must recognise the *prefigured* traditions that are being transformed, and that *prefigured* tradition cannot be recognised without imagining other possibilities *(refiguration)*. In other words, *prefiguration* (tradition) and *refiguration* (innovation) are two sides of the same coin.

Although Ricoeur links the three mimetic stages of *prefiguration*, *configuration* and *refiguration* as a progression, he is clear that the mimetic process is circular, although not in the sense that the end leads back to beginning as in a vicious circle. Ricoeur (1984) speaks of an "endless spiral that would carry the mediation past the same point at different times, but at different altitudes" (p. 72).

Figure 6 (p. 172) depicts Ricoeur's concept of *configuration* as a spiral which circles around and between *prefiguration* and *refiguration*. This chapter explores the experience for teachers and students of making curricular change; that is, being in the spiral of *configuration.*

Figure 6: Configuring the curriculum



The prospect of change

In the week before the new narrative-centred curriculum was launched in 2005, the research group of midwifery teachers talked about what might be challenging about being teachers in the new *refigured* curriculum. Teachers predicted that the prospect of change could be challenging. Lilly, for example, said that people tend to shy away from change:

> *I think anything new and innovative, anything where there's change, people tend to shy away from it because change puts us out of our comfort zone. I think that's normal and natural. But I think as well it's the fact that everyone else will be watching us, it's like "Oh My God how's it going to turn out?"*
> Lilly (Teachers, Gp1, p.4).

As Lilly said, the process of *configuration,* or change, may put some people out of their *comfort zone,* so they may avoid change. Teachers are used to certain ways of teaching, and a teacher may feel uncomfortable with an unfamiliar way of teaching. The potential for discomfort may make some teachers reluctant to make change. For Heidegger, a sense of nervousness, worry and trouble *(angst)* reveals the true state of a person's being, because it shows what a person cares about the most (Harman, 2007).

Lilly also expresses concern that *everyone else will be watching* to see if the new curriculum succeeds or not. When a change is made, the thing which has been changed is often more closely scrutinised than usual. Normally, a curriculum is not examined closely because teaching and learning is assumed to happen in a *prefigured,* traditional way. *W*ith *configuration* of curriculum comes increased surveillance from students, other teachers, the profession and the university. Teachers may be moved out of their comfort zone both due to increased scrutiny, and because they are coming to grips with a new way of teaching practice.

In the next passage Margaret, talked about the prospect of the narrative-centred curriculum being a *natural progression* because she had used an interactive approach to teaching in the past when classes were smaller:

> *I think that when we first started to look at this as a real possibility I was really excited about the idea because for many years we had used a really interactive approach to teaching that suited the quite small class that we had at the time and as the years have gone by and the teaching team have got larger and the student body had got larger, the classes therefore were bigger…it didn't seem like it was a big step forward to move to the narrative base. That seemed like a natural progression really.*
> Margaret (Interview, p.1)

For Margaret who had experience of using interactive teaching methods and stories, the new curriculum was not a big step, but a *natural progression*. She acknowledged that as class sizes had grown, some of the interactive teaching and learning had been lost. Margaret is able to look to *prefigured* curricular processes to have a vision of a *refigured* narrative-centred curriculum. Ricoeur (1984) tells us that as humans experience things and understand them, we do so in the context of the prefigured world which includes history, past experiences, traditions and culture. Innovation itself remains a form of behaviour which is practiced within a world, or paradigm which

allows certain room for variation allowed by that world. Therefore the possibilities that *can* be imagined, and the freedom to uncover new possibilities is largely predetermined by the paradigmatic structures of the world in which one resides. Margaret can imagine, and feels comfortable with the *refigured* curriculum because it is bound to the *prefigured* curriculum which she has experienced. On the one hand Margaret was comfortable about the style of teaching, but on the other she anticipated that making the change to narrative pedagogy was a *huge risk: "But it was a huge risk from my perspective… I was very nervous about the student reaction - very nervous, I did pray that it would be successful"* (Margaret, Interview, p.2).

Students' reactions to the new curriculum were Margaret's main concern. As the Head of Midwifery/Programme Leader, the potential reactions of students caused her *angst*, and led her to feel that a *huge risk* was being taken by introducing a narrative-centred curriculum. From an educational point of view Margaret felt very comfortable with the new curricular approach because of her past experience, but a negative student reaction overrode her comfort and led her to feel that a huge risk was being taken. Student feedback is taken seriously by the university, and as a school head, Margaret would be held accountable for negative feedback about the midwifery programme.

Other teachers anticipated practical concerns for students such as access to resources especially online. A large part of the new curriculum relied on online resources which supported student learning from the narratives. In 2005, when the new curriculum was being introduced, online platforms were new technology for teachers and students. Deborah expresses her concerns regarding student access to online resources:

> *And that is one of my other concerns about those students who could not get access to a computer, and their family commitments are such that they need to be at home (rather than using computers in the library). Those sorts of things that I am concerned about, and we have to be able to, I think, identify them soon. It is not just to get them lots of help, but just to be creative in ways to get them access.*
> Deborah (Teachers, Gp 1, p.5)

Deborah predicted that teachers would need to provide extra help and think of creative ways to help students to have access to, and become familiar with, the online materials. Teachers themselves were only just learning to use the online platform, so

as well as *angst* regarding the new way of teaching, increased scrutiny of the programme and the potential student reaction, the practicalities of the extra support needed to utilise online materials was an added concern for teachers.

The experience of teachers and students of *configuring* the curriculum revealed some important considerations about making curricular change which will be discussed under the following five headings: A champion of the cause; Being prepared for a period of chaos; Responding to students; Managing change; and Sustaining change.

A champion of the cause

For the teachers in this study, one of the key elements of making curricular change was having a champion of the cause who gathered support from others. In the following passage, Margaret recognised the importance of having such a person to drive the change:

> *I think because you (the researcher) were the driving force and you had the initial implementers (the group of teachers) around you, you'd already got those people on board and it's driving the new curriculum along in that way.*
> Margaret (Interview, p.2)

From Margaret's perspective as Head of Midwifery/Programme Leader, the new narrative-centred curriculum was being driven by a *driving force* (champion of the cause), who had gathered a group of *initial implementers* (other midwifery teachers) who were supportive of the idea. The process of implementing curricular change has elements of what Palmer (1992) calls a "movement approach". In a movement approach to change, a champion of the cause makes a stand on an issue. For example, Rosa Parks was a champion of the black liberation movement which changed the way that white people thought about black people. The champion gathers support from others, goes public, and then as the group gains momentum more see the rewards which are gained by being a part of that movement.

A manager needs to support and trust the champion of the cause. As Margaret says in this excerpt it is not always easy to do so:

> *My role was really to trust you to do that and to see what you could come out with and comment on what you came up with. Now this is the first time that we've done a major curricular change within the school that I haven't*

> *actually led, and that personally was difficult for me to let it go enough for me to let you do it and you know I think that just is because it is, but it's felt...there have been times that I've felt "yep that's going O.K" and other times when I've thought "what's going on there, are they alright?"*
> Margaret (Interview, p.5)

For Margaret the curricular change felt difficult because it was the first time that a major change had been made which she herself had not led. For the change to happen Margaret needed to trust the champion of the cause/innovator, and monitor the process from a distance. A manager needs to know when to step in and when to let things go. She had led curricular changes in the past, and now her role had changed to one of supporting the innovator: *"The innovator keeps innovating as you go and the expert teacher and the group manager will manage the group process"* (Margaret, Interview, p.3).

Margaret took on a supportive role for the team, leaving the innovator to directly implement the change. Her role became one of managing things such as group processes, and staff development, which support the teachers who are actively involved in the new curriculum.

The personal cost for the champion of the cause may be high. For example as the curriculum leader, I felt responsible for the experiences of students and teachers:

> *I really wish I hadn't started this, I do feel as if it's all been a complete waste of my time and energy. Why did I bother? We should have left it well alone. I feel responsible for the new curriculum. I suspect that the students who did not pass blame the new curriculum for their failing. I was dreading this morning. I'd woken up at 3am because I'd had such a bad weekend worrying about the students' reaction from Friday. When I checked the emails there was one from one of the most complaining students saying "thank you thank you thank you for the narratives". I knew that I had done the right thing then.*
> (Researcher's Journal 10.6.05)

There were many times when I regretted starting to make the change. It would have been easier to carry on in the *prefigured* curriculum which was comfortable and familiar. The things which assured me that the change was for the better were the positive responses from students and teachers, like the email from a student which said *"thank you thank you thank you for the narratives".* The experience of making a philosophical change to curriculum revealed that for a change such as this to be

successful it is crucial to have a champion of the cause, someone who is prepared to try a new approach, and to weather the period of turmoil which is inevitable.

Being prepared for a period of chaos

In thinking about what frightened teachers about the new curriculum, Deborah thinks about the unknown, and prepared herself for the worst case scenario:

> *It is not what frightens us, but it is the unknown, I mean we do not know, it is new, nobody else has done it at this university…I quite like a challenge, but it is about the unknown and I was thinking about, before the tape went on about what happens if the tsunami hits and the students absolutely hate it? Now that is the worst case scenario in my mind. I do not think it is going to happen, but there is always that possibility.*
> Deborah (Teachers, Gp1, p.3)

For Deborah, making curricular change was a challenge because the change was like going into *unknown* territory. Although Deborah liked a challenge, she worried that the students might hate the new way of doing things, and she prepared herself for the *worst case scenario* in her mind, using the metaphor of a *tsunami hitting*. A tsunami is preceded by a warning period and then creates devastating damage. Being prepared for a period of turmoil when change is taking place is a documented phenomenon (Bland et al., 2000), and could be something which can either be embraced or shied away from during a period of change. Caldwell (2006) uses complexity theory of change to attempt to understand the chaos and uncertainty of making change. Complexity theory shifts the change focus from attempting to maintain stability within systems to "processes" of change. Caldwell (2006) talks about the 'edge of chaos' phenomenon, referring to the narrow zones between order and chaos that allow new patterns of transformation to emerge. This theory offers insights around seeing change as complex and chaotic, but ultimately as an evolutionary process. Deborah has prepared herself for potential turmoil with the new curriculum. Thinking of the worst case scenario helps teachers to be prepared for the anticipated period of chaos and turmoil.

For Deborah, the new curriculum required a leap of faith into the unknown:

> *That is right. It is a bit like when you go into independent practice, you leap in anyway, you do. That is what I always used to say to people when they would say I don't know about going into independent practice, you know, you leap in.*
> Deborah (Teachers, Gp1, p.4)

Deborah has made leaps into the unknown before and has survived, so she remembered times when she had taken a leap in the past (when she went into independent midwifery practice), and those experiences helped her to anticipate and trust the leap she would need to make as a teacher in the new curriculum. Heidegger defines *the leap* as a daring jump that expects nothing: a bold vault into a new beginning (Harman, 2007). Taking a leap is about taking a leap into the future, as yet unknown place. "The broadest leap of all is thinking which moves a person into a new open space"(Harman, 2007, p. 121). Taking a leap involves trusting that the place one is going to leap to is a safe place.

Responding to students

Teachers and students both talked about being responsive to student feedback as we went along. In the next passage one of the students, Chloe, said that teachers have listened to students' concerns:

> *I don't feel we have been entirely on our own because I do feel that they have made the effort to change things, and on that level I don't want to underplay how important that is. I do feel that they have taken what we have said and moved with us and worked for change in that sense. And in that sense of it we were not on our own, and I would say if you went to a lecturer and asked "blah, blah, blah", you would get some guidance.*
> Chloe (Students, Sem 2, Gp1, p.15)

For Chloe, it was important that she did not feel on her own and felt that teachers were listening and made changes in response to feedback. There are many different theories about the best methods for implementing organisational change. Bland et al (2000) found that there were common characteristics associated with successful change efforts. One of the most important characteristics of successful innovation (curricular or otherwise) is a cooperative climate characterised by collaborative problem – solving and effective communication. Strategies that lead to successful innovation include "acknowledging grieving over losses associated with the old curriculum, celebrating successes, providing professional assistance, making minor adjustments in the process, and continuing to monitor progress towards organisational goals" (p.580).

Students were also were being asked to leap into a new curriculum and as Deborah says they needed reassurance from teachers to safely make that leap:

> *I think one of the issues was about reassurance, that students were not being led up the garden path, that yes, this was a new curriculum for them but it wasn't new in something we just picked out of the sky sort of thing. They had to have faith in the process, trust the process, and that we would make sure that they knew their stuff. I think those were the two major issues that I remember.*
> Deborah (Teachers, Gp 3, p.2)

Deborah said that the role of the teacher was to reassure students that although the curriculum was new for them, it had been used in other places. Deborah asked students to *trust the process*, their learning was important to her as a teacher, and she would make sure that they did know what they needed to know to become midwives. The role of the teacher was to make safe passage for students as they adapted to the new way of doing things.

Managing Change

Margaret's role as Head of Midwifery/Programme Leader was to manage the change. She likened managing change to being a *barometer*:

> *Yes I probably have a better barometer around the teachers than the students, a lot of the information I have about the students is second hand because it comes through the teachers but I can tell you that if there's a real problem with students they come and see me, and nobody came and saw me, and when nobody came and saw me - I don't get worried when nobody comes to see me, because they come, if they're really concerned, they will come. They might take a little while to get there, but they come, and they didn't. I had one student who was not doing well who didn't like it at all who came and saw me but that student wasn't liking what was happening before either and wasn't doing very well in the programme so I didn't take that as a major barometer.*
> Margaret (Interview, p.4)

A barometer is a gauge which indicates a change in air pressure, and using the metaphor of a *barometer* for change is very apt. For Margaret, the way she managed change was to act as a *barometer* for problems which emerged. She knew from past experience that students would come to tell her if problems arose, and when they did she would gauge if the problem was significant enough for her to take action.

Margaret felt that students managed the change maturely:

> *The students managed it very maturely through their reps and the team responded by addressing the students perceived issues and we got through that first semester very well I thought without a major explosion and without loss of confidence in our processes.*
> Margaret (Interview, p.3)

The student group communicated with teachers and the Head of Midwifery/Programme Leader through their class representatives. The communication between teachers and students and the response to student feedback Margaret felt was mature, and her *barometer* did not register any *major explosions*! Margaret's *barometer* did register concern when it came to newer teaching staff being asked to take on a new way of teaching do something new when they had just got used to traditional classroom teaching:

> *We had a couple of teachers who were less experienced and they had just got to grips with being effective traditional classroom teachers and now we were asking them to do something quite different - to let go of a lot of what they already knew and to do something different.*
> Margaret (Interview, p.3)

Within the group of teachers who initially implemented the narrative-centred curriculum there was a variety of past experience. Some of the midwifery teachers were relatively new to teaching, and had just gained confidence with giving a lecture to a large group of students. Facilitation of groups was a further skill which not all teaching staff felt confident with, so responding to their needs, Margaret set up a staff development session on facilitating PBL groups for the whole team.

Margaret spoke about setting up the staff development session:

> *I thought that the team of teachers also managed all of that really well. And the intervention stuff we did with a staff development session, I know that that staff development session was really old hat to the majority of teachers sitting round the table that day, but for the people who needed it, it was just the right stuff.*
> Margaret (Interview, p.3)

That staff development session was helpful having someone from outside the team other than the curriculum leader/researcher talking about ways to manage some of

the issues which were arising for teachers. The session served to highlight to teachers that the leap we had taken with the narrative-centred curriculum was sound.

From the Head of Midwifery/Programme Leader's perspective, there were concerns about engaging the whole team of teachers:

> *I was afraid that we wouldn't be able to engage all of our team members in that way of thinking. Managing the change has been easy insofar as the teachers are enthusiastic, they embraced the change and they were getting on with it. My difficulty was that it was quite hard for the rest of the school to really get a handle on what you were doing and it was quite hard to get that out to the others so they could also participate in the thinking change that was going on.*
> Margaret (Interview, p.5)

From Margaret's point of view, she could see the innovators making the curricular change, and the rest of the teaching team being busy with their own work and not fully understanding the change which was happening. The change we were making was a pedagogical change, which required a shift in thinking. Making a complex change that involves changing the way people think creates difficulties in managing it. As Anderson (1999) writes; "Managers of complex systems can only dimly foresee what specific behaviours will emerge when an organizations' architecture is changed. Instead of relying on foresight they rely on evolution; changes that produce cascades of change are retained while those that do not are altered" (p.229).

