# Student Midwives' Experiences of Clinical Placements in Secondary and Tertiary Hospitals

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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 acknowledgments), 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.

Signature…………………………………………………                     Date……………………

# Acknowledgements

# Abstract

Ideally, clinical placements in secondary and tertiary hospitals provide appropriate opportunities for midwifery students to learn clinical skills and develop confidence in the provision of midwifery care. Midwives play a key role in the support and nurturing of students in this environment. But what is the student midwife experience like?

This research study examines 'student midwives' experiences of clinical placements in secondary and tertiary hospitals'. The methodology employed was an interpretive descriptive approach developed by Thorne, Reimer Kirkham, and MacDonald-Emes. Eight second and third year midwifery students were interviewed and asked about their experiences of clinical placements in secondary and tertiary hospitals. The participants' stories were analysed and interpreted, and research findings produced experiential dimensions of the student midwife experience.

Four experiential dimensions emerged from the data: a sense of belonging, the opportunity to learn, challenges in clinical placements, and having confidence. The findings suggest that student midwife clinical placement experiences occur on a continuum ranging from being supported and nurtured by midwives, to negative experiences where obstacles were present and confidence and learning were challenged.

A sense of belonging to the team and the profession was important for the participants. Being welcomed and wanted in clinical placements often set the scene for students. In order to belong participants worked to fit in with the midwife, which sometimes came at a cost to the student. The opportunity to learn was orchestrated by the participants themselves, and the midwives and women the participants worked with. Learning in an environment affected by institutional constraints, such as high acuity and staff shortages impacted on student learning. Participants faced multiple challenges in clinical placements. They had to deal with reluctant midwives and feeling, at times, a burden to the midwives. Sometimes the working environment was unsupportive and participants were party to questionable practice which caused consternation. Self-confidence was the starting point from which participants entered clinical placements; this was sustained, empowered, or challenged further by the woman and midwife.

The one factor present in all these findings was that the midwife is significant to the experience of the student midwife. While the student has a role to play in the shaping of her learning experiences in clinical placements, it is the midwife that takes the major role as conductor of those experiences. Discussion of the findings revealed two key messages: the importance of continuity of the midwife and the need to support the midwife. While relevance to the student midwife and the research question may appear distant, these key messages directly address the circumstances that surround the student midwife experience. Continuity of midwife would optimise learning opportunities for the student and foster socialisation into the midwifery profession. For learning to be facilitated in the institutional setting, attention must be directed to the working environment of the midwife and her role as a preceptor to students. It is anticipated

that this research study will have the potential to benefit both midwives and the educative experience of future student midwives.

# Chapter One: Orientation to the Study

## Introduction

The aim of the research study is to gain an understanding of the student midwife experience in secondary[1] and tertiary[2] hospitals in New Zealand. While there is research on student midwives' experiences from overseas in the literature, there have been no studies, to date, that have researched the experience of New Zealand student midwives. This qualitative study will offer an interpretive description of the experiences of eight student midwives in New Zealand. It is envisaged the findings of the study will have an application potential and provide a basis from which the student midwife experience can further develop.

This chapter will outline the research question, the background of the study, and the regulatory requirements of midwives and students in New Zealand. The impetus for the study and my own personal context in relation to the study are revealed.

## Research Question

What are student midwives' experiences of clinical placements in secondary and tertiary hospitals?

## Methodological Approach to the Study

This qualitative study uses the research approach of interpretive description developed by Thorne, Reimer Kirkham, and MacDonald-Emes (1997). The methodology and methods employed in this research study are detailed in Chapter 3.

## Background

In pre 1900 New Zealand, both Māori and European women were usually assisted at birth by informally trained attendants who had developed their skills typically through an apprenticeship model of learning. Apprenticeship can be described as an experiential and participatory way of learning by a neophyte from a person with experience (Davis-Floyd, 2001). European women relied on the services of these attendants, usually known as *lay midwives* or *handy-women*— often women who had had babies themselves, and had been present at the births of family or friends (A. Clarke, 2012; Papps & Olssen, 1997). Some lay midwives had worked with other midwives or a general practitioner (Donley, 1986; Stojanovic, 2010). There were a few trained midwives (mostly from Britain) who attended women (Donley, 1998); however, their attendance was not readily available, so most women were attended by a neighbour or relative (Hill, 1982).

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[1] A secondary hospital refers to a hospital that provides 24 hour acute services, including (but not limited to) general medical and surgical services, diagnostic facilities, and speciality services such as maternity, paediatrics and community care (Ministry of Health, n.d.).

[2] A tertiary hospital is a hospital that provides all the services of a secondary hospital plus a greater number of specialised services including sub-specialities, public health services, primary response services, and forensic mental health units (Ministry of Health, n.d.).

Missionary wives often felt the need to undertake midwifery training in Britain prior to travelling to New Zealand; not in order to provide skilled assistance to Māori, but to be able to cope with childbirth themselves if required (A. Clarke, 2012).

It is somewhat unclear from the literature who attended Māori women in labour (Hill, 1982). Status and tribal custom afforded Māori women differing birthing experiences (Papps & Olssen, 1997). Māori women of status birthed with attendants present while lower ranked women birthed alone (A. Clarke, 2012). Māori attendants were likely to be a relative of the labouring woman (Biggs, 1960; Papps & Olssen, 1997), although it was not uncommon for a change of attendant during a difficult birth (Biggs, 1960). Husbands and whānau[3] were generally present though their role is vague—as a support to the labouring mother or partaking in a more formal role (Hill, 1982). For younger whānau, presence at a birth would provide a learning platform to be developed at later births and at their own births. The role of men during a woman's labour is ambiguous. A. Clarke (2012) commented that husbands were sometimes the first choice of birth attendant to the labouring woman; however Papps and Olssen (1997) suggested that while men (including husbands) were often present their role was not well defined. Regardless of the gender and relationship of the attendant to the women, it is clear from the literature that the attendants at a birth were knowledgeable and skilled (Donley, 1998). Donley (1998) wrote of a typical Māori lay midwife who learnt the art of childbirth from her mother, subsequently birthed her own babies and then supported other women to birth.

While many of the 'midwives' attending women were competent to practice, others were not (Hill, 1982). Grace Neill's experience of administration in charitable work led her to the conclusion that many working men's wives were (if not attended by unskilled neighbours), at the mercy of "ignorant and often unscrupulous women practising as professional midwives" (Neill, 1961, pp. 49-50). Dr Kenneth Pacey (cited in Hill, 1982) commented that "many were incompetent, dirty and dangerous" (p. 25). However Hill (1982) argued that many of the untrained 'midwives' became experienced and skilled at their profession.

Neill (Assistant Inspector of Hospitals 1895-1906) had been instrumental in the registration of nurses in New Zealand in 1901 and was keen to enable registration of midwives. Concurrently, the government of the day had concerns of falling birth rates among white middle class women and the New South Wales Royal Commission was tasked to address this issue. Among the subsequent recommendations were improvements to maternity practice and facilities. Neill, in partnership with the then Prime Minister Richard Sneddon, decided that this was an excellent opportunity to push forward with both midwifery registration and education (Donley, 1998).

As the architect of the Midwives Act 1904, Neill believed that registration of midwives and the creation of a training programme would address concerns regarding birth and mortality rates, as well as standards of care and aptitude of attendant (Donley, 1998; Neill, 1961; Pairman, 2006). Midwives would be educated and taught in hospitals. According to the Midwives Act

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[3] Whānau is a Māori word for extended family

1904 student midwives would be instructed by means of lectures and practical teaching, and by a period of midwifery work.

While legislation-directed training and registration for New Zealand trained midwives did not eventuate until after the passing of the Midwives Act 1904, there is evidence of hospital based certification for 'midwives' prior to this time. Dr MacGregor (Inspector of Hospitals), in his 1896 report on Hospital and Charitable Institutions of the Colony, reported concerns over Auckland Hospital granting of midwifery certificates based merely on theoretical knowledge (Hill, 1982; Maternity Services Committee, 1976). Given the exclusivity of theoretical learning (with no practice component), this would be one of the few examples of 'midwifery' training in New Zealand that was not based on the apprenticeship model.

Seven Saint Helen's Hospitals were established from 1905 as a result of the Midwives Act 1904 and provided both midwifery services (initially to married women from working class families) and education for student midwives (Donley, 1986, 1998; Hill, 1982). Saint Helen's Hospitals would remain the place of training for midwives in New Zealand until 1979. It was only the principal Saint Helen's Hospitals that were able to train student midwives (MacLean, 1932); students lived onsite and worked alongside registered midwives learning in an apprenticeship model. From 1905 until 1956 midwifery training was available to both direct entry and registered midwife students, although increasingly priority was given to registered nurses (Donley, 1998). From 1925 midwifery training for both registered nurses and direct entry students included a maternity nursing component. From 1956 to 1979 this maternity nursing component was incorporated into the three year hospital-based nursing course resulting in a double registration as a registered nurse and maternity nurse. Midwifery training remained but only for registered nurses, and direct entry midwifery was no longer available (Pairman, 2005). Midwifery training was only available through the three remaining Saint Helen's Hospitals (Pairman, 2005), this was to continue until 1979 when St Helen's Hospitals closed.

In response to the 1971 Carpenter report, which highlighted concerns about nursing training, hospital based midwifery programmes were discontinued in 1978 and midwifery training moved to technical institutes (Workforce Development Group, 1988). From 1979 midwifery training was only available through the polytechnic Advanced Diploma of Nursing (ADN) as a sub option of the Maternal/Child Nursing speciality (Workforce Development Group, 1988). Only 10-12 weeks of clinical experience was offered and the apprenticeship learning style previously employed by the midwifery profession was gone (Pairman, 2006). A separate polytechnic midwifery programme became available from 1989 (only for nurses) while the ADN course remained available until 1991.

In 1990, the Nurses Act 1977 was amended to legislate for midwifery autonomy and direct entry midwifery training. Direct entry midwifery education became available again in 1992 at two polytechnic institutions (Otago Polytechnic (OP), and Auckland Institute of Technology (now known as Auckland University of Technology (AUT)), coinciding with the commencement of degree level midwifery education (replacing the previously taught midwifery diploma courses) (Midwifery Council of New Zealand [MCNZ], 2009; Pairman, 2006). Three more institutes

subsequently offered pre-registration midwifery education (Christchurch Polytechnic Institute of Technology (CPIT), Waikato Institute of Technology (WINTEC), and Massey University) (Pairman, 2006). The change of midwifery education at this time once again changed the mode of learning for student midwives, considerably increasing clinical hours and returning students to a more apprenticeship model of learning.

There was a review of pre-registration midwifery education by the Midwifery Council of New Zealand (MCNZ) in 2004-2006. The review identified concerns regarding consistency of midwifery education, practice experience, preceptor training, access barriers, and expectations of graduates. Stakeholder feedback indicated that student midwives would benefit from increased clinical experience (MCNZ, 2006). A new midwifery programme was introduced and became a 4 EFT (Equivalent Full-Time) bachelor's degree programme with an increase in skill and experience requirements, and a substantial increase in clinical hours. The revised programme of midwifery education commenced in two schools in 2009 at OP and CPIT, and two further schools in 2010 at AUT and WINTEC (Massey University stopped offering new students midwifery education in 2010). Further education for midwives working with students was also addressed in the review (MCNZ, 2009).

## Regulatory Requirements

The Health Practitioners Competency Assurance Act 2003 requires the MCNZ (as the authority appointed in respect to midwives) to prescribe the qualification required of midwives, and to accredit and monitor the relevant educational institutions and programmes. The MCNZ requires student midwives to complete 4800 hours of education, of which a minimum of 2400 are practice hours, and to gain competency in named skills (MCNZ, 2007). Clinical practice hours are based on the student working under the "direct or indirect supervision of a registered and practising midwife" (MCNZ, 2007, p. 18). During these practice hours the student midwife requires appropriate learning opportunities in order to achieve the required standards of competence. Practice hours are spent with a lead maternity carer[4] (LMC) providing women centred care based on a partnership model of care, and within primary, secondary and tertiary maternity units working alongside core midwives[5] who also provide women centred care on a shift by shift basis (N.B. A very small number of hours are spent working with allied health professionals i.e. nurses, dieticians, and medical staff). Given the pre-registration requirements of both clinical hours and skills, student midwives are primarily reliant on midwives for appropriate learning opportunities; there are regulatory requirements that oblige these midwives to work with and support students.

Both the regulatory body and the professional body for New Zealand midwives (respectively the MCNZ and the New Zealand College of Midwives (NZCOM)) detail responsibilities of midwives

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[4] A lead maternity carer (LMC) is a health professional qualified to provide maternity care to women. In the context of this thesis the LMC is a self-employed midwife.

[5] A core midwife is a midwife employed by a District Health Board to work primarily within a hospital setting. Core midwives are also called hospital based midwives.

in relation to the training of student midwives. The MCNZ Competencies for Entry to the Register of Midwives, Competency 4.12 (MCNZ, 2015) states: "The midwife assists and supports student midwives in the development of their midwifery knowledge and skills in clinical settings" (p. 15). Adherence to this competency is a requirement for midwives wishing to practice in New Zealand and midwives are required to show evidence at their Midwifery Standards Review.

The NZCOM, in consultation with the profession and consumers, determines the Standards of Midwifery Practice for midwives and the Code of Ethics (NZCOM, 2015). Of the 10 Standards of Midwifery Practice, one pertains directly to the midwife's responsibility to student midwives: Standard Ten: "The midwife develops and shares midwifery knowledge and initiates and promotes research" (NZCOM, 2015, p. 27). One criteria of this standard states: "The midwife… gives special recognition to student midwives and shares her expertise with them in a supportive manner as a preceptor" (p. 27). The NZCOM Code of Ethics: Responsibilities to Colleagues and the Profession (part j), requires midwives to "participate in education of midwifery students and other midwives" (NZCOM, 2015, p.15).

With requirements from both professional and regulatory bodies that midwives in New Zealand support the educative needs of student midwives, it would be prudent for midwives to receive training in preceptorship. Until recently, most New Zealand midwives had received sparse training in the role of working with student midwives. From 2007 the MCNZ required some midwives to complete preceptor training based on the length and  type of student placement (MCNZ, 2007). In 2015 this requirement was surpassed and all midwives who work with, assess, and provide feedback to students are now required to complete MCNZ approved preceptorship courses ( MCNZ, 2015).

## Impetus for the Study

The research question arose in an unexpected but timely fashion. I was working as a core midwife in a tertiary hospital and undertaking postgraduate study. As I was nearing the end of my post graduate diploma I was thinking about my research thesis and looking for a thesis question. I had spent the day working closely with a student midwife. The day had been busy and there had been a lot of work and learning opportunities for us both. At the end of the shift the student thanked me for working with her and remarked that it had been a great day. She commented that she was seriously considering leaving the midwifery undergraduate programme. She explained that she had had such a traumatic time on her previous clinical placement that she felt her only choice was to leave. The student had given herself a few more days to make her final decision, but given her experience of the present day, leaving was now no longer an option.

While I was pleased that I had been able to nurture this student (albeit only for one shift) to the extent that she now felt confident to remain in the programme, I was very disappointed on hearing about the student's experience. It was the interaction between the student and the midwives that had initiated the student's consideration of withdrawal; both midwives and the

student belonged to the same profession, yet where was the nurturing! As I drove home I mulled over the events of the day. I was certainly saddened about the treatment the student had received and I began to wonder what indeed student midwives' experiences in clinical placements were like. I now had a thesis question!

## Personal Context

My first foray into the New Zealand maternity services was in 1983 as a student nurse when I worked my elective placement in a maternity unit. I returned to this large tertiary unit some years later to work as a registered nurse for a year prior to my midwifery training. I started my midwifery training in 2001, finishing 18 months later to return to the same tertiary facility, this time as a midwife.

My clinical experience as a student midwife seemed to be largely dependent on the midwife I worked with at the time. Some midwives seemed unable to work with a student in a supportive or nurturing way—those days were anxiety fuelled and not the ideal learning environment. Other times my experience was at the other end of the spectrum where I developed confidence from being nurtured by supportive midwives in a manner that enabled me to learn and develop my skills. While my learning encompassed both ends of the spectrum my experience generally sat somewhere in between.

As a core midwife I enjoy working with students. Nurturing students in a way that enables learning is immensely satisfying and benefits the student, midwife, and the woman. However, I do acknowledge that there can be difficulties in a learning and teaching relationship between student and midwife. A busy, high acuity clinical environment is not always an ideal place to learn or teach, as the teaching and subsequent learning is easily adversely affected by the pressures and constraints of the practice environment (E. Smythe, 2000).

As a past student midwife, present core midwife in a tertiary hospital, and a university lecturer working with student midwives on placement in secondary and tertiary hospitals, I have a wide range of experiences to draw on in relation to my research. I am also in the position of hearing first hand from both student midwives and core midwives of their experiences. Some student midwives' experiences resonate with my own experiences, and I regularly witness the interaction between midwife and student within the constraints inherent of a tertiary hospital environment.

## Structure of the Thesis

### Chapter One: Orientation to the Study

In this current chapter I have proffered my research question and the impetus that initiated the research study. The background of the research study and regulatory requirements are also offered. The personal context in which the study was completed is provided.

**Chapter Two: Literature Review**

This chapter explores the literature in relation to the research study. The majority of the literature reviewed is specific to midwifery.

**Chapter Three: Methodology and Method**

I describe the methodology of interpretive description in this chapter. The study design and methods are detailed.

**Chapter Four: Introduction to the findings; A Sense of Belonging**

This chapter introduces the findings of the research study and presents the first findings chapter – the experiential dimension of belonging.

**Chapter Five: The Opportunity of Learn**

Chapter five examines the second experiential dimension of learning. In this chapter the factors that enable or challenge student learning are explored.

**Chapter Six: Challenges in Clinical Placements**

Those factors that challenge student experiences in clinical placements are explored in this third findings chapter.

**Chapter Seven: Having Confidence**

The last findings chapter explores the fourth experiential dimension of confidence. Self - confidence and the confidence attained from working with women and midwives are discussed.

**Chapter Eight: Discussion**

The research study is discussed in this last chapter and two key messages are offered. The implications for healthcare institutions, education providers, and research are explored. The limitations of the study are detailed. A summary of the research study is offered.

## Summary

In this chapter, orientation to the research study has been described. The history of student midwife education in New Zealand has been provided. Regulatory requirements of student midwives in relation to clinical hours, and midwife responsibilities in regards to the training of students are offered. The impetus for the study and my personal context has been detailed. Lastly, an overview of the thesis has been offered.

# Chapter Two: Literature Review

## Introduction

In this chapter the literature related to this research study is reviewed. The literature documents what is known about the experience of student midwives in clinical placements and situates this study in context of past and current literature. A literature review was undertaken, initially through CINAHL, Intermid, Medline (via EBSCO ), MIDRIS, and Ovoid using the keywords 'student', 'experience', 'clinical', 'education', and 'midwife'. The resultant literature subsequently generated further research and discovery of relevant material. The literature reviewed also includes grey material. Thorne (2008) suggested attention to non-traditional literature is warranted and aids the development of an extensive literature review. In the course of the review, research by Begley (1999, 2001a, 2001b, 2002) was found to be often acknowledged by researchers and could be considered as foundational research into the experience of student midwives. Therefore this research, although old, has been included in the current literature review.

A review of literature afforded a substantive view of the history of pre-registration midwifery education in New Zealand, and this has been presented as background to my research study in Chapter 1. There is a small but increasing amount of research dedicated to the experience of student midwives in relation to continuity of care. There is a small body of literature specific to the experience of the students working within the clinical setting (Green & Baird, 2009; Pryjmachuk & Richards, 2008), but no research specific to New Zealand situation. While I have narrowed the focus of my research to the maternity context, not all researchers in this field used student study participants that were student midwives. Of the research literature reviewed, some researchers did not differentiate between student midwives and student nurses, and offered research that collectively covered both fields of healthcare practice (Lloyd Jones, Walters, & Akehurst, 2001; Veitch, May, & McIntosh, 1997), while American researchers reported on student nurse-midwives (Raisler, O'Grady, & Lori, 2003). Pryjmachuk and Richards (2008) suggested the lack of midwifery focused research stemmed (in part) from few countries treating midwifery as profession separate from nursing. They cited two large United Kingdom based research studies that treated midwifery as "a mere category of nursing" (p.109).

One researcher suggested that nursing and midwifery research can be applied interchangeably (Pryjmachuk & Richards, 2008); however, New Zealand midwives and nurses may question this as the ideologies and foundation of care provision differs between the two professions. While midwifery in New Zealand is based on a philosophy of partnership (NZCOM, 2015), nursing exists within a medicalised model of care. The partnership model of care facilitates a relationship between the woman and the midwife (and student midwife) that differs from that found in nursing. This difference might account for varying experiences (e.g. the student's relationship and hence learning opportunities with the woman), but other experiences (e.g. working within a hierarchical institution) may be very similar. For the purposes of this research study I have endeavoured to use midwifery specific literature, although multidisciplinary studies

and literature involving allied health professionals (with similar educative models) have been cited.

The literature reviewed used a number of titles to describe the midwife who works with a student midwife; most commonly *mentor* (Darra, 2006; Finnerty & Collington, 2013; Fowler, 2008; Green & Baird, 2009), and less commonly *preceptor* (Licqurish & Seibold, 2008). In New Zealand, a midwife designated to work with a student is described by the MCNZ (2007) as a preceptor, whereas a mentor is a midwife who works with another registered midwife in a negotiated partnership (NZCOM, 2000). The terms preceptor and preceptorship are also used in New Zealand within the hospital setting to describe a more senior midwife and a relationship with a new graduate or a midwife new to an area, usually for a specific period of time and purpose (Lennox, Skinner, & Foureur, 2008). For the purposes of this study the terms mentor and preceptor will be used interchangeably.

In reviewing the literature several main themes became apparent: the significance of the midwife, positive mentoring, continuity of mentor, mentoring challenges, the woman, the institutional clinical placement, stress in clinical placements, and socialisation into the profession.

## Significance of the Midwife

The purpose of pre-registration midwifery education is to produce new graduates who are competent beginner practitioners (Carolan, 2013) and (in New Zealand) meet the competencies for entry to the New Zealand Register of Midwives (MCNZ, 2007). Clinical practice is based on the student working the necessary clinical hours with a registered midwife. It is, therefore, logical that midwives would significantly influence the student experience, and in order to achieve practice requirements students need to work with willing and enabling midwives.

The literature reviewed revealed that midwives were pivotal to the student midwives' learning experience (Brunstad & Hjalmhult, 2014; Finnerty & Collington, 2013; Gilmour, McIntyre, McLelland, Hall, & Miles, 2013; James, 2012; McIntosh, Fraser, Stephen, & Avis, 2013; McKenna et al., 2013; O'Brien et al., 2014; Sidebotham, Fenwick, Carter, & Gamble, 2015). The importance of midwives was two-fold: firstly midwives were instrumental in the educative experience of students by providing learning opportunities, and secondly the socialisation of students into the profession (Begley, 2001b, 2002; Carolan, 2013; Gilmour et al., 2013; Green & Baird, 2009; Hughes & Fraser, 2011; Jordan & Farley, 2008; Licqurish, Seibold, & McInerney, 2013; McCall, Wray, & McKenna, 2009; McKenna et al., 2013; Sidebotham et al., 2015). Midwives were significant in influencing the midwifery philosophy adopted by students (Jordan & Farley, 2008); likewise new experiences changed students' philosophical perceptions around midwifery (Sidebotham et al., 2015).

In a study of 17 student midwives in Australia, Gilmour et al. (2013) found the most important impact on student learning was that of the midwife. Positive learning experiences were characterised by motivated midwives and continuity of midwife; whereas lack of continuity and midwives who did not want to work with students or provide learning opportunities negatively

impacted on student learning. The difference in midwife mentoring ability is further supported in the literature, including Hughes and Fraser (2011) who suggested that students felt that the mentoring they received varied greatly. *Good* midwives worked *with* students and provided support and education, while *bad* midwives were those who excluded students, were reluctant to teach and had a less than favourable opinion of students (Gilmour et al., 2013). This research study could have relevance to the New Zealand situation, with caution given to the variances of placement models (block and continuous two days per week) that differ from the New Zealand context.

## Positive Mentoring

A positive mentor was a midwife who was approachable, instilled confidence in the student (Hughes & Fraser, 2011), and displayed a willingness to mentor (Gilmour et al., 2013). Students looked to their mentor to provide them with opportunities to meet their learning needs, provide guidance (Steele, 2009) and constructive feedback (Licqurish & Seibold, 2008; Steele, 2009). Mentoring was viewed as important to students (Hughes & Fraser, 2011), and provided a sense of belonging, nurturing (Fraser, 2002; Sidebotham et al., 2015) and being valued in the clinical placement (Barnfather, 2013). A good mentor was a midwife who acted as an advocate for women (Hughes & Fraser, 2011).