Margaret was concerned about resistance to change which might come from the university hierarchy:

> *I was actually much more concerned about the university-wide drivers around education because there's been a concerted move to try and traditionalise the way that classes are offered here in the last few years.*
> Margaret (Interview, p.11)

As a manager of curricular change, Margaret's role was to protect the programme from the moves of the University to offer classes as a tradition lecture/tutorial format. Margaret's role as the manager of change was to act as a barometer at the programme level and a buffer at the university level.

Looking back on the change, Margaret said that the change wasn't *anywhere near the disaster territory* that she had imagined:

> *They just were the sort of things that you'd have expected. Having said that they never went anywhere near the real disaster territory that was in my mind that could have happened. You know, you just have to take risks sometimes and just say look let's do this and see what happens, and whilst it was a risk it wasn't a huge risk in terms of the educational philosophy because there's plenty of evidence that PBL works.*
> Margaret (Interview, p.11)

Margaret had prepared herself for the worst of the chaos, and that had not eventuated. For the manager, *configuring* the curriculum involved monitoring and responding to student and teacher feedback, trusting the champion of the cause, and acting as a buffer between the *prefigured* curriculum and the *refigured* curriculum.

Sustaining change

As time went on we reached a state of being more comfortable with this new way of teaching, and now five years on, there is a sense of having *been through* a period of change. Our research conversations revealed a sense that we have moved from one well-known place to a different, new place, but this place was not static, the momentum of change would continue. The next quote from the final teachers' research conversation shows that we continued to discuss new ways that we could be evolving and expanding the narrative curriculum:

> *I feel that we've not really expanded the narratives as I expected we would. We're still doing the same number of narratives and we're still doing an awful lot of classroom teaching, so I wonder where we're going in the future in terms of expanding you know.*
> Emma (Teachers, Gp7, p.1)

Emma commented that we were still doing a lot of classroom teaching. The pull of the *prefigured* curriculum is strong, and the easy place to fall back to is the comfort of the prefigured way of teaching and learning. It can be difficult to sustain change, especially when the change challenges who we are and understand ourselves to be (Dall'Alba, 2009). The research conversations we had as teachers reveal that change was chaotic and unpredictable in some ways yet we did predict change, we just didn't know what form it would take. We constantly discussed and reviewed the way we

were doing things. This grew out of our own conversations as teachers, but also through discussions with the students, our Head of Midwifery/Programme Leader and others who used narrative pedagogy. Our story unfolded, it evolved, but we have never reached a conclusion. It is dynamic, and it is spiral as we revisit past ideas at a different altitude. Narratives are now embedded in the curriculum, as Margaret said:

> *And I think that it's well established now you know, we've got a team with one of the teachers who was having so much difficulty at the beginning of the year just said to me the other day I said "what are you up to?" She said "I'm just going off to do the narrative" like it was an everyday thing, and that's a mark of a huge achievement you know it's a major change in approach and philosophy that's been implemented and I just think that's just great.*
> Margaret (Interview, p.4)

Conclusion

Reflecting on the experiences of making curricular change for teachers and students at AUT University, Ricoeur's theory offers a framework with which to comprehend our experience. The spiral of *configuration* ran between the *prefigured* world and the *refigured* world. *Configuration* conveys the idea of movement, which fits with the experience of the teachers and students in this study. *Configuring* the curriculum involved having a champion of the cause, who gathered a group of like minds around her. For teachers, students and manager *configuration* involved being prepared to take a leap of faith into the unknown and for the chaos which might eventuate. *Configuration* involved responding to student's concerns and feedback, and making changes as the curriculum was implemented. For Margaret as the manager of change, her role was complex. As a manager of change she facilitated curricular change through trusting the champion of the cause, being a barometer for teacher and student unrest, dealing with the problems which arose, and acted as a protector of the programme.

Chapter Ten: Discussion-preserving narrative pedagogy within the *prefigured* world of education

"All the answers that I started with turned out to be questions in the end"

[Gravity by Alison Krauss and Union Station]

The findings of the research

This thesis has explored the experience of participating in a narrative-centred curriculum as it was being implemented in an undergraduate midwifery education curriculum in Aotearoa, New Zealand. The question of this study was: what is the experience of midwifery teachers and students who are participating in a narrative-centred curriculum? The purpose of this research was to add to the understanding of the implementation of a narrative-centred curricular approach within tertiary education generally, and midwifery education specifically. The conclusions are drawn from my perspective as a researcher, a midwife, a curriculum developer and a teacher in the midwifery programme.

This chapter synthesises the findings shown in the preceding chapters and draws conclusions about teachers' and students' experiences during the implementation of a narrative-centred curriculum. The findings of this study are considered in relation to literature in the area of narrative pedagogy, narrative-centred curricula and the use of narrative and story in education. Recommendations are offered for educators who might be considering using a narrative pedagogical approach. The strengths and limitations of this study will be discussed, along with suggestions for future research. The first chapter is revisited, addressing the original research question, and my own learning from this research process is evaluated.

Reconfiguring the curriculum: Fitting the round peg into the square hole

I argue that pedagogy is fundamental to education. Although pedagogy is often not overtly stated, it is revealed through everything that happens in an education programme from class sizes, timetabling, seating arrangements, textbooks, technology used, the language of curricula documents, the types of assessments used and the relationships between teachers and students.

Ricoeur's (1984) philosophy of narrative interpretation occurring through the processes of *prefiguration*, *configuration* and *refiguration*, has provided a framework

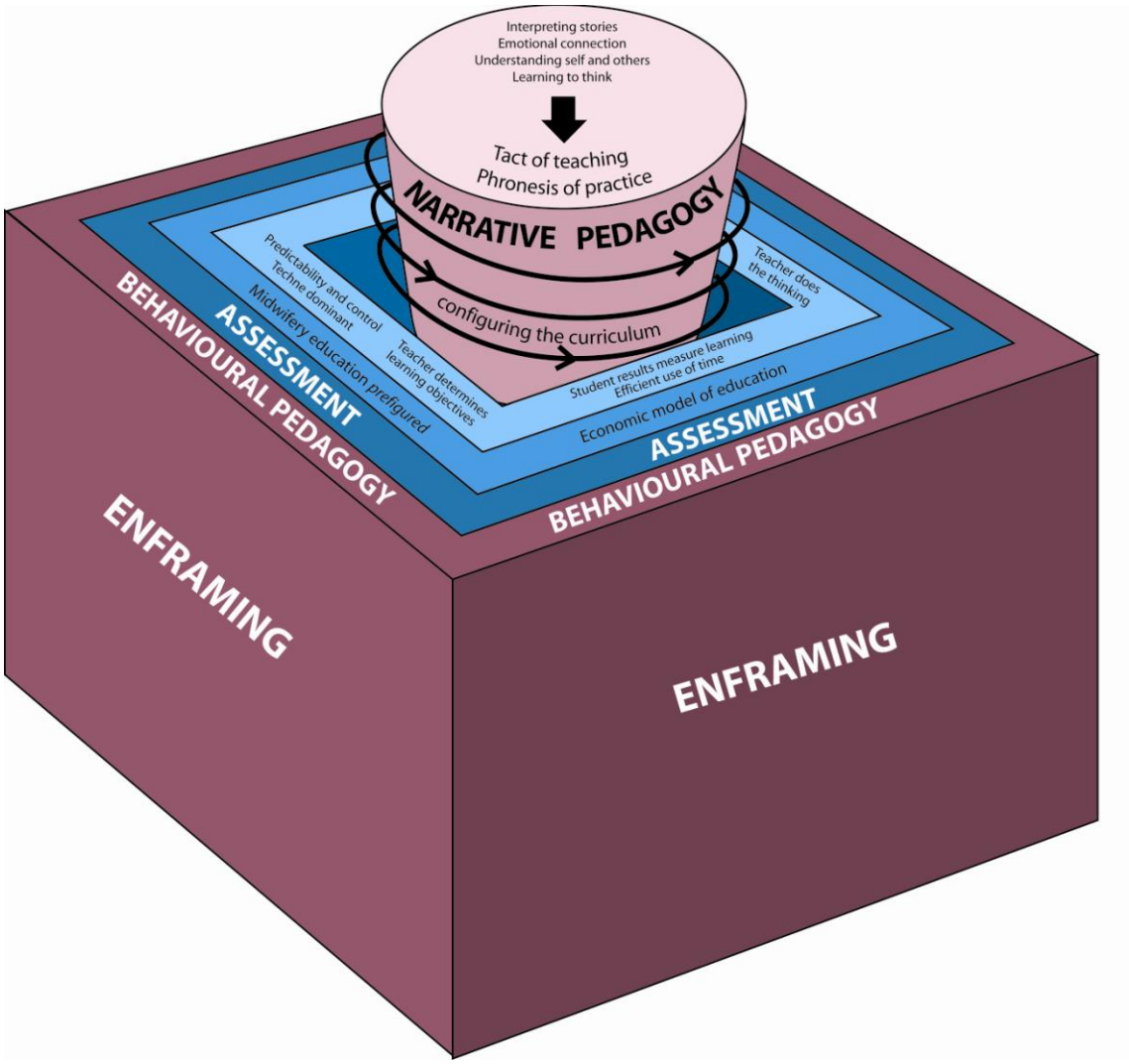
for the model which has been developed (see Figure 7, page 186). Figuratively speaking, this model shows that the *prefigured* world forms a 'square hole' within which fits the 'round peg' of narrative pedagogy. This study found that the pedagogical approach of the midwifery curriculum is enframed by the *prefigured* world of education. For this study, the *prefigured* world included behavioural pedagogy, an economic model of education, and a curriculum shaped by an emphasis on teaching content and skills. Assessment processes were found to be fundamental to the *prefigured* world of midwifery education, and subsequently enframed all pedagogical approaches. The *prefigured* world of education has a profound effect on pedagogy and shapes the possibilities for pedagogical reform.

The curricular structures which have evolved to support the *prefigured* world of behavioural pedagogy and an economic approach to education underpin what is taught and how teaching and learning happen in university education. For example, education increasingly relies on lectures, multimedia technologies, and online platforms to teach large numbers of students on campus and at a distance. In the *prefigured* world of university education the sharing of narratives may be used as an adjunct to illustrate points in a lecture, or in discussions outside formal teaching sessions, but are not central to the curriculum. An economic model combined with the dominance of a behavioural pedagogical approach with its content-laden curricula and lectures as the primary mode of teaching, have created challenges for the development of other pedagogical approaches such as narrative pedagogy.

Fit of the round peg in a square hole

Figure 7 (p. 186) represents midwifery teachers' and students' experiences of *reconfiguring* the curriculum and using narrative pedagogy within a university system based upon the *prefigured* world of education. The round peg which represents the joys of narrative pedagogy that emerged in this study, such as students learning about the *phronesis* (art) of midwifery practice and the emergence of authentic teacher-student relationships, do not fit exactly into the square hole of the *prefigured* curriculum. The tensions of the *prefigured* curriculum such as the drive for content, and the compelling influence which assessment has on pedagogy, pressurises the round peg to conform. The round peg has to create space within the square hole to keep its shape.

Figure 7: The 'enframing' of narrative pedagogy



Diekelmann and Diekelmann (2009) use the metaphor of a road block to describe what could be considered an impasse when it comes to implementing a new pedagogy. The 'square hole' of behavioural pedagogy and assessment processes which enframe all pedagogical approaches could conceivably be viewed as an impasse to implementing a new pedagogical approach. Heidegger (1977) says that the danger of enframing is that people may become 'entrapped', and see no way forward. The risk, therefore, is that assessment could be interpreted as something which entraps pedagogy, and is thus a road block to making pedagogical change. While there were challenges to fitting a narrative pedagogical approach within the *prefigured* world of education, the joys of overcoming them, made it worthwhile.

The round peg: A narrative-centred curriculum fosters phronesis of practice

Interpretation of clients' narratives is an essential skill for midwives and, I would argue, for all health professionals. This thesis found that when narratives were central to the learning environment, students reflected on knowledge, values and beliefs, and related those to the narrative and midwifery practice; a skill which is the cornerstone of practice *phronesis*. As Aristotle (as cited in Bruner, 1999) wisely said "it is an easy matter to know the effects of honey, wine, hellebore, cautery, and cutting. But to know how, for whom, and when we should apply these as remedies is no less an undertaking than being a physician" (p. 4). In other words, knowledge and skills are necessary for practice, but on their own are insufficient. Making appropriate judgments is critical for midwifery. A midwife needs to critically evaluate evidence, support alternative choices, reflect on her own practice, and make clinical decisions in a myriad of contexts, modifying the approach in the light of the woman's response.

Although midwifery curricula tend to emphasise the teaching of knowledge and skills *(techne)*, it was possible for the art of practice *(phronesis)* to emerge when narratives were central to teaching and learning. *Techne* describes the knowledge which informs the 'how to' practice, and *phronesis* is the practice wisdom which is the 'know how' of practice. *Techne* appears as the knowledge and skills which lead to the correct way to practice, yet it is *phronesis* which really makes the difference in the practice setting (Smythe et al., 2009). *Techne* can be learned from lectures, textbooks and multimedia presentations, but *phronesis* cannot be learned by simply absorbing information. Interpretation of narratives helps students to develop *phronesis.* The findings of this thesis concur with Giles (2008) who concluded that for teachers:

> More than the development of theoretical understandings, practical understandings and the development of competencies for application in classroom situations, the pedagogy of teacher educators needs to let students learn towards phronesis. Transmission models of learning and calculative thought are counter-productive to developing sensitivities and sensibilities of phronesis. (p. 161)

Midwifery practice occurs within a context of complexity, uncertainty, and women's individual uniqueness; which means that midwifery actions cannot be deduced simply from knowledge and application of knowledge. Schön (1987) asserted

that “we need to teach students how to make decisions under conditions of uncertainty, but this is just what we don’t know how to teach” (p. 11). Leibowitz et al. (2010) agree, contending that it is “conditions of uncertainty in teaching and learning situations which equip teachers and learners to respond to the uncertainty posed by the complexity of practice” (p. 123). This study found that a narrative-centred curriculum allowed for discussion and reflection on the uncertainty of practice to occur in a safe environment. *Phronesis* cannot be explicitly taught, but interpretation of narratives can help *phronesis* to happen. *Phronesis* may be learned from experience, working alongside an experienced midwife and through interpreting narratives.

McAra–Couper (2007) wrote that it seemed imperative that in an age of increasing intervention, educational opportunities and processes were provided for the passing on of practice wisdom to student midwives, as it is this that will ensure that clinical skills are kept alive. This study revealed that a narrative-centred curriculum is one way of sharing practice wisdom and learning about the *phronesis* of midwifery practice. *Phronesis* matters for midwifery practice, and is at risk of not being privileged unless explicit strategies, such as those of narrative pedagogy, are written into curricula.

Round peg: A narrative-centred curriculum preserves pedagogical tact

The findings of this study show how pedagogical tact can emerge when narratives are central to teaching and learning. There are no theories or models to follow for being a tactful teacher and it is impossible to reduce tact to a set of skills for acting predictably and consistently in situations calling for tact (van Manen, 1991a). For teachers in this study, the tact of teaching was revealed when teachers and students discussed and interpreted narratives together in narrative tutorial groups. It was evident from the teachers’ conversations that, over time, teachers learned to trust their instincts and developed a sense of when to let a discussion flow and when to intervene. The tact of teaching became visible when teachers and students interpreted narratives together.

Heidegger (1954/1968) emphasised the importance of the relationship between teacher and students, saying that “If the relation between the teacher and the taught is genuine, therefore, there is never a place in it for the authority of the know-it-all or the authoritative sway of the official” (p. 15). As teachers in this study gained experience with facilitating narrative tutorial groups, they felt more

comfortable with not needing to be an authority on all topics. Teachers no longer felt as exposed if they did not know the right answer and found a balance between student-directed learning and providing students with answers.