Midwives who worked with students were able to create a supportive learning environment (Carolan-Olah & Kruger, 2014; Cummins, Catling, Hogan, & Homer, 2014; Lange & Powell Kennedy, 2006; Licqurish & Seibold, 2008; Rawnson, 2011; Sidebotham et al., 2015). One student midwife applauded the midwife she worked with, saying: "she is generous with her knowledge and acutely aware of my student status, often interrupting her train of thought with helpful 'things I should know'" (Gallagher, 2009, p. 38). This learning environment facilitated skill practice and acquisition (Longsworth, 2013), which had positive flow-on effects on student confidence (Gilmour et al., 2013).

Midwives were viewed as the gatekeepers to learning opportunities, so students strove to form positive relationships with the midwives (Hunter, 2005; Yearly, 1999). In their grounded theory study of 10 student midwives, Brunstad and Hjalmhult (2014) found that students used strategies to build a positive relationship with the midwife in order to obtain clinical experience in the birthing units. Firstly students had to control their vulnerability (usually by acceding to the midwife), cultivate trust (by demonstrating worthiness), and finally obtain acceptance from the midwives through a good working relationship. Once these steps were obtained clinical learning opportunities would follow.

Learning was enhanced when the student recognised that their theoretical understandings were shared by the midwife (Fraser, 2002; Licqurish & Seibold, 2008; Longsworth, 2013; Veitch et al., 1997) and the clinical placement (Veitch et al., 1997), and that midwifery philosophies were aligned (Licqurish & Seibold, 2008). An effective mentor was a midwife who was a positive role model for the profession (Finnerty & Collington, 2013; Fowler, 2008; Licqurish & Seibold, 2008; Steele, 2009), and who employed evidence based practice (Hughes & Fraser,

2011). However, in a research study involving 125 student midwives, participants recognised that evidence based practice in clinical placements was not always employed in practice (often due to institutional constraints) nor always preferred by the midwife (Armstrong, 2010).

In a positive mentoring relationship learning was facilitated when midwives supported students through teaching techniques such as role modelling, scaffolding and fading (Finnerty & Collington, 2013). Supporting students facilitated a safe environment (Gilmour et al., 2013) where students felt confident asking questions (Hughes & Fraser, 2011), and could learn through mistakes and mastery (Licqurish & Seibold, 2008). In order to enable learning it was optimal if the midwife was aware of the student's learning requirements (Hughes & Fraser, 2011) and this was facilitated when the student worked with a known mentor (Rawnson, 2011).

A positive clinical experience also reinforced the student's decision in regards to the vocational choices they had made (Cummins et al., 2014; Sidebotham et al., 2015). There are also longer term repercussions of the quality of the student-midwife relationship; for graduating students the relationships with the midwives shaped their decisions regarding post-graduate place of work (Cummins et al., 2014; Hughes & Fraser, 2011; McCall et al., 2009; McKenna et al., 2013). Jude Jones, a newly qualified midwife in the United Kingdom, lauded the nurturing afforded to her by the midwives she worked with as a student midwife: "I had felt nurtured there as a student and I knew that those midwives would be there for me as I started my career" (Jones, 2015, p. 10). Jones (2015) acknowledged the positive role these midwives played during her studentship and recognised the importance of her own new role as midwife mentor to future student midwives. For this new midwife her learning experiences were enhanced by knowing the midwives.

## Continuity of Mentor

Continuity with a midwife enhanced the student–midwife relationship, aided assessment of the student's specific learning needs and subsequent provision of relevant learning opportunities (Licqurish & Seibold, 2008). The student–midwife relationship can have a long term effect on the integration of a student into a clinical placement (O'Brien et al., 2014). Continuity with the midwife also fostered a sense of belonging and value for the student (Gilmour et al., 2013), while continuity of placement enabled greater institutional knowledge, the ability to consolidate specific learning, and the opportunity to create positive relationships with a wider group of known staff (Gilmour et al., 2013).

To work with a familiar midwife who recognised the student's knowledge and progression was advantageous (Brunstad & Hjalmhult, 2014; Carter, Wilkes, Gamble, Sidebotham, & Creedy, 2015; Rawnson, 2011). Learning was enhanced in the presence of a known midwife (Rawnson, 2011), while continuity of mentor was instrumental in empowering the student to work more independently (Finnerty & Collington, 2013; Hughes & Fraser, 2011; Velo & Smedley, 2014). Knowledge of the student's stage in the midwifery course was seen as a means by which coordinators could better allocate midwives so that the midwife's expertise matched with the needs of the student (Fraser, 2002). Unfortunately this was not always the case and learning

opportunities for the student were missed. Allocation of a midwife on an 'ad hoc' basis (allocating students to midwives at the beginning of a shift, often with little regard to student learning needs and midwife teaching ability) caused a degree of anxiety and affected the student's confidence and learning (Rawnson, 2011). However Brunstad and Hjalmhult (2014) commented that working with different midwives, while challenging, afforded the student midwife differing experiences. Hughes and Fraser (2011) suggested that students who worked with different midwives benefitted by being able to pick and choose the qualities they admired.

In an Australian based descriptive cohort design study of 16 midwifery students (Carter et al., 2015), nearly 90% of students strongly agreed or agreed that the presence of qualities such as mutual respect, equality and trust were present in their student-midwife relationship. This study was untaken during a continuity of care placement where the relationship between the student and midwife was sustained over a period exceeding one year. While continuity of mentor in the New Zealand hospital setting is less common, the positive mentoring qualities identified in this research could also be present with known midwives within institutions.

A United Kingdom based quantitative research project involving 125 midwifery and nursing students who had named mentors, found that those students who worked less frequently with their named mentor were afforded less learning opportunities, and worked significantly less hours with trained staff in their mentor's absence (Lloyd Jones et al., 2001). While the student midwife in New Zealand works with a preceptor who is present on shift at the same time, the dependence on the preceptor for the provision of learning opportunities is comparable. These findings are further supported by research by Brunstad and Hjalmhult (2014) where the experience and learning opportunities afforded to student midwives is dependent on the midwife and is adversely affected by lack of continuity.

The part time nature of midwifery staff contributed to the lack of continuity afforded to student midwives and affected the educative opportunities in clinical areas (Veitch et al., 1997). This lack of continuity affected the ability of staff to recognise individual student midwives, their abilities, and learning requirements (Gilmour et al., 2013). The part time nature of many in the New Zealand midwifery workforce (41% of midwives worked 32 hours or less in 2014 ( MCNZ, 2014)) would unwittingly facilitate this situation. While the reality of working with one midwife on a continuous basis may prove problematic, working with a small group of midwives may be more achievable, and would be worthy of further research.

Continuity of mentor was seen by students as important early in training, but becoming less important from the second year of study (Hughes & Fraser, 2011). With progression through the degree, the student midwives increasingly knew the midwives and the clinical placement, but as their knowledge and experience increased so too did the expectations on the students (Brunstad & Hjalmhult, 2014).

## Mentoring Challenges

Poor mentoring, characterised by lack of support (Longsworth, 2013), affected the students' confidence and self-esteem, and left students feeling highly stressed (Banks, Kane, Rae, &

Atkinson, 2012; Hughes & Fraser, 2011; Rawnson, 2011). Students felt poor mentors were uncaring (Begley, 2001b, 2002) and at times belittled the student (Begley, 2001b). Midwives who undermined students, especially in the presence of women, had a negative effect on the confidence of the student, and were deemed to be inappropriate mentors (Hughes & Fraser, 2011). Poor mentoring had a profound effect on the student (Hughes & Fraser, 2011), and resulted in a lack of both clinical direction and learning opportunities afforded to the student (Begley, 1999; Lloyd Jones et al., 2001; Longsworth, 2013). Further, learning was inhibited (Rawnson, 2011; Sidebotham et al., 2015) and confidence in skill acquisition was negatively affected (Longsworth, 2013). While working with a midwife should be a positive learning opportunity, some students considered what they had witnessed was "how you don't want to practice" (Carolan-Olah, Kruger, Walter, & Mazzarino, 2014, p. 5).

Students were often looked upon as another pair of hands as opposed to learners (Kroll, Ahmed, & Lyne, 2009; Veitch et al., 1997). Sarah Miles (at the time a student midwife in the United Kingdom) commented that students were frequently asked to perform low skilled, less desirable jobs at a time when their focus should be gaining experience and the acquisition of skills (Miles, 2008). Miles suggested that this might evidence the power held by midwives over students, and is representative of the conflict found in a hierarchical setting such as a labour and birthing unit.

Some students were forgotten or overlooked (Gilmour et al., 2013) or left feeling unwelcomed or unwanted by the midwives (Begley, 2001b; Cummins et al., 2014; Gilmour et al., 2013; Kroll et al., 2009). Some midwives preferred not to work with student midwives, possibly because their practice would be under scrutiny (Hughes & Fraser, 2011), they did not feel their practice was competent (McTavish, 2010), or because of the limited clinical experience of the mentor (Lake & McInnes, 2012). Some midwives do not have the confidence nor competence to teach; Kyle Balkle (a then third year student midwife) commented that "some mentors do not have the confidence in their own skills therefore they are not competent to teach students" (2009, p. 449). Other midwives felt unable to work with students due to time pressures (McTavish, 2010; O'Brien et al., 2014), or when they perceived the students to be demanding or unmotivated (O'Brien et al., 2014).

Students realised that one style of mentoring did not suit every student. The student-midwife experience was dependant on the personalities of both parties; the same student could have a very different relationship with a midwife than another student (Hughes & Fraser, 2011). It was difficult for new mentors to identify the learning needs of student midwives (Rawnson, 2011), while poor mentors could not or did not give consideration to individual student learning requirements (Miles, 2008). A lack of continuity with a mentor affected student learning (Gilmour et al., 2013), and different mentors potentiated the theory knowledge gap (Longsworth, 2013).

A medically dominated and hierarchical environment cultivated poor mentors (Begley, 2001b) who followed rules, lacked autonomy and did not provide evidence based care (Bluff & Holloway, 2008). These midwives were considered to work in a prescriptive manner (Bluff &

Holloway, 2008) and provided midwifery care that was at odds with the students' theoretical and philosophical understandings (Armstrong, 2010; Lange & Powell Kennedy, 2006). Students found the restrictive nature of practice within the hospitals instrumental in impeding their learning (Licqurish & Seibold, 2013) and negatively affected the care they were able to provide to women (S. Davies & Coldridge, 2015). Incongruence of theoretical teachings and midwifery philosophy with the midwifery care afforded to women in institutional environments was distressing (Sidebotham et al., 2015) and frustrating for the students (Begley, 2002; S. Davies & Coldridge, 2015; Fowler, 2008). As more recent graduates are employed by New Zealand District Health Boards (DHBs) into hospital based positions (due to a retiring and aging midwifery workforce), it probable that student and midwife theoretical and philosophical understandings will increasingly align. Fowler (2008) commented that many students working in institutions were not privy to normal birth and did not see midwives working in an accountable way. These midwives were not good role models and Fowler questioned if student midwives were being trained to become autonomous practitioners or obstetric nurses. Given that all New Zealand midwifery students work at some time with core midwives in an environment that is highly medicalised, it is not inconceivable that student midwives would be witness to divergence of teaching and philosophy and may question their role in the hospital environment.

Elizabeth Davis (2010) suggested that the student-midwife relationship can be difficult and traumatic to both parties. Davis commented that midwives who work with students have their own lives and stresses outside of work, and the added professional demands can easily lead to stress, exhaustion, and burnout. It is, therefore, not unconceivable that these midwives find it difficult to provide the nurturing environment that student midwives require.

**The Woman**

The nature of midwifery is to be 'with woman', and students were keen to support and empower women in their care (Carolan, 2013; Rawnson, 2011). Establishing rapport with women enhanced the students' confidence and their ability to respond to the woman's needs (Thorstensson, Nissen, & Ekstrom, 2008). In a study by Carolan and Kruger (2011) midwifery students identified altruism as one of the factors that influenced their decision to undertake midwifery studies. Students identified strongly with women and fostered an empathic relationship with them, but this was at times at odds with what the students perceived the midwife-woman relationship to be (S. Davies & Coldridge, 2015). This difference in ideologies was further explored by Hunter (2005), who noted that the consequence of the student midwife's empathetic relationship with the woman can and does cause friction with the midwives with whom she is working. In a qualitative study by S. Davies and Coldridge (2015), of 11 student midwives, students were seen to want an empathetic relationship with the woman, yet the constraints in the clinical setting (namely the midwife, institutional protocols, time factor) challenged this relationship. When students were unable to establish a relationship with the woman, student confidence became problematic and students would often defer to tasks (Thorstensson et al., 2008).

Much of the literature reviewed commented on midwives providing care that was not in keeping within the accepted midwifery philosophy. The literature revealed that women in institutions were not treated with respect (S. Davies & Coldridge, 2015; Licqurish & Seibold, 2008), they received poor care (Begley, 2001a; S. Davies & Coldridge, 2015), and prescriptive care (Bluff & Holloway, 2008). Uncaring behaviour by midwives towards women was distressing for students (Cummins et al., 2014; S. Davies & Coldridge, 2015). Angela Horler (a National Childbirth Trust antenatal teacher and a then student midwife) wrote of the strength required to be able to practice midwifery according to her midwifery philosophy: "I have stood my ground in my beliefs even in the face of criticism" (2006). However, this behaviour more commonly went unchallenged by the student, and the student would self-remonstrate at her lack of response and betrayal of the woman. In these circumstances it was very difficult for the student to feel a sense of belongingness to the team in which she was placed (S. Davies & Coldridge, 2015).

## The Institutional Clinical Placement

Clinical placement experience is crucial for student midwives to find their own midwifery role (Ekelin, Kvist, & Persson, 2016), put theory into practice (Gilmour et al., 2013) and to develop confidence and competence (Carolan, 2013; Gilmour et al., 2013; James, 2012; McKenna et al., 2013; Rawnson, 2011). Clinical placements afforded student midwives the ability to link theory with care provision in clinical settings that provided increasing complex opportunities and experiences for students (Sidebotham et al., 2015). Unfortunately students found the restrictive nature of practice within the hospitals instrumental in impeding their learning (Licqurish & Seibold, 2013).

Institutions were considered to be hostile to the needs of student midwives (Yearly, 1999) with students having to adapt to institutional traditions in order to achieve their learning needs. Begley (2002) argued that while the medical model of care is dominant in institutions, it is not inconceivable that the economic model of care will take priority. With maternity units governed by either a medical or economic model of care, it could be difficult for students to see a midwifery model of care in practice. Lack of sufficient staff, use of time restrictions for labouring women, and providing task orientated care (Fowler, 2008) are all examples of prioritising institutional policies over the midwifery philosophy of care.

Different practice settings also highlighted the 'theory-practice' gap and challenged the congruence of midwifery care (Lange & Powell Kennedy, 2006). Students were often left frustrated by the diversity in the way things could be done (Armstrong, 2010; "Feel the stress", 1998; McIntosh et al., 2013), and how practice differed from unit to unit (Armstrong, 2010) and from midwife to midwife (Longsworth, 2013). Learning skills prior to clinical practice was beneficial for students and facilitated competence in skill acquisition (Longsworth, 2013). While it was preferable that skill technique was universal (Longsworth, 2013), what students experienced in clinical practice was often different to what they had been taught in theory (Armstrong, 2010; Longsworth, 2013).

In a mixed method study of 70 student midwives in the United Kingdom (Kroll et al., 2009), the authors found that the culture of the ward negatively impacted on the student learning experience. Ward disorganisation meant staff were not expecting students nor were students preassigned, leaving students feeling unwelcomed (Kroll et al., 2009). Midwife managers were aware of the less desirable midwives as preceptors, and managed the situation by judicious allocation (Gilmour et al., 2013). However, students believed that luck also played a part in the type of mentorship they received (Hughes & Fraser, 2011).

The importance and additional effort required by midwives to provide effective learning opportunities were often overlooked by administrative and managerial staff (McTavish, 2010). Busy wards presented to the less organised midwife the dilemma of attending to the women at the expense of providing learning opportunities to the student; however more organised midwives were deemed to be able to attend to both the needs of the woman and the student midwife (Kroll et al., 2009).

Student clinical experience was hampered by the busyness of the ward (Armstrong, 2010) and the ward being understaffed ("Are student midwives adequately prepared", 2007; Begley, 2001a); these constraints often meant that students' learning needs were ignored. Staff shortages severely impacted on student learning by lessening the availability of experienced midwives to work with students (Veitch et al., 1997) and students were often taught quicker ways of performing skills which were not necessarily congruent with best practice or theory (Longsworth, 2013). The student's ability to achieve named competencies was also affected as provision of care took precedence over competency acquisition (Bradshaw, Noonan, Barry, & Atkinson, 2013).

Student midwives were viewed as labour rather than as learners (Kroll et al., 2009; Veitch et al., 1997) and portrayed, at times, as an extra pair of hands (E. Clarke, 2011; S. Davies & Coldridge, 2015; Kennard, 2004; Kroll et al., 2009). Many students felt they were "thrown in the deep end" ("Are student midwives adequately prepared", 2007, p. 46; Begley, 1999, p. 266; 2001a, p. 26; Persson, Kvist, & Ekelin, 2015, p. 138) without direct supervision, and as a result learnt often through trial and error. However in one research study it was unclear if this was intentional from the part of the midwife in order to enable student self-learning, or whether it was purely in response to circumstance (Kroll et al., 2009). From the literature reviewed experience in clinical placements was a source of stress to the students.

## Stress in Clinical Placements

Students often found their time on clinical placements stressful (Banks et al., 2012; Green & Baird, 2009; Pryjmachuk & Richards, 2008). Stressful situations led students to do more familiar nursing skills e.g. doing vital signs (R. M. Davies & Atkinson, 1991), or to literally hide behind the midwife (Gallagher, 2009). S. Davis and Coldridge (2015) found that students on clinical placements were witness to substandard care and lack of respect by midwives towards women. Students were aware of conflict in the workplace and this was another source of stress to the student (R. M. Davies & Atkinson, 1991; S. Davies & Coldridge, 2015).

The source of stress was not exclusive to the clinical placements, but reflected placement, academia, work, and family issues (Carolan-Olah et al., 2014). In a survey of 525 Scottish student nurses and midwives by Banks et al. (2012), the Hospital Anxiety and Depression Scale was employed and anxiety levels were found to be above desirable levels for nearly half of the students, and one in five students had depression scores above a desirable level. In this study, difficulties specific to clinical placements were rated lowest, behind personal, academic and financial difficulties. In a study of 11 student midwives, S. Davies and Coldridge (2015) found that all student midwives had given thought to leaving at some point during their training, either in response to a traumatic event (not necessarily a critical incident) or disillusionment with their experiences.

A research study of midwifery students in Iran found that nearly 60% of students considered staff to be unfriendly and a constant source of stress (Khajehei, Ziyadlou, Hadzic, & Kashefi, 2011). Bullying was identified by many researchers as a source of stress for students (Gillen, Sinclair, & Kernohan, 2008; Hakojarvi, Salminen, & Suhonen, 2014; Sidebotham et al., 2015), and in an exploratory descriptive study of midwives and student midwives in the United Kingdom, Gillen et al. (2008) found that bullying was ingrained in midwifery clinical settings. Of the 164 student midwives who participated in a questionnaire, 50% of the students had either been bullied or witnessed bullying. For the students, the effects of bullying were evident in their self-esteem, confidence, anxiety levels, and their physical and mental health. Forty two percent of the students who had been bullied considered leaving the course. Students typically tolerated the bullying so as not to place their clinical grades and job prospects at risk. The source of the bullying was primarily a midwife or mentor. The authors surmised that bullying occurred in response to lack of control and power imbalances and was aggravated by hierarchical medically dominated institutions (Gillen et al., 2008).

Worksafe NZ (2014) alluded to the bullying of students in clinical placements. A qualitative study by Bentley et al. (2009) found that bullying in the New Zealand health sector was firmly entrenched. While the study did not specifically look at student midwives, it did comment that bullying in DHBs was widespread and affected workers at all levels within the organisation. Future Workforce, DHBNZ Report on Support for Māori and Pacific Nursing and Midwifery Undergraduate Students (Future Workforce DHBNZ, 2009) were advised by two national student bodies that "clinical placements were an area where students felt most vulnerable and unsupported" (p.12). Negative clinical experiences were characterised by unsupportive environments and unsafe staffing levels which consequently impacted on student learning. The effect of bullying could be felt by changes in self-esteem, a feeling of anxiety, stress and/or helplessness, burnout and/or deterioration in physical and mental health (Worksafe NZ, 2014).

In a recent survey by the New Zealand Resident Doctors Association of 3000 members, 20% of junior doctors had witnessed or been subject to bullying or inappropriate behaviour (Tan, 2015, August 5), and in a study of student nurses in New Zealand, 90% of participants identified that they had been bullied (Foster, Mackie, & Barnett, 2004). Bullying in the New Zealand healthcare sector is not a new phenomenon. In her unpublished thesis, "*The History of Midwifery from 1840 to 1979, with Specific References to the Training and Education of*

*Student Midwives*", Hill (1982) commented on the poor manner in which student midwives were treated by the midwifery staff; a participant in the study commented: "the attitude of the majority of the senior nursing staff to the trainees was horrific" (p. 157).

Miles (2008) reiterated the cyclical nature of bullying and the need to address the lack of support and training for mentors of student midwives. Bullying resulted in both psychological and physiological problems and negatively impacted on the students' ability to remain motivated, learn, and become socialised within the profession

## Socialisation into the Profession

Socialisation into the profession plays a major role in the student midwife experience (Green & Baird, 2009; McCall et al., 2009; Yearly, 1999), and is typically developed through the student's sense of *belonging to the team* (Carolan, 2013). In a study by McKenna et al. (2013), students reported a sense of belongingness, empowerment and comfort in clinical practice, and the students felt valued and able to ask for advice and assistance when required. Staff knowing the students name, or being remembered from a previous placement were highly valued by the students (Gilmour et al., 2013). Students found that being overlooked or excluded resulted in feelings of invisibility, feeling demeaned and unrecognised (Gilmour et al., 2013). Students recognised unfavourable staff attitudes but typically kept quiet not wanting to invite repercussions (Kroll et al., 2009). Students were also aware that midwives had the responsibility of assessing their clinical practice (Hunter, 2005).

In much of the literature reviewed, researchers commented that it was important for the student midwife to *fit in* with the midwife (Armstrong, 2010; Gilmour et al., 2013; Green & Baird, 2009; Smith, 2007; Yearly, 1999), and in doing so these students were viewed more favourably by staff. Students felt a strong need to assimilate and be accepted (Armstrong, 2010; Carolan, 2013; Gilmour et al., 2013; Green & Baird, 2009; Smith, 2007), to avoid confrontation (Rawnson, 2011), and this was achieved by adopting the practice of the midwife they worked with; often at the expense of the student's own standards of practice (Armstrong, 2010; Green & Baird, 2009; Rawnson, 2011; Smith, 2007). In order to fit in, students reported keeping "quiet" (Green & Baird, 2009, p. 84), "complying" (Rawnson, 2011, p. 790), or of "the need to tread carefully" (Armstrong, 2010, p. 121).

Following *the rules* was also identified as a way to become accepted (Green & Baird, 2009; Hunter, 2005). However Hunter (2005) cautioned that the rules which a student midwife needed to follow were unwritten and varied. Difference in the ideologies between student midwives and more senior midwives could be explained, in part, by the difference in philosophies—student midwives are taught a women centred approach to midwifery based on evidence based research, whereas senior midwives in institutions were more likely to work within a medical model of care. This difference in ideologies is supported by other research that comments on the medicalised model of health care provided in institutions that is often based on tradition rather than evidence (Armstrong, 2010; S. Davies & Coldridge, 2015; Jordan & Farley, 2008; Licqurish et al., 2013). Suyai Steinhauer (2015) (a newly graduated midwife in the United

Kingdom) wrote in her "Letter to a Young Student Midwife" that midwifery training was to be the "toughest journey of your life so far" (p. 9). She cautioned the reader to hold fast to their own philosophy of midwifery and not be swayed by the wholesale midwifery practice on offer.

In the research literature reviewed direct entry midwifery students were perceived differently from students with a nursing background (Kennard, 2004; Kroll et al., 2009; Yearly, 1999). Student midwives who had a nursing background were already socialised into the hospital environment and experienced less difficulties in clinical placements (Green & Baird, 2009). Claire Kennard (at the time a second year student midwife) commented that at the bottom of the midwifery hierarchy scale was the first year direct entry student who "[doesn't] even know anything about nursing" (Kennard, 2004, p. 9). One researcher commented that remarks by midwives to direct entry midwives about their lack of health care background caused anxiety and affected learning, and as direct entry student midwives, their legitimacy to the title 'midwife' was already being questioned by midwives (Yearly, 1999). It is interesting to note that in New Zealand the majority of student midwives are direct entry, yet the majority of registered midwives have a nursing background, though this situation will change as older midwives retire. The experience of students in relation to being accepted into the profession as direct entry students will undoubtedly change as the proportion of direct entry midwives increases.

## Summary

The question of this research study is 'what are student midwives' experiences of clinical placements in secondary and tertiary hospitals?' This literature review has identified what understandings exist of the student midwife experience in clinical placements. Much of the literature is based overseas, and some is becoming of advancing age, emphasising the need to capitalise on the available literature that is relevant to the New Zealand context. The literature acknowledges the importance of clinical placements for the student midwife in terms of attaining competence in skill acquisition and in the provision of care, and fulfilling regulatory requirements. Clinical placements provide a means by which students become socialised into their profession. The student experiences documented in the literature reflect the multiple influences found in clinical placements including the nature of the midwives and the culture of the unit and institution. However, it was apparent from the literature reviewed that the most important element in the clinical experience of the student was the midwife with whom she worked.

Positive mentors were nurturing and willing to work with students. They were generous with their time and knowledge, and enabled students to gain learning opportunities. Continuity of the student-midwife relationship was beneficial to both student and midwife, facilitating understanding, fostering appropriate learning opportunities and recognising student learning progression. Poor mentoring arose from a wide range of factors and negatively affected students' confidence and self-esteem. Opportunities for skill acquisition and care provision were difficult for students to obtain from reluctant or busy midwives. The institutional constraints sought to limit learning experiences to those within a medicalised model of care, highlighting the theory-practice gap as students sought to provide midwifery care utilising midwifery

ideologies within a hostile environment. Students found clinical placements stressful. While staff were a common cause of stress, so too were clinical and theoretical demands, and family commitments. Bullying is recognised as endemic in the healthcare context and students were subject to this inappropriate and hierarchical behaviour. Students felt a strong desire to be socialised into the profession, but for some students it came at the expense of their own midwifery philosophy and ideologies.

From the literature reviewed, many authors suggested further research in response to their findings and discussion. Recommendations included addressing the practice-theory gap in tertiary hospitals (Lange & Powell Kennedy, 2006), optimising student learning (McKenna et al., 2013), bullying in clinical placements (Hakojarvi et al., 2014), addressing attrition (Banks et al., 2012), socialisation of student midwives (Jordan & Farley, 2008), and lastly the student experience of clinical placements (James, 2010). These recommendations highlight deficiencies in knowledge of the experience of student midwives in clinical placements, and provide direction for future research, including this research study.

While great attempt was made to maximise contextual congruence with student experience in New Zealand, the differences, especially in mentor presence, continuity of midwife, model of placements, pre-registration midwifery education, midwife and student demographics, and philosophy of care, provide sufficient reason to consider some of the findings in the New Zealand context with caution. The provision of midwifery care in New Zealand and the philosophy that underpins that care differs from most of the care settings reviewed in the literature. Some of the research reviewed is ageing and may not reflect the changing profile of student midwives, nor the changes to the provision of midwifery pre-registration education. The changing demographics of midwives in New Zealand will undoubtedly affect the experience of the students they work with. The literature review has highlighted the differences in the climate within which students experience clinical placements and provides justification for a New Zealand based study.

# Chapter Three: Research Methodology and Methods

## Introduction

In this chapter I describe the methodology and methods employed in this research study. I describe the background and principles of the research methodology, and detail its strengths and weaknesses. My rationale for choosing this methodology over and above other more established research methodologies has been offered. The methods employed in the course of this research study are also included.

The methodology chosen for this study is the non-categorical qualitative research approach of interpretive description developed by Thorne et al. (1997). This approach to interpretive description was developed to address the need for a discipline specific methodology that addressed clinical questions. A process of data collection, inductive analysis and interpretation is employed in order to provide credible knowledge of the clinical situation, and to provide potential application possibilities (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004).

## Research Methodology

### *Background of the Methodology*

Interpretive description is a relatively new research methodology (Hunt, 2009). Elliot and Timulak (2005) suggested that the descriptive–interpretive branch of qualitative research evolved around 1970-1980, and draws on the methodologies of grounded theory, empirical phenomenology, hermeneutic-interpretive research, interpretive phenomenological analysis, and consensual qualitative research. While Thorne (2008) acknowledged the origins of interpretive description stem from the methodologies of ethnography, phenomenology and grounded theory, the development of interpretive description signalled a departure from the constraints of these methodologies. Thorne et al. (2004) further break down the ancestry of interpretive description, apportioning grounded theory, naturalistic inquiry, and ethnography to design strategies, while interpretive description data collection methods are related to phenomenology. However, Sullivan-Bolyai, Bova and Harper (2005) suggested that interpretive description is an "adaption" (p.129) of the  traditional qualitative research approaches, while other researchers suggest that interpretive description methodology is aligned with constructionist and naturalistic inquiry (Hunt, 2009), and hermeneutics and constructivism (St George, 2010). While interpretive description is a new approach that seeks to answer the shortcomings of present qualitative research approaches, it nonetheless acknowledges its foundations in these same methodologies.

Historically researchers, particularly nurses working within the practice setting, followed the traditional qualitative methodologies of ethnography, phenomenology and grounded theory (Thorne et al., 1997). In 1991, Morse wrote that nurse researchers brought their own postgraduate disciplinary methodology into nursing despite differences in discipline situation and theoretical context. Thorne et al. (1997) suggested that while some nurse researchers were hesitant to  move beyond these prescribed methodologies and methods (in order to

maintain methodological "purity" (Thorne, 2008, p. 30) and uphold research credence), others adopted a more diverse approach resulting in "method slurring" (Baker, Wuest, & Stern, 1992, p. 1355) or a "sloppy mishmash" (Morse, 1991, p. 15). Other researchers admitted to the incongruence of the established methodologies with the demands of the nursing research and adopted various methodological approaches better suited to their research requirements. Morse (1991) suggested that in a departure from traditional qualitative methodologies, some researchers at the time were undertaking "legitimate qualitative research for which, as yet there is no name" (p. 18). This research was referred to as "unstructured, open-ended interviews and content analysis" (Morse, 1991, p.18) in the absence of participant observation. While nursing and midwifery professions are closely aligned it is difficult to determine if midwife researchers approached research in the same way as their nurse colleagues. Midwifery research is relatively new; historically midwives alluded to research from allied health professionals and midwifery led research was not always regarded positively (Cluett & Bluff, 2006).

Thorne et al. (1997) developed their interpretive description approach in response to nurse researchers wanting a research method more in keeping with the profession's epistemological foundations, systematic reasoning, and with an ability to provide credible and applicable knowledge. However, over time the authors have acknowledged a change in the end-user profile of their research methodology. While Thorne et al's approach to interpretive description was developed in response for a methodology that served the needs of the 'nurse' researcher in the original 1997 article, latter methodological literature is addressed to the wider field of health professionals (Thorne, 2008; Thorne et al., 2004). Interpretive description has been adopted by midwife researchers and used as a methodology in midwifery research (Janssen, Henderson, & Vedam, 2009; Nyman, Bondas, Downe, & Berg, 2013).

*Interpretive Description*

Qualitative research looks at people's experience of everyday issues and concerns in order to reveal understanding (E. Smythe & Giddings, 2007). What distinguishes interpretive description from other qualitative theories is its practice orientation, health discipline specificity and interpretive focus. Thorne et al. (1997) presented interpretive description as a methodological approach that begins with researcher understandings of a phenomena situated in practice, enquiry within the field and engagement with the data, resulting in new understandings. Interpretive description is purpose driven, progressing from the foundations of a practice goal and understandings, to questions within the context of the study. Rather than offering an arbitrary description of the ensuing data, interpretive description provides a deeper understanding of the phenomenon (Neergaard, Olesen, Andersen, & Sondergaard, 2009) through "reflective and critical examination" of the data (Thorne et al., 2004, p. 3). It is a research approach that allows understandings of the individual within a milieu of common realities. The researcher is the key element in interpretive description methodology as it is the researcher that drives the interpretation and hence the findings.

St George (2010) suggested that the two fundamental words central to interpretive description are "applied" and "interpretive" (p.1624). Thorne (2008) stressed the applied nature of the

research and emphasised the importance of the question being situated within practice, and the application potential of the findings in the clinical arena. Interpretive description is a research approach that is geared towards health profession in the citing of the research question, the methods employed and the subsequent findings. Given that my research question about the student midwife experience is a clinical issue, warrants further inquiry, and has a distinct application potential, interpretive description is a good methodological fit. The methods employed in interpretive description are similar to many other qualitative methodologies i.e. generating a question, study design, literature review, sampling, data collection, data analysis, discussion of findings, and implications for practice. These methods are situated in an environment of theoretical allegiance, integrity and credibility. These methods will be discussed later in this chapter.

The theoretical scaffolding suggested by Thorne (2008) comprises a review of the literature, and clarification of the researcher's forestructure. While some qualitative methodologies discourage researcher knowledge through the use of bracketing, interpretive description relies on researcher foreknowledge. Thorne reiterated the importance of the literature review in establishing a firm rationale for the research study and validating the research methodology and study inquiry. A critical review of the literature (primary, secondary, and grey) was undertaken providing existing knowledge in relation to the research question, and this also served to shape study design decisions such as sampling, mode of interviews. While my study was focused on midwifery students, I considered literature in relation to the student experience from other health professions i.e. nursing students. The literature review validated the focus of this study as I could only locate a small number of international studies that addressed the student midwife experience; an absence of any New Zealand based research was revealed. Formal acknowledgement of student vulnerability in the clinical field (Future Workforce DHBNZ, 2009; Worksafe NZ, 2014) also supported the instigation of my research study.

Locating oneself within the discipline is Thorne's (2008) second element of ensuring sound theoretical scaffolding. It is important that the study question is situated within, and is shaped by, the disciplinary orientation. This study is set within the discipline of midwifery. My midwifery perspective shaped my literature review, the study methods, the language used, and the articulation of findings, discussion and recommendations.  Thorne asked the researcher to consider her positioning within the research; integrity of 'one's self' within the research process maintains research quality. Thorne further suggested to researchers that they "capitalize" (p. 64) on themselves as an instrument in the research.  Clinical expertise of the researcher is considered advantageous especially where little is otherwise known about the research question (Hunt, 2009). In terms of expertise, as a core midwife and midwifery lecturer, and previous midwifery student, I have knowledge of student midwife experiences from personal and observer perspectives. In the initial stages of the study it was important for me to reflect on and acknowledge my understandings of the student midwife experience in order to understand my motivations, biases and assumptions.

Thorne et al. (2004) cautioned that this forestructure has the ability to shape data collection and analysis and render findings that are limited only to what was already known. While initial data

and analysis should be sympathetic to the initial forestructure it is expected that this will evolve as the study progresses in order to accommodate new insights and possibilities. It is the researchers' responsibility to minimise any unintended effects stemming from their own understandings (Brewer, Harwood, McCann, Crengle, & Worrall, 2014). An inventory of my own preunderstandings prior to the commencement of data collection was undertaken to address this issue. It is envisaged that attention to the theoretical, disciplinary and personal forestructure will provide an effective scaffold on which to build a robust research study.

### *Rationale*

Giving consideration to the research methodologies available to a researcher was a logical first step in my research journey and one that ensured the construction of a robust and credible study. In selecting the methodology for this research study it was important to ensure congruence between the research question and the methodology. My research question focuses on experience in the clinical field; interpretive description is described as a methodology that is appropriate to both experience and the clinical locale (Hunt, 2009; St George, 2010; Thorne, 2008; Thorne et al., 1997; Thorne et al., 2004). Midwifery education is well suited to utilising interpretive description as a methodology because of the clinical nature of the discipline and the mode of undergraduate education vis-à-vis clinical based learning. Interpretive description offers a methodology orientated towards clinical practice (Thorne et al., 1997; Thorne et al., 2004; Thorne, 2008, St George, 2010); while St George (2010) commented that "practice is the perfect candidate for interpretive description" (p. 1625).

Interpretive descriptive was congruent with the aims of the study's inquiry; there was consistency between the research question, the methodology and the methods. One of the foundations of interpretive description is generating an account capable of informing clinical understanding (Thorne et al., 2004), this is congruent with both the research question and the aims of the researcher.

Thorne et al. (2004) suggested that interpretive description is a realistic methodology to employ for small investigative research study. L. Smythe (2012) agreed, describing interpretive description as being "ideally suited to a master's study" (p. 5). Since this research study is being done to complete a master's degree, there is congruence between research methodology and the purpose of undertaking the study.

### *Strengths and Challenges*

The strength in interpretive descriptive methodology is its "straight forwardness" (L. Smythe, 2012, p. 6), where the researcher asks questions, listens, and then interprets the data. However, L. Smythe cautioned that there is a danger of the analysis not moving beyond what has been said and that themes may emerge or be silenced depending on the relative insightfulness or perceptiveness of both participant and researcher. L. Smythe (2012) and Thorne (2008) both advised the researcher not to align importance of the data with the frequency of participant observation. Other strengths of interpretive description is its applicability and orientation towards clinical practice, as already described in the methodological rationale. The challenges of interpretive description include it being a relatively

new methodology (there are few sources available to refer to other than Thorne), lack of knowledge within academia, and that the interpretive nature of interpretive description may be underdeveloped by the researcher (Hunt, 2009).

### *Personal Engagement with the Research*

E. Smythe and Giddings (2007) cautioned the researcher that in utilising qualitative research, the researcher places oneself in a vulnerable position. The vulnerability of the researcher arises because in the doing of the research the person the researcher confronts is them self: "qualitative research is risk taking because you face-up to 'you' in practice" (p. 43). In using interpretive description methodology, the prominent role the researcher assumes increases the vulnerability of 'one's self' further (as discussed previously in the theoretical forestructure). In this research study my vulnerability arises on multiple levels. I am a core midwife and my research includes the experience of students working with core midwives. I also work as a midwifery educator and these students are representative of the students I work with and of their experience in clinical practice. My gender also renders me vulnerable to the research as midwifery is nearly an exclusively female occupation.

Weight of privilege, desensitisation, vulnerability, hearing untold stories, guilt, and exhaustion were identified as some of the challenges experienced by researchers involved in the qualitative research process (Dickson-Swift, James, Kippen, & Liamputtong, 2007). The authors suggested both formal and informal support measures such as peer and supervisory support, adherence to ethics guidelines and support from family and friends to help the researcher. In undertaking this research I have been privileged to have the support of my supervisor and have guidelines set by AUT Ethics Committee that served to minimise risk to my wellbeing.

### *Consideration of Other Methodologies*

In this chapter I have described why interpretive description is a good methodological fit for my research study. In the process of selecting the methodology, consideration was given to alternate methodological approaches available to the researcher. Neergaard et al. (2009) suggested that qualitative research addresses the "'why', 'how', and 'what' questions" of an experience, whereas quantitative approaches are more suited to the "'when', 'how much', and how many' questions" (p. 2). Given the research study's focus was on experience it was apparent that a qualitative study rather than a quantitative study was more fitting. While a quantitative study could have provided generalised statistics on a range of variables experienced in clinical placements, it would have failed to describe and interpret the experience per se by the participants both individually and collectively.

Phenomenology and hermeneutics are traditional research methodologies and are commonly utilised in the healthcare research arena, including midwifery. Both these methodologies were developed to reveal or analyse meaning within the experience (L. Smythe, 2012); however they follow a specific philosophical lens and (importantly) do not have an application potential.

Narrative analysis provides an insight into the nature of how stories are told (L. Smythe, 2012). Understanding the 'how' of the stories was not the purpose of the research study and hence this methodology was not utilised. Critical and discourse analysis were discarded as a methodology as the researchers interest lay in the experience of the participant rather than revealing the power behind the experience.

Grounded theory was another methodology precluded, as rather than developing a theory or hypothesis the researcher was interested in interpreting the participant's experiences. Action research and ethnography both employ 'in the field' research methods which asks participants to draw on their experiences in differing clinical situations over a period of time (L. Smythe, 2012), this was deemed unsuitable for my research study.

While researching the aforementioned methodologies, commonalities with interpretive description were identified i.e. the emphasis of interpretation of the data within phenomenology and hermeneutics, the data collection techniques of narrative analysis, phenomenology and hermeneutics, and the coding of grounded theory. However, there was a distinct lack of application potential offered in these methodologies. An overriding aim of my research study was to produce results that were applicable. It was, therefore, a process of elimination and confirmation that resulted in the methodology of interpretive description being selected for my study.

## Methods

### *Approval for the Study*

Approval for this research study was submitted to the Auckland University of Technology Faculty Postgraduate Committee and was endorsed on November 8, 2013. Ethics approval (number 14/77) was granted by the Auckland University of Technology Ethics Committee (AUTEC) on May 20, 2014.

### *Concern for the Participants*

Given the research question and methodology employed it was evident that the ideal data were stories of participant's experiences. All participants were aware that it was their experience of clinical placements in secondary and tertiary hospitals that would be discussed. This was detailed in the initial Advertisement (Appendix A) and in the Participant Information Sheet (Appendix B). I was aware that for some participants relaying certain stories or experiences may produce an array of emotions. It was not the intention of the research study to place any of the participants in a situation that might have been uncomfortable for them. It was envisaged that if at any time a participant became uncomfortable or distressed they would be offered a break in the interview process, and asked if they wished to continue with the interview. During the interview process, several of the participants did become distressed, a break in the interview was taken, and all the participants chose to continue. At the conclusion of the interview reassurance of the wellbeing of the participants was sought and obtained. The participants were aware that counselling services were available if needed at the student health centres of the tertiary institution at which they were enrolled. The participants were advised that

at any time they could choose not to answer a question or could end the interview without giving a reason.

### *Concern for the Researcher*

I am a midwifery lecturer at AUT and a core midwife at a tertiary hospital within Auckland District Health Board (ADHB). To avoid a conflict of interest on professional grounds the participants were recruited from midwifery schools other than AUT. Any student who had clinical placements at Auckland City Hospital were similarly excluded from participation.

A 'Researcher Safety Protocol' (Appendix C) was provided and followed since I would be interviewing participants at locations (at that time) unknown to myself. At no time during the interview process did I feel at risk.

### *Consent, Anonymity, and Confidentiality*

As part of the participant recruitment process all potential participants were advised in the Participant Information Sheet (Appendix B) that consent would be a requirement to participate. All the participants provided written consent to the researcher (Appendix D). The participants had the opportunity to ask and have answered any questions, and the participants understood that they had the right to withdraw consent until completion of the data collection.

The participants were known to myself by virtue of my meeting with the participant, email, telephone and/or mail correspondence. The transcriptionist was aware of the first name of the participants (if used) and the sound of their voice. The transcriptionist signed a confidentiality agreement. The electronic recordings and transcripts were held on my computer (password protected) and were devoid of any identifying features. After the completion of my thesis, the recordings and transcripts were removed from my computer, transferred to a memory stick and secured safely at AUT. The consent forms, recordings and transcripts will be destroyed after a period of six years. My supervisor is bound by AUTEC confidentiality requirements.

All verbal and written communication between myself and the participants was first hand. The interviews were conducted in situations where auditory privacy was maintained. All interviews were electronically recorded; only the transcriptionist and I had access to the recordings. After transcribing, the electronic recorder was wiped clean. The participants are anonymised in the findings—the participants were asked if they would like to choose a pseudonym that would be used in the findings. The pseudonym is only known to the individual participant and researcher. Participants will be acknowledged as being second or third year midwifery students only. No information has been offered that could be used to identify the location of the participant's place of abode, clinical placement or educational institution.

### *Participant Selection and Recruitment*

While Thorne (2008) suggested that theoretical sampling is the dominant method employed in interpretive description she urged the researcher to employ a sampling strategy based on  logic and suggested that findings should be considered only within the context of the sample. For this research study participants were chosen through the process of purposive sampling. The

research study specifically looked at the experience of student midwives in secondary and tertiary hospitals; therefore, it was logical to confine the research participant selection process to second and third year student midwives with relevant hospital experience.

The Joan Donley Midwifery Research Collaboration (JDMRC) Database Access Governance Group was contacted and permission was given to use the data base to invite student midwives to participate in the research study. An Introductory Letter to students (Appendix E) and accompanying Advertisement (Appendix A) was emailed to all student midwives on the database, and the students were invited to contact me if they wanted more information or were interested in participating. Students were required to be a second or third year midwifery student at a New Zealand school of midwifery other than AUT. Students who had had clinical experience at Auckland City Hospital were excluded from participation. Students were required to have had some clinical placement experience at secondary or tertiary hospitals. Forty six students contacted me within one week of the email being distributed. Half of the students (including those not eligible for inclusion into the study) were thanked for taking an interest in the research study and advised that their participation was unfortunately not required due to the large number of students interested in participating. Of the remaining students who indicated ongoing interest in the research study, eight were initially chosen to participate in the study. The participants were predominantly in their third and final year of training, and all had experience of working in secondary and/or tertiary hospitals. The participants were from up to three of the four midwifery schools in New Zealand. Collectively the participants had had clinical placement experience in multiple hospitals across many DHB areas. Given I had approval for eight to 10 participants, a preliminary number of eight participants allowed me the ability to increase participant numbers further into the research study if required. Thorne (2008) suggested that participant numbers should be congruent with the intent of the study, and commented that a small study can provide a meaningful description of the phenomenon in question. A small study of eight participants is also entirely appropriate for a master's thesis (L. Smythe, 2012). The study did not move beyond the eight initial participants as I felt the data available to me was sufficient to generate credible findings.

### *The Interview Process*

Each participant was interviewed at a time and place of her convenience. Of the eight interviews, six were face to face and the remaining two were via electronic means. The obvious advantages with face to face interviews is the synchronicity of time and place and the benefit of social cues (Opdenakker, 2006). The remaining two interviews were achieved by electronic means, one with audio and video, one with audio only. While simultaneous audio and video offered a similar experience to that of a face to face interview, several factors affected the overall experience. Not being physically present with the participant limited recognition of subtle cues, the sense of 'being with' the participant was missing, and the electronic delivery of voice and picture was found wanting at times. The interview by telephone was valuable in that data was obtained, but with the absence of a visual component the interview lacked the benefits that a face to face interview would have provided. The one good learning from this interview was that I would not choose to use this technique again given other options. However, interviewing

by electronic means does have the advantage of including participants who would otherwise be excluded from participating due to geographical locale. I also found note taking much easier with these participants, as I felt the physical act of writing in front of someone when they were talking could be considered discourteous.

As a novice researcher I did find interviewing more difficult than I had envisaged. The requirement to listen to what was said, respond in a respectful, purposeful and constructive manner, and at the same time formulate in my mind another question or response was difficult. My interviewing technique evolved and improved as the research study progressed. Another difficultly I encountered was the requirement to leave aside my 'own knowing' in the interview. As a previous student, a midwife and a lecturer, I was able to relate to many of the stories that were shared, but as a researcher it was important that I suspended my knowledge in order to elicit more information from the participant (Thorne, 2008). Yet my natural inclination was to agree with the participants, affirming their experiences, and out of a sense of respectfulness to the participant. At the conclusion of the first interview I was very aware of this inclination and made a concerted effort to respond in the remaining interviews in a way that was more neutral and elicited more information.

In the Participant Information Sheet (Appendix B) I had indicated that the interview might take 60-90 minutes to complete. It was the participant that dictated the length of time of the interview, stopping when they felt their stories had been told. The length of the eight interviews ranged between 44 and 85 minutes. At the beginning of the interview I would repeat the purpose of my research, and then ask the participant if they had a particular story to tell first. I was aware that some participants would approach the interview with a specific story in mind, and I wanted to show my respect of their reflection prior to the interview. During the interviews I would respond in an enquiring manner to elicit more information, asking questions that followed on from the participant's line of thought, or changing direction as required. On a few occasions when I was at a loss as to the nature of the next question I referred to the prepared list of questions (Appendix F). At times I felt the conversation moved away from the research question, and a balance was sought between giving credence to the participant's story and returning back to the research question.

After each interview the electronic recording was transcribed by a transcriptionist. I then listened to the audio recordings with the relevant transcript and any required alterations to the transcripts were made. The transcripts were returned to the individual participants and they were asked if they could review the transcripts for accuracy and were invited to make changes as required. One participant took the opportunity to make minor changes.