Brook (2009) maintained that authentic learning environments are founded on authentic teacher-student relationships. An authentic learning environment is one in which the teacher creates an environment that inspires the formation of students as authentic human beings (Ream & Ream, 2005). Authenticity in teaching means being sincere, honest, caring for students and having an interest in engaging students around the subject matter (Kreber, McCune, & Klampfeitner, 2010). Opportunities for authenticity occurred in the dialogue and discussion which occurred when teachers and students were engaged in interpretation of narratives. While various teaching strategies can be learned or practiced by teachers, pedagogical tact or authenticity cannot be imparted through staff development workshops or study days. Teachers in this study developed pedagogical tact with time, experience, and discussion with other teachers. When Heidegger (1954/1968) says "to teach is... to let learn"(p. 15), he opens the question of how a teacher can let students learn for themselves. Narrative pedagogy provides such an experience.

Behavioural pedagogy and economic drivers enframe pedagogy

When narrative pedagogy was first introduced into AUT's midwifery programme, teachers and students in this study initially reported feeling insecure with a new way of doing things. A narrative-centred curriculum emphasises students determining their own learning based on narratives, and teachers facilitating learning in tutorial groups rather than just lecturing. The different pedagogical approach led to teachers and students feeling apprehensive about their ability to learn or teach in a different way. The apprehension which teachers and students experienced with a new pedagogical approach revealed the *prefigured* curriculum.

Planning and preparation is a dominant practice for teachers in the *prefigured* world of education (Brook, 2009). When teachers in this study first facilitated tutorial groups, they felt unsure of themselves without the usual planning and preparation of teaching materials which goes along with prepared lectures. In the *prefigured* curriculum, teaching was predictable and controlled since it was the teacher who determined learning objectives, provided content, and defined the depth and breadth

of learning. The teacher was the one who did the thinking, and presented students with the results of that thinking. The narrative-centred curriculum asked teachers to cope with the unpredictable nature of interpreting narratives and facilitating students' thinking in tutorial groups.

As well as the emphasis on having planned teaching for a class, the *prefigured* world of education focuses on efficient ways of teaching large groups of students, so lectures with multimedia presentations tend to be the predominant mode of teaching. A narrative pedagogical approach values the learning which comes from smaller groups of students working together to interpret, reflect on, and discuss narratives. Teachers and students felt insecure without the usual constructs of the prefigured world of teaching and learning. Their anxiety revealed the dominance of behavioural pedagogy in determining how teaching and learning in a university ought to occur.

Assessment enframes pedagogy

Assessment practices have a powerful effect on curricular processes and on pedagogical approaches. For students, it was assessment processes which signalled to them what the most important topics were to study, since passing assessments is the way to progress through the programme and graduate as a midwife. While students appreciated the value of the learning they got from the narratives, they questioned their own ability to decide what they needed to study, and to what depth to study. They were concerned that they might spend time studying topics on which they were not examined, and this was seen as time wasted.

Important as it is for public safety to have a way of measuring each midwifery student's level of knowledge and competence *(techne)*, it is equally important that midwifery graduates know when to apply knowledge and competencies in a complex practice environment. The *phronesis* of midwifery is as vital to practice as is the *techne*; however *phronesis* is not as readily taught, learned, or measured as *techne*. When narratives are central to learning, students can learn about the *phronesis* of midwifery practice. As Gadamer (1975/2004) pointed out, "we learn a *techne* and can also forget it. But we do not learn moral knowledge [*phronesis*], nor can we forget it" (p. 315). Examinations and competency assessments can only test that students have cognitive gain or can perform a skill at the time of the assessment. It is assumed that if a student passes an assessment one day that she will be competent in every situation

where she will be required to perform that skill or competency, or use that knowledge (Diekelmann & Diekelmann, 2009). Assessment processes do not test how long students retain knowledge or whether they are able to apply that knowledge to practice.

It is much easier to devise objective assessments which measure cognitive gain than it is to devise assessments which measure *phronetic* understanding. Some midwifery practice assessments and teachers' experience, can determine whether a student demonstrates *phronesis*, but this type of assessment is seen as less objective, and therefore less significant than an examination result. Assessment of competence is essential for midwifery practice in order to ensure public safety; the dilemma is that assessment may actually undermine students' capacity to judge their own work through a reliance on the authority of teachers, or the opinions of others in making those judgments (Leathwood, 2005). In order to sustain narrative pedagogy, this research recommends that other assessment formats (see p. 202) be developed which may better assess students' *phronetic* understanding, and help students to develop their own skills of self-assessment.

Epistemology and ontology of midwifery education and practice

When education focuses on epistemology (acquisition of knowledge, skills and competencies), an ontology (theory of being) is overlooked (Dall'Alba, 2009). If the purpose of midwifery education is conceptualised in terms of developing ways of *being* a midwife, rather than purely providing a set of knowledge, skills and competencies, the focus of midwifery education would change to *becoming* a midwife.

Prior to formal midwifery education, the only way to *become* a midwife was ontologically through observation, experience and listening to practice stories. *Becoming* a midwife today happens epistemologically through demonstration of a set of skills and competencies, and ontologically through practice experience. Important as skills and competencies are for safe practice, the risk is that midwifery education becomes focused on epistemology and ontology is regarded as inconsequential. Whereas behavioural pedagogy seeks an epistemology of teaching and learning through the assumption that when something is taught in a certain way, each and every student ought to learn the same thing in the same way, narrative pedagogy recognises that learning is also an ontological process.

Relate findings to key literature

The literature reviewed in Chapter Two gave a comprehensive history and analysis of the pedagogical approaches to midwifery education in Aotearoa, New Zealand. The literature on the use of narrative pedagogy and narrative-centred curricula were explored in Chapter Three. The findings of this study, of the experience of using narrative pedagogy in midwifery education, confirm and extend the findings of others who have used narrative pedagogy and narrative-centred curricula.

A body of literature has emerged which describes various versions of narrative pedagogy and some studies have researched teachers' and/or students' experiences of incorporating narrative pedagogical approaches in their courses (Andrews et al., 2001; Ironside, 2003a; Scheckel, 2005; Swenson & Sims, 2003). This study recorded the experiences of teachers and students as a narrative-centred curriculum was implemented. It allowed a focus that differs from other studies where teachers or students were interviewed retrospectively about their experience of using narrative pedagogy. There is, however, a resonance between this research and that which has studied experiences of teachers and students as they reflected back on their experiences of narrative pedagogy. There is a particular congruence between this study and the work of Swenson and Simms (2000, 2003), who used a narrative-centred approach at the University of Indiana with post graduate nurses learning to be family nurse practitioners. Swenson and Simms (2003) studied students' experiences of a narrative-centred curriculum and how this way of learning influenced their clinical practice. Students were interviewed over the telephone after they had graduated from the narrative-centred course. Swenson and Simms found, as this study did, that some students struggled to learn in this way, expressing concern that they were not given everything that they needed to know. Other students felt that the narrative-centred curriculum had served them well because they learned to listen to patients in a new way, which Swenson and Simms described as "listening to learn" (p. 184).

As undergraduate midwifery students with far less clinical practice experience to draw on, compared with postgraduate nurses, the students in the narrative-centred curriculum still 'listened to learn'. Having less practice experience was not a hindrance, as all students bring their own life experience to the group discussion. In a traditional curriculum, individual students experience is marginalised, seen as 'only one person's'

experience. The narrative-centred curriculum valued individual student's narratives to be shared which provided learning for other students. Many midwifery students have had children themselves and so can relate the narratives to their own experiences. For students who did not have children, hearing narratives was another way of gaining experience. Listening to, and reflecting on narratives was another way of gaining insight into midwifery practice.

Swenson and Simms (2003) pointed out that it is the process of thinking about and exploring narratives which enable clinicians to make links to practice. Others have also suggested that narratives are a way of linking both *phronesis* and *techne* of practice (Diekelmann, 2001; Ironside, 2003a). It was the discussion and reflection which occurred in the small tutorial groups that enabled undergraduate students to think about the *phronesis* of midwifery practice.

Ironside's (2003b) study of nursing teachers' and students' experiences of implementing narrative pedagogy, found that students tended to describe their experiences of using narrative pedagogy by making comparisons with the educational models and theories they previously used. This thesis confirms and further develops Ironside's finding that implementing a new pedagogy reveals the *prefigured* pedagogy.

One of the key findings of this research has been that when narratives are central to learning, the students gained deeper insight and understanding of their own practice. This finding echoes the findings of others who have used narratives in education such as Chan (2008), Kawashima (2005), Kirkpatrick and Brown (2004), Koenig and Zorn (2002), McAllister et al, (2009) and McGibbon and McPherson (2006). McGibbon and McPherson, for example, found that when content was no longer central to the course, space was created for nursing students to explore their own feelings about family violence in a workshop. McAllister et al.'s study of midwifery students who read and shared their reflections on a novel: 'The Birth House', found that a dialogue between students enabled a reflection on the past and an analysis of the present.

This research corresponds with others who have explored the 'concernful practices of schooling, learning and teaching' (Diekelmann, 2002a; Diekelmann & Mendias, 2005; Diekelmann & Mikol, 2003; Diekelmann, Schuster, & Nosek, 1998; Scheckel & Ironside, 2006). Whereas the 'concernful practices of schooling, learning and teaching' (Diekelmann, 2001; Diekelmann & Diekelmann, 2009) articulated how

teachers could 'be with' students, this study places more emphasis on the effect that placing narratives at the centre of learning has allowed for the emergence of *phronesis* of practice.

One of the consistent findings to emerge from this study and other studies is that when a learning environment fosters dialogue and partnerships between students and teachers, space is created to approach learning in new and innovative ways (Brown et al., 2008). The authentic teacher-students relationships which emerged in this study, correspond with the findings of Giles' (2008) study of teacher-student relationship. Giles argued that teachers who are attuned to relationship show a *phronesis*, or practical wisdom, as they relate moment by moment to students. In the present study, teachers developed skills of tactful and authentic teaching as they interpreted narratives alongside students.

The experience of using narrative pedagogy has highlighted the effect which assessment practices have over pedagogy. This finding resonates with many others who have shared concerns about assessment practices being the driving force behind teaching and learning (Biggs, 2001; Boud & Falchikov, 2006; Falchikov, 2005; Gibbs, 2006; Hallett, 2010; Race, 2005). Race (2005), for example, points out that the main reason assessment has become the driving force for learning is that students are required to show evidence (in the form of grades, certificates, diplomas) that they have demonstrated achievement and met standards. "Learners are rewarded for what they *show*, not just for what they know" (Race, p. 67).

While narratives and stories have often been used in education as an illustration of practice, the sharing and interpretation of narratives is usually used as an adjunct to a lecture. Although formal teaching in the last century has not valued the place of narratives, stories happen informally anyway, in birthing unit staff tearooms, as students travel with a midwife by car to visit women in the community and whenever midwives get together (Firkin, 2003). Palmer (1998) stated that a true community requires something beyond the teacher or students to hold them accountable to something beyond themselves. This study found that narratives can act as that thing. When narratives were central to the teaching and learning processes, narratives provided a very effective way of learning about self and others and fostering authentic teacher-student relationships.

Recommendations for education

This thesis has significant implications for the education of midwives and other health professionals. Raising awareness of the influence which behavioural pedagogy, economic approaches to education and assessment processes have on pedagogy is relevant for educators in all fields and at all levels of education.

A key recommendation for the education of health professionals is the value of the learning which students gain from interpretation of narratives. When narratives are central to the teaching and learning processes, learning about the *phronesis* of practice is facilitated. Despite the challenges, it is worthwhile preserving the benefits of the learning which can be gained from narrative pedagogy. For those who may be considering trying narrative pedagogy the following recommendations result from this study. The recommendations for education are divided into three sections: Preparing teachers for a narrative-centred curriculum; preparing students for a narrative-centred curriculum; and Implementing curricular change.

Preparing teachers for a narrative-centred curriculum

It is recommended that the teaching team are well prepared prior to the commencement of a narrative-centred curriculum. Preparation needs to begin at least six months before the new curriculum is to be implemented. Narrative pedagogy requires a shift in philosophy, so prior to making curricular change, the teaching team needs to understand the taken for granted assumptions of the existing pedagogy, and to agree upon and discuss a shared philosophy which will underpin a new pedagogical approach. There is no one recipe for narrative pedagogy; each educational programme needs to develop its own version within its unique cultural, political and social context. Documenting this curricular change will show others who wish to implement a narrative-centred curriculum some ideas to consider when developing their own unique approach.

The best preparation for teaching in a narrative-centred curriculum is being a part of the narrative session and sitting in with, and working alongside, an experienced facilitator. If the curricular approach is new, this may not be possible. Hence, one strategy to consider is inviting other educators who have used narrative pedagogy to talk to the teaching team, as timely visits may provide the stimulation and confidence for trying a narrative pedagogical approach.

A related recommendation of this study is that the teachers who are going to be involved in the narrative-centred curriculum participate in a workshop which would provide teachers with their own experience of learning through narrative pedagogy. A narrative pedagogical approach would provide teachers with an opportunity to explore their own *prefigured* pedagogy approach and develop their own version of narrative pedagogy.

An example of how this experience could be achieved is to commence a staff development workshop with a narrative session. Below, is a selection of narratives drawn from data in this study. Workshop participants could divide into smaller groups (of 4-5) and interpret, reflect on and analyse the narratives. Participants would then be encouraged to think about their own teaching practice in relation to the narrative and to consider what the group would need to learn about and put in place to incorporate a narrative pedagogical approach in their curriculum. Then teachers could work through their own questions to learn about narrative pedagogy and make a plan for the implementation of a new pedagogical approach which is achievable within the site-specific context.

Underneath each narrative below I have given examples of the kinds of questions which the narrative might raise for a group of teachers who were planning to implement narrative pedagogy.

April's narrative

> *The first narrative session that we had, we kind of all got up and told our stories, and by the end of it most of us were in tears, because it was just so amazing to hear the stories of other people, they were things that I never ever considered that people go through. It was like getting pregnant, and things I had just never ever considered, and it was really amazing and it was a quite special day, to be able to share with everyone. Listening to the stories that women have to share is fantastic, and it makes midwifery be more real, not just in the textbooks.*

- How can we capture the power of narrative into our curriculum?
- How will we create an environment conducive to narrative pedagogy?
- Who could be willing to share their narratives?
- Whose narratives are going to be shared? (Clients, teachers, students?)
- How many teachers do we have available to facilitate tutorial groups?
- What size tutorial groups could we have?
- Where could we have narrative tutorial groups?
- How available are people to share their narratives?

Emma's narratives

> *I feel I should know a lot. I can't keep a lot of information in my head, I am fine with the practice issues, but when it comes to the theoretical things I remember them when I swot them up for a lecture or for an exam…. And I have still got the idea that the teacher should know those things. Like the pelvis, be able to rattle off every little bit of it. I still have got that feeling that I am a bit of a 'Clayton's teacher' when I go to the tutorials.*
>
> *...we have had time to prepare and you've got a lesson plan. It is the security. I am certainly not comfortable going up to the front and facilitating whatever may happen.*

- What are the things about our teaching which we do not want to lose?
- How will we feel as teachers when we don't have the security of a planned teaching session?
- How can we prepare ourselves to think differently about teaching and learning?
- What is working well with our teaching at the moment?
- What pedagogical approach underpins teaching and learning practices currently?
- What are the influences on the pedagogical approach we are using?
- What influences how teaching and learning happens in our programme?

Deborah's narrative

> *You can't not, it comes up and hits you in the face. You have to deal with it because it seems so rude to completely ignore it, I mean in my group there was a student and we were talking… I don't know it was about finding out about community support services for women, and the discussion came to the family violence stuff, and we were sitting around in the group and she was sitting opposite me, and she was the person I least expected in many ways and never had said terribly much anyway and she just started crying but you know very silently and she was sitting across from me so it was like in my direct line of vision. You could see she was distressed but she was pretending not to be, and it was a really hard one – it's like how to deal with a situation like that because everyone else could see she was distressed too, she didn't necessarily want to talk about it, she didn't want to talk about it, I think what I did was get up and sat next to her and put my hand on her arm or something like that and carried on.*

- What skills will we need to facilitate narrative tutorial groups?
- What do we already know about group facilitation?
- How will we manage students who share their personal experiences in a group?
- How can we find a balance between students sharing their experiences and other students' learning needs?