### *Data Analysis*

The recordings were listened to with and without the transcripts—the benefit of listening to the transcripts was that subtle nuances in the participants' voices could be identified and comments added to the transcripts, or notes made. Over the course of many months I became immersed in the data, reading and rereading the transcripts. Part of making sense of the data required me to question what I was reading, for example "what is the participants trying to say?", "what is

going on here?", "where does this fit?", and "what else is happening?" What I garnered from the data would become the data bits that I would use further along the analytic process. It took many readings of the transcripts before I was comfortable that no data bits had been overlooked (although further down the track when themes had emerged I did revisit the raw data to see if data had been missed). It was important to somehow organise the data bits into collections—key descriptions became apparent and the data bits were accordingly collated under these descriptors.

While the main mode of data storage and collation was computerised files, I also utilised data maps to help sort the data. This was in the form of hundreds of post-it notes covered in data bits. These post-it note data bits occupied an entire wall of my study and were constantly moved around under various descriptors (which also changed). In hindsight, given the importance of these visual data maps to the data analysis stage of my research I should have taken a photographic record of the maps. However, I did not and this was one of the many learnings in my research study.

At times it was difficult to decide which descriptor a particular data bit belonged under—this was resolved by making multiple copies of the same data bit and assigning the same data bit to multiple descriptors. The use of descriptors helped address the issue of prematurely grouping and assigning themes. By using ever-changing descriptors rather than concrete thematic headings I was acknowledging the fluidity of conceptual analysis (encouraging different ways of seeing the data). Another method I used was to stand back and see the data as a whole (rather like a cake), and reflect on the different ways the data (or cake) could be cut up. For instance I could have looked at factors such as positive and negative experiences, student led versus midwife led experiences, or what it was like when things were known or unknown.

As the groupings of data bits became clearer, themes began to materialise and replace descriptors. For some data bit groupings themes were apparent, but there were other data bits for which there was no clear overriding theme. This spurred multiple changes in the data map; reflection on the changing collection of data bits often prompted a change to the thematic headings. At several points my data seemingly sat comfortably under thematic headings but after discussions with my supervisor and subsequent reflection my thematic headings and data bits would change yet again. Thorne (2008) suggested this process to "try out" (p. 168) differing organisational themes is an important part of the mechanics of conceptualising the data. At one point I realised that my interpretation of the data would always be evolving, and that I would always be able to comprehend and sort the data in different ways. I finally stopped resorting my data when I could find no other satisfying way in which to sort it!

Throughout this process I was aware of the need to further solidify the structure by which I was going to present the data. Thorne (2008) suggested the reader consider Morse's four cognitive processes in order to conceptualise the data. Firstly *comprehending* the phenomenon, *synthesising* by finding the commonalities and patterns in the data, *theorising* through finding explanations within the data, and lastly *decontextualising* where new knowledge is articulated and could be applied. In my research study my personal context, preunderstandings and the

literature review provided me with a solid comprehension of the phenomenon of interest. The process of listening to the transcripts and identifying data bits allowed me to find typical patterns within participant data sets and across the whole data, and hence address the second process of synthesising. The theorising process found me making multiple "best guesses" (p. 166) about the data, my multiple changes of data maps are testament to this. Lastly, my discussion chapter details the findings in relation to what is already known and highlights the application potential of the new knowledge generated by this research study. While Thorne suggested that writing should preferably commence after the organisational structure of the study has been set, I found that these two processes overlapped.

### *Trustworthiness*

The value of trustworthiness in qualitative research is two-fold, firstly to the researcher who through a process of research transparency has produced credible findings, and secondly to the reader who can peruse and confirm the research study and findings (Carcary, 2009). While it is tempting to approach the concept of trustworthiness with the often utilised and fundamental elements of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985), Thorne (2008) suggested to the interpretive description researcher that the notion of trustworthiness is better served by attention to "epistemological integrity, representative credibility, analytic logic, and interpretive authority" (p. 102). The departure from the traditional techniques to ensure trustworthiness reflects the suggestion by Rolfe (2006) that trustworthiness in qualitative research is better served by individual judgement in relation to specific research, and that a one size fits all approach is inappropriate.

Epistemological integrity of a research study refers to the logical and persuasive connections found within the study (Marshall & Rossman, 2016). Congruence between the research question, methodological approach, methods and the findings (Thorne, 2008) provide an epistemological integrity to this research study. The rationale for the methodology is congruent with the aims of the research study and has been previously discussed in this chapter. The methods of purposive sampling, construction and analysis of the data sit logically with the research question and intent of the researcher. The epistemological standpoint that I approach this research from is credible given my background as a student, midwife and midwifery lecturer.

Representative credibility reflects the congruence of the findings to the context of the phenomenon in question (Thorne, 2008). The intent of interpretive description is to encourage research findings that convey themes and commonalities with individual variations (Thorne et al., 2004) but only within the limitations of the context with which the research study was carried out. While findings of this research study apply to the context of second and third year student midwives working in secondary and tertiary hospitals, I appreciate that some readers may discern similarities in other circumstances. Epistemological support for the representative credibility in this research study was evidenced when I discussed my findings with other midwives and lecturers. Physical indicators of affirmation and vocal endorsement of my findings indicated credibility of my research findings.

Analytic logic demands that an audit trail is required in order to demonstrate that the decisions made during the research process have resulted in reliable, logical and credible findings (Carcary, 2009; Thorne, 2008). While an audit trail benefits both researcher and reader (by enabling or enhancing credibility), the reality is that an audit trail is the exception rather than the rule (Carcary, 2009). Throughout the research process I have maintained notes reflecting my research journey from research question to methodological enquiry, sampling decisions, data collection and analysis, and writing findings. However, my neophyte researcher status is still apparent throughout the audit trail both in relation to the research process and to the audit trail itself.

Interpretive authority details the expectation that the interpretations proffered to the reader are trustworthy, and reflect the data rather than the researcher's own experience (Thorne, 2008). While the findings reflect the researcher's interpretation of the data, it is clear that the researcher's own biases and preunderstandings need to be acknowledged in order to address trustworthiness (Josselson, 2007). To this end, prior to the interview stage of the research I reflected and detailed my preunderstandings surrounding the research question. My positioning as a midwife and as a researcher were acknowledged. During the analysis and findings stages of the research I revisited my preunderstandings and was able to reassure myself that my writings (although my interpretation), reflected the participant's stories. Josselson (2007) commented that interpretive authority tasks the researcher to make clear to the reader and the participants that the findings are the *researcher's* interpretation of the data. I make this assertion clear in the methodologies and findings chapters.

For the purpose of enhancing credibility Thorne (2008) proposed the further consideration of moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth. In terms of moral defensibility my research question will have application potential, and it is anticipated that the research findings will have the potential to benefit the educative experience of future student midwives. Given that midwifery education in clinical placements is both an applied and practice discipline the requirement of disciplinary relevance has been met. Pragmatic obligation requires of the researcher to present the findings in a way that does no harm if those findings are applied in practice (Munhall, 2012). I have reflected on the findings and do not anticipate that application of any of the findings would be to the detriment of a specific person or institution. Contextual awareness leads the researcher to acknowledge that our perspectives reflect the historical and social context in which we live (Thorne, 2008). I have made it clear that the findings of this research study should be considered in the context of which they were constructed. The final element of credibility is the appreciation of probable truth. Given the qualitative nature of my research and the limitations inherent in a small study I can only assert that my research findings will constitute a probable truth. I have acknowledged the limitations of this study (Chapter 8), and the strengths and challenges (Chapter 3) of this study acknowledge research vulnerability.

**Summary**

In this chapter I have described the chosen methodology for my research study. The ancestry, strengths and challenges of interpretive description have been discussed. My rationale for choosing interpretive description over other qualitative methodologies has been explained. The methods (including participant selection, the interview process, and data analysis) and the processes therein have been detailed. The processes employed to ensure research credibility have also been discussed.

# Chapter Four: The Findings; A sense of Belonging

In this chapter I will initially describe the four experiential dimensions that have emerged from the data, and then provide an in-depth explanation of the first experiential dimension 'a sense of belonging'. The experiential dimensions offered in these findings chapters capture key elements of the student midwife experience and have the capacity to convey knowledge from both the commonalities and individual variations that emerged from the participants' stories. From analysis of the data, four experiential dimensions of the study participants' experiences have emerged: 'a sense of belonging', 'the opportunity to learn', 'challenges in clinical placements', and 'having confidence'.

The four experiential dimensions are further divided:

**A Sense of Belonging**: feeling welcomed, the student-midwife relationship, fitting in and being part of the team.

**The Opportunity to Learn**: watching and doing, the supportive midwife, the responsibility is also mine, learning during busyness.

**Challenges in Clinical Placements**:  the reluctant midwife, being a burden, unprofessional behaviour, questionable practice.

**Having Confidence**: developing and sustaining self-confidence, the woman has confidence in me, confidence from the midwife.

In this, and the following three chapters, I offer my interpretation of the data using these dimensions as a guide. While each experiential dimension has been offered as a separate entity it is important to appreciate that each dimension is inextricably linked with the others and that common threads weave throughout all four findings chapters.

### Chapter Four: A Sense of Belonging

Feeling a sense of belonging is an important experiential dimension of being a student midwife. Belongingness sets the scene for the student midwife experience in institutional clinical placements by grounding the student within the midwifery and learning arena. For the participants in this study, belongingness was the starting point from which professional mastery and identity followed. A sense of belongingness develops from the moment the student walks across the threshold into a clinical placement; it continues to develop as the student-midwife relationship evolves, culminating in socialisation within the midwifery team and midwifery profession. In this first findings chapter, a sense of belonging is discussed through feeling welcomed, developing knowingness in the student-midwife relationship, and fitting in and being part of the team.

### Feeling Welcomed

> We've both said how welcomed we've felt. And they've said "we just love having students" and it shows…. When you know that you're welcomed and you know that

they're happy to have you there, it does make you feel so much different. So much differently about what you're doing and how long that shift is going to be. (Jenni)

As the participants commenced their clinical placements they hoped they would be welcomed by the midwives and that their presence would be well received. Students sometimes found new placements stressful and to be welcomed alleviated some of the stress. While participants knew where and when they were rostered, student presence in clinical placements was not always expected by the midwives. When managerial miscommunication failed to advise of student presence, most midwives in the clinical placements were nonetheless very welcoming and thankful for the student presence. While students were welcomed albeit unexpectedly, the reality was that the unit was not prepared for them; they did not immediately feel a sense of belonging there but rather as someone who had to be accommodated:

> Other times you'll come on and they're like "oh, you're here", "ok what are we going to do with you", "where shall we put you?" And they're very kind and pleasant but it's almost a bit of an afterthought that you're tacked on the end. (Ngaire)

Despite occasions where the initial reception was found wanting, the participants recalled instances of being welcomed and wanted by the midwives. Many midwives appeared pleased to have students on the unit and subsequently invited students to work with them for the shift. The manner in which the midwives responded to the presence of the students was recognised by the participants, and a positive reception was considered encouraging: "My experience has been that the midwives are very kind and are very interested in what we are doing and that they're very willing to have us there" (Ngaire). While it would be reassuring to think that all students were well received, not all staff welcomed the presence of students and this negatively affected the participants' confidence. Not wanting to work with students was usually conveyed by the midwives in a seemingly covert manner, but often this was recognised by the participants. One participant recalled how at handover the midwives would indicate that they did not want to work with a student:

> You see them and you see that look [on] their face and they roll their eyes; I don't want to work with them either. Usually they're fine once you get started but it's that *oh no it's my turn for a student* kind of look…. And your heart just sinks and you go *oh no it's going to be a long shift.* (Jenni)

Initial encounters where the midwife articulates or shows reluctance to work with the student can have a devastating effect on the student's confidence (this is examined further in Chapter 6). Initial first impressions produced powerful emotional reactions which for the following participant remained during that placement: "Whether it's just because I got a good feeling or a bad feeling on the first day and I carried that feeling through, or whether actually it is how it is there" (Caroline). Experiences of being welcomed and wanted differed even when students were based in the same placement at the same time.

The experience of being welcomed and wanted by the staff also changed as the participants progressed through their degree. At the beginning of their degree participants were less likely to feel welcomed or wanted, whereas from their second or third year participants were received more positively. The following participant described how the midwives made her feel welcome as a third year student:

> Just instantly sort of treating me like I was part of them, and I guess not making me feel like the student, and making me feel supported which has been really good. I haven't always struck that … maybe because I was the first and second year. (Rebekah)

First and second year students were some time away from becoming a midwife and hence were recognised in their student role, whereas by third year, students were more likely to be seen within a midwifery context. Senior students had increased knowledge and ability, and they were likely to graduate; possibly midwives saw these students as more worthy recipients of their time and treated them accordingly.

To be welcomed and wanted in clinical placements was foundational to the participants' clinical experience. The relationship the students made with the midwives became the basis from which learning occurred and belongingness to the profession developed. While some participants had existing relationships with midwives, other student-midwife relationships were yet to develop.

## The Student-Midwife Relationship

> I think as a student when you start working in a different place or with a new midwife there's a lot of almost pussy footing around, finding out whether they want you, whether they are going to eat you alive or whether they're just happy for you to do your thing and come in and check in with them… everybody's a bit tentative I guess. (Jenni)

The participants were aware that the nature of placements in secondary and tertiary hospitals would be different from placements where they had worked with a known midwife. Working in an institution with multiple midwives employed on a shift basis meant that students could be working with any midwife from a larger pool of possibly unknown midwives. Participants were mindful of the difficulties brought about by the unknowingness inherent within each new student-midwife relationship, and were aware that their sense of belongingness would vary. While participants were aware of their own problems in having to work within a new relationship, they were also mindful of the impact on the midwife: "I know it must be really hard because they don't know you and you don't know anything and you don't know them" (Rebekah). The unknowingness in the student-midwife relationship necessitated an initial period of *getting to know each other* where student and midwife would begin to appreciate each other's capabilities and understandings:

> When you're working with different midwives you are having to build that rapport with them, so sometimes depending on the person they don't let you do everything straight just off the start. You've got to build that relationship with them. (Penelope)

During this time of getting to know each other student participation in care provision was often confusing and inconsistent with their ability. The midwife would typically take a slower and more cautious approach than necessarily expected by the student. The following participant described her initial interactions with unfamiliar midwives:

> [The midwives] sometimes ask you what you can and can't do. And they do the whole sort of take over thing and do everything, and you have to tell them "I can do this, and I'm a third year, and can do pretty much everything." And they kind of get this sense that they feel like they need to be right there. (Rebekah)

Participants recognised the need for a cautious approach, and realised that as understanding of student ability increased and knowingness emerged, more learning opportunities would be available:

> Maybe they are just keeping an eye on how I am on one shift, and then the next time they work with me they're like "Oh well, we know she can do that" and then they'll let me go and do some stuff. (Lily)

Participants acknowledged that having an unknown student share the provision of care might cause some degree of anxiety to the midwife: "That seems hard for some of them because they've just met me and they want to provide the best care to women and so it's a bit hard for them to maybe let go of that" (Caroline). It therefore seemed reasonable to the participants that midwives would be cautious in their approach to sharing care provision with the student, especially a student unknown to the midwife. The participants were mindful that midwives also differed in the degree of trust they bestowed to the students.

Knowingness in the student-midwife relationship began with a period of close supervision, followed by appreciation of knowledge and skill, finally resulting in a greater understanding of the student and her abilities. During this time a sense of belongingness was also developing. Already knowing the midwives absolved the need for unnecessary close supervision and allowed students to immediately provide care appropriate to their knowledge and ability. For Dianne, knowing the midwife meant that clinical placement time would not have to be wasted while a relationship was established:

> I can think of midwives that I've worked with more than once and I think *yes, I've got you again* and you feel good about that, and you don't have to spend so much time establishing your boundaries and things, and you can just get into the shift and get going because you understand each other already.

The advantage of working with known midwives was that the midwives knew the participant's abilities and an element of trust was formed; midwives would trust students to perform certain tasks and cares, likewise the student would take confidence from the midwife's trust in them:

> Working with a known midwife… she understands what you know, she's seen you do things before and so she might say "well why don't you go do this because I know you can do it", and that fosters a sense of independence and confidence … you just have more capacity to try yourself out and learn, because for me that's how I learn from trying things out. You just feel more able to give that a go because you've got someone that understands your capabilities already… I learn more in the shifts where I know the midwife … you're just more willing to give things a go. (Dianne)

Knowing the midwife brought the student benefits of being able to work to their ability and then having the confidence to extend their midwifery skills within a climate of understanding and trust. Participants in the situation of having worked with the same midwives over a longer period of time commented that the midwives had a better understanding of where the student was at and a better view of how the student had progressed. Knowing the midwives prompted participants to be more open to discussing midwifery matters and care management. The students perceived that in becoming known and trusted by the midwives they were at the same time developing a sense of belonging and place within the profession.

The participants who lived and worked at smaller regional hospitals commented on knowing many of the midwives better due to a smaller midwifery workforce and from previous clinical time spent in the hospital. These participants were also more likely to know the midwives outside of the clinical environment, and have a deeper sense of belonging. Building relationships outside of the hospital was seen to have positive ramifications that spilled over into the clinical setting. Known midwives were seen to be more approachable and supportive; knowing the midwives enabled the participants to individualise their way of working with them:

> Another advantage is we know the midwives, so some midwives you approach them differently. Some midwives you kind of ease into it gently and just follow them around for the first half hour or so and then they'll send you off to do something. Some midwives will straight away get you doing more advanced things…. I've gotten to know all of their ways and habits and what they like and don't like quite well. So I can sort of tailor where I'm at, depending on who I'm working with. (Ngaire)

For Ngaire, knowing the midwives enabled her to tailor her approach to the benefit of the student-midwife relationship. However, Rose commented that the knowingness between the midwives and student also resulted in increased expectations of the student:

> I think because we've been there three years now, we've worked with quite a few of the midwives so they know our level of skills and knowledge and stuff. I think they do expect a lot more. "Oh you're third year now aren't you? You need to be doing this, you should be knowing that." (Rose)

From this participant's perspective the growing familiarity with the midwives instigated midwife-led expectations of her knowledge and skills and what she should be capable of during that placement. The expectations expressed by the midwife could be taken as a sign of confidence by the student or conversely a reminder of where the student should be (as opposed to where she considers herself to be). The increased expectations by the midwife for the student to work beyond her own perceived ability placed pressure on some participants, as expressed here:

> I suppose they are just pushing you and saying "come on, you should be up to this, you should be knowing what you're doing," "you should here," "you should be thinking about this," and I think that word should is quite challenging for a student because I have an idea of what I'd like to be able to do. Whether I can or can't do it yet I don't know but the fact that I should be able to do it makes you think *oh okay, there's something wrong with me*, whereas encouraging "maybe you could think about this" or "do you feel like you have a good understanding of that" might be a better way to phrase some of those things rather than this is where you should be at. (Dianne)

For this participant the word *should* had negative connotations, putting pressure on her to perform to the level expected by the midwife, rather than at the level of her ability; words of encouragement would have had a more positive impact. The sentiment described by the previous participant is also captured by this participant:

> As a third year I've heard the comment "well you're nearly there"…"you are essentially a midwife now." "This is your practice year." "This is your apprentice year and so you should be able to do this by now." (Jenni).

While the phrases "you are essentially a midwife now" and "well, you're nearly there" may represent midwife encouragement and confidence, they also serve as a reminder to the student

of the leap from student to midwife. The midwife could be indicating to the student that she will soon belong in the profession as a *midwife* rather than as a *student*, and is willing her along.

Knowingness within the student-midwife relationship enabled appreciation of the student's abilities and facilitated the student to participate in appropriate care provision and skill acquisition. Knowing the midwife often encouraged participants to extend themselves and attempt tasks or cares that had previously not be attainable. However sometimes midwife expectations were considered unrealistic by the student. The knowingness in the student-midwife relationship helped students fit in with how the midwife worked and facilitated a sense of belonging to the wider midwifery team.

## Fitting In and Being Part of the Team

> I really enjoy being seen as a team member and being a part of the team. (Penelope)

Clinical placement experience provided opportunities for students to build relationships with midwives and develop a sense of belongingness with the midwifery team. Feeling connected to their midwife and the midwives in the clinical placement meant that learning experiences were more likely to be attained, and the clinical placement became a more pleasant and satisfying experience. Not having a good relationship with the midwives was detrimental to all aspects of student learning:

> That's why it's so important to get on with your core staff … because you're all going to be working as a team. I don't want to be going into the hospital and thinking *oh no, it's them on duty tonight.* (Rose)

To establish and maintain a positive relationship with the midwife often necessitated the student to fit in with the midwife. Fitting in with the midwife facilitated a more positive student-midwife relationship but required the student to yield to the midwife or the demands of the unit, and this often came at a cost. The following participant was very willing to tackle mundane tasks in order to fit in and be seen as a team member:

> There is an aspect of earning your stripes a little bit. Being willing to do some of the not so fun stuff, like stripping beds and restocking cupboards, because I think its team work again, and there's always jobs that nobody really wants to do…. I think that sort of buys you a bit of good will, so that the next day when it's quieter, you are seen as part of the team because you pitched in the day before and you did some of the not so fun stuff. (Ngaire)

For Ngaire doing tasks facilitated her ability to fit in and in doing so she felt a sense of belongingness and *part of the team*. In this case fitting in could be considered a low cost strategy, but for the following participant fitting in required the student to acquiesce to the midwife's way of doing. This could be considered a higher cost strategy as the participant has had to forfeit (albeit briefly) her own midwifery philosophy or approach:

> It's just easier to look at how she does things and learn as much as you can from that. Even if that's just thinking to yourself "well actually, when I'm in practice I'm not going to do that," then that's fine too. But yeah I do think it's easier to fit in with how they do things. (Dianne)

The participants were mindful that party to their student experience in clinical placements was the experience of the women they looked after. The woman's experience was paramount, and the participants felt that it was often more preferable to go along with the midwife and provide a consistent and unified provision of care than it was to stand one's ground and offer different aspects of advice or care to the woman.

Fitting in and being part of the team enabled a more positive placement experience for the participants, facilitating learning opportunities and skill acquisition and, therefore, aiding their continuation through the degree. Participants were very aware of the key role midwives had in providing feedback to their respective midwifery schools which ultimately decided on the students' progression. Students who did not fit in or who could not adapt to working with the variety of midwives probably did not proceed through the clinical component of the degree:

> I think the students that get this far are good at doing that, because if you weren't good at fitting in, if you didn't have that personality that you could work with just about anybody, then you probably wouldn't have got this far. (Jenni)

Unfortunately not all participants always felt part of the team. Not being accepted as a team member on clinical placement did not make for a positive clinical experience; Ngaire described days in which she did not feel part of the team:

> Probably my not good days are days where I don't feel a part of the team. I feel like I'm not a nuisance but that I don't really have a role. I'm trying to work out where I can be or trying to insert myself into different things that are happening. Feeling unsure about what to do at certain times, not in terms of what to do in a clinical sense. Those are the days that I don't enjoy because I feel it makes the day dragged, it takes a long time to get through a day like that.

This student felt disconnected from the team of midwives she was on shift with, not because her skill or care abilities were being questioned, but because of uncertainty about her position within the team.