- How can we ensure that tutorial groups do not turn into counselling sessions?
- How can we further develop our facilitation skills?

Chloe's narrative

> *My phone rings constantly with the people that I study with ringing me up and going, "do I need to know this?", and it is not because they are asking me, but because we are all doing it to each other, we are constantly ringing up and going "oh my God, I just found this in the book, do we need to know that?" What is the level that we are supposed to be at?*

- How can we ensure that students feel confident enough to learn the right things?
- How much guidance should we give students, and what form should that guidance take?
- What do we do when students go off on tangents?
- Does it matter if groups create different learning objectives?

Sarah's narrative

> *...I find that a bit of a concern. There are some wonderful students, but some of them you just think "arrgh". Would you want that person to look after your sister or personal friend or yourself... So there are lots of different things that we are trying to do with the assessment tool, it is public safety.*

- What body/bodies dictate the content required for your programme?
- What are the expectations of stakeholders for graduates of our programme?
- What assessment processes are working well?
- What assessment processes do we want to retain?
- Are there different assessment processes which we could develop?

April's narrative

> *I do not know how much learning I can get from the stories, and from the way I usually see learning, like the things that I am going to be examined on, but it makes me think about what the experience was like, and having not had children, you know, I think about it a lot, and to have someone come in and share that experience with you and it makes me think what it is like for your client, and so I guess it builds on your empathy there, so you can, when you are out in practice, relate that. Which is a type of learning I guess, but I feel at the moment I am more focussed on trying to learn all the important stuff that I am supposed to know just to pass this paper, and it is great to learn all of that, and always at the back of my mind is am I missing out on some of the science that I really need to know.*

- How can we prepare students for a different pedagogical approach?
- How can we foster the value of the narratives and self directed learning?
- What learning support will be needed for students (For example librarians, computer access, online learning materials)?
- How can we reassure students that they can determine their own learning?

Margaret's narratives

> *I was afraid that we wouldn't be able to engage all of our team members in that way of thinking. Managing the change has been easy insofar as the teachers are enthusiastic, they embraced the change and they were getting on with it. My difficulty was that it was quite hard for the rest of the school to really get a handle on what you were doing and it was quite hard to get that out to the others so they could also participate in the thinking change that was going on.*

- When will the teachers meet to monitor the new curriculum as it is being implemented?
- When will the teachers and students meet to monitor the new curriculum as it is being implemented?
- Are we all committed to narrative pedagogy?
- How will we ensure that all the teachers are on board with the philosophy?
- How committed are the teachers to implementing narrative pedagogy?
- Who will lead the curricular change?
- How committed is the manager to making change?
- How can our manager best support the curricular change process?

> *I was actually much more concerned about the university-wide drivers around education because there's been a concerted move to try and traditionalise the way that classes are offered here in the last few years.*

- What are the institutional requirements for making curricular changes?
- What are the institutional processes which we work within?
- How committed is the institution to curricular reform?
- Who are the stakeholders in our programme?

Through discussion and reflection on the above narratives, teachers would be expected to identify their learning needs for teaching in a narrative-centred curriculum. Each site has its own context and needs. Therefore, the kinds of things which would be useful for teachers to think about for teaching in a narrative-centred curriculum, which would probably be raised when teachers reflect on the above narratives include:

- Developing skills in facilitating small groups.
- Learning strategies to listen and connect with students.
- Developing skills in facilitation of student learning, to ask questions without providing answers.
- Dealing with challenges such as the student who does not contribute, the student who dominates the group, or when stories cross boundaries leading teachers into an inappropriate role of therapist.
- Plan for regular and ongoing teaching team meetings.
- A consideration of how new teachers will be inducted to the narrative approach.
- Planning a written guide for tutors in the narrative-centred curriculum process.

Preparing students for a narrative-centred curriculum

Another recommendation from this study is that prior to the first narrative session students are introduced to the philosophy and the process of the curriculum. For a narrative-centred curriculum to be successful it is important that students engage with the process. If students understand how the curriculum will help them with their learning, they will be more likely to feel positive about learning in a narrative-centred curriculum. Providing written documentation of the process they will be using and what is expected of them is helpful for students. See Appendix N for an example of a student guide for a narrative-centred curriculum.

Practical considerations to prepare students would be issues such as the availability of librarians to help them to learn how to search for information. Library tutorials may be required. Also consider computer access for students. What is the availability on site or will students need to have access at home?

It is important to acknowledge that initially for students the narrative pedagogical approach may seem confusing and unstructured. They need reassurance that their discussion and reflections are really valuable for their learning. Our experience has been that as students graduate, students new to the programme are reassured that they too can learn in this way. For students who are early in the programme or new to narrative pedagogy we have found that more structure is needed initially, and it is helpful for teachers to guide novice students more than experienced ones. Thus, bringing students who have come to recognise the value of this approach to talk to the new cohort of students could be of great value. Most importantly, it is recommended to have regular meetings between teachers and

students to find out how students are experiencing the way of learning, and to respond to their concerns.

Implementing curricular change

Redesigning a course to take on a new pedagogical approach needs to involve the group of teachers involved in the change to adapt the pedagogy to their context and environment. Palmer (1992) pointed out that when an educational change requires a change in the way people *think*, a step by step, organisational approach is unlikely to be effective. For change to the pedagogical approach to be successful, this study found that a champion of the cause is needed who gathers a group of supporters (teaching team) around them. The team of teachers need to be on board with the curricula philosophy and involved in the planning stages. Management needs to be totally behind the change and trust the champion of the cause. In this study the manager served as a barometer for change and responded to teacher and student concerns when necessary.

A further recommendation of this study is in relation to processes to monitor the change, and to keep teachers, students and management on track. Teachers, students and management need to meet regularly together, and separately, before, during and after the new curriculum is introduced to facilitate ongoing discussions about curricular processes.

Implications for assessment

The reported experiences of teachers and students of participating in a narrative-centred curriculum have shown what a huge effect assessment had on what students learned and how they studied. For narrative pedagogy to be sustained, the pull of assessment processes needs to be harnessed to show students that learning about *phronesis* is equally as important as learning about *techne*. Assessment needs to serve both as a measure of each student's competency to practice midwifery, and as a useful learning tool for students which they could take through into their practice and develop their own skills of self-assessment.

The recommendations of this thesis are that assessment of student health professionals is an area which would benefit from further consideration. A need exists to develop assessment formats which may better assess students' thinking and

understanding, as opposed to assessing what has been memorised. A proliferation of literature has arisen on the topic of assessment in tertiary education giving case study accounts and comparing diverse assessment methods (Bryan & Clegg, 2006; Knight & Yorke, 2003) such as portfolios (Carlson & Apple, 1998), journals (Pavlovich, 2007), peer assessment (Falchikov, 2005) and group based assessments (Brown & Glasner, 1999). Boud and Falchikov (2006) say that formative assessment will prepare students for lifelong learning so that they can make "judgments about their own work and that of others in the uncertain and unpredictable circumstances they will find themselves in the future" (p. 402). Formative assessment which provides feedback and an opportunity for reflection may support students to a higher level of independence and ability to assess their own learning (Boud & Falchikov, 2006; Leathwood, 2005; Price & O'Donovan, 2006). Examples of other assessments congruent with a narrative pedagogical approach might include:

- An examination where students read a woman's narrative and plan midwifery care based on the narrative.
- Students mark their own assignments according to the marking criteria. Hand in, and then teacher marks – if the mark differs, then it is discussed, otherwise the mark stands.
- For a multiple choice examination, students are given the correct answer, and have to say why it is the right answer.
- An examination where students have access to the same resources which would be available to them in a practice setting.
- Simulated clinical assessment where actors tell their narrative (history) to each student who makes midwifery decisions and gives advice accordingly.
- Online platforms where students create their own multiple choice questions to test themselves and each other. For example, 'Peerwise'[17](Peerwise University, 2010).
- A portfolio of assessment throughout the degree, where students reflect on what they have learned from each assessment point.

Implications for further research

A number of possible studies which could support and add depth to the findings of this thesis have become apparent. Further research and exploration of different ways of

[17] PeerWise is a freely available online tool to support the construction, display and organisation of student-contributed assessment questions.

implementing and preserving narrative pedagogy in health professional education could enable a more widespread and sustained use of narratives in education.

Of particular interest for further research is the ongoing effect of a narrative-centred curriculum for midwifery graduates. Such a study could focus on how graduates were able to carry through their learning of narrative interpretation to their midwifery practice. Focus groups of graduate midwives in their first and subsequent years of practice would elicit valuable information such as whether a narrative-centred curriculum makes a difference in practice for students, women or midwives. Since the narrative-centred curriculum has been in place, teachers and practising midwives informally comment that students are performing better in clinical practice. Research to see how effectively students are linking theory to practice when they learn from narratives would substantiate the informal observations.

Another research topic which could add to the findings of this study would be to investigate the effects of different kinds of narratives on student learning. For example, does it make a difference if the narrative is oral or written, from a woman, a midwife, or the students themselves? Further to this, an exploration of the factors and processes which facilitate students' learning from narratives would be beneficial. Such a study would provide valuable insight for teachers who are using narrative pedagogical approaches.

A further area of interest would be researching students who do not achieve in a programme. A question which the incidence of a non-achieving student raises is: is a narrative pedagogical approach letting non-achieving students down or is it revealing their deficits more clearly?

Potentially, the experience of using narrative pedagogy may differ between students from different cultures. For example, researching the experience of students who are using narrative pedagogy in different contexts and cultures would be an area worthy of further exploration.

Assessment is an area not addressed in depth in the literature around narrative pedagogy. Through interpretation of the experience of teachers and students, assessment was one area which this study highlighted as problematic. The exploration of different assessment processes which could assess students' thinking would be invaluable (as discussed in the previous section).

Strengths and limitations of the study

The participatory hermeneutic approach based on the philosophy of Paul Ricoeur used in this study has provided insights into the experience of midwifery teachers and students as a narrative-centred curriculum was implemented. The aim of participatory hermeneutic research is not to produce objective results that can be directly generalised to other situations, but to open up possibilities for conversation, reflection and new bases for action (Herda, 1999). The analysis of this study led to the development of the model of a 'round peg in a square hole' which depicts the fit of narrative pedagogy into the prefigured world of education. Understandings gained from Ricoeur's philosophy provided the insights from which the model emerged. The methodology used for this study based on Ricoeur's philosophy and participatory hermeneutics was fitting.

The participatory approach of this study made the struggles and the joys of using narrative pedagogy very real. The research had a direct impact on the curricular processes which were happening at the time. Once the curriculum and this research were underway, it would have been very hard to stop the process, as this thesis rested on the narrative-centred curriculum continuing.

As a teacher, curriculum developer, researcher and participant, I was intimately involved with the entire research process which offered both strengths and limitations for this study. The strengths were that as a close colleague of the teacher participants, I had ready accessibility to them and understood first-hand what they were experiencing. The limitations were that I felt responsible for the teachers' experiences of the new curriculum, and teacher participants may also have wanted to protect me from the worst of their feelings. Some things may therefore have been silenced due to my involvement.

At other times, the closeness made me vulnerable as I had a vested interest in the curriculum working. As discussed in Chapter Four, Ricoeur's (1981) notion of *distanciation* allows for a researcher to distance themselves from the research temporally and contextually. This was important for this study where, as a teacher involved in day to day teaching and assessment of the students who were participating in the research, and at the same time leading the introduction of a new curriculum process, I had a vested interest in the success of the new curriculum. I felt responsible for the other teachers' interests. These things would understandably influence my

interpretation and analysis of the research conversations and focus groups. The process of *distanciation* made it possible for time and distance to alter my perspective.

The experience may have been different if this research had been done by an outsider not directly involved with the curriculum and the teaching. If an outsider had conducted the research, a critical lens could have been used. A critical lens for this research would have involved a critique of my own position as the key driver, and a critique of people and processes to which I was accountable. I was too exposed to allow for a critical stance in this research. The philosophical stance used brings particular understandings to the research process (Geanellos, 1998). The findings of this study are therefore limited to the philosophical approach that underpinned this study and a different philosophical approach may have produced different findings. For example, a critical approach may have brought issues of organisational power to the foreground.

This study was undertaken in the particular context of undergraduate midwifery education in Aotearoa, New Zealand. While each educational context has its own specific requirements, this research provides some useful recommendations and insights that give educators a greater understanding of narrative pedagogy and will assist others who would be interested in adapting a narrative approach to their own educational context.

A particular strength of this study was that data was collected *as* the curriculum was being implemented which added a fresh and very real aspect to the experiences. A limitation of this research is to do with the scope of the study. Finding times that teachers could meet was not always easy, and during parts of the study the full complement of teachers were not available to meet. A further limitation of the study is the quality of the student data because of the necessity for the student focus groups to be run by a research assistant. The numbers of students who participated in the student focus groups were reduced in the second semester as the pressures of practice and assessments grew.

The findings of this study are not expected to be generalised, and there is no anticipation that the study would produce the same findings if replicated elsewhere.

Conclusions of this research

This participatory hermeneutic study set out to show the experience of implementing narrative pedagogy in to a midwifery curriculum. It began with the question "what is the *experience* of midwifery teachers and students who are participating in a narrative-centred curriculum?" The aim of this research was to create a text which shows *where we have been, where we are and where we are going* with a narrative-centred curriculum in midwifery education. This research has highlighted the joys and challenges of implementing and participating in a narrative-centred curriculum within a university setting in Aotearoa, New Zealand. To my knowledge, this is the first trial of a narrative-centred curriculum in midwifery education anywhere in the world. Also, I believe that this is the first time that experiences of teachers and students have been collected *as* a narrative-centred curriculum was being introduced. Other studies reviewed have collected data retrospectively, once the course using narrative pedagogy had finished.

Through interpretation of the experiences of midwifery teachers and students as a narrative-centred approach was implemented, this study has explored the use of a narrative-centred curriculum for undergraduate midwifery education. The original intention had been to illuminate educational practices which occur when narrative pedagogy is used. This thesis has developed a model based on Ricoeur's (1984) framework, which shows how narrative pedagogy can be preserved within the *prefigured* world of education which includes behavioural pedagogy, economic imperatives of education, and the all encapsulating assessment which enframes the possibilities for pedagogical approaches.

Narrative pedagogy can be applied in a myriad of ways, but the original vision of teachers and students sharing and interpreting experiences to develop a learning community remains fundamental to the way narrative pedagogy has been applied in a midwifery curriculum. The findings of this study both confirm and extend the work of others who have founded curricula on narrative pedagogy. The link between assessment and pedagogical approach which this study has revealed has not been made apparent in other studies about narrative pedagogy.

Narrative and story are not traditionally seen as integral to learning processes, but when teachers and students interpret narratives together learning is enhanced due to the emotional involvement with the narratives, seeing the *otherness of the other*,

and students recognising their own values and beliefs. The goal of the narrative-centred curriculum was to promote reflection on and interpretation of narratives, to promote thinking, application of theory to practice, and to put learning into 'real-life' narratives. As teachers and students jointly shared, discussed and interpreted narratives, learning about *phronesis* of practice was fostered and the tact of teaching emerged.

For the university, student pass rates (student outcomes) are the measurement of the success of the programme, not the curricular processes (how students got there). In the *prefigured* education system, the university, teachers and students view results as the measure of what students have learned and teaching effectiveness. For the *refigured* narrative-centred curriculum, it is the thinking which happens along the way which is equally as valuable as the outcome of that thinking (student results). For this study this means that as a researcher I shared a commitment with the teacher participants to make curricular change. This shared commitment provided a critical means for moving beyond the *prefigured,* established way of teaching and learning, towards a *refigured* narrative-centred curriculum.

To return to Ricoeur's (1984) framework, which can illuminate factors that contribute to events, Table 4 below shows the agents, motives and circumstances which have contributed to the implementation of narrative pedagogy into AUT's midwifery programme.

Table 4: Agents, motives, circumstances and narrative pedagogy in midwifery at AUT

Agents:	**Professors Melinda Swenson, Sherry Simms, Pamela Ironside and Emeritus professor Nancy Diekelmann (nursing educators who had implemented narrative pedagogy in the U.S.A)**
	Myself (Andrea Gilkison) as the teacher with the experience of PBL and a desire to try a new pedagogical approach
Motives:	**Increasing knowledge and competencies needed for midwifery practice leading to an 'additive curriculum'**
	Students not linking theory and practice
	Focus of learning on examinations
Circumstances:	**Teaching team, manager and university open to innovation**
	Increased computer-based access

Closing Thoughts

As I look back to the beginning of this research journey, having told the story of how the midwifery curriculum was *reconfigured* to design a midwifery curriculum based on narratives, I realise how much I have learned and how far I have come. I can appreciate now that much of my understanding about teaching and learning was shaped by the *prefigured* world of education. The findings of this thesis were not what I expected. I had expected to discover a blueprint for narrative pedagogy; instead this study has found ways to protect narrative pedagogy within a university system where behavioural pedagogy is dominant. I have raised more questions than answers, especially around the area of assessment. The lyrics from the song by Alison Krauss called 'Gravity' "*All the answers that I started with turned out to be questions in the end"* summarise my learning from this research experience.

What I now understand about narrative pedagogy informs my practice as a midwifery teacher. Our narrative-centred curriculum has evolved, and continues to evolve through a hermeneutic process involving conversation and reflection. There are stories within stories within stories; this story tells the teachers' and students' stories of the narrative tutorial groups, which have stories within themselves, and in turn are interpreting the stories of the women who are central to the work of midwives.

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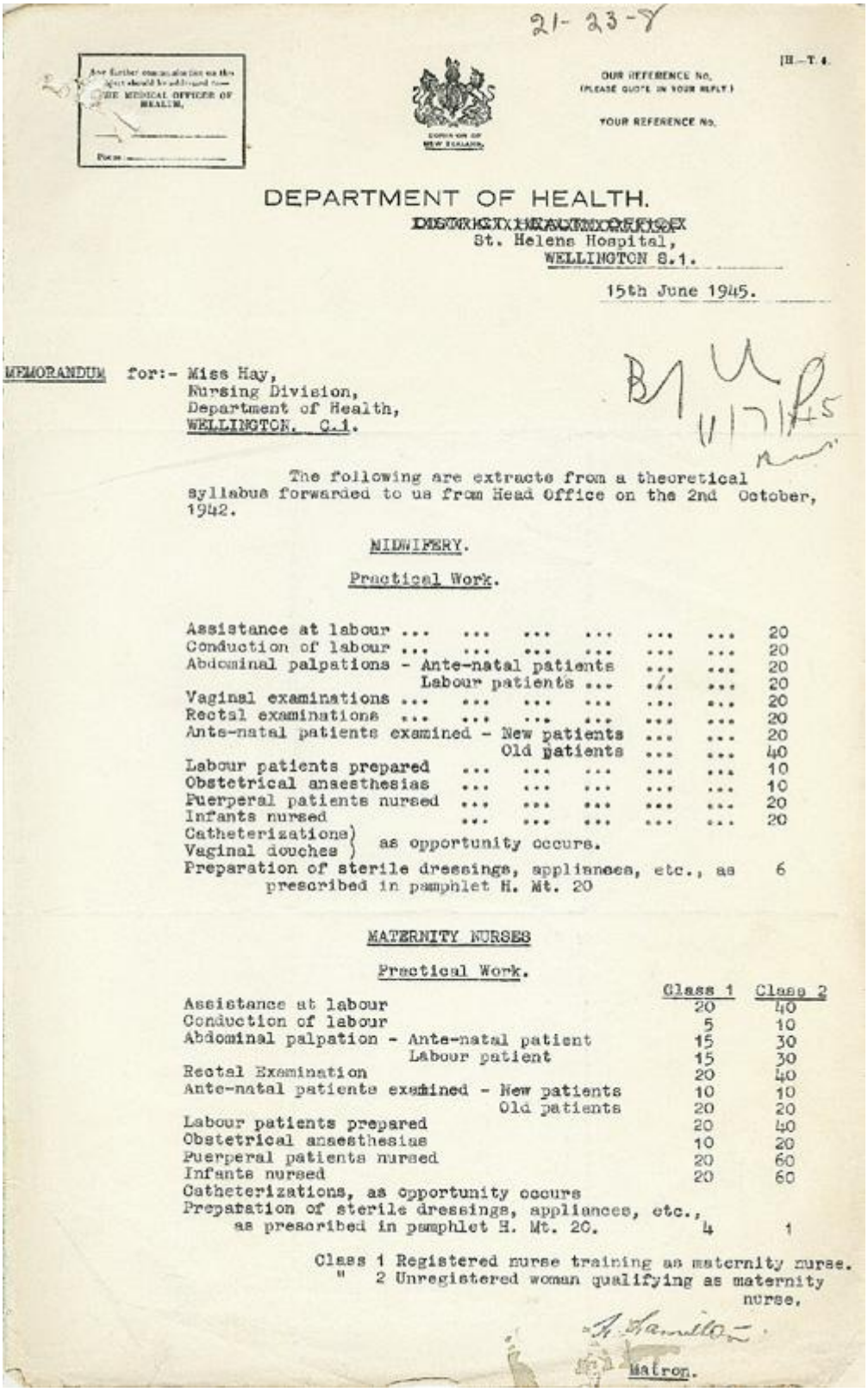
Appendices

Appendix A: 1945 Midwifery Syllabus



21- 23-8

[H.—T. 4.

Any further communication on this subject should be addressed to—THE MEDICAL OFFICER OF HEALTH,

Town

OUR REFERENCE No. (PLEASE QUOTE IN YOUR REPLY)

YOUR REFERENCE No.

DEPARTMENT OF HEALTH.

~~DISTRICT HEALTH OFFICE~~
St. Helens Hospital,
WELLINGTON S.1.

15th June 1945.

B/1 4 11 7 1/45

MEMORANDUM for:- Miss Hay,
Nursing Division,
Department of Health,
WELLINGTON, C.1.

The following are extracts from a theoretical syllabus forwarded to us from Head Office on the 2nd October, 1942.

MIDWIFERY.

Practical Work.

Assistance at labour	20
Conduction of labour	20
Abdominal palpations - Ante-natal patients	20
Labour patients	20
Vaginal examinations	20
Rectal examinations	20
Ante-natal patients examined - New patients	20
Old patients	40
Labour patients prepared	10
Obstetrical anaesthesias	10
Puerperal patients nursed	20
Infants nursed	20
Catheterizations, Vaginal douches — as opportunity occurs.	
Preparation of sterile dressings, appliances, etc., as prescribed in pamphlet H. Mt. 20	6

MATERNITY NURSES

Practical Work.

	Class 1	Class 2
Assistance at labour	20	40
Conduction of labour	5	10
Abdominal palpation - Ante-natal patient	15	30
Labour patient	15	30
Rectal Examination	20	40
Ante-natal patients examined - New patients	10	10
Old patients	20	20
Labour patients prepared	20	40
Obstetrical anaesthesias	10	20
Puerperal patients nursed	20	60
Infants nursed	20	60
Catheterizations, as opportunity occurs		
Preparation of sterile dressings, appliances, etc., as prescribed in pamphlet H. Mt. 20.	4	1

Class 1 Registered nurse training as maternity nurse.
" 2 Unregistered woman qualifying as maternity nurse.

A. Hamilton.
Matron.

Source: (New Zealand Archives, 2005)

Appendix B: Letter to Kawawhakaruruhau

School of midwifery
Division of Health Care Practice
Auckland University of Technology
Private Bag 92006
Ph 64-9-917 9999 ext 7720
Fax 64-9- 917 9695
Email andrea.gilkison@aut.ac.nz

27 October 2004

Caroline McKinney
Chairperson
Kawa Whakaruruhau
Health Faculty
Auckland University of Technology

Dear Caroline

I am writing to Kawa Whakaruruhau to seek your advice regarding my proposed PhD research project to ensure that the principles inherent in the Treaty of Waitangi are integrated into this research project. I wish to consult with you to develop a framework for working with participants who identify as Maori.

In 2005 we plan to introduce a narrative-centred approach into two second year midwifery papers. This involves each topic being introduced a story. This could be a story told by a woman, her whanau, students, or a midwife. These stories, or narratives will form the basis for student learning. We are developing online support which will promote self-directed learning related to each topic, although students will still have lectures, tutorials and demonstration rooms timetabled.

My Ph D research has two parts and aims to analyse the experience of midwifery lecturers and students of a narrative-centred curriculum in an undergraduate midwifery programme.

Part one will involve recording, reflecting on, and analysing the experiences of the midwifery lecturers involved in the implementation of a narrative-centred curriculum in an undergraduate midwifery programme. This will involve inviting midwifery lecturers (including the researcher) involved in the implementation of the new curriculum to participate in focus groups where we will discuss issues such as;

Is there a difference in the way students seem to be learning?

What learning is emerging for us as teachers?

What tensions are arising?

Part two of the project aims to explore the experiences of the students involved in the new curriculum. Students who agree to participate in the study will be asked to keep a reflective journal where they are asked to reflect on how each narrative has influenced their learning. This journal will be handed in anonymously after the paper has been completed.

There are major ethical issues in researching colleagues and students of the researcher. I am addressing these issues in seeking ethical approval through AUTEC. One of the main issues will be to ensure that participants do not feel coerced in any way to participate in the project.

It is possible that potential participants will identify as Maori so I wish to ensure that I can develop a framework for working with these participants, and welcome an opportunity to open a dialogue with Kawa Whakaruruhau to discuss these issues.

Kind regards,

Andrea Gilkison
Senior Lecturer
School of Midwifery

Appendix C: Correspondence from AUTEC

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM

Academic Services

To: Liz Smythe
From: Madeline Banda
Date: 13 December 2004
Subject: 04/222 Midwifery students' experience of participating in a narrative centre curriculum

Dear Liz

Your application for ethics approval was considered by AUTEC at the meeting on 06/12/04.

Your application was approved for a period of two years until 13/12/2006.

You are required to submit the following to AUTEC:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda
Executive Secretary
AUTEC

cc: Andrea Gilkison, andrea.gilkison@aut.ac.nz

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM

Academic Services

To: Liz Smythe
From: **Madeline Banda**
Date: 20 October 2004
Subject: 04/184 The experience of midwifery lecturers in implementing a narrative-centred curriculum into an undergraduate midwifery programme.

Dear Liz

Thank you for providing amendment and clarification of your ethics application as requested by AUTEC.

Your application was approved for a period of two years until 20 October 2006.

You are required to submit the following to AUTEC:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

Madeline Banda
Executive Secretary
AUTEC
CC: andrea.gilkison@aut.ac.nz

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM

Academic Services

To: Liz Smythe
From: **Madeline Banda**
Date: 21 June 2005
Subject: Ethics Application Number 04/184 **The experience of midwifery lecturers in implementing a narrative-centred curriculum into an undergraduate midwifery programme.**

Dear Liz
I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 13 June 2005 approved an amendment of your ethics application to allow extending the sample by including an interview of the midwifery programme leader. Your application continues to be approved for until 20 October 2006.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/research/ethics*, including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/ethics*. This report is to be submitted either when the approval expires on 20 October 2006 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles

Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 917 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Andrea Gilkison andrea.gilkison@aut.ac.nz

Appendix D: Student Participant Information Sheet

Participant Information Sheet
For Midwifery student participants

Date Information Sheet Produced: 14th November 2004

Project Title: Midwifery students' experience of participating in a narrative-centred curriculum.

Invitation: As you are a midwifery student involved in the narrative-centred curriculum being introduced into undergraduate midwifery education at Auckland University of Technology in 2005, you are invited to participate in this PhD study which aims to analyse the experience of midwifery students as this new curriculum is implemented.

Who am I?
As you know, I am one of your lecturers, Andrea Gilkison. I am a midwife, midwifery lecturer and part time PhD student. I completed my Masters degree in education in 2000, and have a strong interest in combining my two passions; midwifery and education through implementing an innovative new midwifery curriculum.

What is the aim of the study?
This study aims to record and analyse the experiences of undergraduate midwifery students as a narrative-centred curriculum is implemented.

Who can be participants in the study?
All AUT midwifery students who are enrolled in the paper the 'Art and Science of Midwifery' in Semester 1, 2005.

If you decide to participate what will it involve?
If you decide to participate, you will be contacted by a research officer who will arrange a time and place for you to meet in a 'focus' group of 6-8 students. The research officer will ask the group some questions about the narrative-centred curriculum which will encourage discussion in the group about your experience as students learning in this new way.

I anticipate that each focus group will take approximately one hour, and will meet twice; once in the middle of the semester and once towards the end. The focus groups will be audio-taped and then transcribed. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. I will never listen to the tapes so will not be able to recognise your voice. I will never know who did or did not participate in the focus groups. Following transcription, the tapes will be destroyed. The transcripts will remain confidential to my typist, my research supervisors and myself.

You may withdraw yourself or the information you have provided at any stage prior to the completion of the data analysis by informing the research officer.

If you identify as Maori
You have the opportunity to request participating in a group with other Maori students, on a marae if you wish, and in a group facilitated by a Maori research officer.

What will the risks and benefits be of participating in this study?
I do not anticipate any risks to you from this study. However, sometimes sharing personal thoughts and ideas can make a person feel unsafe. If you feel on reflection after participating in a group that you have said too much or exposed things that you wish you had not, you may ask the research officer to delete any material you do not want to be included in the final work.

In the unlikely event that you were harmed in any way while taking part in this study, the research supervisor can support you in seeking counseling through the AUT student counseling services.

As one of your lecturers I wish to absolutely assure you that your study or assessments will not be advantaged or disadvantaged by participating in this study. Your participation in the study is entirely voluntary. You do not have to take part in the study.

I hope that the benefits to you will be in exploring your own philosophy around learning, and that being a part of an innovative new midwifery curriculum will create a sense of satisfaction.

What will happen to the results of this study?
The final research will be published as a PhD thesis, which will be available in the Auckland University of Technology library and other libraries. Articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

How will your privacy be protected?
Pseudonyms will be used for all participants in the analysis and the written work. You may choose your own pseudonym and no-one will know your true identity. Any information with your name or contact details will be kept in a locked filing cabinet. Only you, me and my supervisors will read the transcripts.

What are the costs of participating in the project?
The only cost to you that I envisage is your time. This could be up to 2 hours. I appreciate that you are giving your time voluntarily.

Opportunity to receive feedback on the research
On completion of the research, students will have access to a copy of the thesis and all students will be invited to a presentation of the findings.

Opportunity to consider invitation
Thank you for reading this information sheet and considering being a participant in my study. If you would like to be participate in this study, or have any questions regarding the study or your involvement, please contact my research supervisor, or complete the enclosed consent form and return to my supervisor in the envelope provided. If you do not return the consent form it will be assumed that you do not wish to be a part of the study, you do not have to give a reason and it will not be discussed with you further.

Participant Concerns
Any concerns regarding the nature of this project should be notified in the first instance to my supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 917 9999 ext 8044

Researcher Contact Details:
Andrea Gilkison
Ph: 917 9999 ext 7720
Mob: 027 4442865
Andrea.gilkison@aut.ac.nz

Project Supervisor Contact Details:
Lynne Giddings
Auckland University of Technology
Ph. 917 9999 ext 7013
lgidding@aut.ac.nz

Liz Smythe
Auckland University of Technology
Ph. 917 9999 ext 7196
Liz.smythe@aut.ac.nz

Ethical approval for this research granted by AUTEC No: 04/222.