While it would be preferable for all students to be acknowledged and valued by midwives, participants did feel their student status a hindrance to being accepted as a member of the team: "I guess it sort of puts you slightly on the back foot as a student because you know your place" (Jenni). Participants were aware of the hierarchal nature of institutions, and as a student found their status to be challenging. The tearoom and the conversations held within were seen by the participants as a potential for inclusion and for establishing and maintaining relationships. The tearoom was an area where comments or topics deemed inappropriate in the clinical arena could be discussed. One participant provided two very different experiences of tea room conversations:

> …if you're included in them, you feel good because hey everyone's talking to you and making you feel as though you're actually part of this, and so yeah tea room conversation if you're included in it, can be really morale boosting.…[but if you are not included] you're just a little student in the corner eating your lunch. Yeah if you're not included you feel very much you're in your place as a student…. Sometimes you'll feel really confident to sit down and have a conversation and that's fine, and other times you're like nah I'm not even going there. And it all depends on who's there and what their attitude towards you is. (Dianne)

The student experience of the being in the tearoom is dependent on multiple factors, for example, the personalities of the students and midwives, and how the student is regarded by the midwives. Students regard inclusiveness highly, however, midwives may underestimate the importance to the students of being included, even in tea room conversations. Inclusion or exclusion in the tea room conversations had far reaching connotations that affected the students' self-esteem, confidence, and feeling wanted and valued. While the tearoom did provide students with the opportunity of discussion and inclusion, it was also a venue where the students were party to the midwives vocalisation of their dissatisfaction at work. Participants were mindful that many midwives were discontent with the conditions they worked under and midwives were seen to be overworked and stressed. The participants in this study were disheartened to see members of a profession that they themselves would soon be eligible to join to be so discouraged and despondent about their working conditions. The following participants made comment on the welfare and workload of the midwives:

> I think everywhere I've worked in, they all seem under staffed and over worked… they also feel the pressure of their day to day work, and what they are and aren't getting done… they're generally over worked anyway. Yeah, they've got more to do than they can fit in, in the hours. (Caroline)

> There's lots of midwives crying on shifts, they're walking out. Loads of people resigned. You just think all of this experience is leaving [the] hospital because they can't deal with the politics…. There's not enough resources for the core midwife. They're over worked. The amount of the work they have to do is awful. It's really awful. (Rose)

While the participants recognised that midwives were at times discontent in their working situation, the participants acknowledged the efficiency and knowledge with which midwives went about their work: "Core staff are excellent, and they play a really important role for women and LMC midwives. I think they're fantastic and I think they do their jobs really well" (Penelope). The participants were complimentary about how midwives managed to provide (often complex) care in sometimes difficult and rushed circumstances:

> I've just had this huge admiration for core midwives, is their ability to just build relationships with women in a moment … and I'm just in awe of how they do it …. I really want to reiterate again how grateful I am for the support from the core midwives in our unit and how really skilled they are at balancing the secondary aspect of their work with the care and nurturing of the woman and her baby. They're pretty impressive. (Ngaire)

Despite the politics, the environment and the working conditions, the participants were positive about how the midwives worked. In an environment that appeared not to support midwives, participants were able to see past the physical and administrative aspects that stretched the midwives, and appreciate the midwives for their support of each other and of students in such trying conditions:  "[The midwives] for the most part they really are good women and they have good hearts and they absolutely want us to succeed as students" (Lily). Another participant continues:

> The place is rundown and everything's old and kind of falling apart. It really is. Such a lot of their stuff is just old and tired and the building is just old and tired. But the staff make it such a cool place to work. (Jenni)

Possibly as a consequence of midwives discontentment with their working conditions, midwives sometimes reminded students of the reality of working as a midwife, and in doing so questioned the student's decision to become a midwife. Dianne felt challenged by these conversations with midwives and needed to revisit her initial decision making in order to regain her confidence:

> I've been told time and time again by core midwives and LMC midwives, "why are you doing this?" "What are you getting yourself into?" And then you sort of think *well, what am I getting myself into*? And then you have to look back at why you did it in the first place to get motivated again.

Being accepted as part of the team was made more difficult by the continuing debate about midwifery education and postgraduate employment. Participants described having conversations with midwives regarding the midwifery course they had embarked on, in particular the endorsement of direct entry students, and the ability of new graduates to work as LMCs after graduation. Some midwives would ask about the student's background, in particular if they had nursing experience, while others would make comments about the need for new graduates to work in a hospital:

> I do find a lot of midwives aren't so supportive of the new course. There's still a lot that believe that you should be a nurse first, and … there's still a lot believe you must be in a hospital for a good amount of time before you consider being a LMC. It takes a bit to breakdown that barrier. (Caroline)

Participants commented how midwives views of the midwifery curriculum influenced the way in which they worked with student midwives; midwives dissatisfied with the educative process tended to challenge students rather than support them: "We had a group of [overseas trained] midwives at the hospital that I worked with and they were very scathing of the way that we were educated and quite hard on us as students" (Dianne).

However, many core midwives were supportive of both the direct entry criteria and of new graduates becoming LMCs:

> We have a lot of midwives who have been LMCs since 1990 … nobody really thinks anything too much of it being direct entry. I certainly haven't had any flak from any of the midwives saying you should be a nurse first. (Lily)

There are increasing numbers of midwives who were direct entry students themselves and/or who have had the ability to work as an LMC immediately following registration. The differing attitudes encountered by the participants regarding midwifery education and employment could reflect the educative demographics of the midwives.

Clinical placement experiences provide the opportunity for skill acquisition and initiation into the midwifery profession. Working to fit in with the midwife helped participants to build a positive relationship with the midwife which not only had clinical learning benefits but also facilitated a sense of belongingness. However fitting in with the midwife was not always without disadvantage to the participant. Being part of the team facilitated a sense of belongingness but in doing so highlighted to the participants the difficulties experienced by the profession.

## Summary

Relationships are the foundation for the participant's clinical learning experience and facilitate a sense of belongingness to the midwifery profession. In this chapter I have described how belongingness is shaped from the first encounter the participants have in their clinical placements, and continues through their relationship with the midwife they are working with and the wider midwifery team.

The initial interactions the student encounters on a clinical placement sets the scene for the students; students want to feel welcomed and to belong in the clinical placements. Participants wanted their presence to be regarded favourably and took confidence when they received a positive response. Feeling welcomed and wanted was multifactorial and depended on factors particular to the student and the midwives. It was apparent from the participants' stories that many midwives did appreciate the students' presence and that participants experienced a sense of belongingness; however there were midwives that did not welcome nor want to work with students.

Knowingness within the student-midwife relationship conferred benefits to both parties, fostering a sense of belongingness for the student and allowing students to partake in the provision of care at an increasing but appropriately level. However, some participants working with known midwives felt expectations were at times pushed beyond their own comfort and confidence. A new relationship between the student and midwife necessitated a period of getting to know each other. While this period conferred benefits to both midwife and student by establishing trust, student capability and safety, it had the capacity to stifle learning opportunities for the able student. The circumstances found in smaller hospitals facilitated knowingness and belongingness in the student-midwife relationship, and had learning and relational benefits.

Working with midwives often necessitated the need to fit in with the midwife's way of working. While this had the benefit of a better student-midwife relationship, sometimes this came at a cost to the student. Being part of the team facilitated belongingness, but also highlighted to the student the struggles and difficulties experienced by midwives working in secondary and tertiary units. The prerequisite of a nursing background for pre-graduate midwifery education, and the ability to work as a LMC after graduation continue to be identified as areas of concern by some midwives.

The relationship between student and midwife was instrumental in developing the participant's sense of belonging. Belongingness developed further when participants found themselves part of the midwifery team. The positive relationships students developed with midwives facilitated learning and this is covered in the following findings chapter.

# Chapter Five: The Opportunity to Learn

The second experiential dimension of the student experience revealed in this study is having the opportunity to learn. Clinical placements in secondary and tertiary units provide opportunities for students to work closely with midwives and to gain experience. Mastery in clinical skills and care provision is the primary reason for placement experience; however, participants in this study become conscious that learning was complex—receptive to constructive input but vulnerable to disinterest and constraint. Learning was reliant on the learning opportunities availed to the student, and required a positive student-midwife relationship and confidence in the student. Hence in the findings, learning should not be viewed as an isolated entity; rather interdependent on other experiential dimensions. This chapter will discuss how students experience the opportunity to learn through watching and doing, working with a supportive midwife, taking responsibility for learning, and learning during busyness.

## Watching and Doing

> It's what you live for as a student. That hands on I'm actually doing it sort of feeling. (Ngaire)

The participants described the importance of *watching* and *doing* in clinical practice. While these were key activities, learning also involved discussion with the midwife, building confidence through practice and, finally, skill acquisition. Into this mix was the knowledge the student brought to the clinical arena, reflection, and the relationship the student had with the midwife. Learning was enhanced by the student-midwife relationship where the midwife offered tools to facilitate learning such as *stepping back,* and *checking in*.

Participants acknowledged that while watching was an important part of learning, its greatest benefit was as a precursor to the doing. The following participant made comment about the learning benefits of watching then doing: "There is [watching] to start with, but I think there's much more learning in doing it yourself" (Penelope). It was important to the participants that learning by doing was offered by the midwives during the student's clinical placements. Only being able to watch served to frustrate participants culminating in (for the following participant) a less than ideal learning opportunity:

> … I guess it's when you're not able to show what you can do, you know? And you're not encouraged to give anything a go, you're basically observing the whole day, which I still learn from and it's all good learning, but sometimes there's some skills that would be good to be the one doing it. (Caroline)

The importance of doing rather than watching was reiterated by Penelope who described the ideal learning experience for student midwives:

> I would just like them to work with midwives who really support them and listen to them, and help them to facilitate their own stuff, and let them do things, rather than them just having to stand there and watch.

Once participants felt they had mastered watching, it was imperative that the doing was then accessible to the student. However, participants cautioned that doing did not always equate to learning. To have the clinical experience narrowed to skills already mastered was not considered learning nor the best use of clinical placement time, when other experiences could have been offered. Rebekah goes on to describe a less than ideal day where despite doing, her learning was limited and satisfaction wanting: "… days when you kind of feel like you haven't learnt much where … you're in an assessment and just end up doing blood-pressures and CTG's. Yeah those are the least satisfying days."

It was recognised that the doing was a process of initially being *watched doing* and culminating in *doing the doing independently*. The following participant detailed her conversation with a midwife asking for initial close support and then having the confidence to continue by herself independently:

> "Oh, can you just talk me through it? Can you just remind me what the procedure is?" Sometimes it's the order the steps are in…. "Can we just talk through it first and then I'm confident to go and do it?" … "How about you come with me and watch me with the first one so that you're there if I make a mistake or if I forget something, and I'll go and do the other two after that on my own?" So yeah they make it really safe and I feel really supported. (Lily).

Lily appreciated the support she received from the midwife during her learning. She likened the support she received from the midwife to that of a parent helping a child learn to walk:

> So it reminds me a little bit of when your kids are learning to walk. I feel like they are starting to let go of my hands now and let me walk on my own a little bit. And if I'm unsteady on my feet they're right there to catch me.

For the participants, being involved and *doing the doing* was the pinnacle of their clinical practice. While mastery was the ultimate end point of student learning, learning did not always progress in a linear fashion. Learning was labile and fluctuated at times, there was always the possibility of errors but practice ultimately facilitated achievement. Mastery was acknowledged when the student was able to work independently. For a student to achieve independence the midwife was required to step back from the situation to enable the student to provide care. The stepping back by the midwives facilitated this participant to advance her learning:

> I am learning what I need to know and I am going to get to the end of this and am going to know what to do. As midwives they really facilitated me to do that that by just being there and stepping back. (Ngaire)

While students were working independently, the midwife would on occasion *check in* with the student. Checking in served to reassure the midwife that the student was capable to deal with the task(s) at hand: "Sometimes they come and they check in on you quite frequently until they know that you're ok" (Jenni). Checking in also provided a reassuring reminder to the student that she was on track, and that support was available if required. However, checking in was not at the sole prerogative of the midwife, students would also choose to check in with the midwife for the purposes of reassurance, clarification and direction.

While participants were active learners, watching and doing with support from the midwife, what they observed when working with the midwife was a multitude of ways of doing. Students were

taught best practice in the classroom setting, yet what they saw in practice was midwives undertaking tasks in many different ways. While different ways of doing might serve to frustrate and confuse students, the participants were open to differing practice and saw advantage in seeing the diverse nature of practice. Jenni saw the different ways of doing as a smorgasbord from which to select her preferred approach:

> It may be that you get to a point where you actually don't know what you are doing, or you don't know which way you want to do it because you've always just done it the way that everybody else has does it…. I think you have to know which way, you have to have some idea of how it is that you want to practice, so that you can pick the one that sits most comfortably for you, and do it that way.

Given the multitude of learning opportunities it was valuable for the participants to reflect on the diverse experiences offered to them. The reflective process was an important aspect of student learning and practice, while skills might not be mastered on the first attempt, using reflection as a learning tool aided eventual mastery. The following participant perceived reflection to be a key facet of her learning:

> There's learning, but the real learning comes later on at home and reflecting, and sometimes going back and having the conversations with the midwives…. I think *oh actually we did that, but I don't really know why, what was behind that? I don't really understand the significance behind that?* If you just take it as face value and it happens cos it happens—but yeah sometimes I need to drill down on it a little bit. (Lily)

This participant was cognizant that reflection facilitated her to question and learn from her clinical experiences. The clinical placements available to the students provide opportunities of watching and doing, but these are only possible when a student works with a midwife who is supportive of the student and aware of her learning requirements.

## The Supportive Midwife

> The most important thing is the midwife to actually believe in you enough to give you a go. And that's where I've learnt the most. (Dianne)

Participants were very aware that midwives were instrumental to their learning. Midwives supported and encouraged students and provided opportunities for students to learn. The participants described how the midwife's support affected their learning; the midwives' confidence increased student confidence, and subsequently influenced the student's engagement in learning in a positive way. Midwives were aware that students were there to learn and that learning opportunities needed to be provided to the students. The best case learning scenario for the participant would see midwives consider the women on the unit and the learning opportunities inherent in their care, and judicial allocation would follow to the benefit of the student and woman. For Dianne recognition by the midwives of her learning needs and matching those needs with learning opportunities available was reassuring:

> I think midwives in tertiary settings are really aware that if a really complex case that comes up that you as a student are going to be interested in that, and they're going to look for opportunities for you to get as much variety in the work that you're doing and the experiences you're seeing as possible…. They're saying "oh well, what women have we got on the ward today." "Oh, this looks like a good case, you could learn from

this." And that reinforces to you that you are there to build your knowledge and build a wider base of knowledge as possible.

However the nature of the learning offered to the student varied from midwife to midwife, with some midwives instinctively knowing how to provide the student with the learning experiences the student needed. Conversely some midwives were not able to show that they understood the kind of learning that the students needed. One participant described how midwives differ in their approach to teaching and supporting students to learn:

> Some of the midwives are very much about teaching us and having expectations of us, and pushing us and challenging us. Others are very much about having us hanging out almost, and being there and going with them and doing what they're doing. (Ngaire)

Working a shift with a midwife either unaware or unable to fulfil the students learning needs was not a positive experience. Likewise, undertaking midwifery skills that were already mastered did not provide optimal learning opportunities for the participants. Participants relied on more and more complex and stimulating situations for their learning. Being presented with challenging opportunities that served to broaden Ngaire's knowledge base was the catalyst for her learning:

> I think the further I get through my training the more I look for the midwives who want to give me a little shove, because that's where the growth is. It's great to be doing lots of hands on with women and to be consolidating the things that I have beginning knowledge of, but it's the times when I'm pushed out of my comfort zone and given something to do that I've never done before and I know is going to be challenging, that I feel really worthwhile as learning experiences…. Some of the [midwives] are more likely to do that, challenging, really valuable learning stuff.

While challenging experiences have positive learning benefits, they needed to be offered in a constructive and supportive environment. The midwife needed to have a realistic appreciation of the student's abilities; participants appreciated questions by the midwife to make clear their abilities and specific learning needs. The discussion with the midwife at the beginning of a shift was a key time for the participants where student ability could be ascertained, the situation of the woman understood, and the learning opportunities realised. Having the midwife appreciate the student's abilities and learning needs meant the day was more likely to be one of learning and of value to the student.

Supportive midwives who listened empowered students and gave them confidence: "It was a really good experience for me because the midwife listened to me, and she took on what I was saying" (Penelope). These midwives also gave credit to the student for the knowledge they had: "They treat you like you actually know some stuff, like you understand" (Rebekah). To have a midwife listen and recognise that the student had knowledge and was valued was empowering for the participants. Supportive midwives also reassured students that learning happened over time. For the participants to hear that learning was piecemeal and that student's skill acquisition did not happen in a linear fashion was reassuring. However, not all midwives reminded their students of this, nor were all midwives able to work with students in a supportive way:

> They're the ones that remind you that you've got a long way to go, and not necessarily outwardly but that's the way I come away feeling…. Sometimes you do feel like they don't really want to have a student. (Caroline)

Participants who worked with midwives who were reluctant or unsure of how best to support a student did not feel the relationship was a positive one to learn in: "… [a] less supportive midwife might just drag you along and you follow them, and if you get to do anything you're sort of a bit shaky" (Dianne). However, with some midwives the initial hesitancy would lessen, and student involvement and learning would occur:

> Other times they don't let you do much, perhaps they might say "oh well, you just come with me and I'll do this" and you just quietly weave your way in, and then suddenly you're doing something, and they're like "oh, okay, and you can do that next time as well." (Jenni)

Working with a supportive midwife had positive ramifications for the student in terms of self-esteem and confidence. Participants acknowledged that the midwife's confidence in the student and the student's self-confidence were interdependent on each other: "It's the midwives that foster the belief in yourself that you can try something and even if you don't do it correctly, if you can believe that you can try, that's where you learn much more" (Dianne). The supportive midwife enabled appropriate learning opportunities for the student, but this also relied on the resources of the student.

## The Responsibility is also Mine

> I believe that the responsibility is up to me…. If I don't put it out there, then it just happens around me. (Lily)

For the student to attain learning experiences they relied on the midwives to recognise and make available the opportunities, but also accepted the responsibility to actively look for, and seek out, such experiences. The ability of the student to garner learning opportunities depended on factors such as overcoming reluctance, putting oneself forward, and the relationship the student had with the midwife and with the woman. While many midwives were keen to avail learning opportunities to the student, there was a place and time when student responsibility for learning was necessary. Obtaining learning opportunities was a skill and being reluctant to put ones hand up resulted in missed learning opportunities for students: "Sometimes [I am] annoyed at myself for not saying 'oh can I do that'" (Ngaire). Reluctance was a powerful sentiment that needed to be overcome in order to obtain learning opportunities. As they progressed through their degree, reluctance lessened and the ability of the participants to get their own learning opportunities increased:

> I'm really rubbish at stepping forward and saying "I'd really like to do that because I really need to do that," "I need to have a go at that because I don't feel like I'm confident with it." I'm not very good at doing that, I'm getting better. But it's good because I'm running out of time. (Jenni)

Despite the reluctance, it was necessary that participants took responsibility to articulate their learning needs to the midwife. Participants who planned ahead and came to clinical with clear objectives were able to identify situations that would address their specific learning needs, and could then ask for involvement in the woman's care. Relationships with the midwives afforded

the participants the confidence to ask to be involved in women's care. Continuity of midwife and continuity of placement both support stronger relationships with midwives and gave the participants increasing confidence to ask for learning opportunities. Another participant detailed how the language she used influenced the midwives perception and confidence in her and enabled her to get learning opportunities:

> It is about getting the practice and the skills and things like that … and sometimes just stepping forward and saying "can I have a go at that" and sometimes you say "can I have a go" and they go "oh god, she doesn't really know what she's doing." As opposed to "I *can* do that, could I do it this time"…. Sometimes, you know I am saying "can I have a go. I'm not convinced I can do this, but I'll give it a shot." (Jenni)

Being mindful of the language used and how it can convey confidence and competence was a useful strategy by Jenni. The following participant felt it was her responsibility to prove to the midwives that she was able to provide the required care, and in proving her ability she was rewarded with yet more learning opportunities:

> As I've worked with midwives more and you've got to prove yourself and prove that you do have that knowledge and that ability to do things, and then the more labour and births you do the more they let you do. (Penelope)

While the participants acknowledged it was also their responsibility to acquire learning opportunities, the act of having to seek out and ask to be included in a woman's care made some participants feel a nuisance to the midwives. Some participants had the confidence to ask for learning opportunities and were happy to make that request, other participants were less forthcoming and would have preferred to have been approached and asked. Regardless of the reluctance at times to acquire experience, participants were aware of the importance of experience and skill mastery. The MCNZ midwifery practice requirements for pre-registration midwifery education (2007) necessitates students gain competency in named skills and that minimum numbers of some of these named skills are completed. The participants acknowledged that the responsibility for achieving the required numbers for named skills was theirs. Getting *the numbers* at times caused anxiety and dominated the student's clinical experience:

> It's a necessary evil really. I guess that is some of the pressure behind everything else. I think that there are some students that are so focused on the numbers that every little thing they do [is about achieving the numbers]. (Lily)

However, the need to achieve skill numbers was motivation for participants to actively look for or make themselves available for opportunities:

> Being third year, and that much closer to being out and kind of feeling like well if I don't do it now I'm going to miss the opportunity to do things. So probably [I should] have put myself forward a little bit more. (Jenni)

On reflection this participant recognised with regret that learning opportunities had been missed and was now more conscientious of taking the opportunities as they presented. The pressure to attain the required skill numbers increased as the participants progressed through the degree towards the third and final year: "…it plays on your mind when you are not far from finishing" (Caroline). The numbers became an unwelcome yet overriding presence that increasingly

dominated the participants' clinical experience and had the ability to interfere with the care afforded to women:

> Everyone says "how many numbers." "Oh if this woman's alright, I'll let you come into this birth." I don't want to just walk into this woman who's nine centimetres about to push the baby out; I just don't think it's appropriate. But then they're going "oh yeah, come in, she won't mind, come in, come in." And you're like "oh, but I mind." "But you need your numbers." Which is very sad I think. (Rose)

It was clear from the participants that the woman was at the centre of their student experience, and that the optimising the woman's experience was important. Participants who required specific experience in order to achieve numbers were presented with a conundrum of getting the numbers but sometimes at the expense of woman's experience. The following participant described her disquiet at having to move her focus of care in order to get the numbers:

> For the last two nights I've started out with this case load of two women sometimes three, and I've ditched them halfway through the night to go into a birth. Which I feel really torn about because actually those women deserve just as good care and I'm ditching them [not] because something more exciting is happening but actually for me it's about my numbers. (Jenni)

Participants were very clear about the uneasiness with which they felt forced to prioritise numbers over their preferred provision of care for the woman. While they felt that the situation was not ideal, it did reflect the reality of student practice especially in their third and final year.

The student's responsibility to acquire the necessary learning opportunities was acknowledged by the participants. However, despite the participants' best intentions sometimes situations transpired to make learning difficult such as the busyness of the ward.

## Learning during Busyness

> On busy days when everybody is just trying to get through the day, definitely the learning and the supervision both are backed off a little. (Ngaire)

Student learning relies on opportunities in clinical placements to be available to the students. Learning was optimised when the midwife was able to spend time with the student and appropriate learning opportunities were available. During periods of significant busyness, characterised by high acuity and insufficient or inappropriate staffing levels, learning opportunities for students were adversely affected. There were more pressing issues for midwives to deal to, there was less supervision from the midwives, learning opportunities were fewer, and student status changed.

When the unit was busy, participants felt their role changed from a position of learning to working. Participants were often considered an extra pair of hands and were no longer regarded by the midwives as students only there to learn. The scope of the student's activities broadened to include duties of a supportive nature (such as cleaning and clerical work) rather than just midwifery focused activities. In doing so participants felt useful, they were able to contribute to the workload and they felt part of the team. In times of busyness participants found themselves performing tasks, often for other midwives as well as their allocated midwife.

When the unit was busy the participants found that the midwives were not always able to provide the direction that was usually on offer: "On busy days when everybody is just trying to get through the day, definitely the learning and the supervision both are backed off a little" (Ngaire). However, in the midst of the busyness participants felt more autonomous in their practice as the degree of direct supervision lessened and students worked independently of the midwife. When the participants received less supervision they generally found themselves doing skills that they had already mastered: "Because the midwives are busy and they need you to go and do these things that you can do without them around, so you just head off and do those by yourself" (Penelope). While practicing already mastered skills was helpful, it did not contribute to the participant's acquisition of new skills: "Doing things that you know how to do is good practice but it's not actually new learning" (Ngaire). While the occasional busy day would not unduly affect the student's learning, recurrent busy days where students performed skills already mastered would fail to meet the student's learning needs.

With students having to work without close midwifery supervision it was important that the student worked only within her scope of ability. This was more achievable when there was a known student-midwife relationship where student ability was already recognised. While appropriate supervision would be both expected and ideal, one participant highlighted the difference in the degree of supervision offered at times of busyness and cautioned against inappropriate direction:

> Sometimes it's just being thrown in the deep end. You always know you've got your midwife calling next to you to support you, to guide you. Make sure they're there, not just "there you go" and just walk off and leave you there. (Rose)

Participants described the conundrum between needing to disengage from the midwife during busy periods but also knowing that this would be at the cost of their learning. Rose highlighted the cost of disengagement: "When they're really busy…you just think *oh I just feel like I'm on your heels all the time* and you want to back off. But when you back off you're losing out on the learning opportunities." While there were times when the participants thought it prudent to remove themselves from the situation, Lily described how she felt she need to be proactive in finding her own learning opportunities during periods of busyness: "And when it is really busy sometimes those [learning] opportunities have to be found…. I guess if I wasn't so proactive sometimes there would be situations that got missed." The participants were aware of the stress that busyness brought to the midwives, and how busyness affected the care the midwives were able to provide:

> [A] busy day is that people hardly talk to each other. They just do their jobs, run from one room to another, having no breaks, stressed. You can just feel the stress out of everybody. Even the women are saying "oh, it's really busy here today." People are coming in and out compared to other times where midwives can sit and help with breast feeding education or can really have some one-to-one care with women. (Rose)

In the midst of busyness the time available for the midwife to practice the *art* of midwifery was lost, and tasks were inevitably prioritised. During these periods, students felt more able than the midwives to find the time to provide the necessary attention to women. The difference in the ability of midwives and students to provide care during times of busyness is highlighted by this

participant's description of being able to sit with a woman when the ward was busy and what that meant to her:

> There's many times on the post-natal ward where the babies are given formula when actually half an hour of sitting and helping will suffice often, and that's where I really like my role as a student… as I can say "alright, you carry on, I'm going to sit in here." I really like that.... It feels like you can actually practice midwifery. (Caroline)

The busyness of the unit had wide ranging ramifications for both the student and midwife. The provision of care was compromised and so too was student learning.