Appendix E: Student Consent Form

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Consent to Participation in Research

Title of project: Midwifery students' experience of participating in a narrative-centred curriculum.
Project supervisor: Lynne Giddings, Liz Smythe
Researcher: Andrea Gilkison

- I have read and understood the information sheet provided about this research project (dated Nov 14th 2004)
- I have had an opportunity to discuss this study. I am satisfied with the answers I have been given.
- I understand that taking part in this study is voluntary.
- I have had time to consider whether to take part.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I consent to the group discussions being audio-taped and transcribed

☐ Tick here if you identify as Maori and wish to participate in a group with other Maori students, and in a group facilitated by a Maori research officer.

Participant signature: ……

Participant name: ……..

Phone number & email address (for research officer to contact you to arrange focus group)

Phone ……

email address……..

Date: …….

Ethical approval for this research granted by AUTEC No: 04/222.

Appendix F: Lecturer Participant Information Sheet

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Participant Information Sheet
For Midwifery lecturer participants

Date Information Sheet Produced: 3rd September 2004

Project Title: The experience of midwifery lecturers in implementing a narrative-centred curriculum into an undergraduate midwifery programme.

Invitation: As you are a midwifery lecturer involved in implementing a narrative-centred curriculum into undergraduate midwifery education at Auckland University of Technology in 2005, you are invited to participate in this PhD study which aims to document the experience of midwifery lecturers as we implement this new curriculum.

Who am I?
As you know, I am your colleague, Andrea Gilkison. I am a midwife, midwifery lecturer and part time PhD student. I completed my Masters degree in education in 2000, and have a strong interest in combining my two passions; midwifery and education through implementing an innovative new midwifery curriculum.

What is the aim of the study?
This study aims to document the responses of midwifery lecturers as they make their journey through the implementation of a narrative – centred curriculum.

Who can be participants in the study?
All AUT midwifery lecturers who are involved in the implementation of a narrative-centred curriculum in 2005.

If you decide to participate what will it involve?
We arrange to meet as a group at a mutually agreeable time and place before the new curriculum is implemented (Nov 2004), and then 2-3 weekly during semester 1 2005 to reflect on, and discuss our experience of teaching in a curriculum which incorporates narrative pedagogy.

I anticipate that each meeting/discussion will take approximately one hour. Our conversations will be audiotaped, and then transcribed. These tapes and transcripts remain confidential to my typist, my research supervisors and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity.

Copies of the transcripts will be available to you, and you will be invited to add further comments and delete any parts of the interview you do not want included in the study.

In total it is anticipated meeting up to 12 times between November 2004 and July 2005 so that the process we go though can be described and analysed.

You may withdraw yourself or the information you have provided at any stage prior to the completion of the data analysis. At the end of the study the audiotape will be destroyed.

What will the risks and benefits be of participating in this study?
I do not anticipate any risks to you from this study. However, occasionally such interviews in which you share your personal thoughts and ideas can make a person feel unsafe. If you feel on reflection after the interview that you have said too much or exposed things that you wish you had not, you may delete any material you do not want to be included in the final work.

In the unlikely event that you were harmed in any way while taking part in this study, I can support you in seeking counseling through the AUT staff counseling services.

I hope that the benefits to you will be in exploring your own philosophy around teaching and learning, and that being a part of an innovative new midwifery curriculum will create a sense of satisfaction.

Your participation in the study is entirely voluntary. You do not have to take part in the study. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information provided, up until the time when data analysis is complete. After that time it may be impossible to separate data from individuals. If you choose to withdraw you do not have to give a reason.

What will happen to the results of this study?
The final research will be published as a PhD thesis, which will be available in the Auckland University of Technology library and other libraries. Articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

How will your privacy be protected?
Pseudonyms will be used for all participants during interview transcriptions, analysis and the written work. You will choose your own pseudonym and the researcher and the research group will be the only people who know your true identity. Any information with your name or contact details will be kept in a locked filing cabinet. Only yourself, the research group, my supervisors and myself will read the transcripts.

What are the costs of participating in the project?
The only cost to you that I envisage is your time. This could be up to 12 hours including group discussion times and time for reading transcripts. I appreciate that you are giving your time voluntarily. If expenses are incurred (e.g.parking), I will ensure you are reimbursed.

Opportunity to receive feedback on the research
On completion of the research participants will have access to a copy of the thesis and will be invited to a presentation of the findings. They will also be sent a report from the research.

Opportunity to consider invitation
Thank you for reading this information sheet and considering being a participant in my study. If you would like to be participate in this study, or have any questions regarding the study or your involvement, please contact me, or complete the enclosed consent form and return to me in the envelope provided. If you do not return the consent form I will assume that you do not wish to be a part of the study, you do not have to give a reason and I will not discuss it with you further.

Participant Concerns
Any concerns regarding the nature of this project should be notified in the first instance to my primary supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 917 9999 ext 8044

Researcher Contact Details:
Andrea Gilkison
Ph: 917 9999 ext 7720
Mob: 027 4442865
Andrea.gilkison@aut.ac.nz

Project Supervisor Contact Details:
Liz Smythe
Auckland University of Technology
Ph. 917 9999 ext 7196
Liz.smythe@aut.ac.nz

Ethical approval for this research granted by AUTEC No: 04/184.

Appendix G: Lecturer Consent Form

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Consent to Participation in Research

Title of project: The experience of midwifery lecturers in implementing a narrative-centred curriculum into an undergraduate midwifery programme.
Project supervisor: Liz Smythe
Researcher: Andrea Gilkison

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* I have read and understood the information sheet provided about this research project (dated Sept 3rd 2004)
* I have had an opportunity to discuss this study. I am satisfied with the answers I have been given.
* I understand that taking part in this study is voluntary. I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
* I have had time to consider whether to take part.
* I consent to the group discussions being audiotaped and transcribed.
* I wish to receive a copy of a report from the research.

Participant signature: ……

Participant name: ……

Date: …….

Ethical approval for this research granted by AUTEC No: 04/184.

Appendix H: Transcriptionists Confidentiality Agreement

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Typist's Confidentiality Agreement

I, ……., understand that the transcribing of interviews with participants in Andrea Gilkison's research study involves issues of confidentiality. I undertake to respect the privacy of those individuals by not divulging any of the content within the audiotapes. I will store the audiotapes and any hard copies awaiting collection in a secure environment, namely a locked filing cabinet.

Signed…….

Date…….

Appendix I: Prompt Questions for Student Focus Groups

Questions to be used as prompts asked by research officer in focus groups

Mid-semester:

1. How do you feel when you listen to the stories in the narrative sessions?
2. How are the narrative sessions influencing your learning?
3. How do you find yourself learning from the stories?
4. Is the way you learn changing?
5. Are you exposed to the right amount of 'content' knowledge?
6. How do you continue the learning that has been triggered in the narrative session?
7. How do the stories relate to 'real' life?
8. Does the narrative connect to what you already know?
9. Do you find yourselves reflecting on the stories told in the narrative sessions?
10. How are you feeling about being a student midwife at AUT?
11. How do you feel when you listen to women's stories?
12. How do you feel about telling stories?

End of semester - July
Key Questions

1. How do you find yourself learning – has this changed from the beginning of the year?
2. How do you relate learning with clinical situations?
3. How do you feel the narrative-centred way of learning has linked to assessment processes e.g exams and assignments?
4. If you were asked to describe the Narrative Curriculum to a first year student how would you describe it?

Informing questions…. Mainly covered in first interview.

1. How does the narrative connect to what you already know?
2. Do you find yourselves reflecting on the stories?
3. How do you relate learning with clinical situations?
4. How are you thinking in clinical situations?
5. How are you feeling about being a student midwife?
6. How do you feel when you listen to women's stories?
7. How do you find yourselves listening to women's experiences?
8. How do you think about women's stories now?
9. How have the narrative sessions influenced your learning?
10. How do you find yourself learning from the stories?
11. In what ways has the way you learn changed?
12. How have the stories influenced your own learning goals?
13. Have you been exposed to the right amount of 'content' knowledge?
14. How do you feel about telling stories?

Appendix J: Template for Students' Written Reflections

When I heard the stories about getting pregnant today I was thinking...

Appendix K: Information for students' regarding written reflections

Dear midwifery students: Thank you for posting your reflections on today's narrative in this box. This exercise is a part of Andrea Gilkison's PhD study about midwifery students' experience of a narrative-centred curriculum. It is voluntary for you to participate in this exercise. If you choose to hand in your reflection it implies that you agree that your reflections may be used as data for analysis and future publication.

Thank you, Andrea Gilkison

Ethical approval for this research granted by AUTEC No: 04/222

Project Supervisor Contact Details:
Lynne Giddings
Auckland University of Technology
Ph. 917 9999 ext 7013
lgidding@aut.ac.nz

Appendix L: Excerpt from Researcher's Journal

7/2/05

Today I ran the tutor workshop for the narrative curriculum. Everyone came exceptone, even though they're not directly involved in the new curriculum.

It was supposed to start at 8.45am, but true to form we were late starting. The teacher who is teaching research came along and she was just great.

I'd spent 6 hours at work yesterday (Sun) preparing what I was going to do and writing a tutor guide. We went through that.

They were concerned about a few things –

1. The objectives, what to do if students don't cover them all, we debated whether students should see them on the day, later or not at all. I think we ended up agreeing that they needed to see them, but after they had gone through the PBL process themselves.
2. Long discussion about what to do if a student dominates the group, how to shut them up if they go off on tangents. Joyce was particularly worried about that.
3. Also concerns about whether students would challenge each other/evaluate/give feedback.
4. Didn't think they would get those objectives from the story (in the example)

Reflecting on the workshop, I think I was quite pleased about how it went, they certainly all got the idea, and thinking about it, the concerns that they have are very much what teachers in a PBL curriculum also have.

I got them to go through the process of sharing stories about how they learned to be midwives, trying to tease out about how students learn to think like midwives. It was good, but of course had to be shortened

because we were running out of time. They were a bit slow in coming forward with their stories which surprised me. Also, they tended to jump to analysis & get into 'how can we teach "them" to think?' kind of question, rather than really thinking about the stories we had heard. Even though none of us talked about 'numbers' or learning from books, teachers, they still kept going back to that conventional pedagogy.

The research teacher was really keen and is going to incorporate aspects into her classes. She wants them to find articles related to their learning objectives. She also wants to come to the narrative sessions.

I have the first interview/focus group with the year 2 teachers on Weds, arghhh I feel so nervous, yet they're all just so fabulous & supportive. Emma sent me this fantastic email with Cecily on it, saying " Cecily hesitated momentarily before signing the consent form, then said "what the heck" and signed it anyway. It really made me laugh. My supervisor thinks I should keep it as an appendix for the thesis!

Appendix M: Head of Midwifery/Programme Leader Participant Information Sheet

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Participant Information Sheet
For Midwifery lecturer participants

Date Information Sheet Produced: 1st May 2005

Project Title: The experience of a Head of Midwifery/Programme Leader in implementing a narrative-centred curriculum into an undergraduate midwifery programme.

Invitation: As you are a Head of Midwifery/Programme Leader and lecturer involved in implementing a narrative-centred curriculum into undergraduate midwifery education at Auckland University of Technology in 2005, you are invited to participate in this study which aims to document the experience of midwifery lecturers, students as we implement this new curriculum.

Who am I?
As you know, I am your colleague, Andrea Gilkison. I am a midwife, midwifery lecturer and part time PhD student. I completed my Masters degree in education in 2000, and have a strong interest in combining my two passions; midwifery and education through implementing an innovative new midwifery curriculum.

What is the aim of the study?
This study aims to document the experience of a Head of Midwifery/Programme Leader as a narrative – centred curriculum is implemented at AUT.

Who can be participants in the study?
Only yourself, the midwifery programme leader.

If you decide to participate what will it involve?
We will arrange to meet at a mutually agreeable time and place once or twice during semester one 2005 to discuss your experience as a manager specifically in relation to your involvement in implementing a curriculum which incorporates narrative pedagogy.

I anticipate that each interview will take approximately one hour. Our conversations will be audiotaped, and then transcribed. These tapes and transcripts remain confidential to my typist, my research supervisors and myself. It will be extremely difficult to protect your identity, but a pseudonym or false name will be used on all the tapes, transcripts and reports to offer some protection.

Copies of the transcripts will be available to you, and you will be invited to add further comments and delete any parts of the interview you do not want included in the study.

You may withdraw yourself or the information you have provided at any stage prior to the completion of the data analysis. At the end of the study the audiotape will be destroyed.

What will the risks and benefits be of participating in this study?
I do not anticipate any risks to you from this study. However, occasionally such interviews in which you share your personal thoughts and ideas can make a person feel unsafe. If you feel on reflection after the interview that you have said too much or exposed things that you wish you had not, you may delete any material you do not want to be included in the final work.

In the unlikely event that you were harmed in any way while taking part in this study, I can support you in seeking counseling through the AUT staff counseling services.

I hope that the benefits to you will be in contributing to the body of knowledge around narrative pedagogy, and that being a part of an innovative new midwifery curriculum will create a sense of satisfaction.

Your participation in the study is entirely voluntary. You do not have to take part in the study. If you do agree to take part you are free to withdraw from the study, including withdrawal of any information provided, up until the time when data analysis is complete. After that time it may be impossible to separate data from individuals. If you choose to withdraw you do not have to give a reason.

What will happen to the results of this study?
The final research will be published as a PhD thesis, which will be available in the Auckland University of Technology library and other libraries. Articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

How will your privacy be protected?
If you so choose, a pseudonym will be used during interview transcriptions, analysis and the written work. You may choose your own pseudonym and the researcher and the research group will be the only people who know your true identity. Any information with your name or contact details will be kept in a locked filing cabinet. Only yourself, the research group, my supervisors and myself will read the transcripts.

What are the costs of participating in the project?
The only cost to you that I envisage is your time. This could be up to 3 hours including interview times and time for reading transcripts. I appreciate that you are giving your time voluntarily. If expenses are incurred (e.g.parking), I will ensure you are reimbursed.

Opportunity to receive feedback on the research
On completion of the research participants will have access to a copy of the thesis and will be invited to a presentation of the findings. They will also be sent a report from the research.

Opportunity to consider invitation
Thank you for reading this information sheet and considering being a participant in my study. If you would like to be participate in this study, or have any questions regarding the study or your involvement, please contact me, or complete the enclosed consent form and return to me in the envelope provided. If you do not return the consent form I will assume that you do not wish to be a part of the study, you do not have to give a reason and I will not discuss it with you further.

Participant Concerns
Any concerns regarding the nature of this project should be notified in the first instance to my primary supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, 917 9999 ext 8044

Researcher Contact Details:
Andrea Gilkison
Ph: 917 9999 ext 7720
Mob: 027 4442865
Andrea.gilkison@aut.ac.nz

Project Supervisor Contact Details:
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Liz Smythe
Auckland University of Technology
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Liz.smythe@aut.ac.nz

Ethical approval for this research granted by AUTEC No: 04/184.

Appendix N: Head of Midwifery/Programme Leader Consent Form

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Consent to Participation in Research

Title of project: The experience of a Head of Midwifery/Programme Leader in implementing a narrative-centred curriculum into an undergraduate midwifery programme.
Project supervisor: Lynne Giddings, Liz Smythe
Researcher: Andrea Gilkison

---

* I have read and understood the information sheet provided about this research project (dated May 1st 2005)
* I have had an opportunity to discuss this study. I am satisfied with the answers I have been given.
* I understand that taking part in this study is voluntary. I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
* I have had time to consider whether to take part.
* I consent to the group discussions being audiotaped and transcribed.
* I wish to receive a copy of a report from the research.

Participant signature: ……

Participant name: ……

Date: ……

Ethical approval for this research granted by AUTEC No: 04/184.

Appendix O: Data Categories

Category Data Art v Science

ERICA(Student Sem 1 Gp 1 p2)

And the other thing, I don't know if anybody else has found it, but often with the objectives you come up with in the tutorial group, they lean more towards the art side of the paper, taking the art from the story, whereas if you look at the core objectives it is the science, and the narrative just does not help with the science.