## Summary

Student learning is complex and relies on the student and midwife to identify and provide learning opportunities, preferably in a supportive environment. In this chapter I have described how students learn through watching and doing, the importance of working with a supportive midwife, the student's responsibility to learning, and the challenge of learning during busyness.

Learning was multifactorial, consisting of knowledge acquisition, watching, doing and reflection, all with differing degrees of supervision and independence. Watching was very much a precursor to doing, which, when done independently, was regarded as the pinnacle of student learning. Learning did not happen in a linear manner but occurred piecemeal according to the opportunities and circumstances at the time.

Students worked with a variety of midwives—from those reluctant to have a student or unsure of how to work with a student, to those midwives who were supportive of student learning. The supportive midwife appreciated and facilitated the learning needs of the student, and sourced relevant learning opportunities where possible. The midwife was in a position to provide support and encouragement to the student, confidence and trust developed and this was often reciprocated within the midwife-student relationship. The supportive midwife showed regard for the student's knowledge and abilities, and provided reassurance to the student of her learning. Working with numerous midwives also offered students different ways of doing.

While midwives provided many learning experiences for students, the responsibility of finding the learning opportunities was also the students. Factors that influenced the ability of the student to obtain learning opportunities included the relationship the student had with the midwife, ability to communicate learning needs, self-confidence, and the student's knowledge and ability. Participants acknowledged that getting the numbers was their responsibility but at times this requirement dominated the student's experience.

The busyness of the unit affected both the student and midwife. The student role was broadened to include non-midwifery duties. The degree of supervision proffered by the midwife lessened, learning opportunities were reduced, and mastery of new skills were negatively affected. However, being thrust into this environment also gave the students a sense of autonomy and independence, and the opportunity at times to practice the art of midwifery.

Clinical placements provide experiences for student midwives; it is the student and the midwife that capitalise on the learning opportunities within. While participants were empowered to learn,

circumstances that challenge the student midwife experience are also present and are discussed in the following findings chapter.

# Chapter Six: Challenges in Clinical Placements

The third dimension experienced by participants of this study is having to deal with challenges in clinical placements. Secondary and tertiary units provide learning opportunities for students but in doing so also present challenging relationship and learning situations. Participants were dismayed to experience clinical placements that struggled to nurture students or facilitate learning opportunities. Participants recognised that while some difficulties were midwife driven, others were a symptom of the constraints and limitations placed on midwives by the institutions. As student learners, participants were rarely in a position to effectively deal with these situations. In this chapter I discuss challenges to the student of working with reluctant midwives, feeling a burden, unprofessional behaviour, and being party to questionable practice by the midwife.

## The Reluctant Midwife

> I'm just here to learn. I'm here to learn off you …why aren't you willing to teach me? (Penelope)

Participants found that many midwives were very welcoming towards the students and pleased to work with them. Unfortunately, the participants also realised that there were midwives who were not keen to work with and teach students: "You can just see it in her face when you walk in. You can really tell that she doesn't want to be there talking to you" (Penelope). The first inkling that a midwife was reluctant to have a student usually occurred at the beginning of the shift during handover. Verbal and non-verbal cues by the midwives indicating reluctance were often apparent. One participant commented that her fellow students had been greeted with "oh god, who's going to have the students?" (Lily). Another participant described how at handover, few midwives would indicate a willingness to work with students: "The charge midwife says 'who wants a student', [and] not many hands go up usually" (Dianne). Participants were dismayed by the reaction shown to them by some of the midwives, but acknowledged that this was the reality of being a student and that the onus was on themselves to deal with the situation.

When participants realised it would not be advantageous to work with a particular midwife they adopted strategies to try to work with another midwife instead. One participant recalled asking to look after a particular woman, not because of the specific learning opportunities that would be afforded to her by looking after the woman, but so that she could avoid working with a particular non-supportive midwife. Participants knew that while there may be reluctant midwives there were other midwives who were willing to work with a student for the shift.

Student allocation was often ad-hoc with little preplanning on the part of management, and where midwives often self-selected who would or not work with students. Some midwives pre-empted the situation of possibly having to work with a student by prematurely leaving handover. One participant described how midwives who did not want a student would self-allocate

themselves a woman at the very beginning of handover and quickly walk out of the office before the opportunity arose for student allocation:

> But if they don't want you, they don't want you. They're like "no, I'm working on this one" and they'll just walk out of the room, and that's fine…. They'll say "I'm taking room one", and "I'm taking room two" and off they go. (Rose)

Rose took a pragmatic approach to the midwives' reluctance: "If they don't want to work with me, that's fine. I'll find somebody else." While it would be clearly preferable for students to work only with willing midwives, students were sometimes allocated to midwives who clearly did not want a student:

> They're probably the ones that try really hard not to have students on shift, or they say they are happy to, but actually they're not really, and you know that when you work with them because you can just tell. (Jenni)

Midwives who were reluctant to have a student work with them responded in a variety of overt or covert ways. One midwife verbalised her displeasure by telling the student that "I don't have time for you today" (Penelope), while another midwife was "not being nice in a very subtle way" (Rebekah). Some student-midwife relationships did not start well but morphed with time into a workable relationship as the student and midwife got to know each other. Participants described midwives who agreed to work with students but who did not acknowledge or communicate with them, the midwives would then go about their day ignoring the student:

> If you get a midwife who just sort of gets into her space and gets on with it … it makes things more difficult.... she kind of doesn't communicate, doesn't know you, she just kind of does stuff and goes off and she doesn't acknowledge that you're there, because she's maybe in her space. (Rebekah)

Some students were thrust upon unwilling midwives who responded in unsupportive ways, these midwives would often focus solely on their tasks, frequently disappear or engage in work without involving the student. Midwives leaving students without support was not an uncommon occurrence when students were teamed with reluctant midwives.

One participant recognised that for some midwives it might be difficult for them to have a student: "It must be hard having a student and having to step back completely and let someone else take control of what you would normally be taking control of yourself" (Penelope). The same participant continued: "Maybe they feel judged? I don't know. Because they've been doing it this way for years and we're getting taught a different way, and we're watching how they're doing it." Participants seemed keen to find empathy with these midwives and provide an excuse for their behaviour, possibly out of allegiance to their profession.

Students working with these reluctant midwives found their learning experiences were negatively affected. Midwives were seen as the gatekeepers to the student experience and to work with a reluctant midwife impacted on the learning opportunities afforded to that student. Penelope worked with a midwife who was reluctant to let her be involved in an active learning capacity:

This midwife has a hard time letting me take the lead so I wasn't allowed to do everything at the labour and birth. She [the midwife] said to me "I don't want you to do … because I want to know what's going on."

Students who worked with such midwives would need to be strategic to ensure they worked with other more supportive midwives; to work with reluctant midwives again would affect the extent of their learning. When students were allocated a midwife who did not want a student, they adopted different strategies to help them get through the shift. Participants recalled feeling inadequate at the hands of the midwife and so retreated to the safety of familiar and achievable tasks such as doing the observations and supporting the woman:

I just felt completely inadequate with the midwife, and I thought *well I can do obs, I can do that, and I can support the women*, so I'll do the observations and I'll support the woman and I'll just follow whatever instructions the midwife gives me, and I'll do that, but I know I can support the woman. You just hang on 'til the end of that shift and do what you can do, and try not to take criticisms to heart. (Dianne)

This participant described how she moved from the role of learning to be a midwife to that of a support person, thereby distancing herself from both midwifery learning and from the midwife. Not only was the participants' learning affected by having to work with reluctant and unsupportive midwives, so too was their confidence. Participants working with these midwives lost the confidence to capitalise on potential learning opportunities:

For me it was basically counting down the hours. It almost felt as though that shift was going to be a bit of a right off because you just weren't feeling confident enough to take what you would normally take from it, so what I tend to do is just think *well, I just need to get through this eight hours, if I can get through this and I can go home and I can relax and I can start again tomorrow*. (Dianne)

While students were unable to participate in the provision of midwifery care they also felt psychologically removed from the situation: "If you're on that shift with the midwife that doesn't really want you with her you're a little bit separated, you're thinking about the end of it rather than what's in it" (Ngaire). Jenni verbalised what she thought she ought to do when faced with working with a reluctant midwife: "Actually I should probably say 'I can tell you are really uncomfortable having a student, is there any way I can make it better for you", but when asked if she had ever done that she replied "no I haven't. I couldn't" (Jenni). So while this participant felt that the situation should be addressed, she did not have the confidence to do so and instead the status quo remained.

When working with a reluctant midwife participants looked to more supportive midwives on the same shift for clinical experience and gradually moved away from their allocated midwife. Working with another midwife was not difficult to do especially when the allocated midwife ignored or refused to acknowledge the student. The allocated midwives appeared content with this arrangement as it removed the student from their domain. Participants working with reluctant midwives described how they coped during the week by "scratching the days off the calendar" (Rebekah), or thinking ahead to their last shift of the week. Strategies such as these helped highlight to the participant that the unpleasant working conditions were temporary and that there was an end point in sight. However, other participants seemed to just accept less

than ideal behaviour from midwives, reminding themselves not to take things personally, to cope with whatever eventuated, and to move on:

> I just think I have to deal with the midwife if I don't particularly like her. Just be respectful and expect her to be respectful to me. You just talk to people how you want to be talked back and hopefully it works…. Other times I go "oh my god, what am I doing with this". That's a long shift. (Rose)

One participant would remind herself that the shift was for only 8 hours and that she should be grateful that a midwife was working with her.

The participants expressed gratitude to the midwives they worked with. While it would always have been ideal to work with supportive midwives, the participants knew that working with unsupportive and unhelpful midwives at times was the reality of being a student. The participants also acknowledged that having a student was not always easy for the midwife, and that at times their presence was a burden to the midwife.

## Being a Burden

> Other times I'm a hindrance because I can slow things down if I'm not so fast as them. (Caroline)

Participants were mindful that having to work with a student affected the midwives capacity to function. Participants felt that they were, at times, an unwelcome presence to the midwives: "I felt like a burden that day. But I don't know why they [the midwives] would feel like we were burdens. Maybe because we're right there and we have to follow them round" (Penelope). Student presence was perceived to increase the workload of the midwife, and having a student to teach effectively slowed the midwife down. The consequence of working with a midwife reluctant to provide experiences was having to ask for learning opportunities and feeling onerous for having to do so:

> I know that we are adult students and we are learning … but it would still be nice to have that support as well and to have those opportunities provided rather than having to seek out and asking everybody "can I come in," "can I do this," "can I do that," and feeling a bit of a pest all the time..… So you do feel like a pest, you're pestering all the time to do things. (Rose)

Participants were aware that some midwives would prefer not to be working alongside a student: "You've got this feeling like you were there to be babysat and they [the midwives] would rather carried on with the shift without you" (Rebekah). Participants were cognisant of the dilemma of either staying with the midwife and continuing to feel a nuisance, or removing themselves from working with the midwife at the expense of learning. Some participants who continued to work with the midwife employed strategies to appease the midwife, even if it resulted in doing mundane jobs. Being very helpful and doing the more tedious tasks served to free the midwife to attend to other duties and seemingly took the pressure off, resulting in a less stressed midwife and one who was more inclined to be pleasant and attentive to the student.

The busyness of the unit and the workload of the midwives served to compound the participants feeling that student presence was onerous to the midwives. The following participant described herself as a nuisance at times but also provided justification for why she

might feel like this: "[It's] just the nature of just being a student in an institution where people are busy and have responsibilities, and often don't have enough time, or there are stressful situations" (Ngaire). For Ngaire it seemed preferable to blame the system rather than the individual midwife, possibly out of regard for individual midwives or out of professional courtesy.

Being regarded as an onerous presence weighed heavily on the participants and did not make for a positive experience in clinical placements. Another cause for concern during clinical placements was unprofessional behaviour by midwives.

## Unprofessional Behaviour

If you weren't a strong person you could feel really bullied in that environment. (Rose)

Despite any newness of the placement and the unknowingness of the experiences available to them, some participants seemed more apprehensive about the midwives they would work with than the situations (regardless how complex) that the participants would encounter:

Every shift I go to I have some sense of nervousness. I think for me personally it's more about how things are going to be with the midwife. It's not so much about the cases that I'm going to encounter with women because I feel as though that's a part of my learning and that's exciting. I think the stressor for me would be the relationships within the institution. (Dianne)

By virtue of working in clinical placements, participants were witness to or subject to inappropriate behaviour by midwives: "There's quite a bit of bullying that happens … and I've been exposed to a little bit" (Penelope). This participant relayed a story of being bullied by a midwife in front of a woman. That the bullying was witnessed by a woman, in the woman's room was very distressing for the participant, in particular the lack of respect shown to the woman by the midwife. This participant acknowledged that the worst aspect to the situation was having a woman doubt the quality of care afforded to her by the student:

It just makes you feel … that guilty sick nauseous feeling in your stomach and you carry that around with you all day…. And you do feel guilty because you want that woman's experience to be the best one that she can have. (Penelope)

This participant was aware of more appropriate ways of discussing provision of care and providing constructive criticism to a student, which in this situation the midwife failed to adopt: "Constructive feedback is fine and any feedback is fine and negative comments are fine, but it's the way you put them. And not doing it in front of the woman. Oh, not doing it in front of the woman" (Penelope). The participants were very mindful that the woman's experience was paramount and participants shared the burden of unprofessional behaviour that was directed to or witnessed by the woman they had a professional relationship with.

Participants who felt they were not treated well by midwives recognised the need to manage the current situation, and be in a position where they felt they could return to that same placement. Relationships students have with many midwives continue following graduation and registration, to that end it was important for the student to be, and remain onside, with the midwives. Rose took a pragmatic view of difficult student-midwife relationship situations:

You've just got to be able to communicate and deal with what's thrown at you. I think it's good… to get your head around that. You can't take things personally, you've just got to get along with it. Because that's how it's going to be in midwifery.

Not all students could cope with an unsupportive work environment in such a pragmatic manner. One participant who was subject to bullying coped by relaying her experience and seeking reassurance from a family member, another participant who was intimidated by a midwife was so upset that at the end of the shift she retreated to the safety of her car and cried:

> That experience that I had with the one midwife—that was enough to put me off—she was absolutely horrible to me. And the other midwives … why didn't someone actually speak into that situation? It makes me wonder if they just didn't want her wrath. The other midwives were saying "Are you ok?" because they could see how I had been treated, but none of them said anything to her, and in the end I just went and sat in my car and cried. (Lily)

This participant was let down by the failure of other midwives present to act in response to what they had witnessed. The reluctance of other midwives to intervene could be a protective mechanism, they too may have been victims of the midwife's unprofessional behaviour in the past and to respond would have been an invitation to be bullied again. Other participants described instances of undesirable behaviour occurring in the hospitals they had worked in. One participant was warned about working with particular midwives before she had had a chance to meet them and form her own opinion:

> You're exposed to horizontal violence as soon as you walk in the hospital doors. You say "Hi … I'm a student and I'm starting work here." "Ooh are you, well don't work with this midwife because she's awful, and don't work with her because she's awful." So you're kind of like, *whoa, ok, I haven't even had a chance to meet these women and I'm already being told how awful they are*. Then there's been screaming matches between midwives in corridors and gossiping sessions behind a midwife's back in the tea room. (Penelope)

Participants who had been victim to inappropriate behaviour or working with unsupportive midwives found themselves in a position where they felt they could not verbalise their feelings to many in the midwifery profession. Participants acknowledged that the midwifery community is very small and were wary that their discontentment with a midwife might be discussed within the community: "Students bad mouthing midwives they've worked with, and of course it's a small community it comes back. And you're like nah, you can't be saying anything like that. You've got to keep your mouth shut" (Rose). Participants expressed that they would hope that certain non-supportive midwives would not be on duty during the participant's allocated shifts. If participants found themselves on shift with these midwives then they would employ strategies to ensure that they did not work with them. One participant described if she knew a particular midwife was going to be on duty then she would approach another midwife before handover asking to work with her, and when student allocation was discussed the student would already have an allocated midwife obviating the need to work with the unaccommodating midwife.

The hierarchical nature of many hospitals was recognised by the participants, and some midwives chose to emphasise hierarchy to the detriment of the student. These midwives reminded the participants of their student status, reiterating their lack of knowledge and experience, and dismissed any knowledge that the student brought to the situation:

> They are the midwives that they, maybe, don't know if condescending is the right word, they talk a lot and they share a lot of information but its more reiterates your place, like you don't have anything valuable necessarily to offer … there's no sort of way of saying "I do have something to say about that" and "I do know a little bit about that." So rather than sharing their knowledge it's sort of just reminding you that they're there and *you're there* [emphasis added]. (Caroline)

The hierarchical nature of the hospital made it difficult for students to deal with the conflict they were witness to:

> That's that tricky part, where you try to negotiate how you're going to deal with more difficult interactions and things in the hospital. Especially when it's so hierarchical anyway, like there's already conflicts happening between people within that institution, and you're just sort of thrown into the mix. (Dianne)

Being witness to, or on the receiving end of, unprofessional behaviour was challenging to the participants. Also challenging was being witness to questionable behaviour by the midwife.

## Questionable Practice

By virtue of working with a multitude of midwives the participants were party to a range of differing midwifery practice. A lot of the practice the participants saw mirrored what they had been taught and was what they expected to see in practice. Being in a learning and observational role afforded a view of the bigger picture as the following participant commented:

> I learnt a lot, and I guess too being a student you do have the beauty being one step removed, and you can see things a little bit more clearly than other people might be able to, rather than being right there in the thick of it. (Caroline)

Being one step removed provided the participants with the space to consider what they were seeing and being exposed to. Participants felt they had a sense of what was considered best practice; likewise they were able to recognise questionable practice. Unfortunately participants were witness to what they considered questionable practice on the part of the midwife:

> I've seen them [midwives] be bad towards women. I just think *I'm not going to practice like that*, and I've seen lots of different midwives doing different things and I've thought *I'm not going to take that into my practice, but I'll take that into my practice* and I think that is the benefit of working across midwives. You can take, you can pick and choose things that can work and don't work. (Rose)

For participants, the education that arose from being party to questionable behaviour was the learning of what *not* to do: "Definitely I sometimes just think to myself *I'm not going to do that, I don't know what to do with it now, but I know I won't be doing that*" (Ngaire).When a situation arose that the participants recognised was not based along best practice guidelines, the participants were then confronted with the question of what to do about what they had seen: "*Do I just keep my mouth shut? What do I do?* And that's when I get that *oh I don't know what to do*" (Rose). Being party to questionable practice presented a huge conundrum to the participants. The participants knew that what they had seen or heard was not right, they wanted to advocate for the woman, but were unsure what to do: "I don't think that was right. I think there were things that just happened that weren't right, and I don't know what to do about it" (Lily). Participants commented that they were rarely able to address issues of questionable practice with the midwife. Some participants they felt they had no right to question midwives or

their practice; midwives were considered to be responsible for their own practice. The participants were very aware that the midwives were the gatekeepers to the student experience and to discuss a contentious issue with either the midwife concerned or another midwife could be a risky undertaking; to be off-side with a midwife was to risk losing learning opportunities:

> I find it really challenging to sometimes say nothing, [but] I know that if I'm not onside with the midwives I won't get the chances and opportunities that I get or I may not, I mean I don't know that for sure, but I may not get those chances. (Ngaire)

While the participants were upset by the situation they found themselves in and wanted to speak up, they anguished in the realisation that to do so might jeopardise their future studies:

> At the end of the day [the midwives], they're the ones that are going to pass us or fail us aren't they. They're the ones that are going to write "This student is really good to work with, she shows initiative" or not. And at the end of the day we need that for our portfolio, and we need that to get a good pass. (Jenni)

Longer term ramifications of speaking up were noted as well. These midwives were likely to be future colleagues and the student-midwife relationship would be foundational to their relationship as colleagues. One of the participants spoke about being able to have the courage to speak up:

> Many years ago I made a promise to myself then that I would not stand by and let stuff like that happen, so I spoke up, and that was one of the situations where I wished that I didn't have to but it was the right thing to do. (Lily)

The participants were very aware of the potential ramifications of questioning midwives and were careful to only engage certain midwives in this kind of conversation. Participants considered carefully who they would approach for an explanation of their actions: "There are some midwives that I will happily say 'I don't know why you did that', and others I would not go there" (Ngaire). Knowing the midwife gave students the confidence to ask questions of the midwife, while for others their status as a student was helpful in this regard: "I think sometimes as students we are in quite a privileged position where we can ask" (Lily).

If the participants were prepared to address practice issues with the midwives they were careful to ask or question in a way that was non-confrontational and not perceived as being critical. One participant said: "The question that I'm thinking is *I don't know why you would have done that*. But I can frame that up as a question like 'Oh, can you explain to me why you do it that way?'" (Lily). So while the thought remains the same, the question is framed in a way that is more palatable to the midwife, less likely to cause offence, and less likely to cause friction in the student-midwife relationship. Participants were keen to question the midwife's practice, not to be critical but to gain insight into their practice. Gaining insight into practice was yet another source of knowledge for the student but it needed to be approached carefully and with regard to the student-midwife relationship.

## Summary

Clinical placements provide opportunities for students to learn, but in doing so exposes students to situations that challenge their learning and midwifery presence. In this chapter I

have described the challenges to students of working with a reluctant midwife, being a burden, unprofessional behaviour, and being witness to questionable practice.

There was a varied response by midwives to the presence of students in clinical placements. Most midwives seemed pleased to work with students, however all of the participants relayed stories of midwives who clearly did not want to work with students. The reluctance to work with a student was often resolved by the midwives themselves through self-exclusion from student allocation, or working in a manner that minimised or eliminated student engagement. Participants were cognisant that for some midwives working with a student was difficult. Participants were pragmatic at times and employed coping strategies to deal with the reluctance of midwives—moving away from the role of a student, finding safety in doing mundane, easily achievable tasks, or working with more accommodating midwives who were happy to support students and provide learning opportunities.

Being regarded as an onerous presence weighed heavily on the participants; feeling burdensome was a consequence of factors such as midwife reluctance, time constraints and the busyness of the unit. While some participants countered this difficultly by working strategically with midwives, other participants elected to relinquish learning opportunities to minimise pressure on the midwives.

Unprofessional behaviour by midwives was challenging to the participants. Participants were at times subject or witness to behaviour that was intimidating and bullish towards women, students and other midwives. Participants used strategies to cope with this behaviour. The hierarchical nature of the hospitals and the status of students challenged the participants.

Being witness to questionable behaviour presented the participants with the quandary of not knowing what to do with what they had seen. While the participants were cognisant of the rights of the woman, they were also very aware of the potential ramifications of speaking out. The participants realized that while they were constrained in what they could do about the clinical practice they were party to at the time, they could use that experience to build their own midwifery practice—retaining the good examples and discarding the rest.

Challenges in clinical placements were the reality for participants. While some midwives chose to facilitate experiences that were intimidating, unsupportive, and hierarchical in nature, other midwives were keen to work in a positive manner, and in doing so enabled confidence in the student. This will be covered in the next and final findings chapter.

# Chapter Seven: Having Confidence

The last experiential dimension, having confidence, was closely aligned to the other dimensional findings in the research study. There was a symbiotic relationship of confidence with learning, belongingness, and the challenges experienced in the clinical placements. Analysis of the participants' stories showed that confidence revealed itself in both the individual, and the collective context. The student brought confidence into the clinical arena, and this was affected by her experiences during placement. It was not just the learning experiences *in* clinical placements (e.g. provision of care, skill acquisition) that affected confidence; it was also the experiences *of* the clinical placement (hierarchy, student status, culture). In this chapter I describe how students developed and sustained self-confidence, and the effect the woman and the midwife have on student confidence.