CHLOE(Student Sem 1 Gp 1 p4)

But I mean we do have to learn about how a woman responds to these things, and that is an important aspect of the art side of it, but I just feel like the narrative is great for the art, it really is, it starts conversation, it does all that. But the science -

Interviewer: So is it the content side that you think needs to be –

ERICA (Student Sem 1 Gp 1 p5)

I almost feel the art and science needs to be two separate papers. Just to do the art, have that in a separate paper, and have essay assessments, and however many essays they want, but have that as a whole separate thing, so then you can concentrate on the science, and actually have lectures, and for God's sake teach it.

DONNA(Student Sem 1 Gp 1 p7)

The trouble with the narratives is they are women's experiences, and they are normally social side, whereas what we seem to be fighting with the curriculum is the physiological side and the practice side, and as far as the experiences are helping it is great to have that understanding of how the woman is getting on with whatever subject it is, but when you come back to what we are trying to study it doesn't help.

AGNES(Student Sem 1 Gp 1 p7)

It doesn't work for the science.

GERALDINE

It doesn't.

DONNA(Student Sem 1 Gp 1 p7)

So I think, like you, I think we should have done maybe the narrative art side of it now, and assignments for it, and then the physiology and anatomy and all the physical side of it in another paper where it was a lecture structure. So we *knew* what to study, because they do not relate to each other..

CHLOE(Student Sem 1 Gp 1 p8)

Although, like this is just running through my head now and I haven't actually thought about this, but we had Annie's day and then an exam, and I think it is, the essay would be art stuff and the exam is the science stuff, it doesn't matter if they do it at the same time, what it comes down to is teach us the science, actually teach us the science, tell us, don't say go out and find out what the normal blood ranges are, tell us. That is safty, we have to know that, we need to be safe.

CHLOE(Student Sem 1 Gp 1 p11)

I think it could be. I think it could be, if you separated out the science stuff, and the science side of it can't be done in narrative. Like the breastfeeding paper, right, because that was narrative as well, and we had the story and the lovely story on the first day… but then we had a whole bunch of lectures, we had great lectures that talked about the composition of the breast, and made it really clear what we needed to know. I feel fine about that paper. If I do the work, and I know what I need to do, then I will be great.

FREIDA(Student Sem 1 Gp 1 p14)

Yes, the relationships more than the science part, the art part, for me it is really hard, yes, because the science part I really like to have something detailed written

down how much should be the blood sugar, or how much should be the HB, or these things details so that in the clinical I can apply.

CHLOE(Student Sem 1 Gp 1 p15)

Whereas the other side of the science stuff, which is placenta and foetal interaction, physiological changes in pregnancy, those things, what level are we going to be going to, renal changes in pregnancy, do we need to go to the fact that there are some? Do we need to go to what they are? Do we need to go to how they happen, or do we need to go into what would stimulate that to happen, and how and when. There is a huge range there, but basically we are all crossing our fingers that we study to the right level, and when we go to the exam we will find out whether we have or not.

ERICA(Student Sem 1 Gp 1 p20)

I still think it comes to the separation between the art and the science.

DONNA(Student Sem 1 Gp 1 p20)

They tell a story about a specific event, in whatever period, and within midwifery I suppose, and we are expected to come away from that and learn from it. I can remember the story but I cannot see how it relates to what we are supposed to be doing in midwifery.

AGNES(Student Sem 1 Gp 1 p20)

I have forgotten the stories, I am too busy concentrating on the science….

DONNA(Student Sem 1 Gp 1 p20)

That is what I mean, I do not understand how that narrative is supposed to be a narrative curriculum, because they were just a couple of stories we were told, and then they moved us straight onto objectives.

ERICA(Student Sem 1 Gp 1 p20)

And again it is the separation between the science and the art.

Interviewer: So it is the partnership thing, the partnership model?

GERALDINE (Student Sem 1 Gp 1 p21)

Well, not really. I think it is more art than science. It is all about art, which is normal life.

AGNES (Student Sem 1 Gp 1 p24)

We are not going to ask the person who comes in to tell their story about scientific stuff, they are a consumer, they do not know that stuff. I am not going to put my hand up and say to this woman, what do you think the physiological signs in the hormones were behind you getting pregnant. I mean, she is going to say, what the hell, what are you talking about. And I would say well do you know how your placenta developed? Does she really have to know the answer?

CHLOE (Student Sem 1 Gp 1 p24)

But we do need to be able, and I think it does enable us to having them together, is we need to link up their social, why is this woman crying on the third day after birth, you know, there is a physiological and an emotive tie in there, and we do need to link the science, the understanding of the science so that we can then with the art, deal with it.

Cross talk (Student Sem 1 Gp 1 p25)

Once again, we said that the narrative was not teaching us the science.

CHLOE(Student Sem 1 Gp 1 p25)

You know how just in this last week and with those shock sessions with Lynne, right,

okay, how many stories has she thrown into that, that just makes sense of the science, and that is where narrative designs can work really well together. Here is the science, and here is a story.

AGNES (Student Sem 1 Gp 1 p25)

We have completely turned around, before we were saying art and science.

CHLOE(Student Sem 1 Gp 1 p25)

But it is not story to science, it is science and a story that backs that up, and that triggers it for you. So Lynne told us this is what happens in a hyperglycmic shock, now that woman whom she found lying on the floor wedged between the toilet, who is going to forget that. You are not going to forget that and it reminds you that everything she said before about hyperglycmic shock.

AGNES(Student Sem 1 Gp 1 p25)

Midwifery Practice I, in the first semester last year, that is a science paper, really, it has a bit of a mixture of both, and we had Judith and Claire telling us their experiences, and that worked fantastically well, didn't it?

Yes, I agree…**general agreement**

ERICA(Student Sem 1 Gp 1 p27)

And so I feel like I am a broken record here, but again it comes back to the science, the exam is going to be the majority of it around the science, and okay the critical thinking and applying it and everything like that, but you still to be able to apply it and critically think you have to know the science. So I feel it is a vicious circle.

AGNES(Student Sem 1 Gp 1 p32)

But we do ask the questions about what she expected from her midwife, they have been asked, but it still does not give you the science. Because she is still the

consumer, she still hasn't got the knowledge that we are expected to hold. It is layman's terms really.

AGNES(Student Sem 1 Gp 1 p33)

Yes, the women's stories unfortunately do not relate to the scientific side, which is the higher percentage of the content of this paper.

Right.

AGNES(Student Sem 1 Gp 1 p33)

Unfortuntely the women's stories, they just do not correlate unfortunately, they work with the art.

FREIDA(Student Sem 1 Gp 1 p34)

I find that the stories helped me in the art part, not the science part.

DONNA (Student Sem 1 Gp 1 p7)

So I think, like you, I think we should have done maybe the narrative art side of it now, and assignments for it, and then the physiology and anatomy and all the physical side of it in another paper where it was a lecture structure. So we *knew* what to study, because they do not relate to each other..

EFFIE(Student Sem 1 Gp 2 p14)

I agree with you, I think it is really valuable, but for me I would prefer to have them separate the art and science and have it two separate papers, because I think what you have said, it is really valuable having these stories for us to listen to them and keep our focus on the woman but I would prefer to have the science part taught as science.

ERICA(Student Sem 2 Gp2 p3)

Because again it comes down to that art and science split, and the exam was the science, and I mean I still feel I cannot learn science from the narratives, and they

have taken that on board this semester and they are giving us the science more in lectures.

CARMEL(Student Sem Gp2 p1)

It is almost like they need to separate the art and the science, because the stories are really good, and I think it is really nice that these women want to come in and share, but that just does not work for science for me. I don't see how women's stories can help me understand how the placenta grows, because she does not know how the placenta grows, and if I was to say to her please explain to me from your story placental development, she would not be able to tell me that, but I mean she can tell me all about the interaction, and how important it is to have a relationship with your midwife, but that is art, not science.

CARMEL(Student Sem 1 Gp 2 p7)

Especially next semester when this paper continues, I mean I am sure that half of the stuff that we are finding is relevant for this half of the paper and the rest of it is more relevant for the next half, because next semester, I think that is when we start embryology, and I am buggered if I know how the woman's story is going to help me understand embryology, you know what I mean? I sort of think, for the real real science part like that, I do not really know how it is going to work.

Appendix P: Student guide to Narrative-Centred Curriculum

Auckland University of Technology
School of Midwifery

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Student Guide to Narrative-Centred Curriculum

Semester 1 2005

Art & Science of Midwifery I

Overview:

We have called this paper the *Art* and *Science* of midwifery because we believe that midwifery is both of these things. Science underpins our midwifery practice, it includes our knowledge of anatomy, physiology and biosciences. This science becomes useful to us only when we practice the *art* of midwifery, which is how you put your knowledge and skills into practice when you are working with women and their whanau when they are welcoming a new baby into their lives.

This paper will develop your knowledge base and skills for midwifery care related to '*normal'* childbirth and the '*normal*' neonate within the model of partnership.

This paper is divided into 5 main topics:
Getting pregnant
Being pregnant
In labour and giving birth
After the birth and the newborn baby
The woman who has had surgery (Direct entry midwifery students only)

This year, we are introducing a new way of learning in the form of a 'narrative centred curriculum'.

Narrative-centred Curriculum

What does this mean?

A narrative-centred curriculum is all about learning through stories. You will be hearing lots of stories this year from women, other students, your lecturers and other midwifery practitioners.

Rather than *us* deciding what *you* need to know about normal pregnancy, birth and the postnatal period, with this way of learning you will be much more self directed in deciding what learning you need to do, based on the stories, or narratives you hear.

Each of the main topics will begin with a story or 'narrative' session. Sometimes we will invite women in to tell their stories, you will also be invited to tell your stories (if you want to) and one narrative we have is a 'digital narrative'. Learning this way, involves listening to the stories and really thinking about what is being said (or not said), and thinking about what is important about each story you hear.

After each narrative session you will be dividing into tutorial groups, each with a teacher. In your tutorial groups you will all be encouraged to discuss the story you have just heard and to go through a process of:

- identifying the main issues which arise from the story
- discussing what you as a group already know about these issues (identifying your prior knowledge)
- deciding on a list of questions (learning objectives) which you will each work on for the week

A teacher will be there to guide the group process, and to make sure that you are covering the 'core' objectives for the topic. These will also be included on the online information for each topic. DON'T WORRY if your group's objectives are different to others – it is important that *your* group decides what *your* learning objectives are, based on what you have discussed as the key issues and what you already know about the topic. We will be monitoring what each group covers and will put these online for everyone to see. If you don't cover something with one story it is highly likely it will come up in another story, and a teacher will be there to guide you so you don't go off on complete tangents!

You will then go off for the week to find out the answers to your group's learning objectives. We will be making an extensive effort to support your learning through:

- online learning
- lectures
- tutorials
- demonstration rooms

You will also need to make good use of:

- the library – be familiar with finding books and journals (using the electronic databases is a must)
- the internet
- community organisations
- practitioners you meet in clinical
- women you are involved with
- EACH OTHER

At the end of each week of learning you will meet back with your tutorial group to go through your group's learning objectives share and discuss what you have learned. This is an opportunity for you to share and discuss different sources of information and to help each other to understand the topics you have been studying.

As this is a new way of learning we will be asking for your feedback frequently.

We need to know what is and isn't working for you. Please tell us!!!

We will be evaluating each narrative by asking you to write a 'one minute reflection' at the end of each narrative session. This is **anonymous** and **optional** for you to do it. If you choose to write it you will be asked to put this into a box in the classroom. These will be read by us as teachers because it is our way of seeing what is being effective. What you write may also be used as a part of Andrea Gilkison's PhD research, so could be published in articles or presented at conferences. More information about this will be given to you.

You will also be given the opportunity to participate in a focus group to discuss this way of learning mid way through the semester and at the end of the semester. These groups will be organised by a research officer who is not involved with teaching you. More information and consent forms will be given to you by someone who is not actively involved with the midwifery programme.

We hope you will enjoy learning this way, and remember we are here to help and support you.

Appendix Q: Tutor Guide for Narrative-centred curriculum

Auckland University of Technology
School of Midwifery

AUT
AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Midwifery Lecturer Guide

Narrative-centred tutorials

in

Art & Science of Midwifery I

526914

Semester 1 2005

Art & Science of Midwifery I

Overview:

We have called this paper the *Art* and *Science* of midwifery because we believe that midwifery is both of these things. Science underpins our midwifery practice, it includes our knowledge of anatomy, physiology and biosciences. This science becomes useful to us only when we practice the *art* of midwifery, which is how knowledge and skills are put into midwifery practice.

This paper develops students' knowledge base and skills for midwifery care related to '*normal'* childbirth and the '*normal*' neonate within the model of partnership.

This paper is divided into 5 main topics:
Getting pregnant
Being pregnant
In labour and giving birth
After the birth and the newborn baby
The woman who has had surgery

This year, we are introducing a new way of learning in the form of a 'narrative centred curriculum'.

Narrative-centred Curriculum

What does this mean?

A narrative-centred curriculum is all about learning through stories. Each of the topics above will be introduced with a narrative, or story. This is timetabled as a 'narrative session' where we will be sharing stories told by women who have offered to come in,

from the students themselves, our stories, other midwives and one narrative we have is a 'digital narrative'.

For example, the first topic 'getting pregnant' (which covers early pregnancy topics), students will be invited to share their stories of their own or a friend/ mother's/sisters experience of getting pregnant, how they found out, how they felt about it, how they felt physically…whatever they wish to share.

After each narrative session students are divided into 4 tutorial groups, each with a teacher. In this tutorial group students will all be encouraged to discuss the story they have just heard and to go through a 'problem-based learning' process of analysis, in order for each group to decide on what their learning objectives will be for this topic.

Rather than *us* deciding what students need to know about normal pregnancy, birth and the postnatal period, with this way of learning students will be much more self directed in deciding what learning they need to do, based on the stories, or narratives they hear, and the analysis that their groups go through.

Obviously there are still a set of 'core' objectives which we do expect that as midwifery students they will need to cover. These will be available for all students to see on the online part of the course. The 'core' objectives tend to cover straight content knowledge that students need to know. Some groups will already know some of these objectives so do not need to cover them, and I would expect that groups will derive more objectives, perhaps exploring women's experience, or specifically relating to the stories they have heard. We will be monitoring each group's learning objectives, and will put these online for everyone to see.

Tutorial groups: how will they work and what do we as lecturers do?

As teachers our role is to guide the group process, to guide the group through the problem-based learning process of analysing the story, to make sure that students don't go completely off track, that no-one dominates the group and that all students participate. It is important that each group decides what their learning objectives are, based on what they have discussed as the key issues and what they already know about the topic.

Learning this way, involves listening to the stories and really thinking about what is being said (or not said), and thinking about what is important about each story. The emphasis is not merely on sharing/hearing a story but on collectively interpreting the meaning and significance of the story. The first step therefore is for the group to think about the stories and to try to interpret the meaning of what has been said.

Here are some things which will help us to think about when we are listening to, and interpreting stories:

- The idea is that we 'practice *thinking*' in tutorial groups. The teacher does not provide answers, rather the emphasis is on the teacher and students learning to interpret situations by discussing what they are *thinking* when they hear a story.

- Stories go in circles. They don't go in straight lines. So it helps if you listen in circles because there are stories inside stories and stories between stories and finding your way through them is as easy and hard as finding your way home

- Any story includes what is *not* said as well as what *is* said

- Be willing to listen to your own stories as you hear those of others

- Be open to the possibility of anything showing up… (Not easy to accomplish because of our tendency to see events or objects as things which that already have meaning, as things we already understand…well known problem that we do not always see what is there or that we can often be lured into seeing something that does not exist because we assume too quickly that we understand the problem)

- Stories join the worlds of thought and feeling. They connect the storyteller's experience of pregnancy, birth with their feelings- feelings of joy, sadness, aloneness, anger. They acknowledge the centrality of affect and subjectivity in human ways of knowing.

- Look beyond the surface; a range of possible meanings accompanies each word, sentence and text that extends the range of possible experiences; what stands out in every story is what is meaningful to the listener and to the teller.

- Words matter – think about the words the storyteller uses. The words chosen indicate attitudes, beliefs and hold hidden meanings. e.g. "they had to tell me when to push"

- Listening requires cognitive, emotional and intentional presence- notice and understand nuances of language, actions, silence, rhythm, theme and to the meaning invoked.

- Listen to range of voice, variations of speech, tones and textures, sounds of joy and anger, mixture of sadness and laughter, the edgy, uncertain words of fear, the myriad facial and body expressions…the lengthy silences and continuous stream of words and all the ups and downs of ecstasy and misery

- Listen to metaphors; the "contractions were like waves", "contractions were like hell" what do these metaphors tell us about the experience…why the differences??
- Think about similarities and differences between the stories (if there are more than one)

Example of a story & how it could be analysed

Mary Jane is 24. She comes to see you in your antenatal clinic because she has just done a home pregnancy test which shows she is pregnant. She is in floods of tears. Mary Jane tells you that she already has 4 boys. The youngest one is with her, he is 1. She says their house is too small, 3 small bedrooms, so the boys double up in bunks, but the 1 year old usually ends up in their bed because he wants a feed to go to sleep and then in the morning. She has no idea where a new baby could go. Her husband works but doesn't earn much so they get family support, but even now they have problems paying the bills, and can't afford to get the car fixed so she has to get the bus to go anywhere. It's not easy with 4 kids, then carrying the shopping home again…

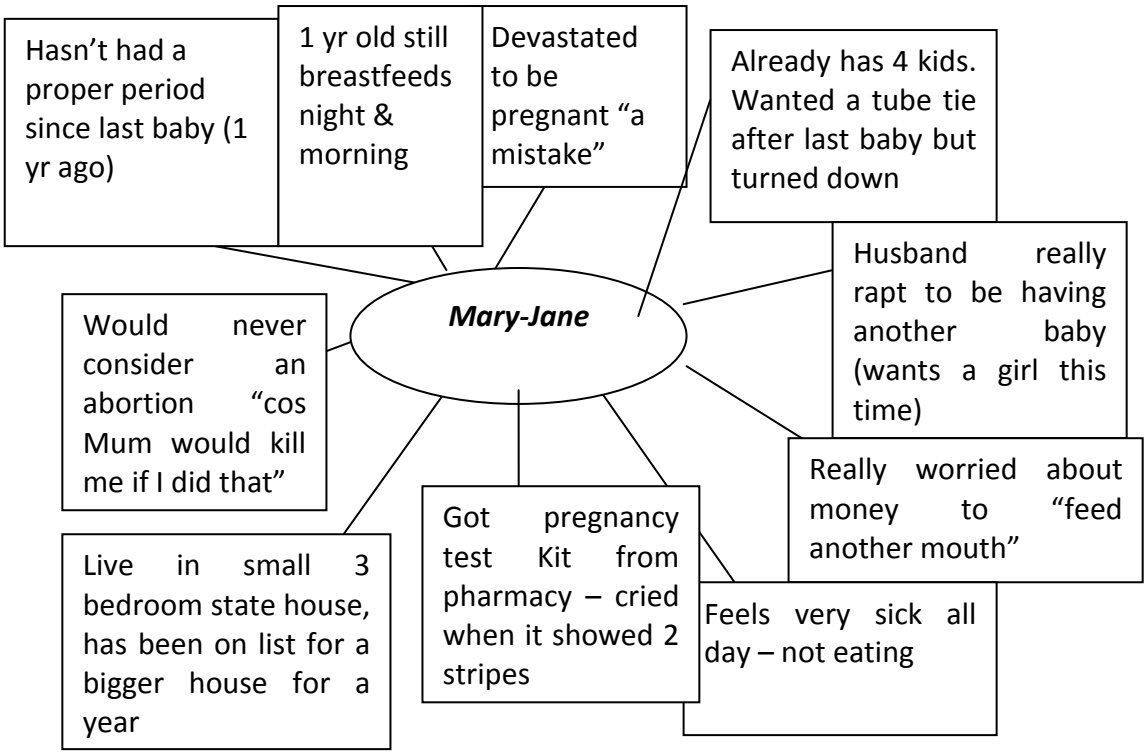
She thought of 'getting rid of it', but her husband would never agree, he wants a girl this time, and anyway her Mum would "kill her" because she doesn't agree with abortions. She says she's feeling really grotty, not chucking up, but feels sick all day and can't eat. She has no idea when she got pregnant, she thought she'd be safe because she hasn't had a period since the 1 year old was born. She really wanted to have her tubes tied after no.4 baby but they said she was too young.

Once the students feel they have discussed their interpretations of the story/ies, move on to the next step of the process which is based on a problem-based learning approach. This is a shortened 3 step approach

- **ANALYSE THE STORY**: identify the main issues which arise from the story
- **EXPLORE THE ISSUES:** discuss the issues & decide what they already know about these issues (activate prior knowledge).
- **FORMULATE LEARNING OBJECTIVES:** decide on a list of questions (learning objectives) which they will each work on for the week.

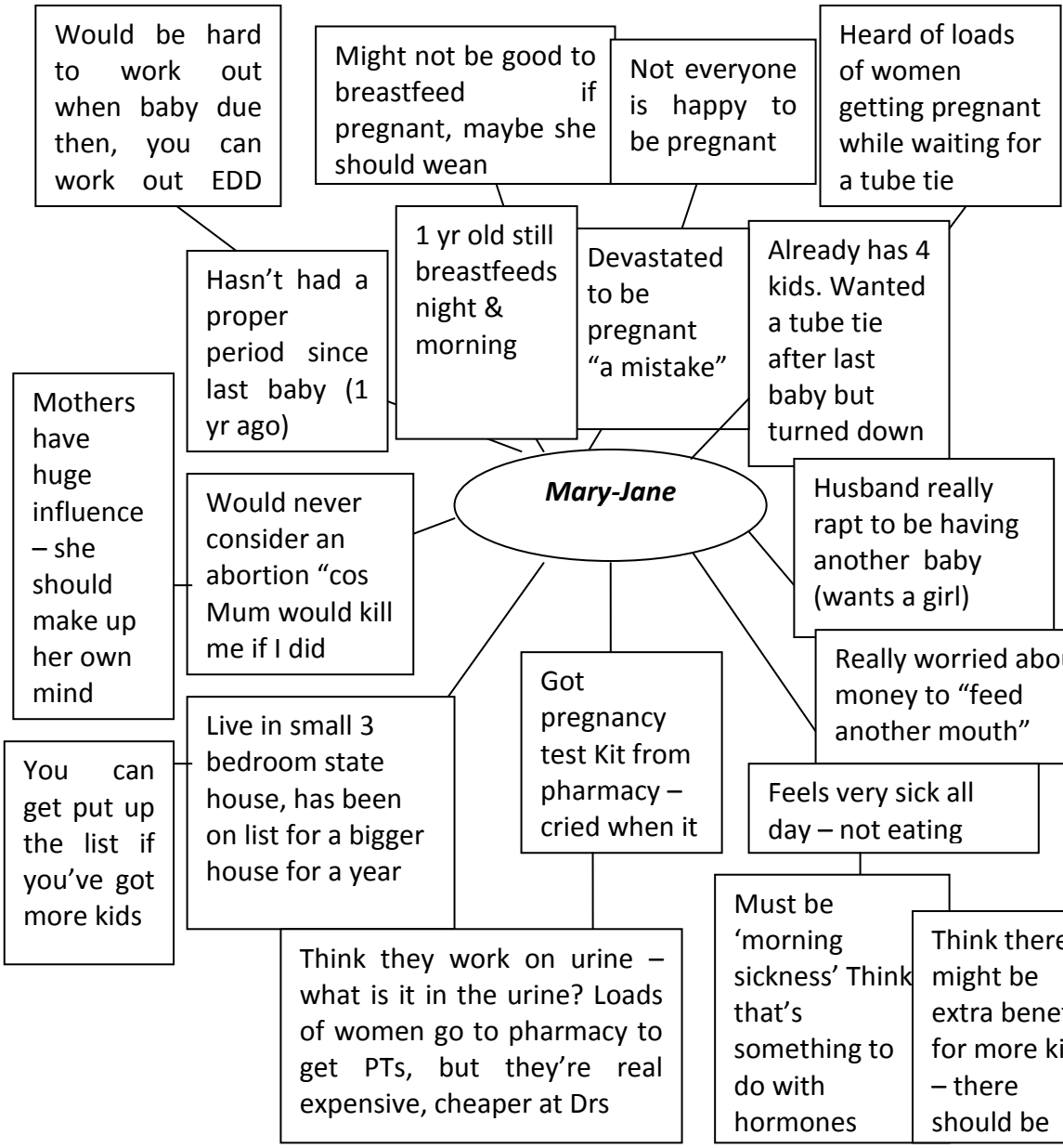
1. ANALYSE THE STORY

To analyse the story one of the students volunteers to be the 'scribe'. The group will 'brainstorm' the story, saying whatever comes into their mind about the story. On the whiteboard the scribe will write down what everyone says, creating a 'mind map'. It might look something like this….



2. EXPLORE THE ISSUES

The group then discusses what they have put up on the board. They can decide to rub things out if they think they are irrelevant. They tease out the issues on their mind map, thinking about what they already know & understand about the topic. For example the mind map may look like this after exploring the issues and activating prior knowledge.



3. FORMULATE LEARNING OBJECTIVES

The group then needs to work around their mind map and create a list of learning objectives that they will work on. Learning objectives need to be written as questions which are answerable. This will make it much easier for their self-study. Objectives which might arise in this case could be…

1. What is morning sickness caused by? Why do some women get it all the time, and is this bad for the baby?
2. How do pregnancy tests work? Can midwives do them for free? Why would women prefer to do a home pregnancy test kit?
3. How could a midwife help Mary Jane to get a bigger house and extra benefits? Is it the midwife's role to do this?
4. Can/ should midwives offer to refer for abortions?
5. How do women come to decisions regarding getting pregnant or whether they will keep the baby? What would influence their decisions?
6. How do you work out when a baby is due from a period? What does a midwife do if the woman doesn't know when her last period was?
7. Should you still breastfeed when you are pregnant? What effect would it have?
8. How do they decide if a woman can have her tubes tied?
9. How is a boy or girl baby created?

You will note that these objectives are similar, but not exactly the same as the 'core' objectives for the 'getting pregnant' topic (shown below). This really does not matter. It is important that students have confidence in their own learning objectives. They will probably need to understand the 'core' objectives to answer most of their questions anyway. If they don't cover them this time, they are bound to come up in a future date. If not, they can always come back later and check that they have covered the 'core' objectives.

Getting Pregnant

Expected 'core' objectives for this topic are:

1. What are the hormones of a normal menstrual cycle, and how do they relate to the phases of the menstrual cycle?
2. What is the ovarian cycle?
3. What is oogenesis & spermatogenesis?
4. How do conception and fertilisation occur?
5. What are the hormonal changes which occur in early pregnancy?

6. What are the tests and investigations which may be done in early pregnancy?
7. What are the major structures of the female reproductive system?
8. What are the signs and symptoms of pregnancy?
9. What is the midwife's role in early pregnancy? (Include pregnancy testing & dietary advice)

At the end of this session, check that the group has an idea where they can find the answers to the questions. They may like to delegate some of the more straightforward questions to one person, e.g. one student could ring up WINZ to find out what housing benefits are available, another could ask a midwife if she is able to do pregnancy tests. On the whole though, every student should cover every objective, especially if it involves learning something like hormones of pregnancy for example, which they all need to understand.

Students then go off for the week to find out the answers to the group's learning objectives. We will be making an extensive effort to support their learning through:

- online learning
- lectures
- tutorials
- demonstration rooms

They will also need to make good use of:

- the library – be familiar with finding books and journals (using the electronic databases is a must)
- the internet
- community organisations
- practitioners they meet in clinical
- women they are involved with
- EACH OTHER

At the end of each week of learning you will meet back with your tutorial group to go through the group's learning objectives and to share and discuss their learning. This is an opportunity for students to share and discuss different sources of information (e.g. why a textbook might say one thing and an article something different) and to help each other to understand the topics they have been studying. Go through the objectives one by one, and try to ensure that everyone contributes (without going round the table one by one). Encourage students to explain things to each other if someone doesn't understand something, this really helps them to learn.

At the end of this session, ask the group to evaluate:

a) How they feel they have met the objectives
b) Are their any 'holes' that they need to work on?

c) How they have worked together as a group
Also, write down your group's objectives so they can entered online under each group.

'Core' Objectives for the first 4 topics (these are on the online Art & Science under each topic):

Getting Pregnant

1. What are the hormones of a normal menstrual cycle, and how do they relate to the phases of the menstrual cycle?
2. What is the ovarian cycle?
3. What is oogenesis & spermatogenesis?
4. How do conception and fertilisation occur?
5. What are the hormonal changes which occur in early pregnancy?
6. What are the tests and investigations which may be done in early pregnancy?
7. What are the major structures of the female reproductive system?
8. What are the signs and symptoms of pregnancy?
9. What is the midwife's role in early pregnancy? (Include pregnancy testing & dietary advice)

Being Pregnant

1. What are the hormonal changes that occur in pregnancy?
2. What are the changes to occur to a woman's reproductive system during pregnancy?
3. How do the placenta and fetus develop and inter-relate?
4. What are the changes that occur in the cardiovascular system, the respiratory system and the renal system in pregnancy?
5. What are the 'minor' discomforts of pregnancy and what advice can a midwife give a woman about these?
6. What tests and investigations are done in pregnancy, why are they done and what are the normal results?
7. What is the midwife's role during pregnancy? (Include choosing an LMC, 'booking' visit, antenatal assessment)

When students are working on the 'Minor discomforts' it might be an idea to direct them towards this sort of format (these are under 'Being Pregnant' online)

When you are working on your groups learning objectives around the 'minor' discomforts of pregnancy, think about the following issues...

a) **Cause of the symptom**
b) **Effect on the woman**
c) **When the problem is likely to present during the pregnancy and how long it might continue**
d) **Differential diagnosis as to whether the complaint is 'normal' or whether it requires referral.**
e) **'Natural' type remedies and strategies that might assist the woman to cope with the discomfort**
f) **Possible pharmaceutical or medical treatment where indicated**

The 'discomforts' to be discussed may include the following; your group might like to divide these between you and put together a booklet for everyone

Nausea and vomiting
Urinary frequency
Urinary tract infection
Fainting
Heartburn
Ptyalism
Pica
Palpitations
Breathlessness
Constipation
Haemorrhoids
Varicosities
Oedema
Carpal tunnel syndrome
Fatigue
Emotional changes
Backache
Symphysis Pubis pain
Leucorrhoea

In Labour and Giving Birth

1. What are the bones, ligaments, diameters of the female pelvis, and how do they relate to childbirth?
2. What does the pelvic floor consist of, what are the muscles and ligaments and how do they relate to childbirth?
3. What are the structures and diameters of the fetal skull and how do they relate to childbirth?
4. What are the 3 stages of labour, what is happening physiologically, and what is the midwife's role in each of the stages?
5. How does the mechanism of labour and birth happen?
6. Why does pain happen in labour, how to women cope and what is the role of the midwife in working with pain?

After the birth & the newborn baby

1. How does a newborn baby adapt to extra-uterine life?
2. What are the assessments and care a midwife makes of a baby at birth and throughout the postnatal period. (Includes Apgar scoring & assessment up to discharge at 4-6 weeks)
3. Why is vitamin K offered to newborn babies and what is the role of the midwife regarding this?
4. What are the issues around immunisation of babies and what is the role of the midwife with regard to this?
5. What is the normal process of physiological changes for the mother in the postpartum period?
6. What are the assessments and advice a midwife gives to a woman in the postpartum period from birth up to discharge at 4-6 weeks?

With acknowledgements and thanks to:

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Whose advice, experience & work has formed the basis of this curriculum

Appendix R: Example scenario based examination questions

Maria is a 29 year old primigravida who is 12 weeks pregnant. She has asked you to be her Lead Maternity Carer (LMC). At Maria's booking visit you ask her to have her booking blood test. Maria asks you what the blood test is for.

1. Discuss your reply to Maria. INCLUDE your description of all the tests which are included in the booking blood test, and the information you will give Maria.