## Developing and Sustaining Self-Confidence

> I was really quite chuffed at the end of it. I was doing that dance, you know, inside, where no one can see. (Jenni)

Self-confidence was significant to the learning experience as a student midwife. Self-confidence reflected self-esteem, previous placement experiences, skill progression and acquisition, a sense of belongingness, and relationships with the women and the midwives. The students' confidence in clinical sphere reflected their self-confidence as a person outside of studentship (vis-à-vis a wife, sister, daughter, friend, mother), but modified by their experiences in the student midwife role. Self-confidence changed further as the student midwife interacted with the woman and the midwife, and a shared or collective confidence became apparent.

While it would be reassuring if self-confidence was always positively realised, the reality for the participants was that self-confidence had varying starting points, and developed or diminished in response to a variety of factors. One participant saw herself as usually a confident person, but her experiences as a student midwife were enough to challenge this. Self-confidence was expressed in language that affirmed ability, aptitude and capabilities, while challenges to self-confidence reflected uncertainty. Jenni described her confidence as "a tentative thing" and "easily knocked", while Lily described her own self-doubt as her "biggest stressor in clinical."

One aspect of how self-confidence is enhanced is through the achievement of care provision or skill acquisition. A sense of confidence was not only confined to achieving mastery, but also occurred with *progression* towards mastery. One participant described the relationship of progressing towards mastery and confidence: "You're not going to learn straight away. It's always an experience. It always builds up. You try, you don't get it, try again, and try again. It always builds up your own confidence by trying all the time" (Rose). The connection between skill mastery, care provision, and self-confidence was very strong. The participants' stories would typically describe mastery of an aspect of midwifery care and a subsequent expression of confidence and proficiency. While the expressions were in the 'here and now', they often revealed the ultimate end point, vis-à-vis becoming a *midwife*: "It's what you live for as a

student. That hands on *I'm actually doing it* sort of feeling … and feeling like a midwife and thinking *wow*" (Ngaire); "It feels like we're actually doing real midwifery. Like a real [midwife] and it's great. It's good for your confidence" (Jenni). While it was clear that these participants were students, they were verbalising their actions in the context of a midwife. Their confidence allowed them to jump ahead and see themselves not as a student, but in the midwife role, albeit for that short moment in time. While moments like these were positive and boosted self-confidence, they were mitigated by other experiences that challenged student confidence. Learning was not a linear process and for participants, confidence in their learning also wavered:

> Sometimes I see things and I think I'm never going to get this, and I miss things, and I think this should happen, and then there's a reason why that wasn't what should happen, and it can get a little bit discouraging, but when you have a time like that when it all comes together you think it's going to be ok. (Ngaire)

Awareness of the knowledge gap between student and midwife was a cause for concern for some of the participants who wondered how they were going to fill the chasm: "Even though I feel relatively confident with where I am at, at the moment, I still feel as though it is a massive gap between here and just being able to roll with it like they [the midwives] do" (Dianne). Although gaining registration as a midwife was up to 18 months away for the participants, achieving skills gave them the confidence that their skill acquisition and mastery of care was progressing towards this goal.

While the focus of clinical placements is care provision and skill acquisition, it was not always the nature of these experiences that had the biggest impact on confidence; rather it was the relationships encountered during the experiences. This sentiment was shared by many of the participants, and the impact on confidence has been described by Dianne: "It is probably about the interactions with staff members much more than it is about what you are going to encounter with the women." Midwives are extremely influential in the experiences of student midwives in clinical placements. The way in which student midwives were greeted and welcomed into the clinical placement was significant in that it affected the confidence of the student, sometimes for the entire placement. Midwives who were reluctant to engage with students in a supportive manner negatively affected the participants' confidence.

The participants recognised the midwife to be instrumental in nurturing, sustaining or challenging student self-confidence. They were acutely aware of the preceptorship role midwives played, and the opportunities available to them as students because of this relationship. Learning opportunities were the means by which student learning progressed and confidence in providing midwifery care developed. The following participant described the complexity of the student-midwife relationship in regard to expectation, learning opportunities, and confidence:

> [The midwives are] giving you confidence in yourself,  and being supportive, and acknowledging that you don't know everything, and that you haven't tried everything, and that you're still learning, and that you can be honest about that, and you don't feel like you have to pretend to them that you know more than you do. But also then giving you every opportunity to provide care. (Caroline)

Analysis of the participants' stories revealed that expectation of student ability had the potential to be either empowering or demoralising. The expectation by the midwife that a skill or provision of care could be achieved by the student was at times empowering, signalling to the student that the midwife had confidence in her ability. Conversely, unrealistic expectations challenged student confidence. Sometimes these expectations were midwife driven, other times driven by the student themselves, as described by the following participant:

> I expected to get to the third year and be able to do it all. The reality was I couldn't just yet, not on my first placement anyway. I thought I should. I really did. So the first placement was all about getting up the confidence to do things. (Jenni)

While previous positive experiences gave confidence, negative experiences served to discourage, and for some participants it was necessary to start anew: "If you keep stewing over things all the time it can get you really down unless you deal with it. You need to deal with it and put it to the side, and move on" (Rose).

The variety of clinical placements and different opportunities on offer were usually viewed positively by the participants; however the unknowingness of new placements can be a cause for anxiety. Caroline described walking onto a new unit/ward as "nerve wracking" although she continues: "I think it's got easier and easier now because I think I'm a bit more end focused and you've just got to get in there and get things done." For another participant the requirement to work in new clinical placements was at times problematic and presented the participant with uncertainties and difficulties that challenged her confidence:

> The processes in the hospitals or whatever facility you are going into, you just don't know what the norm is, so you're sort of trying to navigate—where is this, where is that, what time do I do that, and where do I meet up for handover. All those logistical things that you worry about. Am I going to get a carpark and all that kind of thing.... For some people they may be perfectly confident working in a new place but that's just not me. (Dianne)

While self-confidence was important, it is but one facet of the confidence that students experience in the clinical arena. The interactions the student has with women further nurtures, sustains, or challenges student confidence.

## The Woman has Confidence in Me

> You've actually meant something to the woman, and that can change your confidence going out of that shift. (Dianne)

The woman's experience is central to the provision of midwifery care, so it is logical that the woman's confidence in the student would be of significance in their working relationship. Developing a positive relationship with the woman was crucial to building and sustaining the student's confidence. A favourable rapport with women facilitated provision of care opportunities which afforded reward beyond the obvious skill based learning, and served to positively influence qualities such as confidence and self-esteem in students. Values displayed by the woman, such as willingness to have a student and showing trust in the student, gave the participants the opportunity to provide care and increased their confidence. The following participant described the benefits from providing midwifery care to a woman:

I've found that most women … are really happy to have you involved and if you're the kind of person that focuses on them, then, by the end of the shift you can have a really good relationship with them, and I suppose that's what core midwifery is all about. But as a student that's really exciting when you finish the day and you think like you've actually managed to build the relationship, and you feel really good about the care you've provided, because you've actually meant something to the woman, and that can change your confidence going out of that shift. (Dianne)

For Dianne, being thought of as making a positive difference to the woman's experience was satisfying and served to enhance her confidence. The midwife, being the other member of the student-woman-midwife trio, can also influence the impression and level of confidence the woman forms of the student. The participants recognised that women often looked to the midwife to gauge the midwife's confidence in the student. Participants felt valued when the midwife communicated verbal and non-verbal confidence to the student in front of the woman. Such a public display of confidence could assure the woman of student trustworthiness and ability:

She [the midwife] handed over to me like she would have handed over to another midwife coming into the room. I think that gives the women confidence in us and it makes me feel really valued, and gives me confidence in myself. (Ngaire)

When confidence was conferred by the woman to the student, the participants felt more confident in their ability to provide care. A positive relationship with the woman could then develop further during the course of the provision of care. The participants described women as being very open to being cared for by student midwives, providing care and learning opportunities, and offering verbal support and encouragement.

In the setting of a secondary or tertiary hospital the opportunity to work with known women was often limited. While unknowingness does not preclude involvement (participant stories are testament to the willingness of women to involve unknown students in their care), knowing the woman did influence the confidence of the student. One participant recalled looking after a woman whom she had met with previously and articulated how their knowingness facilitated confidence and a trusting environment: "I felt really chuffed at the end of it. … I had met her the night before so she knew me and I knew her. I knew that she trusted me" (Jenni).

Confidence in the student was expressed by the women in their willingness for student involvement, verbal and non-verbal communication and the feedback they provided. The participants acknowledged that the confidence shown to them by women facilitated their learning and had a positive effect on their levels of confidence. Just as the woman's confidence was crucial to the experience of the student, so too was the midwife's.

## Confidence from Midwife

Oh she thinks I can do this, ok. Maybe I can. Perhaps I should think I can do this too. (Jenni)

The student's confidence on the clinical placements stemmed from self-confidence, the relationship with the woman, and the confidence and trust instilled by the midwife. As discussed earlier in the findings the midwife was key to the experience of the student, both in the skill

based learning opportunities afforded to her and in the relationships the student was able to establish and maintain. Self-confidence alone was insufficient to sustain student learning in clinical placements; the students required confidence shown to them by the midwife as well:

> You have confidence in yourself because the midwife has confidence in you. It's just having somebody just believes in you enough to be able to give something a go. I found, of any placement that I've been in, that's the most important thing, is the midwife to actually believe in you enough to give you a go. (Dianne)

The midwife's consideration towards the student influenced the ability of the student to have the confidence to engage and learn. Participants valued midwives who were able to put themselves into the shoes of the student, to identify with the uncertainties inherent with learning, and to provide the necessary mechanisms to support the student.

Midwives were integral to the type of experience the student would ultimately have during that shift or placement. The participants described how they took confidence from the midwives who expressed or indicated a desire to work with them. One participant recognised the enthusiasm in midwives who were keen to work with students, and reflected on the impact this had on her confidence:

> So there are midwives who clearly love to teach, and they see a student and their eyes light up, and it's almost like they are planning in their head right then and there what the day's going to look like and what they are going to get you to do, and they say "oh good, you're here, I can get you do to this" and "you can do that" and "this woman is coming in and she's got this … so we can get you doing that" and you feel really welcomed and really valued, and really like ok someone is going to be steering me through this. (Ngaire)

The midwife and the charge midwives were considered to be the gate keepers of the student experience and instrumental in building or crushing student confidence. The participants recognised that the experiences on clinical placements were largely dependent on their allocated midwife and, to a lesser extent, the other midwives and charge midwife on that shift. A supportive midwife and charge midwife afforded students learning opportunities within an environment that was nurturing and empowering. However, the participant experience was that midwives and charge midwives were not always supportive and enabling, and this had a huge impact on student confidence:

> There are these situations that have been really challenging but then on the other hand some midwives have been incredibly supportive and really actively looking for opportunities for you to learn and to give you confidence, and you're doing ok, and it really comes down I think to the individual that you get on the day. If you strike the right midwife and the right charge midwife and you can have a great shift, and if you hit the wrong one it can be a bit soul destroying. (Ngaire)

Participants had differing relationships with the charge midwives. Some charge midwives seemingly had a high administrative load and were rarely seen on the clinical floor, while others were attentive to the presence of the student and ensured that appropriate learning opportunities were available. Caroline relayed a story of a charge midwife showing her interest and confidence in the student by directing the midwife she was working with to stand back and

support her: "Now remember the third year student, she's to be taking lead, you just support her."

Working with a supportive midwife provided an environment where student knowledge and abilities could be appreciated by the midwife and realistic expectations of the student fostered. The participants described how midwives provided structured support to students by establishing the student's knowledge base, and providing close supervision, followed by less supervision as skill acquisition was achieved and as the participant became more proficient:

> They take the time, all the time, to be just explaining things, just standing right by my shoulder while I'm gaining confidence in doing things, asking me if I feel confident enough to do it on my own, or do I want them to come with me. So there's that sort of thing where I guess they're gauging where I'm at as well and sometimes they are like "Ok, I'm ok with you going and doing that, come back and let me know." (Lily)

The ideal midwifery support would reflect an accurate assessment of the student's abilities and would be appropriate to the student's needs. For some participants having a midwife physically present during provision of care was reassuring, while other participants recognised their capability to provide aspects of care independently without the need for a midwife to be present. The following participant found she was more confident to attempt skills when she was accompanied by a supportive midwife:

> [The midwife saying] "Do you think you'd be comfortable doing it if I stand right beside you and guide you through it?" That makes a huge difference to have somebody say "well I'm happy for you to give this a go, I'm not going to leave your side." You can actually give this a go and it's going to be alright. That's massive, getting midwives to do that. (Dianne)

Midwives providing appropriate support encouraged students to attempt and ultimately achieve skills, and also to move beyond their comfort zone to address more complex or advanced learning needs. Within a supportive relationship Jenni found the confidence to advance her knowledge and skill set: "The majority of midwives … that I've worked with have been really good at encouraging me as a student to do things that I might not have thought that I could do."

Acknowledgement by the midwife that student skill acquisition was a process that takes time and practice was reassuring to the participants. This reassurance gave the participants confidence to attempt skills and tasks knowing that even if mastery was not achieved they were still on track and progressing towards achievement. While participants aimed to provide quality care, they did need reassurance that if the provision of care was not at the expected standard that the reaction from the midwife would be constructive and not disparaging: "So that we do feel confident to have a go knowing that actually we might not actually do it quite right and we won't get our heads bitten off for it" (Ngaire).

Midwives gave students confidence by facilitating a learning environment shaped by nurturing and support. Participants described the quiet unassuming presence of the midwife in the room, watching rather than doing, providing affirmations in subtle ways, generous with knowledge, and there to support rather than to assess or scrutinise. Here a participant detailed how the midwife supported her:

It's just the way she explained how to do it… just really gently guiding me through the things without rushing and making sure the woman's comfortable. It's just such a lovely caring, nurturing environment… it's just like "okay we've got plenty of time to do it. Let's just do it." And I've just come leaps and bounds by that kind of nurturing…. I was telling her what I was doing and she'd just stand back and watch. (Rose)

The physical act of the midwife *stepping back* provided a huge psychological boost to the participants. The participants described how the stepping back of the midwife was perceived as confirmation of the midwife's confidence in the student and endorsement of her care. Participants felt confident to provide care knowing that while the midwife had stepped back she was still there for the student, able and willing to *step back in* and support the student as needed. The following participant described how she felt when the midwife stepped back, enabling her to provide care independently:

[The] midwife was just so supportive of me and she stepped back and was like "look, you're a third year. I'm so confident that you know what you're doing. I'm just going to stay back here and let you just do everything that you want to do and I'll be here to support you." …. You just want to prove to yourself and to them that actually you know what you're doing and you can do that. And that's what this midwife did and it just made me feel so proud and so happy and just made that experience really great for me. (Penelope)

Participants acknowledged the generosity of the midwives in stepping back, providing the participants with opportunity to demonstrate knowledge and provision of care. Providing quality care was not just satisfying to the participants and the women, but also recompense to the midwife for her generosity. While the stepping back by the midwife can be encouraging and empowering to the student it can also be a challenging time for the student, as this participant noted:

It was a little bit scary because I thought *am I doing it right?* There were times that I wanted to say *what should I do*, and I thought *no, they obviously have a level of trust in me* and I think they'll tell me if they think I need to be doing something different. And just having that real safety net to just go ahead and do what I thought was the right thing to do, knowing that if I was getting something wrong, she was there to let me know, but they actually had that degree of trust in me to just do that. So that was a great day, it was fantastic. (Ngaire)

One participant shared a story of working in a birthing unit in her third year. The participant was working with a midwife who encouraged the student to take the lead in caring for the woman, and then proceeded to show her confidence in the student by excusing herself from the room, telling the student she could call her if she was needed at any time. The student's initial reaction was one of feeling terrified, but once she realised that the midwife was showing that she had confidence in the participant's abilities, the participant was reassured and proceeded to provide the necessary midwifery care. The participant recognised this as a key moment in terms of building her confidence to a greater level:

And I've said "what do you mean? You're going? Okay, that's okay, I'll call you when I need you"… The first time it happened I was so blown away I didn't say much. I kind of thought *what do you mean? Why are you going?* Actually, she was just outside the door at the desk … if I yelled loud enough she would have heard me. (Jenni)

This gave rise to participant reflection of her knowledge and ability, and reassurance that the confidence displayed by the midwife was deserved, and that she did indeed have the capabilities required:

> I think I am really aware of what I don't know. And I'm probably fairly hard on myself about what I don't know. I probably know more than I think I do. So I probably would call someone sooner rather than later. Yeah, I kind of thought *oh, ok, I can do this, I'll take that charge…* I think it terms of my confidence it was a huge game changer. Oh she thinks I can do this, ok. Maybe I can. Perhaps I should think I can do this too. (Jenni)

Being left to provide care without close physical supervision can be a powerful and productive learning experience when the confidence in the student is deserved and accurately reflects the student's abilities and confidence levels. However, inappropriate support served to challenge student confidence, as the following participant described:

> But again I'm a student, and I just thought I still didn't really know if it was [normal] … And it just made me feel really uncomfortable that I'd been left in that room, in that position. And I just thought *where is the midwife?* I thought *what do I do?…* I came walking out of that room and I actually felt quite shaky. (Lily)

Confidence appeared to be a frail entity at times, labile and wavering in response to a multitude of factors. When confidence was high, students had strength and showed resilience whereas low confidence conferred vulnerability to the student. Student confidence was negatively affected by midwives who created an environment that was not in keeping with the ability or learning needs of the student. Midwives who would take over or strictly supervise students, challenge rather than support, or refuse students the opportunity to provide care also tested the confidence of the student. Student status was problematic especially in institutions that were considered to be hierarchical in nature; it is difficult to sustain or build confidence in an environment where status defines worth. Some midwives would choose to remind students of their student status, their limited knowledge and skills, and not allow them to practice in a way that encouraged learning. Rebekah described how her confidence changed when midwives did not trust her to provide care: "When I'm being super strictly supervised … not being trusted, and when the midwives takes over and does everything, that kind of diminishes my confidence." This participant pondered as to why the midwives felt the need to take over: "I guess they [the midwives] just don't know how much I can do or can't do maybe? A lack of communication, being busy and maybe not having had many students before?"

## Summary

The woman, midwife and the student were all key players in enabling, sustaining and challenging student confidence. In this chapter I have described how students sustain self-confidence in clinical placements, and how this can change according to the student's experiences and relationships with women and the midwives.

Students entered the clinical placements with varying degrees of self-confidence. Confidence wavered from day to day, placement to placement, but was mostly dependent on the midwives. Participants found that relationships and experiences challenged or enhanced their confidence.

Women were very willing to involve student in their care, and in doing so gave students confidence. The woman's trust in the student was often moderated by the woman's perception of the midwife's confidence in the student. The participants have described the ways in which midwives gave them confidence, the participants identified that their confidence grew when they worked with a midwife who recognised their knowledge and showed trust in them. For a midwife to acknowledge that skill acquisition took time was reassuring and gave the participants the confidence to keep trying. Midwives providing support at an appropriate level gave the participants the confidence to try, knowing that support was there as needed. Lastly, midwives gave confidence to the participants by stepping back and providing the participants with the time and space to provide care in a supportive and nurturing environment. Participants described with gratitude the generosity of midwives in sustaining and growing student confidence through a supportive learning environment.

# Chapter Eight: Discussion

## Introduction

This research study has explored the experiences of eight student midwives working in secondary and tertiary hospitals in New Zealand. The findings present my interpretation of the participants' stories of their experiences in clinical placements. The findings revealed four experiential dimensions of the student midwife experience: a sense of belonging, the opportunity of learn, challenges in clinical placements, and having confidence.

In this chapter I describe the discussion emanating from the research findings. The limitations of the study are detailed, and the implications for practice are discussed in relation to healthcare institutions and pre-registration midwifery education providers. Implications and suggestions for further research are detailed. Lastly a summary of the study is provided.

The question of this research study is 'what are student midwives' experiences of clinical placements in secondary and tertiary hospitals?' The nature of the question would suggest that following on from the findings, the study discussion would directly incorporate the student. What has transpired through the findings is that while the student has a role to play in the shaping of her learning experiences in clinical placements, it is the midwife that takes the major role as conductor of those experiences. The participants in this study continually referred to the midwife as the significant factor in their clinical experience. While *the midwife* did not constitute a major individual finding per se, a search through the findings chapters would highlight the central role the midwife played in each of the experiential dimensions of the student midwife experience. The significance of the midwife to the learning experiences was identified by all the participants, as illustrated by Dianne's comment: "… it really comes down I think to the [midwife] that you get on the day." The midwife dominated all four experiential dimensions of the student experience, so to advance the learning experiences of the student attention must be directed towards the midwife.

Thorne (2008) suggested that the discussion of the study is an opportunity to reflect on the findings in way that differs from the findings themselves, bringing to light key messages. Key messages reflect the significant themes found in the findings that require further consideration. From the findings described in the previous four chapters, two key messages for discussion have arisen: the importance of continuity of midwife and the need to support the midwife. At first glance relevance to the student midwife and the research question may appear distant; however, these key messages directly address the circumstances that surround the student midwife experience. Therefore they are of direct relevance to the student and the clinical placement experience.

## Continuity of Midwife

Consistent to all four experiential dimensions of the student learning experience was the importance of continuity of midwife. Continuity of midwife almost certainly implies continuity of

placement, and while continuity of placement in itself was not deemed as important, in the absence of continuity of midwife, continuity of placement provided continuity of (a small group of) midwives. There are multiple midwifery research studies that espouse the value of continuity in the student-midwife relationship (Cherney-Morris, 2015; S. Davies & Coldridge, 2015; Gilmour et al., 2013; Hughes & Fraser, 2011; Licqurish & Seibold, 2008; Muleya, Marshall, & Ashwin, 2015). While continuity of midwife per se was not specifically identified as highly significant by the participants in this study, continuity pervaded every experiential aspect of the participant's clinical experience. Continuity fostered knowingness in the student-midwife relationship which subsequently conferred two distinct benefits to the student—socialisation into the midwifery profession and enhanced learning opportunities.

The findings revealed that participants wanted a close relationship with midwives and to be immersed within the community of their chosen profession. Participants in this study recalled how knowing the midwife encouraged the student-midwife relationship to develop; participants found themselves situated within a midwifery team, and their socialisation into the midwifery profession grew. The importance of the student-midwife relationship to professional socialisation is well supported in the literature (Carolan-Olah & Kruger, 2014; Licqurish & Seibold, 2008; McKenna et al., 2013; Rawnson, 2011); likewise the role continuity has in socialisation (Carolan-Olah & Kruger, 2014; Carter et al., 2015; Gilmour et al., 2013; Rawnson, 2011). In this study the participant's continual relationship with a midwife fostered values such as respect and trust. It was with these foundational values that relationships developed and learning needs were met, this finding is replicated in research by Carter et al. (2015).

Participants worked with midwives keen to develop a positive student-midwife relationship. However, the student-midwife relationship was not always achieved without compromise nor effort. Participants reported having to acquiesce to the midwife in order to maintain continuity of a relationship which was essential for the students belonging and learning during a clinical placement. Participants recalled times of having to fit in with the midwife, working in a way that was not always congruent to their own theoretical or philosophical understandings, but nonetheless maintaining a relationship and gaining experience. Working in such a way to fit in is well documented in midwifery literature as a strategy to attain a sense of belongingness (Armstrong, 2010; Carolan, 2013; Gilmour et al., 2013; Green & Baird, 2009; Rawnson, 2011). Participants also commented on the time and energy required to establish relationships, and this finding is supported by research by Brunstad and Hjalmhult (2014) where participants found building relationships tiring. Continuity reduces the number of new relationships participants were required to make during their clinical placements and allowed more time and energy be directed towards learning rather than building foundations of relationships.

Continuity with hospital-based midwives led to a greater understanding by the participants of the difficulties inherent in working in a large institution where economic factors and philosophical differences constrained the practice of the midwives. Despite theoretical and philosophical differences, participants were at times keen to empathise with the midwives, often providing a sympathetic rationale for the midwives actions. Providing justification for the manner in which the midwife worked has been commented on in few research studies (S.

Davies & Coldridge, 2015; Licqurish & Seibold, 2008), and in this study could be considered testament to the students' defence of members of their profession. The study participants also identified the hospital environment as being stressful both for the midwives and themselves, and saw their close relationship with the midwife as a counterbalance to this.

Some study participants worked with a small number of midwives, often in small regional units, whereas other participants had worked within larger midwifery teams in large tertiary units. Participants in this study who worked in smaller regional hospitals with fewer students requiring clinical placements were more likely to comment that the placement was familiar, the midwives were known and they had many learning experiences availed to them. Participants also commented on knowing the midwives from outside of the hospital locale.

Participants working in large tertiary hospitals appeared to have less flexibility and experienced more difficulties in securing continuity with a midwife. Research by Green and Baird (2009) found that students felt disadvantaged by large cohort numbers (as experienced in big institutions). Given the large numbers of students attaining clinical experience in some major tertiary hospitals, it may be problematic to provide continuity of midwife, but the concept of continuity of placement (and in doing so providing continuity of a small group of midwives) may be possible. The value of continuity of placement concurs with research by Gilmour et al. (2013), Carter et al. (2015) and McKenna et al. (2013) who found that students with continuity of placement also had a deeper sense of belonging.

Participants recognised that some factors that impacted on continuity and belongingness were beyond the realm of the midwife; due instead to management or institutional issues. Organisational difficulties that impact on continuity and belongingness are well recognised in the literature (Gilmour et al., 2013; Kroll et al., 2009; Lloyd Jones et al., 2001; Miles, 2008). While continuity promoted belongingness in the student-midwife relationship and socialisation into the midwifery team and profession, the other major benefit of continuity was the ability to enhance the learning opportunities for the student.

Participants were very aware that midwives were the gatekeepers to the experiences availed to them, and that a positive and knowing relationship with the midwife was necessary in order to attain those learning opportunities (Gilmour et al., 2013; Sidebotham et al., 2015). Participants acknowledged that to achieve and sustain this kind of relationship it was necessary to work with the midwife for a continuous period of time. Continuity with the midwife fostered knowingness (Brunstad & Hjalmhult, 2014; Muleya et al., 2015; Rawnson, Brown, Wilkins, & Leamon, 2009), where student and midwife would firstly get to know each other, leading to an appreciation of student knowledge and skills. Party to this knowingness between student and midwife was the formation of trust, a key component of a positive student-midwife relationship. This concurs with research by Hughes and Fraser (2011) where continuity, confidence and trust were closely linked. Participants acknowledged that once ability and trust were established, and learning needs were identified, learning opportunities were availed and opportunities became increasingly relevant and complex.

While working with known midwives had the benefit of facilitating learning opportunities, the findings showed that working with unknown midwives required time and stifled learning opportunities. Participants found continuity obviated the need to repeatedly build relationships with new midwives which was often at the expense of student learning, this resonates with research by Gilmour et al. (2013) that lack of continuity limits student learning. The unknowingness that exists at the beginning of each new student-midwife relationship interrupted the participant's skill progression, with participants often having to prove their abilities before midwives would provide learning opportunities, which concurs with research by Cherney-Morris (2015). Participants acknowledged the difficulty in attaining learning opportunities from midwives they did not know. Not knowing the midwife or uncertainty in the student-midwife relationship caused students to distance themselves from learning opportunities. This finding is also discussed in research by Brunstad and Hjalmhult (2014). Participants acknowledged that not all midwives were good mentors, and that working with a midwife (even on a continual basis) did not guarantee a positive student-midwife relationship or learning opportunities.

Participants recognised that known midwives were better able to assess and respond to student learning needs and ability. This corresponds to findings from researchers who link continuity with clearer assessment of student ability (Brunstad & Hjalmhult, 2014; Cherney-Morris, 2015; Raisler et al., 2003), assessment of learning needs, and optimisation of learning opportunities (Licqurish & Seibold, 2008). Continuity with a midwife resulted in greater ability to work independently (Carter et al., 2015); however, participants found that higher expectations were also placed on them by the midwife, this coincides with research by Brunstad and Hjalmhult (2014). Continuity also enhanced the participant's ability to assess how the midwife/midwives worked and this aided their relationship and subsequent learning opportunities. Research by Gilmour et al. (2013), where continuity in placement with the same midwives aided student assessment of how individual midwives worked, supports the participants' viewpoint.

The participants recognised the value of continuity in earlier clinical placements where skill acquisition and a sense of belonging were just developing. The value of continuity during early placement periods is supported by research by Hughes and Fraser (2011), Muleya et al. (2015), and Raisler et al. (2003). Participants provided varying viewpoints of the importance of continuity of midwife in latter stages of their degree. Some participants recognised their confidence and competence was sufficient to comfortably work with other (albeit often known) midwives, and in doing so were exposed to varying ways of working. Working with numerous midwives provided the participants with variety in skill and care provision and a smorgasbord of practice options to choose from. These findings are reinforced by Cherney-Morris (2015) and Muleya et al. (2015) who highlighted the importance of working with a small number of midwife mentors in order to gain the benefits of both continuity and variance. Other participants recognised that the knowingness that continuity with a midwife provides enabled them to work in an increasingly independent way. This finding concurs with literature that links continuity to increased learning opportunities and independence (Brunstad & Hjalmhult, 2014; Carter et al.,

2015; Hughes & Fraser, 2011; Rawnson, 2011) and research by Hughes and Fraser (2011) who contended that continuity in latter placements are important for working independently.

Participants recalled the ad hoc nature of some student-midwife allocation which thwarted the opportunity for the student to attain continuity with a midwife. Further hampering the attainment of student-midwife continuity were the work habits of core midwives. The ideal learning environment is one where students would have midwife continuity; yet with a high percentage of midwives who work part-time in New Zealand (MCNZ, 2014) providing continuity of midwife in the institutional setting is problematic. This situation is not confined to New Zealand maternity units and has been previously discussed in overseas literature (Gilmour et al., 2013; Wood, Harben-Obasuyi, & Richardson, 2011). In these situations, continuity for the student could be conceivable with students working consistently with a small group of two or three midwives.

While continuity of midwife in regards to socialisation and student learning was an important and key message to consider in relation to the experience of the student midwife, the other key message is the need to support the midwife.

## Supporting the Midwife

The second key message to arise from the experiential dimensions of the student experience relates to supporting the midwife working within the institutional setting. Support for midwives should address two distinct areas: first, the need to support midwives in their preceptor role and second, to address the hospital culture and working environment of midwives. Improving the working environment of the midwife who works with and orchestrates the experience of the student will ultimately benefit both midwife and student through enhanced workplace satisfaction, a more positive student-midwife relationship, and a facilitative learning and working environment. Supporting midwives to precept students will help address personal and educative barriers that have hindered the manner in which midwives manage their preceptoring role.

In this study, participants worked with many midwives who were skilled at providing an environment in which students were encouraged and nurtured to learn. However, participants also recognised that some midwives simply did not have the necessary skills to work with a student. Participants identified midwives who were reluctant to, and chose not to, precept students, and those midwives reluctantly working with students in a non-supportive way. This concurs with research (albeit overseas based) that shows that the role of the midwife preceptor was not well understood and that not all midwives knew how to mentor students (Gilmour et al., 2013; Green & Baird, 2009; Muleya et al., 2015). Recent changes to preceptor education requirements for midwives in New Zealand may help to address this issue. Requirements for preceptor training for midwives working with students on a medium or long term basis (MCNZ, 2007) have now changed to include all midwives who work with students and assess or provide feedback (MCNZ, 2015). The benefits of training and providing ongoing support to midwife preceptors is discussed in research by  O'Brien et al. (2014) where midwife preceptors who were supported were more satisfied in their role.

It was also apparent to the participants that institutional factors served to constrain the midwife. Muleya et al. (2015), and Hughes and Fraser (2011) revealed that institutional constraints such as the busyness of the ward and lack of support interfered with the ability of the midwife to work with the student. These findings are also evident in the findings from this study. Participants described how staffing shortages, inappropriate skill mix, and high acuity resulted in very busy acute units where midwives at times struggled to cope with an excessive workload. During these periods participants recognised that not only was it challenging for the midwife to provide the necessary midwifery care, but it was very difficult for the midwife to continue to effectively work with a student. Having a student placed extra workload onto a midwife who was often already overworked, this concurs with research by Licqurish and Seibold (2008), Raisler et al. (2003), Kroll et al. (2009) and Cherney-Morris (2015). Participants recalled the disappointment they felt when they saw midwives struggling to deal with a high workload, and when women did not receive the care they deserved.

The participants made comment that midwives seemed powerless to change their working environment and that the challenging situations often stemmed from poor management decisions, and institutional constraints and requirements. To work effectively with students, midwives need an environment that facilitates the provision of midwifery care and that supports the preceptoring of students. Participants identified the need for more training and support for midwives preceptoring students. This finding corresponds with research that identifies the need for more institutional support for the midwife and in her preceptor role (Muleya et al., 2015; Raisler et al., 2003; Richmond, 2006; Steele, 2009; Wood et al., 2011).

Participants had worked in the clinical placements for varying lengths of time, getting to know the midwives and allied staff, and during this time they formed impressions of the units and hospitals in which they had worked. Participants had experienced a variety of institutional climates, ranging from empowering and enabling, to dispirited, hierarchal, and lacking in midwifery autonomy. Some participants made comment on bullying behaviour they identified as occurring within the institution and the effect this had on students and staff. Participants recognised that bullying negatively influenced the working environment of the midwife, affecting student learning, and influenced student's decisions regarding the post-registration place of work. Miles (2008) suggested that students incur the wrath of midwives discouraged by working in an environment characterised by bullying and power games. She recommended that training and support for mentor midwives is a necessity to counter this.

In congruence with the participants' observations, bullying in the midwifery workplace is also widely recognised in the literature (Gillen et al., 2008; Gillen, Sinclair, Kernohan, & Begley, 2009; Hakojarvi et al., 2014; Hastie, 2006; Royal College of Midwives, n.d.). While this literature is overseas based there is evidence of bullying in the New Zealand context; although midwifery specific evidence is scant (Worksafe NZ, 2014). Bullying has been reported in the New Zealand healthcare sector (Bentley et al., 2009), by medical students (Brown, 2015; Tan, 2015, August 5) and nurses (Stewart, 2010). Stewart (2010) suggested that the culture found in New Zealand healthcare institutions support bullying behaviour. Addressing the hierarchical and bullying culture found in institutions has the potential to revolutionise those midwifery workplaces.

In summary, the provision of continuity of midwife or continuity of placement would greatly benefit the student-midwife relationship, student sense of belonging, and optimise student learning opportunities. Likewise, support and resources for midwives working with students would assist midwives to understand and meet the learning needs of students. If support can be provided to midwives to work more willingly and effectively with students then students will benefit from more positive student-midwife relationships and enhanced clinical placement experiences. Attention to the constraints inherent in the institutional workplace is warranted, likewise the unsupportive and challenging culture that exists in some hospitals needs to be addressed. To do so would ultimately benefit not only midwives and students but all healthcare workers and provide a positive workplace and institutional environment.

## Limitations of the Study

I acknowledge multiple limitations in regards to this study – my neophyte status as a researcher, the size of the research study, the recruitment process, and the necessity to limit participants based on midwifery school and clinical placements.

As a novice researcher I acknowledge my inexperience in qualitative research. I recognise that my interview technique reflected my inexperience but this was refined as my research progressed. While I have endeavoured to keep to the methodological requirements of interpretive description research, my ability to capitalise on the rich data afforded to me by the participants is not as developed as that of a seasoned researcher.

There were eight participants involved in this study. This number could be considered an appropriate number of participants for a small interpretive descriptive study (L. Smythe, 2012). It is acknowledged that while this study provides findings based on the commonalities and individual variations found in the experiences of a small number of student midwives, a much larger study would provide greater scope, depth and application potential. Further, the students were recruited through the JDMRC Database Access Governance Group, hence only student midwife members of the NZCOM were invited to participate.

As a core midwife at a tertiary hospital and a lecturer at one of the New Zealand schools of midwifery it was necessary to exclude those students that worked or studied in either context. I am hopeful that those students then affected will identify with the sentiments spoken by the participants, with my interpretation of the data, and with the resultant discussion.

The findings and discussion in this research study are based on interviews with eight student midwives, from no more than three of the four midwifery schools in New Zealand, discussing their experiences of working in many, but not all, secondary and tertiary hospitals in New Zealand. While it is anticipated that the stories told by the participants, and my interpretation of the data would resonate with other student midwives, it is acknowledged that experiences can and do differ and that another researcher's interpretation may differ from mine.

**Implications for Healthcare Institutions**

The findings of research study showed that some situations in clinical placements proved difficult for both students and midwives. To minimise these challenging situations and enhance the student-midwife experience in hospital placements the following recommendations could be considered:

- Judicious allocation of midwives to precept students is organised prior to student arrival
- Continuity of midwife and placement be considered (in consultation with the educational providers)
- The extra time commitment required for midwives to precept students is recognised
- Midwives who precept students are supported through ongoing education
- The factors that constrain the ability of the midwife to provide women-centred midwifery care are addressed
- The institutional culture is examined and a commitment made to address bullying and hierarchical behaviour

**Implications for Pre-Registration Midwifery Education Providers**

An effective interface between pre-registration midwifery education providers and institutions could enhance the student midwife experience. The following recommendations could be considered:

- Facilitating communication of when student presence in clinical placements is expected
- An opportunity for orientation to clinical placements could be timetabled prior to commencement so that students have had an opportunity to familiarise themselves with the staff and environment
- That continuity of midwife and placement be considered (in consultation with hospital management)

**Implications for Further Research**

It is hoped that this research study will become the impetus for further New Zealand based research on the experience of both midwives and student midwives. While this small qualitative research study has provided some insight into the experience of a small group of student midwives, further research could increase knowledge of how, and in what circumstances, students learn. Given the small amount of existing research involving students and midwives in New Zealand, the scope for further qualitative or quantitative research is unlimited. The following research suggestions could be considered:

- Studying the manner in which students learn in clinical placements
- Comparing the learning and experience of student midwives working in varying placement models
- Exploring the experience of core midwives working with student midwives
- Exploring the experience of midwives working in the institutional setting

**Summary**

This small study researched the experience of student midwives working in clinical placements in secondary and tertiary hospitals. The findings of the study identified four experiential dimensions of the student experience. A sense of belonging stressed the importance of being welcomed and wanted in the clinical placements. The student-midwife experience was central to student socialisation into the midwifery profession and to the learning opportunities availed to the student. Participants strove to fit in and belong to the team but in doing so challenged their philosophical and theoretical understandings and beliefs. The opportunity to learn highlighted how watching and doing facilitated student learning. While midwives were the major initiator of student learning opportunities, participants recognised that learning was their responsibility as well. However, not all clinical placement experiences were conducive to learning. While the ideal learning environment was nurturing and supportive, the reality for participants was that, at times, there were factors inherent in the student-midwife relationship and the hospital environment that sought to challenge the student presence. There were midwives reluctant to work with a student and participants felt a burden to midwives. Participants found themselves party to unprofessional behaviour and questionable practice; participants were then confronted with what to do with what they had just witnessed. Confidence was the last experiential dimension discussed in the findings. Participants developed their own self-confidence, and confidence was fostered by working with the midwife and the woman. There were, however, challenges to developing and sustaining confidence.

While the aforementioned dimensions were important findings from the study, the overriding theme that stemmed from the findings was that the midwife was central to the experience of the student. The two key messages of the study, continuity of midwife and the need to support the midwife, require acknowledgement and consideration by pre-registration educational providers and hospital management. Continuity of midwife has the ability to enrich the clinical experience and learning opportunities for the student midwife. Continuity would enable a greater sense of belonging for students and facilitate socialisation into the midwifery profession. Providing support to all midwives in the workplace by addressing the constraints and challenging culture that occurs in institutions would undoubtedly benefit the working environment of the midwives, and the learning experience of students. Supporting the midwife in her preceptoring role would facilitate learning within the student-midwife relationship. By addressing the learning and working circumstances that occur within the institutional setting the midwifery profession has an opportunity to enhance the working environment of midwives and the clinical placement experiences of students.

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# Appendices

## Appendix A: Advertisement

<div style="border:1px solid black; padding:1em;">

# Student Midwives

I am a midwifery lecturer and hospital midwife based in Auckland. I am currently working on my Master of Health Science (Midwifery) degree, and am embarking on a thesis entitled:

## 'Student midwives' experiences of clinical placements in secondary and tertiary hospitals'.

I would like to interview up to ten second or third year student midwives about their experiences. The interview would take approximately 60-90 minutes at a location convenient to you or via electronic means (e.g. Skype). Your participation would be confidential.

Why would this interest you? Most students love to tell stories and share their experiences. The findings of this research study will be shared within the midwifery profession and could be used to enhance future students' experience of working in clinical placements.

Students studying at AUT and those students with clinical placements at Auckland City Hospital are not eligible to participate.

If you are interested in helping me with my research please contact me:

Tracey Rountree

trountre@aut.ac.nz

021 2228644 (AUT mobile)

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# Participant Information Sheet

**Appendix B: Participant Information Sheet**

**Date Information Sheet Produced:**

21.02.2014

**Project Title**

Student midwives' experiences of clinical placements in secondary and tertiary hospitals.

**An Invitation**

I am a midwifery lecturer at Auckland University of Technology and a core midwife based in a tertiary hospital in Auckland. As a student midwife (2001-2) I was party to a wide range of clinical experiences. As a core midwife and university lecturer I am still aware that student experience can differ widely. I am presently undertaking a research study that will explore the experiences of second and third year midwifery students working in secondary and tertiary hospitals. This research study will also complete my Master of Health Science (Midwifery) degree.

Should you decide to participate in this research study your participation would be confidential, and your name, location, school of midwifery and location of clinical placements would only be known to me. Participation in this research study is entirely voluntary. You can withdraw from the study at any time prior to the completion of data collection.

I invite second and third year students from the midwifery schools at Otago University, CPIT and WINTEC to participate. Students at AUT and those students who have had clinical placements at Auckland City Hospital are unfortunately unable to participate in this research study due to possible researcher conflict of interest.

**What is the purpose of this research?**

This research study is in part a requirement for my Master of Health Science (Midwifery) degree at Auckland University of Technology. It is envisaged that the completed research study will be presented at a New Zealand College of Midwives conference or forum, and be submitted for publication in the New Zealand College of Midwives (NZCOM) Midwifery Journal.

**How was I identified and why am I being invited to participate in this research?**

Participation in this research study is entirely voluntary. Midwifery students will have been identified through the NZCOM network, including the NZCOM Student Committee, the NZCOM regional meetings and the NZCOM conference (2014). Students will be provided with the research study information sheet and are invited to contact me (contact details below). If you met the criteria you will be invited to participate. Eight to ten students will be asked to participate in this study.

Students at AUT and those students who have had clinical placements at Auckland City Hospital are unable to participate in this research study.

## What will happen in this research?

The research study involves an interview with me where you will be asked to describe your experiences of working in a secondary or tertiary hospital. It is entirely up to you what experiences or stories you wish to relay. It is envisaged that the interview will take about 60-90 minutes. The interview will be recorded and a transcription of the interview will be made available to you to approve. I will use the stories and comments from all the interviews to find themes and patterns.

## What are the discomforts and risks?

Most students enjoy the opportunity to talk about their experiences. However some experiences can be uncomfortable to discuss. I would hope that you would find the interview a supportive experience and do not envisage that participation in this research will pose any risk or discomfort to you.

## How will these discomforts and risks be alleviated?

It is entirely up to you what experiences and stories you wish to discuss. Should you feel uncomfortable or distressed at any stage of the interview you have the right to stop the interview process. You do not have to give a reason. You also have the right to decide whether any or all of the interview can be used by me in the research study. Should you feel you need to explore your experiences further, counselling is available at student health centres at all the polytechnics and universities of the students involved.

## What are the benefits?

The benefits to you personally will stem from having the opportunity to tell stories and to relay your experiences in a way that suits you. The benefits to the wider midwifery profession are that the findings could be used by both educational institutions and health providers to better understand the student experience.

## How will my privacy be protected?

Interview recordings and transcripts will only be available to the primary researcher, the supervisor and the transcriptionist. The primary researcher, the supervisor and the transcriptionist are all required to protect participant privacy and confidentiality. Your name, school of midwifery, and area of clinical learning will not be identified in any way. Any quotes used in the research study will be attributed to a pseudonym (known only to the participant and primary researcher).

## What are the costs of participating in this research?

The primary cost you is time. You will need to consider whether you wish to participate in the research study. The interview will take approximately 60-90 minutes of your time. The transcripts of the interview will be sent to you to read and change if you so wish. The time taken to this will be up to the individual participant.

## What opportunity do I have to consider this invitation?

I would appreciate an indication from you within 2 weeks of receiving this information.

## How do I agree to participate in this research?

If you agree to participate I will ask you to read and sign a consent form and send it to me (consent form, pre-paid envelope and address will be supplied).

## Will I receive feedback on the results of this research?

A summary of the findings will be available to all the participants. This will be sent once the research study is completed. You can choose not to have the findings sent to you.

## What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Annette Dickinson, annette.dickinson@aut.ac.nz, 09 921 9999 xtn 7337

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

## Whom do I contact for further information about this research?

### *Researcher Contact Details:*

Tracey Rountree, trountre@aut.ac.nz, 021 2228644 (AUT mobile)

### *Project Supervisor Contact Details:*

Dr Annette Dickinson, annette.dickinson@aut.ac.nz, 09 921 9999 xtn 7337

**Approved by the Auckland University of Technology Ethics Committee on 20 May 2014.**

**AUTEC Reference number *14/77.***

# Researcher safety protocol

Title of research: Student midwives experiences of clinical placements in secondary and tertiary hospitals

Researcher: Tracey Rountree

Mode of research that requires researcher safety protocol: Interviews of participants

Dates of research: TBA

Location of research: TBA

Possible risks: Risks to personal safety, safety of belongings

Factors employed to reduce risks to personal safety:

- Provide a list of interview appointments to the primary supervisor including date, time, name, and address of interview
- Take a mobile phone to the interview
- Ensure that the conduct of the interview employs appropriate and culturally safe language and behaviour
- Take AUT identification
- Interview only during daylight hours (if face to face)
- Be sure of exact location of interview
- Contact the primary supervisor before and after each interview
- If the primary supervisor does not receive a communication from the researcher three hours after the commencement of the interview then the primary supervisor must attempt to contact the primary researcher. If the primary supervisor cannot contact the primary researcher than the primary supervisor is required to contact the primary researcher's next of kin to make contact with the primary researcher.
- If the interview is at a private address, ask if there is a dog on site and ensure the   dog is restrained
- If the researcher feels their safety is threatened the researcher will terminate the interview immediately
- To contact the primary supervisor if de-briefing is required post interview. Counselling services also available at AUT

Factors employed to reduce risk to safety of belongings

- Take only the required equipment
- Keep all equipment within sight at all times
- Keep valuables at a minimum and hidden at all times if possible

# Consent Form

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**AUT UNIVERSITY**
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

**Appendix D: Consent Form**

*Project title:* **Student midwives' experiences of clinical placements in secondary and tertiary hospitals**

*Project Supervisor:* **Annette Dickinson**

*Researcher:* **Tracey Rountree**

○ I have read and understood the information provided about this research project in the Information Sheet dated 21.02.2014.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ 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 information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): Yes○    No○

Participant's signature: ...................................................……………………………………

Participant's name: ...................................................……………………………………

Participant's Contact Details (if appropriate):

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…………………………………………………………………………………..

Date:

***Approved by the Auckland University of Technology Ethics Committee on 20/05/2014 AUTEC Reference number 14/77.***

*Note: The Participant should retain a copy of this form.*

**Appendix E: Introductory Letter**

Dear student midwife,

You have received this email because you are a student midwife member of the New Zealand College of Midwives. I am writing to you because I need help with a research project that involves student midwives. My research project is entitled "Student midwives' experiences of clinical placements in secondary and tertiary hospitals".

Please find attached brief information regarding the research, and how you can contact me. If you contact me I will send you further information regarding the research study.

I encourage you to become involved in my research study, and thank you for taking the time to consider my request.

Kind regards,

Tracey Rountree

**Appendix F: Interview Questions and Prompts**

# Questions for interviews (if required)

This research study employs an interpretive descriptive methodology and hence relies on the stories that participants bring to the interview.

It is not the intention of the researcher to enter the interview with prearranged questions.

The participants will be aware (through the recruitment, information and consent process) that the research study concerns clinical placement experience, and that it is the participants' stories of these experiences that I am interested in hearing. I am very keen to allow the participants to shape the interview how they see fit and feel comfortable, however if the participant needs (at some point) a beginning point to start from then I could employ any of the following prompts:

Tell me about (how you felt on) your last shift.

Tell me about (how you felt for) the first ten minutes when you walked onto a ward/unit for the very first time.

Tell me about (how you felt) working with a staff member for the first time.

Tell me about (how you felt) working with staff other than midwives.

Tell me about how staff support you or not.

Tell me about a time when you felt very supported or unsupported.

Tell me about a normal shift.

Tell me about finishing your shift.

How did you feel knowing you never had to return to that ward/unit?

How did it feel working with other students on the same ward/unit?

What did you enjoy the most on your placement?

What did you enjoy least on your placement?

When you described… what did you mean

I'm' really interested in what you just described….

Can you tell me a bit more about….

What did you understand by that…

Why do you think that was like that…